Will the Ockenden report lead to change in how we consent in Obstetrics?

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With the Ockenden report finally published, obstetric negligence is back in the headlines. One of the main concerns in the report was the trusts refusal to grant women's wishes for Caesarean section and their desire to keep caesarean section rates low. These are the same issues raised in the Montgomery case in 2015. Nadine Montgomery successfully sued for medical negligence after her baby suffered severe hypoxic ischaemic encephalopathy following a shoulder dystocia. She had diabetes and the baby was large for gestational age, given these risk factors it was considered she should have been offered caesarean section, and that if she had, she would have opted for caesarean and the injury would not have occurred.

This case clarified in law the appropriate standard for informed consent. Her obstetrician had stated in court that although the patient had asked if there would be any problems with the baby being big, she did not discuss shoulder dystocia and caesarean section, because if she did that with everyone, everyone would request Caesarean. This was not accepted as justification by the court which stated that the patient should have been informed of the risks and benefits or vaginal delivery and offered alternative delivery options. This has led to an overhaul in how we consent women in certain situations, most obviously in those found to have large for gestational age babies, but in other groups (e.g. low risk women) change has been less overt. With the issue of women being refused Caesareans presenting itself again do obstetricians need more clarity on when to offer Caesarean section?

I think there are two key issues that need to be clarified, to whom are Obstetricians discussing risks of vaginal delivery with and when should these discussions be taking place. Addressing the issue of "who", low risk women are not routinely offered a discussion of the risks of vaginal delivery or the option of Caesarean as an alternative. The RCOG states that "Doctors will not recommend a caesarean section unless it is necessary for medical reasons."

However, the standard of consent is not whether Caesarean is "necessary" from a doctor's perspective, but instead if the risks posed by vaginal delivery would be great enough that "A reasonable person in the patient's position would be likely to attach significance to the risk". This level of risk was reached in Montgomery but not in other cases such as Mrs A *v* East Kent Hospitals University NHS Foundation Trust, where the risk was the same as background risk. This may support not routinely discussing caesarean section with low-risk women, but when a low-risk woman requests a caesarean the position is clear "For women requesting a CS, if after discussion and offer of support a vaginal birth is still not an acceptable option, offer a planned CS" .

Essentially this creates a situation where women already aware of some of the risks are being provided with appropriate information and given choice, while the most vulnerable women who may not be aware of the risks are not. Is this unjust?

The second issue of "when" is more complicated. Antenatal counselling is common practice and easily done, but this is more difficult when the patient is in labour. Labour management is extremely dynamic with constantly evolving and sometimes unpredictable risks with limited staff and theatre availability. It is relatively common for a woman with a low-risk pregnancy who has never previously raised the issue to request a Caesarean in labour where there is no medical indication to perform one. These women have capacity and a right to autonomy and Ockenden affirms that their wishes should be respected. However, this can be extremely difficult for an obstetrician with limited resources. Is it appropriate to take a woman with no medical indication for a caesarean to theatre, when this could delay an emergency caesarean to prevent harm to another woman or a baby? Do they have a risk or regret? Guidance around maternal requests caesareans in labour would be useful and may provide support for resources to be increased to be able to accommodate this safely.

Similarly, women who were low risk at the onset of labour frequently develop risk factors as the labour progresses (e.g. the presence of meconium or infection). In the concluding statements of the Montgomery ruling, it is stated that the doctor should offer the pros and cons of each delivery option in "any case where either the mother or the child is at heightened risk from a vaginal delivery". Therefore, although it may not be unreasonable that they have not had delivery options discussed antenatally, as their risks increase in labour, should they be discussed and offered Caesarean at this point? There is no evidence for example to support Caesarean for meconium alone, but the risk is higher than the background risk. Difficulties with resources aside, would this be seen as clinicians offering treatments due to legal considerations rather than in the patient's best interests.

Thankfully Caesarean section rates are no longer to be used to measure a unit's performance, as this is clearly a hurdle to supporting a women's choice for Caesarean Section. However further clarification is needed in regard to when this choice is to be overtly offered. As the cases above clearly demonstrate if the doctor is no longer to decide at what level of risk to offer caesarean, and a patient's belief that a risk was significant enough they should have been offered one is not supported in court, who is it that is deciding? With a lack of guidance is a situation where a judge is required to give clarification on whether a risk was significant after the fact, appropriate for a high-pressure emergency specialty?

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