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Consent to treatment post Montgomery - Plus ça change?

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By Stuart Bramley

The law governing consent to treatment, and refusal to consent which is often more important to birthing women, stood essentially unchanged since a 1985 legal case1. Those principles were well summarised by a Department of Health guidance issued shortly afterwards –

> "*Patients are entitled to receive sufficient information in a way they can understand about the proposed treatments, the possible alternatives, and any substantial risks so that they can make a balanced judgement. Patients must be allowed to decide whether they will agree to the treatment, and they may refused treatment or withdraw consent at any time*".

Thirty years later, in 2015, came the Supreme Court case of *Montgomery v Lanarkshire Health Board.* Arguments still run as to whether Montgomery established new principles or simply confirmed and clarified the old ones. It is worth considering the facts.

It is generally accepted that when pregnant in 1999, Nadine Montgomery and her unborn child faced enhanced risks. She was diabetic, 5 foot tall and of slim build, a combination of which the medical experts on both sides in the claim agreed would create a 9-10% possibility of shoulder dystocia. Mrs Montgomery had raised her own worries with her obstetrician that she may not be able to give birth vaginally but did not ask for the precise risks in her case. Her obstetrician was aware of the higher chance of dystocia but felt that if Mrs. Montgomery was told she could ask for an elective caesarean she would choose to have one, which the doctor felt would not be in Mrs Montgomery's best interests.

Shoulder dystocia did occur, but led not solely to Erb's palsy, but also to hypoxia and cerebral palsy due to the length of time the baby was impacted before being freed. Mrs. Montgomery brought a legal claim in negligence based on obstetrician's failure to warn of the risks.

At the Supreme Court she succeeded. Whilst recognising that a doctor, or any other health care provider, is not obliged to discuss risks with someone who specifically asks not to know these, the judgment held that in normal practice the patient (or, in the case of maternity, pregnant or birthing woman) is entitled to be told.

This was a lengthy judgment and it is tempting to quote here numerous comments of relevance by the Law Lords. Much of the verdict seems to simply reflect the old principles – *"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*". However, the Montgomery case is significant because of the way the court defined what is a *"material risk*". Before this, the test had been a purely objective one, and to an extent Montgomery still retains aspects of that – *"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 …"* but the Law Lords then added a subjective test as well – "*…or the doctor is or should be aware that the particular patient would be likely to attach significance to it*".

Arguably this is not the end of the consent story but just the end of the beginning. Opposing lawyers for patients and hospitals will still press for their preferred definitions of *"should be*", "*likely to*" and precisely what constitutes "*significance*". However, a lack of precision has never meant that those affected by poor medical care cannot seek and win legal remedy. Civil claims still revolve around exactly what comprises negligent treatment even though the case which set the test of negligence was heard over 60 years ago (Bolam -v- Friern Hospital Management Committee (1957) 2 All ER 118).

What the Montgomery case has allowed, which can be much more important to people than the chance to bring a legal claim for compensation, is a recognition of the right of birthing people and patients to make and enforce their own decisions regardless of what a *"reasonable patient*" in their position might favour. Women must be informed of what **they** want to know, not what someone treating them thinks they ought to know. Some have argued that this was happening well before Nadine Montgomery attended her antenatal appointments, so it may be argued that the decision comprised the obituary rather than the death knell of medical paternalism. But even if that were true, many AIMS members and supporters will have heard of, or experienced, the 'doctor/midwife knows best' stance, regardless of what the particular hospital's guidelines may have trumpeted about patient autonomy and rights.

This development may be of real interest to women who, for instance, are told that they **must** submit to an induction even where that is not clinically essential. That alone would be a breach of their rights; if as a result of the induction the woman or baby is injured such as by forceps, if the injury is serious enough there may also be grounds for a civil claim for compensation even if the use of the forceps was not itself substandard. Mrs. Montgomery won her claim not because the steps taken to overcome shoulder dystocia were themselves brought to the court as part of the case of negligence, but because she should

never have been in that situation in the first place. The failure to offer a Caesarean**was** the negligence, regardless of the adequacy or otherwise of what happened during the birth itself.

Hopefully the old paternalist attitudes will wither away from a combination of a more compassionate and respectful approach to women's rights, and the rights of patients in other areas of health care, and a bedding-down of the Montgomery repercussions. My fear is that if the situation before the Montgomery decision was to recur in real life, it will instead do so where unexpected, often emergency steps are needed. A mum-to-be may well decline a particular intervention if the pregnancy and intrapartum period are going as planned, but the challenges of birthing can change very swiftly, preventing a full and detailed consent discussion even where the obstetrician or midwife would normally support and want that. The situation is not helped by a widespread misconception about the rights of the unborn child trumping those of the mother (they don't: in summary, women cannot be forced to undergo care just because that is thought to be in the interest of the fetus).

What is likely to remain a grey, and hence dangerous, area is where the treatment is given to a woman without her consent, not because her own views can be overridden but because she temporarily cannot give consent – for instance where an *unexpected* decision not previously outlined in, say, a birth plan has to be made whilst she is under general anaesthetic. Here, Montgomery has changed little. Treatment must be given in the woman's best interests but, if no discussion with her was previously held, best interests defined by whom? The views of family members should be taken into account but ultimately the decision is for the treating doctor – family members, including the baby's father, cannot give or withhold consent on behalf of a patient who temporarily cannot.

It is also worth considering at this point that where a woman has received Continuity of Care from a known midwife or doctor through her pregnancy, who is then also present at her birth, this gives the health care provider the opportunity to understand that specific woman's wishes and needs far better than when she is giving birth with attendants who have never met her. This is safer for women and for the health care provider even though they cannot make consent decisions on the woman's behalf.

But away from the situation of a patient unable to give consent, what Nadine Montgomery has done for pregnant women is a real advance in patient autonomy. How much of an advance? In 1972 the Chinese premier Zhou Enlai was asked about the effect of the French Revolution* and famously replied "*It is too early to say*". I hope the effect of the Montgomery judgment will be clear much sooner than in 200 years' time. Although this is only anecdotal my experience is it is possible that because it was reported much more widely than most legal judgments we are already seeing a greater awareness of the legal requirement to provide information to support informed decision making, and more respect for the decisions of women and other patients who with to enforce their own choices in health.

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(*It was subsequently reported that Zhou was referring not to the events of 1789 but to the student revolt in Paris in 1968. Probably true, but it spoils a great quip.)

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instead represented patients bringing actions against the health service. He specialises in birth claims, particularly involving Erb's palsy injuries and Group B Strep infections, and has many years of experience in advocacy at Coroners' inquests where the patient has died as a result of the care received. Stuart lives in Devon with his wife and twin daughters.

AIMS Comment

It is not clear in the legal documents upon what evidence the medical experts in Montgomery used to obtain the risk of shoulder dystocia (SD) being as high as "9-10%". As a mother with Type 1 diabetes Nadine Montgomery's risk of shoulder dystocia was probably higher than that of a non-diabetic mother with a similar predicted birth weight[2]. This assertion requires more discussion:

The Royal College of Obstetricians and Gynaecologists[3] has stated that shoulder dystocia affects between 6 and 7 out of every 1000 women who give birth vaginally (0.6-0.7%) and that "There is a relationship between fetal size and shoulder dystocia, but it is not a good predictor: partly because fetal size is difficult to determine accurately, but also because the large majority of infants with a birth weight of ≥4500g do not develop shoulder dystocia. Equally important, 48% of births complicated by shoulder dystocia occur with infants who weigh less than 4000g." In other words, it's very hard to tell with any accuracy how big a baby is going to be at birth, most large babies – even if over 4500g (9lb 15oz) - are born without any difficulty, and almost half of all cases of shoulder dystocia occur in babies that weigh less than 4000g. Note that these figures refer to ALL women, and the figures for women with diabetes will be different.

One significant issue is the definition of SD. It has been variably defined as:

1. More than 60 seconds after the birth of the head[4]
2. Birth requiring manoeuvres to release the shoulders[4]
3. Body not being born after the shoulders when the mother continues to push and there is traction (by a birth attendant) on the head[5]

All of these definitions have serious flaws, explained here, which means that being able to quantify the chance of a SD is even harder because there is no clear definition of what one actually is.

Perhaps more helpful is to consider the outcomes for mothers and babies who do experience SD. A Cochrane Review[6] looking at whether induction reduces the chance of an adverse outcome for babies expected to be macrosomic (over 4000g) tells us that of women who had expectant management, 6.8% experienced shoulder dystocia, 3 babies in 1000 suffered nerve damage, and 20 in 1000 had a broken collar-bone (which usually heals quickly). Where labour was induced early, 4.1% had shoulder dystocia, and 4 babies in 1000 had a fracture, but there was no significant difference in any other outcomes. This Cochrane Review does not look at how diabetes might affect the outcomes, however, nor whether well controlled diabetes may make a difference compared to less well controlled diabetes. It also doesn't examine how planned caesarean birth might change outcomes. The huge challenge here is working out the risk profile for individual women and babies – and then working out the best way to deal with those

risks.

AIMS looks at these issues in its new book, "The AIMS Guide to Induction". In this book we show that:

- It is known that predictions of birthweight in late pregnancy have limited accuracy.
- There is some evidence that early induction when a baby has a predicted birthweight of over 4000g (8lb 13oz) might reduce, though not remove, the risk of shoulder dystocia, but the evidence isn't conclusive.
- Mothers with diabetes have a higher chance of experiencing shoulder dystocia, especially if they have one or more other risk factors. In particular, the risk seems to be much higher if the predicted birthweight is over 4500g (9lb 14oz).
- For mothers with gestational diabetes good blood glucose control in pregnancy should help to reduce this risk. It is less clear whether it has the same benefit for mothers with pre-existing diabetes. Even so, we do know that even with well-controlled diabetes the fat distribution on a baby can be altered.

References

1. 1985 legal case: Sidaway -v- Board of Governors of the Bethlem Royal Hospital & Maudsley Hospital (1985 AC 871; 1985 2 WLR 480).

2. An objective definition of shoulder dystocia: prolonged head-to-body delivery intervals and/or the use of ancillary obstetric manoeuvres. www.ncbi.nlm.nih.gov/pubmed/7651656
Acker D.B. et al "Risk factors for shoulder dystocia." Obstet. Gynecol. 66(6), 762–768 (1985). www.ncbi.nlm.nih.gov/pubmed/4069477 and Nesbitt TS et al "Shoulder dystocia and associated risk factors with macrosomic infants born in California." Am. J. Obstet. Gynecol. 179(2), 476–480 (1998) www.ajog.org/article/S0002-9378(98)70382-5/fulltext

3. RCOG Green-top Guide "Shoulder Dystocia", 2012 www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg42/

4. An objective definition of shoulder dystocia: prolonged head-to-body delivery intervals and/or the use of ancillary obstetric manoeuvres. www.ncbi.nlm.nih.gov/pubmed/7651656

5. Shoulder dystocia: incidence, mechanisms, and management strategies www.ncbi.nlm.nih.gov/pmc/articles/PMC6233701/#b5-ijwh-10-723

6. Induction of labour at or near term for suspected fetal macrosomia www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD000938.pub2/full