

Informed Consent Challenges in Obstetrics

by Elizabeth J. Buechler, MD

Dr. Buechler practices obstetrics and gynecology at Harvard Vanguard Medical Associates and is Chair of the CRICO/RMF Obstetrical Providers Guidelines Committee.

The ethical purpose of informed consent is to reinforce patient autonomy.¹ A collaborative informed consent process demonstrates respect for the patient and the patient's right to decide what medical interventions are appropriate. The optimal consent process occurs over time in which the medical provider and the patient discuss the proposed actions, risks, benefits, and alternatives. The process requires disclosure of pertinent information, comprehension by the patient, and voluntary agreement.

Obstetrics, however, brings some unique challenges to informed consent. During the antenatal period, obstetrical providers and patients should discuss the patient's plans and desires for the childbirth experience (*see* Fein, page 11). Each discussion should also include an explanation of obstetrical interventions that might occur, many of which are neither planned nor desired (e.g., vacuum extraction, cesarean section). With the wide variety of possibilities, a detailed discussion of the risks and benefits of each one is not practical or desirable. A written consent form should acknowledge a diverse discussion and formalize the patient's consent for care and treatment during labor and delivery. An example is in the appendix of the CRICO/RMF Clinical Guidelines for Obstetrical Providers.²

Too Much or Not Enough

Given that a full discussion of all the possible actions is impractical, a number of questions arise.

- How much information *should* be provided in the antenatal period and how do patients view this consent?
- Can the laboring women, in pain, exhausted, distracted, and (frequently) medicated give true informed consent?
- What is the role of the partner, doula, or other support persons during the labor?
- What happens when the wishes of the mother have the potential to adversely affect the fetus?

Little scientific study has been devoted to determining how much information a woman should receive about possible interventions during labor. Many believe that excessive focus on possible complications and treatments can increase anxiety. Others propose that women would rather have detailed information so that they are less fearful of potential unknown complications. A 1999 study of nulliparous patients in spontaneous labor at term sought to identify what factors contributed to a positive labor experience.³ The patients in this study reported

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But how much of the consent discussions is recalled and how do patients view the consent process? Unfortunately, patient recall of the details of a consent form is likely to be low. A study related to transfusion⁴ showed that most patients remembered signing a consent form (80 percent), but a majority did not remember having a discussion of transfusion risks. Recall was improved for

those patients who received written information in addition to oral discussion. A second study questioned 732 patients who had undergone obstetric or gynecologic surgery in the preceding year.⁵ One in 10 patients reported not knowing what she agreed to at the time of written consent; 40 percent reported that they only signed the form so they could get their operation. Three-quarters of patients *did* report that signing the consent helped make them aware of risks of their operation. These studies highlight the importance of providing an antenatal patient with a written summary of potential events and risks. Repeated conversations covering the important aspects of labor care may help increase recall.

Studies of a woman's capability to assess risks while in labor are rare. The majority of studies concerning the quality of informed consent in labor are recorded in the anesthesia literature, evaluating women's competence in giving consent for an epidural. A small (82 women) study in 1988 indicated that patients had reasonable recall of the consent process.¹⁻² Only two women felt, retrospectively, that they were unable to give valid consent. A second study of 60 actively laboring women assessed understanding of epidural risks after the request for epidural but before pain relief.⁶ The authors concluded that the ability to understand risks was not affected by pain, anxiety, opioids, or duration of labor. Based on these and other studies, we can conclude that laboring women are able to provide competent consent and should be engaged in ongoing discussions of medical events and proposed interventions, risks, and benefits.

Labor Support

The role of the other participants in labor support may be a challenge to the clinician. The partner or doula may be disturbed by deviations from the original birth plan and, on occasion, may try to interfere with decision making of the patient. To minimize this type of conflict, the obstetrical clinician, patient,

and partner (or other support person) need to address this during the antenatal period. The clinician should confirm that the patient is the person best able to make a decision about the conduct of childbirth and that those decisions may change based on the reality of the labor. Medical providers and labor support persons all need to acknowledge the patient's right to autonomy and decision making during labor.

Mother or Child?

Conflict between the needs of the baby and the mother is rare, but is one of the most challenging and difficult situations faced by obstetrical providers. Both the American College of Obstetrician-Gynecologists (ACOG) and the American Academy of Pediatrics have issued statements reviewing the ethics of intervention when a pregnant woman declines care that the obstetrical providers believe to be critical to good fetal outcome. The ACOG document mentions three basic choices for the care providers: 1) agree to respect the patient's decision making; 2) decline to participate further and transfer care to another provider; or 3) seek intervention of the courts.⁷

An anecdote provided by a practicing obstetrician may illuminate the issues more clearly. Several years ago, a colleague reported a difficult situation. While covering the hospital for his group practice, a patient he had not met was admitted in labor. The fetal tracing was concerning and he recommended an urgent cesarean section. The patient refused. About two hours later, he delivered the baby vaginally. The baby was depressed at birth and ultimately died. My friend was very distressed by this situation.

Two years later, I met a woman in a social setting who told me about her difficult experience in childbirth. Two years previously, she had been newly arrived in this country with limited English skills. Her cultural background made dealing with a male clinician very difficult. Her labor was premature and her husband was out of town. A male physician, whom she had never met, came into the hospital room when she thought all was going well. He insisted on a cesarean section. Surprised, confused, upset—and not understanding that the baby was really at risk—she refused. I recognized her story, an unfortunate confluence of failed communication, different cultural expectations, language constraints, and perhaps impatience on the part of the care provider.

This anecdote demonstrates many of the issues that may contribute to conflict. Almost all women are willing to accept medical interventions to improve the fetal outcome. Careful explanation, cultural awareness, and sensitivity to the patient's concerns will usually help the care team through these challenges. In the event that a simple resolution cannot be reached, the obstetrician should attempt to explore other, mutually acceptable, resolutions. Consultation with an ethics committee may be helpful, if time permits. If resolution can still not be achieved, most clinicians would agree that the patient is ultimately entitled to refuse intervention for herself and her child.

To minimize the risk of "uninformed" patients, the process should start during the antenatal period via formal discussions and written consent. At that time, the obstetrical providers should explain potential procedures and review their general approach to childbirth, while asking about the patient's preferences. Once the labor is underway, the clinicians should continue to provide information in a clear manner, offering alternatives. When challenged by the patient or her support persons, the clinician needs to remain calm and work to diffuse hostility, which often arises from fear and anxiety. Luckily, in the majority of cases, the interests of the mother and the interests of her unborn child coincide. ■

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