

## Exploring the ‘informed’ element of informed consent

A consistent issue across many contemporary reports of failing maternity services in the United Kingdom (Ockenden, 2021; Kirkup, 2022) is the mismatch between the aspirations for informed consent and the reality of how women and birthing people experience the process. Informed consent serves as a central and guiding principle of safe and respectful maternity care, continuing to be referenced explicitly within various iterations of national policy and guidance (NHS England, 2016, 2021, 2023; NHS, 2019). Despite this, these repeated themes of poor informed consent practises negate aspirations towards personalised maternity care and has shone a stark spotlight on disrespectful practices in the UK and across the globe. The aim of this article is to briefly discuss historical context and introduce some key legal cases which underpin the rudiments of what does and doesn’t represent consent, focussing on the ‘informed’ element, contextualised within contemporary maternity practice.

It has been argued that consent, at its simplest, is saying yes (Birthrights, 2017), equally, one could posit, is the ability to say no (Madeley, 2022). Why issues around informed consent continues to present challenges within maternity care is frequently attributed to a multitude of complex factors including (but not limited to) clinicians lack of understanding of key underpinning legal and ethical principles that underlie the informed consent process at varying points along the childbirth continuum, service users being unaware of their rights around consent when accessing maternity care, organisational and systemic challenges such as culture, inflexible guidelines, understaffing, under-resourcing and the influence of a risk avoidance culture (Lanceley, 2022; Watkins et al, 2022). Studies have suggested that power and control dynamics as well as anxiety around the regulatory action and fear of litigation in women and birthing people who withhold consent to care feature in motivations for coercive and obstetrically violent practices, intended to interfere with autonomy in decision making in a system which has an expectation of compliance (Golden, 2018; Feeley, Downe and Thomson, 2021; Madeley, Earle and O’Dell, 2023).

Additionally, exploration of experiences of black and minority ethnic women and those within the LGBTQ+ community highlight how discriminatory and prejudicial care, poor cultural competency and language barriers contribute to poor consent practices (Birthrights, 2022; LGBT Foundation, 2022; Peter *et al.*, 2022). Valid informed consent centres around the three principles of adequate information (appraised of the risks, benefits, reasonable alternatives including doing nothing taking into consideration the test of materiality), voluntariness

(freely given, consent offered by the woman or birthing person, not influenced by others nor coerced in any way), and competence (the woman or birthing person being capable of offering their consent, including the ability to understand and process the information being offered) (HMSO, 2005; NHS, 2022). It is the principle of adequate information that the following discussion seeks to explore.

Faden and Beauchamp (1989) suggest that historically, the fundamentals of informed consent as we understand them in a contemporary context, are a relatively recent development in medical ethics, with increasing emphasis brought about through a series of domestic legal precedents. Two key cases in particular set the legal scene until 2015, for application to issues related to negligence and the provision of information when obtaining consent.

*Bolam vs Friern Barnet Management Committee (1957)* surrounded the case of a patient who was subjected to electroconvulsive therapy in the absence of administration of a muscle relaxant and consequently suffered injury. The Court found the doctor in that case had not acted negligently towards their patient, ruling that if a doctor conducted their care in such a way that might be considered common practice and reasonable supported by a body of similarly skilled peers who would have made a similar decision, then they would not be deemed negligent. The second case, *Sidaway vs Bethlem Royal Hospital Governors (1985)* revolved around the case of a woman who was claiming for damages having suffered a paraplegia resultant of a decompression procedure to alleviate suffering from neck, shoulder, and arm pain. During the consent process, the neurosurgeon failed to advise the claimant that there was a chance of paraplegia, albeit <1%. The Court ruled against the claim for damages, suggesting that providing information that wasn't explicitly sought by the patient would do little more than unnecessarily deter them from undergoing the procedure and that professional judgement should be used to decide what information to provide, that providing information on every risk isn't necessary, suggesting that the duty was to provide sufficient information, and that relied on a professional judgement for the necessity of the intervention, alternatives available and how common serious consequences might be.

Since these rulings, professional standards and national guidance supporting informed consent and decision making have been largely developed to be patient centric in their approach to informed consent (NMC, 2018; GMC, 2020), however it was not until 2015 that the law changed to in line with these publications as a result of the UK Supreme Court landmark ruling in *Montgomery v Lanarkshire Health Board (Montgomery v Lanarkshire Health Board [2015])*. Nadine Montgomery was a diabetic woman who had raised concerns to her obstetricians

of vaginally birthing a large baby, having become aware during scans and subsequent obstetric consultations that her baby was measuring over the 95<sup>th</sup> centile. Despite her concerns she was advised not to worry and was not informed of the chance of a shoulder dystocia. The obstetrician's routine practice was not to advise diabetic women of such risks, her opinion being that in discussing the risk of shoulder dystocia with every diabetic woman they would likely opt for a caesarean birth which she felt wasn't in their best interest. Mrs Montgomery was encouraged therefore to have an induction of labour and vaginal birth which resulted in her son sustaining serious birth injuries and a subsequent diagnosis of cerebral palsy. This case turned the way in which informed consent should be sought on its head, from the "paradigm of the doctor-patient relationship" of Bolam (Bolam v Friern Hospital management committee [1957]) , to that of ensuring the woman remains the central decision maker, preserving their rights to autonomy and self-determination. Indeed, the ruling explicitly stated that "*patients are widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession*" and that steps are taken to ensure that the woman has been made aware of any "*material risks involved in any recommended treatment and of any reasonable, alternative or variant treatments*" (Montgomery v Lanarkshire Health Board [2015]). Key to understanding the application of the Montgomery ruling in relation to information provision relies on that of the test of materiality, that being "*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.*" (Montgomery v Lanarkshire Health Board [2015]). This does not mean, as might appear, or as is frequently observed in clinical practice, that every possible finite risk be discussed with, or provided in writing to women or birthing people to obtain informed consent.

Firstly, material risk requires that a discussion be facilitated to discover what might be important to that person including exploring any alternatives or indeed the option of doing nothing. Such discussions should not be offered as a one-off event, but rather an opportunity to revisit them when necessary, providing opportunities ask questions and consider decisions prior to making them. The ruling also explicitly identified that steps be taken to ensure that alongside information, support be given to confirm understanding of any informed offers (Mordel v Royal Berkshire NHS Foundation Trust , 2019) of intervention or care. Since the Montgomery case, other rulings and reports have continued to clarify issues around informed consent, information provision, ensuring understanding and support for autonomy (Mordel v Royal Berkshire NHS Foundation Trust, 2019; Keh v Homerton University Hospital NHS Foundation Trust, 2019; Wile and Einion-Waller, 2021).

Ensuring that clinicians have a straightforward understanding of the historical and contemporary underpinnings of informed consent can be useful in contextualising key elements of good clinical practice and reinforcing respectful advocacy in informed consent. At its core, informed consent when undertaken appropriately and correctly safeguards not only the autonomy of women and birthing people, protecting other ethical principles such as justice, non-maleficence and beneficence (Beauchamp and Childress, 2001), but effectively safeguards the professional conduct of midwives by fulfilling their duties in relation to their professional code of practice (NMC, 2018). Furthermore, systemic and organisational barriers such as inflexible guidelines and processes that are not conducive to the dynamic nature of ongoing consent can be safely challenged, revised and developed to support personalised and safe care.

What informed consent is	What informed consent isn't
<ul style="list-style-type: none"> <li>✓ A right, protected in law.</li> <li>✓ Required for each offer of intervention or recommendation.</li> <li>✓ Revisited where necessary, especially in the case of signed consent forms prior to a procedure days or weeks before.</li> <li>✓ An ongoing process with the ability of the women or birthing person to change their mind.</li> <li>✓ Actively listening to the woman and birthing person.</li> <li>✓ A process that has a meaningful dialogue seeking from the woman or birthing person what matters to them.</li> <li>✓ The exchanged of personalised and proportionate information related to material risks.</li> <li>✓ Supported by processes to ensure the information is understood.</li> </ul>	<ul style="list-style-type: none"> <li>✗ Always required in an emergency BUT don't assume this.</li> <li>✗ A once only act</li> <li>✗ Set in stone</li> <li>✗ Simply a form.</li> <li>✗ Being asked to 'consent' someone</li> <li>✗ Assuming what information might be needed for that person</li> <li>✗ Assuming what the woman or birthing person might consider significant in relation to material risk, the importance they might attached to the risks</li> <li>✗ A reliance on leaflets to provide information without checking understanding</li> <li>✗ A long list of risks and consequences recorded in notes or handed to women and birthing persons, particularly if withholding consent to treatment.</li> </ul>

<ul style="list-style-type: none"> <li>✓ The ability to have the time to think about the information provided and decide.</li> <li>✓ Freedom to withdraw consent at any point.</li> <li>✓ Free from coercion or manipulation.</li> <li>✓ From an assumed presumption of mental capacity, even if withholding consent to the recommended intervention.</li> <li>✓ The provision of risks, benefits, alternatives, and the option to withhold consent considering ‘what next’ ?.</li> <li>✓ Can be express, implicit, tacit, presumed, verbal, or formally written (Beauchamp and Childress, 2001)</li> <li>✓ Should be recorded in notes.</li> <li>✓ Provided in a format that can be understood including considerations such as language, learning differences, disabilities etc. Consider visual aids.</li> <li>✓ Information where possible focussed on the individual rather than population risk.</li> <li>✓ Respectful of decisions that may differ from expectation, especially where this might have challenging consequences.</li> </ul>	<ul style="list-style-type: none"> <li>✗ Continuing with a particular intervention, process, or treatment when the woman or birthing person says withdraws or withholds consent.</li> <li>✗ Accompanied by discussions by actions that might be considered coercive, manipulative, or threatening.</li> <li>✗ Assuming a lack of capacity if a decision is made that is challenging.</li> <li>✗ Consistently repeating information and risks until consent is obtained if consent is being withheld or withdrawn.</li> <li>✗ Presenting information that has been ‘cherry picked’ to sway a decision.</li> <li>✗ Withholding information</li> </ul>
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