Informing clients of risk: Immediate implications of a landmark supreme court decision

Abstract

In March 2015, the Supreme Court published its decision in Montgomery v Lanarkshire Health Board, a case involving the failure to warn a pregnant diabetic woman of the risk of shoulder dystocia and the possibility of having a caesarean section to avoid this risk. The risk materialised and the baby suffered oxygen deprivation. The lower courts had applied the test for the standard of care that had been in place since 1985, which has been criticised for protecting doctors not patients. The Supreme Court has introduced a new, autonomy-based, patient-centred standard. This article examines the case and explains the importance of the change for future midwifery practice. When disclosing risks, midwives must identify what a reasonable person in the woman's position, with this woman's specific characteristics, would consider a significant risk. They could be held liable for non-disclosure even if the woman does not ask about specific risks.

Keywords: Informed consent, Disclosure, Risk, Law

Louise Terry
Reader in law and ethics
London South Bank University

Maura Deegan
Senior Lecturer
London South Bank University

On 11 March 2015, the Supreme Court handed down its decision in Montgomery v Lanarkshire Health Board (2015) UKSC 11, a case involving the failure of an obstetrician to warn a pregnant woman with diabetes of the risk of shoulder dystocia if she gave birth naturally and the possibility of having a caesarean section instead. The risk materialised and delay in delivering the baby led to oxygen deprivation and subsequent injury. The lower courts had applied the Bolam test standard Bolam v Friern Hospital Management Committee [1957] 1 WLR 582) that has been in place since the House of Lords decision in 1985 in the case of Sidaway. This standard asks what a reasonable competent obstetrician would have told the woman. Over the last few years, this standard has been criticised for being doctor-centred not patient-centred and for failing to recognise patients' rights of autonomy and self-determination (Maclean, 2012). The Supreme Court decision has over-ruled Sidaway and therefore, a new, autonomy-based, patient-centred standard applies with immediate effect. This article provides an overview of the facts of the case itself, the allegation of negligent failure to warn of the risk of shoulder dystocia, and contextualises the risk of shoulder dystocia in light of contemporary research. It explains the importance of the Supreme Court decision for future midwifery practice.

The facts of the case

Nadine Montgomery's son, Sam, was born on 1 October 1999 at a maternity hospital in Lanarkshire, Scotland. Mrs Montgomery is an insulin-dependent diabetic, said to be of 'small stature, being just over five feet in height' (para 6). Consequently, her pregnancy was deemed high-risk so she attended a combined obstetric and diabetic clinic. She was aware that she was carrying a 'larger than usual baby' (para 13) and had fortnightly clinic appointments at which fetal size and growth was monitored. At 36 weeks gestation, her doctor, Dr McLellan, noted that Mrs Montgomery was 'worried about [the] size of [the] baby' (para 17) and indeed had mentioned her concerns 'more than once'. At that appointment, Dr McLellan decided that there would not be a further ultrasound examination at 38 weeks as Mrs Montgomery was becoming anxious about whether the baby could be delivered vaginally. Based on the estimate of fetal weight at 36 weeks, Dr McLellan calculated that the estimated fetal weight at 38 weeks would be 3.9 kg. Due to Mrs Montgomery's small frame, Dr McLellan had decided that a caesarean section would be appropriate if the baby's weight was likely to exceed 4 kg although the customary practice with diabetic mothers was to offer a caesarean at 4.5 kg or above. Dr McLellan was aware that estimations of fetal size carry a margin of error of +/- 10% but ignored this since it would mean 'you would be sectioning virtually all diabetics' (para 16). Despite Mrs Montgomery's concerns about having a large baby, she had not asked 'specifically about exact risks' (para 17). As no specific questions had been asked, Dr McLellan did not disclose the risk of shoulder dystocia; in her opinion, 'the risk of injury to the baby was very slight', therefore it was reasonable to allow a vaginal birth. It was clear that had Mrs Montgomery

requested an elective caesarean section, she would have been given one. Arrangements were made to induce Mrs Montgomery at 38 weeks, 5 days. Dr McLellan later accepted that these extra 5 days should have been taken into account when calculating the likely birth weight of the baby. The birth was induced by syntocinon and labour commenced but arrested, so further hormones were administered. The baby's head failed to descend, so Dr McLellan used forceps. The baby's shoulder became impacted and 'half his head was outside the perineum'. Dr McLellan had never encountered this situation before. A general anaesthetic was administered to Mrs Montgomery in order for a Zavanelli manoeuvre to be carried out and a caesarean to be performed. However, Dr McLellan decided to try to deliver the baby vaginally. She pulled the baby's head with 'significant traction' (para 21) and attempted a symphysiotomy but, as she did not have a scalpel with a fixed blade, the blades became detached before complete division of the symphysis joint was achieved. Eventually, with a 'huge adrenalin surge', Dr McLellan managed to pull the baby free. Twelve minutes had elapsed between the baby's head appearing and birth, during which time, the umbilical cord was 'completely or partially occluded' depriving the baby of oxygen. Consequently, the child has dyskinetic cerebral palsy affecting all four limbs, and injury to the brachial plexus causing Erb's palsy. The court held that these injuries could have been avoided by an elective caesarean section.

Contextualising the risk within midwifery practice

It is estimated that 650 000 women give birth in England and Wales every year and 2-5% of pregnancies involve women with diabetes. Pre-existing type 1 diabetes, as in the case of Montgomery, accounts for 0.27% of births (National Institute for Health and Clinical Excellence (NICE), 2015) and diabetes is associated with significant risk of mortality and morbidity to both mother and baby. Diabetes can be complicated by macrosomia (>4.5 kg) and birth injury is more common in babies born to women with pre-existing diabetes (NICE, 2015). Macrosomia is a risk factor for shoulder dystocia and brachial plexus injury, which is a significant event complicating 2.3–16% of such births (Royal College of Obstetricians and Gynaecologists (RCOG), 2012). The additional oxytocin augmentation and forceps birth in this case increased the risk of shoulder dystocia (RCOG, 2012). There is a wide variation in the reported incidence of shoulder dystocia—between 0.58 and 0.70% (RCOG, 2012).

> "It is estimated that 650 000 women give birth in England and Wales every year and 2–5% of pregnancies involve women with diabetes."

Historically, health professionals practised in paternalistic 'doctors know best' climate; however, this was replaced by the perception that 'bioethicists know best' (Dresser, 1996: 156), which placed a greater emphasis on the rights of patients to be autonomous and informed of risks. Therefore, NICE (2015) recommend that pregnant women with diabetes should be made aware of the small risk of shoulder dystocia. Until the Supreme Court decision, the law lagged behind on this view.

The legal position

In order to claim compensation for avoidable harm, it is necessary for the claimant to prove that she is owed a duty of care which has been breached by act or omission, thereby causing foreseeable harm (McBride, 2012). The issue for the Supreme Court was whether the duty of care had been breached by a failure to disclose the risk of shoulder dystocia to Mrs Montgomery. To establish whether the duty of care has been breached, expert witnesses are called to provide evidence to the court, which the court can consider against the legal test for determination of standard of care. The lower courts had followed the 1985 House of Lords (now the Supreme Court) decision in Sidaway v Governors of Royal Bethlem Hospital [1985] AC 871, which held that when determining how much information a patient should be given regarding the risks of a proposed treatment, the Bolam test (Bolam v Friern Hospital Management Committee [1957] 1 WLR 582) should be applied. This asks what a reasonable, competent doctor would have told the patient. Even at the time, this departed from the patient-centred approach taken in countries like Canada (in Reibl v Hughes [1980] 2 SCR 880) and later in Australia (in Rogers v Whittaker [1992] 175 CLR 479).

In the case of Montgomery, the expert witnesses differed over whether a woman who expressed concerns over her unborn baby's size should be told of the potential risks of shoulder

dystocia (paras 24–5). In addition, the lower courts considered that the relevant question was: would Mrs Montgomery have chosen to have a caesarean section if she had been told of the risk of shoulder dystocia? Mrs Montgomery said she would have asked for a caesarean section if informed of the risk. Despite this, the lower courts held that she would not have elected to have a caesarean since the risks were low and Dr McLellan would have continued to advise a vaginal birth. This seems to contradict the earlier statement (at para 16) reporting that Dr McLellan said she did not disclose the risk because if she did, almost all diabetic women would opt for a caesarean section. Likewise, the lower courts had rejected the argument that Mrs Montgomery's 'undisputed' concern regarding the size of her baby and her ability to birth vaginally had triggered a duty to disclose risks. Finally, the lower courts held that the interpretation of Sidaway by the House of Lords in Chester v Afshar [2005] 1 AC 134 that a reasonable, competent doctor would disclose the risks that a reasonable, prudent patient would wish to know, was not applicable to Mrs Montgomery on the grounds that Ms Chester's neurosurgical operation, the risks of which she later felt had not been fully explained to her, could have been deferred whereas the birth of a baby cannot. Therefore, the Supreme Court had been asked to 're-consider the duty of a doctor towards a patient in relation to advice about treatment' (para 4).

The Supreme Court, unusually sitting with seven judges, carried out a detailed examination of the law of informed consent since 1985 in the lead judgment written by Lords Kerr and Reed (and agreed by four of the other Law Lords, with a separate judgment from Lady Hale, which gave additional consideration to the nature of pregnancy). In Sidaway, it was held that there was no duty to disclose 'unsolicited information about risks', although Lord Scarman disagreed. The Supreme Court paid particular attention to Lord Scarman's approach, which centred on the 'patient's right to make his own decision, which may be seen as a basic human right protected by the common law' (Sidaway v Governors of Royal Bethlem Hospital [1985] AC 871: 882). The judges noted that in recent years, medical ethics has rejected 'paternalism' (para. 81) and sees patients as 'persons holding rights' (para 75); therefore, the notion that disclosure of risks to patients should depend on what a reasonable doctor would disclose is not longer appropriate. In support, they referred to the General Medical Council's (GMC, 2013) *Good Medical Practice,* and interpreted this, and other evidence submitted by the GMC to the court, as meaning that 'the informed involvement of patients in their treatment … is regarded as an integral aspect of professionalism' (para 78) and noted the ease with which patients can now obtain medical information (para 76).

The Supreme Court has over-ruled Sidaway as 'unsatisfactory' (para 86) and set a new test for disclosure of treatment risks. They approved the approach taken in the Australian case of Rogers v Whitaker [1992] saying that it is 'undoubtedly right' that the doctor's duty 'takes its precise content from the needs, concerns and circumstances of the individual patient, to the extent that they are or ought to be known to the doctor' and that the fact that a particular patient did not ask about a specific risk should not mean that the doctor should be exonerated for failing to warn (para 73). The new Montgomery standard of care for disclosure of risk is as expressed in Rogers v Whitaker [1992] so UK doctors and midwives are now:

> ***'…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.'***

The Supreme Court also emphasised the 'advisory role' of the doctor (or midwife) 'involves dialogue, the aim of which is to ensure the [woman] understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives' and 'bombarding the [woman] with technical information' or 'routinely demanding a signature on a consent form' is not sufficient (para 90). Information may, however, in rare circumstances, be withheld from the [woman] if the disclosure of the risk 'would be seriously detrimental to the [woman's] health' (para 88).

This new test provides an autonomy-based, patient-centred approach in line with contemporary medical and obstetric ethics which hold that 'informed consent is foundational to the midwifery model of care' (Thachuk, 2007: 47). Women must be told about all material risks

involved in any recommended treatment and of any alternative or variant treatments, procedures or diagnostic tests. When providing information, midwives should ask themselves: 'What would a reasonable person in the patient's position, with this woman's specific characteristics, consider a significant risk?' They must:

- Consider patient-specific characteristics as well as known facts relating to the risk of the proposed treatment
- Ensure the woman understands the seriousness of her condition and the anticipated benefits and risks of the proposed treatment or procedure and any reasonable alternatives
- Provide information in a way that is comprehensible to the specific patient
- Ensure that they do not abuse the therapeutic exception.

Applying the new test in midwifery practice

Midwives in the UK describe themselves as practising within a 'paradigm of normality' (Scamell and Alaszewski, 2012: 209). This is reflected in Gould (2000), Sandall et al (2009) and Department of Health (2010). However, the ethnographic study by Scamell and Alaszewski (2012) revealed that midwives could only see that normality existed in hindsight, after the events of birth had concluded, and that midwifery activity was orientated not to confirm normality but to searching for the absence of abnormality. This confirms that midwives are usually highly alert to risk. Midwives actively work to engender a trust-based relationship; therefore, the concept of risk and how we communicate risks to our women is a constant topic for debate within the profession (Ahmed et al, 2013; Lee, 2014). Midwives consider how women are likely to perceive the statistical risk, or how likely an event is to occur (MacKenenzie Bryers and van Teijlingen, 2010) and the psychological risk perception, which includes how women feel about risk (Alaszewski and Horlick-Jones, 2003). The study by Lee (2014), which sought to gain risk perceptions in women with high-risk pregnancies suggests that risk perception affects women's attitude towards antenatal care and that they may not perceive risks in the same way as health professionals. It was clear that the lead obstetrician in the Montgomery case perceived the risk of shoulder dystocia to be so significantly small that she chose not to mention it, and that her motive was not malicious: she felt the disclosure would cause anxiety in her client. However, as Saxell (2000) suggests, like many physicians, Dr McLellan presented information in such a way that compliance (a vaginal birth rather than a caesarean) was achieved. It is also evident that had the woman in this case asked about specific risks, she would have been told in detail. Sherwin (1998), in the context of disclosure of risks, discusses the power differentials enshrined in the physician–patient relationship and that this may infringe on the professionals' capacity for determining what the client needs and additionally hamper the patients' sense of validity in any questions they may have. The Supreme Court is clear that liability for failure to disclose risk can occur even if the client has not asked about specific risks.

The constant drive to remember and deliver evidence-based facts and figures in the form of risk-scoring to enable women to make informed decisions is clouded by the notion that divulging risk factors will heighten the anxiety of women to a level which induces fear and lack of confidence in the body's ability to give birth normally (Thachuk, 2007). This leaves professionals open to blame or litigation if that risk was not discussed in depth (Scamell and Alaszewski, 2012). The purpose of risk-scoring systems is to aid, not govern, the development of a plan of care and although they may be effective in predicting outcomes within a diverse population according to Saxell (2000), this is not necessarily the case on an individual level.

The Supreme Court decision means that the default position for midwives is that all risks must be disclosed as it will be difficult to assess what is material to the specific woman in advanced labour if the midwife has met her for the first time. The new Nursing and Midwifery Council (NMC) *Code* (2015, 4.2) states 'make sure that you get properly informed consent and document it before carrying out any action'. Taking on a wider role in relation to informing pregnant women about options and risks may prove challenging as a recent UK study reported that midwives held diverse views about whether they should only provide factual information or discuss the information in depth (Ahmed et al, 2013). Midwives may need guidance on risk disclosure and how to support pregnant women to assess risks, such as amniocentesis (Aune and Möller, 2012), induction of labour (Skyrme, 2014) or safe sleep for babies (Ball, 2015).

The Supreme Court noted that the treatment that doctors (and midwives) offer depends not only on their clinical judgement, but also on bureaucratic matters, such as resource allocation, cost containment and hospital administration: decisions which are taken by non-medical professionals. Whether this will, in future, mean that women should be warned of risks, such as a

Key points

- The Supreme Court has set a new patient-centred, autonomy-based standard of care for disclosure of treatment risks, which requires that patients are made aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments
- Midwives must ask themselves: What would a reasonable person in the woman's position, with this woman's specific characteristics, consider a significant risk?
- Liability for failure to disclose risk can occur even if the woman has not asked about specific risks and the default position will be full disclosure of risks, particularly if the midwife has only just met a woman who is already in labour
- Midwives must not withhold information from women out of concern that full disclosure might psychologically harm the patient or that full details accounts of procedures might cause a client to forego life-saving procedure
- Midwives should respect women's rights not to be informed if they decline to be told about risks but should endeavour to have dialogue with the woman to explore their refusal

shortage of midwives or the absence of consultant cover, remains to be seen. In the light of criticism of midwifery-led units such as Morecambe Bay (Kirkup, 2015), it is likely that disclosure of risks should include poor patient outcomes so patients could opt to attend an alternative birthing centre. In Canada, the informed consent doctrine has been extended to include a duty to disclose the risks of being on a waiting list and the risks implicit in cost-containment mechanisms (Caulfield, 2002).

Conclusions

As the NMC (2012: 7) advises, each UK midwife: 'must make sure the needs of the woman and her baby are the primary focus of your practice and you should work in partnership with the woman and her family, providing safe, responsive, compassionate care in an appropriate environment to facilitate her physical and emotional care throughout childbirth'.

Recommendations

To incorporate the new doctrine on informed consent into midwifery practice, it is recommended that midwives:

- Do not withhold information from women out of concern that full disclosure might psychologically harm her or that full detailed accounts of procedures might cause the woman to forego a life-saving procedure
- Are in a position of advocacy for the woman and therefore will have a duty of care to ensure that risks material to the specific woman are disclosed
- Respect women's rights not to be informed if they decline to be told about risks but should endeavour to have dialogue with the woman to explore their refusal
- Should actively seek out opportunities to facilitate women's understanding of specific risks by identifying examples of risk grounded in everyday experiences
- Negotiate a time-intensive approach to care that will enable the mother and midwife to foster better relationships in an environment where there is openness and honesty, which are essential for full disclosure
- Consider whether some models of care are more appropriate to women's needs for risk disclosure in terms of sensitivity, partnership and continuity
- Engage in research to generate further knowledge in respect to the theoretical and conceptual frameworks of how risk is perceived by professionals and women in light of the Supreme Court decision. **BJM**

Ahmed S, Bryant L, Cole P (2013) Midwives' perceptions of their role as facilitators of informed choice. *Midwifery* **29**(7): 745–50. doi: 10.1016/j.midw.2012.07.006

Alaszewski A, Horlick-Jones T (2003) How can doctors communicate information about risk more effectively? *BMJ* **327**(7417): 728–31

Aune I, Möller A (2012) 'I want a choice, but I don't want to decide' – a qualitative study of pregnant women's experiences regarding early ultrasound risk assessment for chromosomal abnormalities. *Midwifery* **28**(1): 14–23. doi: 10.1016/j.midw.2010.10.015

Ball H (2015) Empowering families to make informed choices about sleep safety. *British Journal of Midwifery* **23**(3): 164–5

Bolam v Friern Hospital Management Committee [1957] 1 WLR 582

Caulfield T (2002) Malpractice in the age of health care reform. In: Caulfield T, von Tigerstrom B, eds. *Health Care Reform and the Law in Canada.* University of Alberta Press, Edmonton:11-36

Chester v Afshar [2005] 1 AC 134. www.bailii.org/uk/cases/UKHL/2004/41.html (accessed 15 June 2015)

Department of Health (2010) Midwifery 2020: Delivering expectations. DH, London

Dresser R (1996) What bioethics can learn from women's health movement. In: Wolf S (eds) *Feminism and Bioethics: Beyond Reproduction.* Oxford University Press, New York: 156

General Medical Council (2013) Good Medical Practice www.gmc-uk.org/guidance/good_medical_practice.asp (accessed 17 March 2015)

Gould D (2000) Normal labour: A concept analysis. *J Adv Nurs* **31**(2): 418–27

Kirkup B (2015) *The report of the Morecambe Bay Investigation*. Stationery Office, London

Lee S (2014) Risk perception in women with high-risk pregnancies. *British Journal of Midwifery* **22**(1): 8–13

MacKenzie Bryers H, van Teijlingen E (2010) Risk theory, social and medical models: a critical analysis of the concept of risk in maternity care. *Midwifery* **26**(5): 488–96

Maclean A (2012) From Sidaway to Pearce and beyond: Is the legal regulation of consent any better following a quarter of a century of judicial scrutiny? *Med Law Rev* **20**: 108–22

McBride N (2012) *Tort Law.* 4th edn. Pearson, Harlow

Montgomery v Lanarkshire HB [2015] UKSC 11 (On appeal from: [2013] CSIH 3; [2010] CSOH 104). www.bailii.org/uk/cases/UKSC/2015/11.html

National Institute for Health and Clinical Excellence (2015) NICE Clinical guideline NG3 Diabetes in pregnancy: management of diabetes and its complications from preconception to the postnatal period. www.nice.org.uk/guidance/ng3 (accessed 17 March 2015)

Nursing and Midwifery Council (2012) Midwives Rules and Standards. NMC, London

Nursing and Midwifery Council (2015) The Code: Professional standards of practice and behaviour for nurses and midwives. NMC, London

Reibl v Hughes [1980] 2 SCR 880. http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/2563/index.do (accessed 15 June 2015)

Rogers v Whittaker [1992] 175 CLR 479. www.austlii.edu.au/cgi-bin/sinodisp/au/cases/cth/HCA/1992/58.html?query=title(Rogers%20%20and%20%20Whitaker) (accessed 15 June 2015)

Royal College of Obstetricians and Gynaecologists (2012) *Shoulder Dystocia: Green-Top Guideline No. 42 2nd Edn*. RCOG, London

Sandall J, Hatem M, Devane D, Soltani H, Gate S (2009) Discussions of findings from a Cochrane review of midwife-led versus other models of care for childbearing women: continuity, normality and safety. *Midwifery* **25**(1): 8–13

Saxell L (2000) Risk: theoretical or actual? In: Page LA (ed) *The New Midwifery: Science and Sensitivity in Practice.* Churchill Livingstone: Edinburgh: 87-104

Scamell M, Alaszewski A (2012) Fateful moments and the categorisation of risk: Midwifery practice and the ever-narrowing window of normality during childbirth. *Health Risk Soc* **14**(2): 207–21

Sherwin S (1998) A relational approach to autonomy in health care. In: Sherwin S (ed) *The Politics of Women's Health: Exploring Agency and Autonomy.* Temple University Press. Philadelphia: 19–47

Skyrme L (2014) Induction of labour for post-term pregnancy. *British Journal of Midwifery* **22**(6): 400–7

Sidaway v Governors of Royal Bethlem Hospital [1985] AC 871. www.bailii.org/uk/cases/UKHL/1985/1.html (accessed 15 June 2015)

Thachuk A (2007) Midwifery, informed choice, and reproductive autonomy: a relational approach. *Fem Psychol* **17**(1): 39–56