MEDICAL MALPRACTICE

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INFORMED CONSENT IN THE OBSTETRICAL CONTEXT: DO WOMEN HAVE A RIGHT TO CAESAREAN SECTION?

The issue of patients' rights with respect to their medical decisions is always an important consideration, but one that does not often get a lot of attention. Our society, as a whole, has a great respect for the medical profession. Part of that respect is a recognition that physicians have more extensive and much deeper knowledge of medical issues and treatments than the general public. As a result, patients very frequently defer to their physicians when making medical decisions and will proceed with whichever treatment option the physician recommends. The consequence of this is that a patient's rights to make contrary decisions are rarely considered in depth. The rights do exist, however, and physicians must abide by established rules when discussing medical treatments with their patients.

The law has long recognized individuals' rights to self-determination. A core part of that right is a right to accept or refuse medical treatment. Battery is the "unprivileged and unconsented to invasion of one's bodily security" (*Reibl v Hughes*, [1980] 2 SCR 880). The provision of medical treatment without consent is battery. So long as a patient has capacity, he or she must give consent (free from coercion or undue influence) to any medical treatment before it can be provided. A claim in battery will arise even if there is no subsequent injury. A plaintiff must simply prove that he or she did not consent to the treatment provided. Battery cases arising from medical care rarely appear among reported cases.

Consent in the medical malpractice context, however, extends beyond simple consent and battery. In medical cases, consent must also be "informed". The theory behind the informed consent doctrine is that, in order for patients to make a meaningful decision about their medical options, the information imbalance between physicians and patients must be addressed. Physicians have an obligation to inform a patient of the nature of his or her condition, as well as the risks and benefits of the proposed treatment and alternatives (*Brodeur v. Provincial Health Services Authority*, 2016 BCSC 968). All material risks of a treatment option must be disclosed. This includes all risks that "a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to… in deciding whether or not to undergo the proposed therapy" (*Hopp v. Lepp*, 1980 CanLII 14 (SCC)). Material risks includes risks of complications that are likely to occur and risks of complications that are rare but have serious consequences (such as paralysis or death). In their discussions with patients about the risks and benefits of the proposed treatment, physicians must also disclose to their patients the alternative treatments.

The informed consent doctrine is part of the law of negligence. To succeed in an informed consent case, the plaintiff must prove that the defendant owed a duty of care to the plaintiff, that the defendant breached the standard of disclosure, that "but for" the failure to obtain informed consent a reasonable person in the patient's position would not have gone ahead with the procedure/treatment, and that the procedure/treatment caused the plaintiff's injury. The procedure/treatment itself need not have been performed negligently to succeed in a claim based on informed consent.

Physicians are expected to know exactly what risks, benefits and alternatives are relevant to the treatment in question and will discuss it all with their patients before recommending one option or another. In some circumstances, however, the line between what alternatives must be discussed/offered and what treatments are beyond the realm of required disclosure can become quite controversial. One great example of this is childbirth.

The Society of Obstetricians and Gynecologists of Canada (SOGC), the professional body that sets guidelines for practicing obstetricians, released a Committee Opinion statement last year making it clear that informed consent must be obtained in the obstetrical realm (**No. 361 – Caesarean Delivery on Maternal Request** July 2018, Volume 40, Issue 7, Pages 967-971, Eman Alsayegh, MD - Toronto, ON, Hayley Bos, MD - Victoria, BC, Kim Campbell, RM - Vancouver, BC & Jon Barrett, MD - Toronto, ON). Caesarean section births are on the rise, and twenty-eight percent of the babies born in Canada in 2017 were born via caesarean section (-p. 968). As more women opt for

caesarean sections, there has been significant controversy over whether physicians are required to provide elective caesarean sections with no medical indications (-p. 968).

There are situations where vaginal delivery will carry a higher than usual risk and physicians will recommend a planned caesarean section. These can include positional issues with the baby, multiple pregnancies, infections or medical concerns with the mother, scars from previous abdominal surgeries and babies showing signs of distress. Under these circumstances, the physicians are expected to outline the risks and benefits of vaginal birth and the risks and benefits of caesarean section. The patient then has a choice (with a physician likely making a recommendation). When there are no medical indications for caesarean section over vaginal birth, some physicians believe they need not offer elective caesarean sections to their patients. Often the underlying rationale for this belief is that caesarean section, like any other surgery, carries risks (including infection, blood loss, cardiac arrest, respiratory issues for the baby, reactions to anesthetic). In addition, consideration must be given to utilizing limited resources for an elective procedure when those resources are simultaneously in demand from patients with medical issues on waitlists for corrective surgeries.

However the law is grounded in values such as personal autonomy and self-determination. The law protects a woman's right to make her own medical decisions and accept or reject medical treatments. Those who advocate for a woman's right to elect caesarean section without medical indication can base their arguments in the legal respect given to autonomy for other medical decisions and question why this would not extend to methods of childbirth.

Vaginal birth is not without risk. Vaginal deliveries carry a higher risk of pelvic floor damage and postpartum hemorrhage in the mother. Also, there are risks to the baby from a variety of causes which, if not treated immediately, can lead to brain tissue death. Importantly, in addition to consideration of any risks, women have a fundamental right to control what happens to their bodies.

The law requires physicians to discuss the proposed treatment, its risks and benefits and any reasonable alternatives with their patients. It does not matter, legally, if the physician disagrees with the patient's choice or believes that a different treatment would be safer, cheaper, or more beneficial. If the patient's choice is one of the reasonable treatment options, he or she is entitled to make that choice and the physician cannot impose his or her recommended treatment. Yet, somehow, obstetrics is an area in which this informed consent process has historically been lacking. In the past, it has been acceptable to refuse a patient's request for a caesarean section if it was not, in the doctor's opinion, medically necessary. This practice, however, is slowly changing (Stechyson, Natalie, **'Pregnant Women Have The Right To An Elective C-Section To Avoid Vaginal Birth, Doctors Say'**, https://www.huffingtonpost.ca/2018/06/27/elective-c-section_a_23469591/).

The obligation of the medical team (doctors, nurses, midwives) is to communicate to their patients, in an understandable way, the risks and benefits of both planned caesarean section (for non-medical reasons) and of attempted vaginal delivery. The discussion of risks should include both common risks (i.e. pain after delivery) and rarer, long term consequences (brain damage, death, complications in future pregnancies, etc.).

The SOGC points out that there are currently no studies comparing the safety to mother and baby of these two methods of delivery. Studies have been done on the safety of caesarean section versus vaginal delivery but this data includes the risks associated with all caesarean sections, including those done on an emergency basis for medical crises. Some of the information from existing studies can aid in the risk/benefit discussion, but the inclusion of emergency caesarean sections in the studies likely results in higher numbers of poor outcomes from caesarean sections. What is needed are studies which only include caesarean sections that were done at the mother's choice, without medical reasons to choose caesarean section over vaginal delivery (-p. 698).

The SOGC is clear that the discussion about elective caesarean section should be focused on the individual patient. Medical professionals should not assume that all people place the same value on the mode of delivery. They have an obligation to provide up-to-date, evidence-based information and the risk/benefit discussion needs to take into account their patient's values, beliefs and individual needs. The physician/midwife is required to explore the patient's reasons for the request, fears and concerns. The discussion should be culturally appropriate and the physician should respect cultural differences (-p. 967, 970).

Without diminishing the importance of medical professionals offering medical recommendations for the appropriate mode of delivery, the SOGC mandates respect for the patient's autonomy. The mode of delivery is not to be imposed by a physician. The patient must agree with the planned method of delivery without bias or coercion. Physicians are not obligated to perform a caesarean section if they are not comfortable (for medical, ethical or other reasons) with the decision to proceed with this method of delivery. If a patient requests a caesarean section, however, the physician must either perform it, refer the patient for a second opinion or transfer her care to another physician. Physicians may not simply refuse to perform a caesarean section and force the patient to have a vaginal delivery (-p. 971). V