AIMS For a better birth...

The Montgomery ruling and your birth rights

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Editor's note: The duty of doctors, nurses and midwives to gain the patient's consent for treatment has been enshrined in law for many decades, and bodily integrity or the inviolability of the body, has been a human right for even longer. Yet, we still hear story after story in which well-educated articulate people emerge from maternity care having agreed to treatment they didn't want because they didn't know they had a choice, or because they were afraid to say no. In this article, Emma Ashworth explains a 2015 development in the law that has strengthened the rights of everyone considered as 'having capacity', to make informed decisions about their care. This is followed by three scenarios that allow the AIMS reader to hear exactly how the offer of treatment should sound in practice.



By Emma Ashworth

One of the single most important legal cases that absolutely every birth worker needs to understand is commonly referred to as "Montgomery"[1]. In this case, Mrs Nadine Montgomery brought legal action against the Lanarkshire Health Board in Scotland, and the outcome of the hearing led to one of the most crushing changes to medical patriarchy in British history.

When Mrs Montgomery was pregnant with her son, she mentioned to her obstetrician that she was concerned about her body's ability to safely birth vaginally. Although most women and people in Mrs Montgomery's position would be able to have a safe vaginal birth, she did have a higher chance of experiencing complications than women and people without her medical condition (type 1 diabetes). She is also small in stature and was expecting a baby that was estimated to be quite large, possibly due to the

effect of excess sugar in her body related to her diabetes.

Although Mrs Montgomery raised these concerns multiple times, her obstetrician chose to not discuss the option of a caesarean with her. The doctor was of the opinion that caesareans should not be discussed because then *"everyone would ask for [one]"*.

Unfortunately, Mrs Montgomery experienced a shoulder dystocia during her birth, which eventually led to serious injuries to her and her baby boy.

The Montgomery case made it very clear that it was not acceptable for doctors* to make decisions on behalf of those in their care, but instead they had an obligation to*offer* to discuss:

- Any material risks, as well as possible benefits, to the mother/birth parent and/or their baby of any recommended course of action (for instance, induction of labour)*and*
- The risks and benefits of any reasonable alternatives (for instance, awaiting spontaneous labour/having a caesarean)

**The judgement only refers to doctors, but it is assumed that the courts would apply the same principles to other healthcare providers, such as midwives.*

The discussion must be personalised, taking into consideration what the doctor either knows or reasonably believes is important to that person. For example, they would need to offer to discuss the risks of a caesarean to future pregnancies when talking to someone they know to be, or expect would be likely to be, planning more babies.

Unfortunately, many doctors and midwives have misunderstood Montgomery, and they think that it means that they have to tell women and people all the risks of not accepting offered interventions. This is understandable, because the case was brought against a doctor who did not discuss the possible risks to Mrs Montgomery of a vaginal birth. However – and the importance of this cannot be overstated –***this is an incorrect interpretation of this judgement.***

So, for instance, giving pregnant women and people:

- a list of reasons why home birth may be risky without discussing the risks of hospital birth, or,
- a list of reasons why waiting for spontaneous labour at 41+ weeks may be risky without discussing the risks of induction and the benefits of waiting, or,
- a list of reasons why declining an induction at 39 weeks because of an estimated 'big baby' may be risky without explaining the risk of prematurity or harm from induction…

…is not legal, and does not follow the requirements of the Montgomery ruling.

For these examples, to be acting legally, the doctor must offer to discuss the benefits and risks of all of the options, with special focus on those important to the mother or birth parent, impartially and without bias or coercion.

The pregnant or birthing woman or person *does not have to* take part in these conversations if they are planning to decline an intervention. For instance, if they are intending to birth at home, and therefore decline the intervention of hospital treatment, they do not have to discuss their plans with the doctor unless they want to.

These misunderstandings have somewhat undermined the positive changes that birth activists hoped would come from Montgomery. Despite this, the legal reality is that there must not be any 'decisions about us, without us', and the patriarchal concept of 'doctor knows best' has been clearly and unambiguously shown to not be legally acceptable.

The Montgomery ruling reaffirmed that the only person who can make a decision about their body is the person who owns their body, and in order to make an informed decision, they need to know *"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 court has ruled: Medical patriarchy no longer has any place in maternity care.

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[1] Montgomery v Lanarkshire Health Board (2015, March 11): www.bailii.org/uk/cases/UKSC/2015/11.html.