Coercion or consent?

All patients have the right to consent to, or refuse, treatment, but this can present ethical dilemmas when pitted against medical expertise. Paul Golden examine the legal implications for midwives

The principle of 'do no harm' has been a part of medicine since the Hippocratic oath more than 2000 years ago. Expanded upon by the United Nations' Universal Declaration of Human Rights (1948), this has long been part of English law.

'Bodily autonomy' has been respected in law as a fundamental right including the right to decide who touches or treats a person. In the case of Airedale NHS Trust v Bland [1993], Lord Keith stated that:

> ***'Even when his or her own life depends on receiving medical treatment an adult of sound mind is entitled to refuse it. This reflects the autonomy of each individual and the right of self-determination.' (Airedale NHS Trust v Bland [1993] 1 All ER 821 at paragraph 860)***

The UK Supreme Court case of Montgomery v Lanarkshire Health Board [2015] demonstrated how the courts were willing to uphold women's choices, ensuring informed consent and refusal are respected. Women are experiencing and reporting coercion in childbirth (see 'Women's Voices' Facebook campaign, which has spread to many countries including the US and Italy). This has been named 'obstetric violence', a term that focuses on systemic issues of coercive practices coming from health professionals (Skoko and Battisti, 2018).

There may be a scale of breaches until a tipping point is reached. Not gaining consent to take a pulse or palpate an abdomen can escalate to failing to gain consent for a vaginal examination or instrumental birth. The cases that get to court are representative of a larger number of cases that go unreported, many of which may involve women with depression, anger or other unresolved negative feelings around their birth experience, including post-traumatic stress disorder (PTSD). All breaches are potentially liable in law.

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The role of the midwife in raising concerns about consent

The role of the midwife as advocate as stated in *The Code* (Nursing and Midwifery Council (NMC), 2015) can be compromised by defensive midwifery practice that may be more focused on the midwife keeping their job or registration. However, the NMC *Code* (2015) states that midwives should:

> ***'Balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment.'***

and ensure that they

> ***'Get properly informed consent and document it before carrying out any action.'***

Midwives should raise and, if necessary, escalate any concerns they may have about patient or public safety, or the level of care that people are receiving in any healthcare setting, in line with guidance (NMC, 2015; 2017) and local working practices. If there is coercion or lack of proper information about risks, this needs to be documented, without opinion or emotion, in the woman's notes. Midwives should also record what, if any, action was taken, and if these concerns were escalated (NMC, 2015). If there is a later investigation or case, this will be crucial evidence.

Health professionals with a little legal knowledge can be unhelpful to service users when said health professional states that a newborn baby has its own rights. This is true, but with parents there to make the best decisions for their baby, there is no need for a doctor or midwife to coerce—or worse, to implement safeguarding—unless there is real risk of harm. If so, safeguarding procedures are enacted by court order (unless in emergency, when only treatment that is necessary and no more than is reasonably required may be given). Even in a perceived emergency, giving a medical treatment that is not essential could expose the clinician to the possibilities of legal action or regulatory sanctions.

Intravenous antibiotics are potentially beneficial to prevent life-threatening infections, yet they are still a potent treatment with possible side-effects. These risks must be explained to, and understood by, the woman, to satisfy the requirements for informed consent or refusal. A woman who was coerced into accepting intravenous antibiotics in labour successfully challenged the hospital doctor with the Scottish Public Services Ombudsman (SPSO), which stated that:

> ***'She did not properly consent to the treatment administered and was wrongly put under extraordinary pressure during labour when she was in a very vulnerable situation.' (SPSO [2012])***

Implied acceptance of treatment

Midwifery is such an area of intimate personal care that it is essential to have express consent. Midwives are required to respect bodily autonomy; that is, to touch

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only when the woman has agreed and invited this touch with the awareness and ability to withdraw consent at any time, for example by saying 'stop'. A midwife or doctor may presume that their relationship of trust and confidence with the woman extends to one where they can decide what is best for her, but this could be a breach of the law. Explicit consent is therefore the clearest way to show that the woman has understood and agreed to the treatment or examination being proposed.

In one case at the European Court of Human Rights (ECHR) (Konavolova v Russia [2014]), the court heard how clinical staff had allowed students to practise vaginal examinations and turning the syntocinon on and off while a woman was in labour—all without her consent. The staff argued that they believed the institution allowed it rather than the woman, but the court ruled in favour of the woman, stating that her right to private and family life, according to Article 8 of the European Convention on Human Rights, had been breached. ECHR decisions are lessons for the UK to learn from as the same human rights conventions apply in the UK.

Possible solutions to problems of coercion

Is the problem the way that healthcare staff operate under pressures of time and lacking resources? Under these sorts of stresses, communication, both verbal and non-verbal, can be perceived as threatening or unreasonable by the woman/claimant. The law requires informed consent in maternity care to have a clinician provide clear information that is understood by the woman. For women who do not speak English, this may require professional interpretation, rather than translations by family or friends, as there is no way to be certain that the information was given accurately. This is a particular concern in relationships where a partner or parent says, 'Yes she agrees' when the woman has not. This is evident in the case of Kimberly Turbin, an American woman whose episiotomy was caught on video (Improving Birth, 2017). In the video, Ms Turbin can be clearly heard to say, 'Do not cut me' , while her mother says, 'Go ahead and do it'. As a result, the doctor performed an episiotomy without Ms Turbin's consent, which was captured on video. There then followed a long legal case that was eventually settled in mediation.

The case of Montgomery v Lanarkshire Health Board [2015] showed that risks and benefits of any medical procedure need to be explained, a with special focus on all material (possible) risks being understood. Stating that the baby could die without interventions such as intravenous antibiotics, induction of labour or instrumental birth, without stating the risks of these treatments, is not informed consent. The decision in the Montgomery case aimed to ending paternalistic decision-making by others. The patient decides, or in the case of a baby, the parents decide.

In the case of Hassell v Hillingdon Hospitals NHS Foundation Trust [2017], the claimant maintained that she was inadequately advised of the risks of spinal surgery. During the operation, she suffered an injury to her spinal cord that left her paralysed and permanently disabled. The judge did not criticise the medical skill of the health professionals involved in the case, but maintained that there was a lack of informed consent and refusal, and awarded the claimant £4 million in damages. This case can be applied to a midwifery context: if, for example, a baby has an adverse reaction to a medical intervention such as intravenous antibiotics, after a failure to explain the risks and to gain properly informed consent, this can be actionable with greater financial consequences.

Civil cases affect the employer and may possibly affect the midwife as an employee and registrant. The dilemma therefore is how does a midwife support the mother and baby keep their job and registration? Midwives are required to balance clinical expertise with respecting the woman's right to consent to or refuse treatment, yet the law requires midwives to respect women's informed choices above what is believed to be best clinical practice. This may require a cultural shift and a sensitive use of advocacy skills. Some hospitals, such as St Thomas' Hospital in London, are engaging with mediation services to help parents and staff. Organisations such as Association for Improvements in the Maternity Services (AIMS) and BirthRights will assist staff and families and organisations with informed consent education.

Conclusion

Careful documentation of the consent process, including all material risks, is the only way to demonstrate and effect truly informed consent and refusal. BJM

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