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Consent and caesarean section

M. Dass*

Department of Obstetrics and Gynaecology, The Jessop Wing, Tree Root Walk, Sheffield S10 2SF, UK

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Summary Clinical Governance has ensured that risk management is an integral part of medical practice. All doctors are closely involved in applying legal principles in their daily practice, with the commonest and most important being consent. Consent, patient choice and co-operation are important aspects of health care in relation to decision-making. A patient can either assent to treatment or refuse it, provided he/she is competent. Consent requires the relevant mental capacity, which means that the patient is able to receive information and retain it, believe in it, weigh it up and communicate the decision. This decision must be given freely, without undue duress or coercion from either third parties or health professionals. With the help of two case scenarios, this article illustrates issues that could arise in connection with consent, involving competent pregnant women.

Introduction

English law recognises a patient's right to determine what should or should not be done to their body. The concept of consent to treatment has its root in the autonomy of an individual. There are essentially two areas of law which come into play if consent is not properly obtained: trespass to the person in carrying out treatment without consent, and negligence in failing to give the required information and advice for consent. Treatment without valid consent is unlawful and a health professional may be liable to legal action by the patient and their own professional regulatory body.

Legally it is assumed that adults are capable of self-determination and hence competent to consent or refuse treatment. The decision rests with the patient whether to receive the treatment offered or not. A competent adult patient, by exercising his or her autonomy, has a right to refuse treatment. In most cases this affects only the patient. The case of a pregnant woman refusing treatment raises medical, ethical, legal and social dilemmas. Her unique physical relationship with her unborn child means that this third party is affected by her decision.

Although under British law the fetus has no legal rights, the medical profession has historically favoured the life of an unborn child and/or saving the mother's life over maternal autonomy. This is evident from the number of cases concerning refusal of treatment by pregnant women being brought before the courts.

*Present address: Consultant Obstetrician and Gynaecologist, Barnsley District General Hospital, Gawber Road, Barnsley S75 2EP, UK. Tel.: +44 1226 777 775; fax: +44 1226 202 859.
E-mail address: Meena.Dass@bdgh-tr.trent.nhs.uk (M. Dass).

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Awareness of patient autonomy and changes in maternity care have resulted in women taking an active role in their own maternity management. This has also resulted in unexpected decisions, such as the result of a survey showing that 31% of London's female obstetricians would choose an elective Caesarean section for themselves. So whilst some women are demanding Caesarean section for social reasons, others are refusing Caesarean section and risking their own health and that of their child. Reports of an increasing Caesarean section rate, from 18% in 1997–8 to 22% in 2000–01, have led to more women querying the decision for Caesarean section.

The two case scenarios presented below illustrate issues concerned with consent and competent pregnant women.

Case scenario of refusal of consent

The facts

A Somalian woman in her fourth pregnancy was overdue by 2 weeks and required induction of labour. She did not speak English. After a home visit she was advised of the need for induction of labour. Her husband acted as her interpreter and she refused to be induced but agreed to daily fetal heart recording.

She was admitted a week later in spontaneous labour. Her birth attendant spoke limited English. Halfway through her labour, pathological fetal heart tracing was noted. The need for emergency Caesarean section was discussed with the patient and her attendant. The patient refused the operation. Urgent attempts were made to contact her husband and interpreter. In view of the urgency of the situation, the interpreter spoke to the patient by telephone, but despite the patient understanding the potential implications, she refused to consent to Caesarean section. Meanwhile her husband arrived but would not communicate the recommendation to his wife. He emphatically stated their desire for vaginal delivery as a reason for refusal of Caesarean section. Fortunately, half an hour later, the patient had a normal delivery of a baby boy in good condition.

Legal principles

Communication of information

This was an important issue in this case, where ineffective communication could have resulted in the health professionals being held negligent. In view of her language difficulties, it could be argued that she did not completely understand the information given to her. This issue could have been highlighted at her booking, along with her views on Caesarean section. Her wishes and birth plan could have been documented clearly in her notes. Moreover, communication should have been conducted via an interpreter and not through her husband.

Consent

This patient refused consent for induction of labour, and later for Caesarean section. Her decision was respected because she was competent. Having had three normal deliveries, she wanted a normal labour and delivery for this pregnancy as well. She refused induction of labour, but consented to daily fetal assessment, implying her understanding of the risk post-maturity posed to the fetus.

Similarly, her refusal of consent for Caesarean section was respected. It could be argued that the patient lacked information because of the language barrier, but the facts seem to indicate that she understood the consequences of her decision. The obstetricians did not abdicate their responsibility but continued trying to make her understand their concerns. Good documentation during her labour was an essential part of risk management.

The final outcome of a vaginal delivery with an uncompromised baby was in keeping with the patient's wishes. However, the issue of ineffective communication was of serious concern, and had it been an adverse outcome, the resulting legal action would have been justified.

Discussion

It is hard for obstetricians to stand by and watch the fetal heart rate plummet, but the rights of the mother take priority, as established in law. Moreover, in today's climate, with 70% of medical litigation related to obstetric care, it is hardly surprising that there is a rise in defensive behaviour by the medical staff. This is evidenced by the increased medical litigation bill facing the NHS, which has risen to £2.6 billion in 2001—double the amount for 1997.

In the UK, the Confidential Enquiries into Maternal Deaths report shows that, in general, women from ethnic groups other than white are at twice as much risk of maternal death. Any minority group takes more effort to get noticed. Recommendations have been made for health carers to take all reasonable steps to facilitate