Troubling consent: pain and pressure in labour and childbirth

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Introduction

In *Montgomery v Lanarkshire Health Board*[1] the United Kingdom Supreme Court confirmed the importance of autonomy and communication in healthcare decision-making, and emphasised that pregnancy does not dilute the legal protections available to an individual. It is well-established that informed consent is the principle mechanism through which autonomy is protected in the healthcare context and this legal principle is reflected in professional and clinical guidance, including those related to the provision of maternity care.[2] Standard maternity care in the UK includes obstetric vaginal examinations to monitor the progress of labour[3] as an element of ensuring safe births for women and babies.[4] The NICE Clinical Guidance on "Intrapartum Care for Healthy Women and Babies"[5] states that women should be offered vaginal examinations if the clinician is of the opinion that the examination is necessary and will add useful information to the decision-making process.[6] The Guidance document also emphasises the importance of obtaining informed consent from the woman; ensuring her dignity, privacy and comfort is respected; explaining the reason for the procedure and what is involved to her; and communicating the outcome of the examination to her and any impact that may have on her birth plan.[7] However despite this clear emphasis in law and clinical guidance on the importance of consent, some women are experiencing unwanted vaginal examinations during labour and childbirth. The circumstances in which this occurs may vary,[8] but the focus in this paper is on the impact of pain and pressure in labour on the validity of consent.

The paper will begin by briefly locating the discussion of consent, pain and pressure in labour within the broader legal context in the United Kingdom. The paper is primarily grounded in case-law on consent and treatment refusal involving pregnant women, but there is no existing

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[1] [2015] UKSC 11.

[2] See Royal College of Obstetricians and Gynaecologists, *Obtaining Valid Consent: Clinical Governance Advice No. 6,* January 2015; Royal College of Midwives, *Evidence Based Guidelines for Midwifery-Led Care in Labour: Assessing Progress in Labour* (2012).

[3] For further detail see discussion in "Non-Consented Vaginal Examinations: The Birthrights and AIMS Perspective" in this volume.

[4] The terms "woman" and "women" are used throughout this article while recognising that *trans and non-binary people can become pregnant, and so these terms are intended to include all those who may become pregnant and require care during labour and childbirth. The term "baby" or "babies" is used, rather than foetus, to reflect that for most women who have carried a pregnancy to term and who are in labour that is generally how they think about and speak of the foetus. This is also usually the terminology used by those who care for women in labour and childbirth.

[5] [CG190, 2014, 2017].

[6] Para 1.4.5.

[7] Para 1.4.5.

[8] See discussion on 'implied consent' in Herring 'Implied Consent and Vaginal Examination in Pregnancy' and on forced vaginal examinations in Pickles 'When ''Assault'' is not Enough: Unauthorised Vaginal Examinations during Labour and the Crime of Battery' in this volume.

body of case-law on vaginal examinations and treatment refusal in labour, which indicates that these issues are, to date, being addressed (or not) in locations outside of the courts. Part I will outline the interconnectedness of pain and pressure and highlight the role of *Montgomery* in normalising the pregnant subject. Part II will focus on decision-making in labour and childbirth and will seek to trouble the current binary model of consent which struggles to accommodate the pregnant woman in labour who does not neatly fit within the existing binary framework. This discussion will briefly refer to the existing narratives and stereotypes of pregnant women, illustrated by the enforced caesarean section case-law, which further complicate the recognition of women's autonomy in labour and childbirth. At the centre of Part II is a discussion of *ML v Guy's and St Thomas' National Healthcare Foundation Trust,*[9] where the High Court considered the impact of pain in labour on decision-making in the context of a request for a caesarean section. The paper will conclude with reflections on the need for a more flexible model of consent, one which stretches the temporal context, if the recognition of autonomy for pregnant women in labour is to be meaningful. It also acknowledges the challenges and risks associated with the suggestions put forward.

Part I: Consent

Consent to any healthcare treatment or intervention must be voluntary,[10] informed[11] and provided by someone with decision-making capacity.[12] The absence of any one of those elements will vitiate consent.[13] The courts have acknowledged that pain (unrelated to labour) can have an impact on the capacity of a person, and therefore on the validity of consent. In *Re T (Adult: Refusal of Medical Treatment)*[14] Lord Donaldson stated that a person may be

[9] [2018] EWHC 2010 (QB).

[10] This principle was reaffirmed in *Freeman v Home Office* [1984] 2 WLR 802 (CA). In this case the trial court and the Court of Appeal rejected claims that the plaintiff had been physically restrained and had medical treatment forcibly imposed on him in prison. The Court of Appeal did however accept that some situations, including a prison setting, would require a closer examination of consent to establish voluntariness.

[11] In *Montgomery* the approach of the law to information disclosure was characterised as one which recognises patients as adults who are capable of understanding that medical treatment contains certain risks, who accept responsibility for taking risks which affect their own lives, and who then live with the consequences of those decisions (para 81). The Supreme Court set out the test for informed consent in the following terms "[a]n adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in 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." (para 87)

[12] It is a core principle of medical law that an adult with capacity has an absolute right to consent to or to refuse medical treatment. This is the case even if the decision, for example to refuse treatment, will lead to the death of the patient. This has led Donnelly, in *Healthcare Decision-Making and the Law: Autonomy, Capacity and the Limits of Liberalism* (Cambridge University Press, 2010) at p. 90 to describe capacity as the "gatekeeper for autonomy."

[13] For a more detailed discussion on the moral and legal underpinnings of consent see Herring, 'Implied Consent and Vaginal Examination in Pregnancy' in this volume.

[14] [1992] EWCA Civ 18.

deprived of capacity or have it reduced "by reason of temporary factors, such as unconsciousness or confusion or other effects of shock, severe fatigue, pain or drugs being used in their treatment."[15] This can be contrasted with *NHS Trust v T*[16] where the court adopted a more absolute approach and stated that only where confusion, shock, fatigue, pain or drugs "completely erode capacity" should it be found that there is no consent. The Irish Supreme Court in *Fitzpatrick v White*[17] also recognised that pain or stress can have an impact on the ability of a person to fully comprehend and make an informed decision on a proposed medical intervention.

Interconnectedness of pain and pressure

For the purposes of this paper pain and pressure, and their impact on decision-making in labour, will be considered together. This is because they are interconnected – the presence of pain can make someone more susceptible to pressure or "heavy duty persuasion."[18] The links between pain and pressure were recognised in the Court of Appeal in *Re T.* This case involved the refusal of a blood transfusion by a young woman who had been brought up by her mother as a Jehovah's Witness, although she not been practicing her faith prior to her illness. She signed a written refusal of a blood transfusion[19] following a number of visits from her mother, who was a devout Jehovah's Witness. However, prior to signing the refusal form she had also sought reassurance from the clinical staff that alternatives to blood products were available.[20] While the Court of Appeal upheld the right of a competent patient to refuse treatment, even life-sustaining treatment, on the facts the court found that the right did not apply for reasons of undue influence,[21] her weakened and medicated state, and a failure of the medical staff to provide her with accurate information.[22]

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[15] Para 27. However, while pain was a factor in this case it was not relied on to find that the consent of the young woman in *Re T* was not valid. While the pain may have been a contributing factor to her will being overborne by her mother, the court was more focused on the pressure and undue influence that had been applied.

[16] [2004] EWHC 1279.

[17] [2008] 3 IR 551, at 565 the Court considered that "[t]here are obvious reasons why, in the context of elective surgery, a warning given only shortly before an operation is undesirable. A patient may be stressed, medicated or in pain in this period and may be less likely for one or more of these reasons to make a calm and reasoned decision in such circumstances." On the facts the court found that there was no evidence that the plaintiff had been affected in any of the ways outlined above and so the timing of the warning and disclosure was not found to be a breach of the duty of care.

[18] Scott, *Rights, Duties and the Body* (Hart, 2002) pp. 236-45 makes the case for persuasion as a mechanism to deal with treatment refusal by pregnant women, and suggests the use of "sympathetic discussion and counselling" (p.375). At p. 243 she argues that in relation to pregnant women who refuse treatment "heavy duty persuasion" should only be used in circumstances where the treatment being refused "does not involve significant pain or risks" and where the reasons for refusal are "insufficiently serious", "trivial", "irrational/inappropriate and purposeless" or "non-existent."

[19] In circumstances where the full consequences of that action were not clearly explained to her.

[20] She was also advised by hospital staff that the likelihood of her requiring a blood transfusion was very low.

[21] The undue influence was exercised by the young woman's mother. Lord Donaldson stated "the influence of her mother was such as to vitiate the decision which she expressed." (para 22).

[22] The issue of undue influence has rarely come before the courts in the medical context since *Re T*. One such case is *Mrs U v Centre for Reproductive Medicine* [2002] EWHC 36 (Fam). This involved the applicant seeking to

Lord Donaldson noted that the strength of will of the patient is of crucial importance in determining if the decision was truly their own. In this respect he observed that "one who is very tired, in pain or depressed will be much less able to resist having his will overborne than one who is rested, free from pain and cheerful."[23] This is significant in the context of labour and childbirth where being tired and in pain is, for many women, a central feature of the process. In Lord Donaldson's approach to undue influence in a healthcare context there are two important factors – the strength of will of the patient and the relationship of the persuader.[24] Justice Butler-Sloss in *Re T* also observed the interplay between pain and pressure and consent and stated "[a]lthough the issues of capacity and genuine consent or rejection are separate, in reality they may well overlap, so that a patient in a weakened condition may be unduly influenced in circumstances in which if he had been fit, he would have resisted the influence sought to be exercised over him."[25] Given that the presence of pain or tiredness or a weakened condition is a significant element in the case-law where pressure impacts on the validity of consent in a healthcare context I am going to address pain and pressure together throughout the paper.

Normalising the pregnant subject – Montgomery v Lanarkshire Health Board

Nadine Montgomery was not in labour when she was given inadequate information about the risks of vaginal delivery in her particular circumstances and the alternative possibility of caesarean section.[26] There was no question that pain or pressure were factors impacting on her decision-making ability. However the significance of *Montgomery* for the purposes of this paper is that it reaffirmed the importance of autonomy and consent in healthcare decision-making in a case centred on a pregnant woman. It included a discussion of harm to the woman, as well as to the baby, as a factor to be taken into consideration in weighing up the risks of choosing one delivery option over the other.[27]

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overturn her husband's signed refusal of consent to the posthumous use of his sperm. She argued that the refusal had been made as a result of the undue influence of a staff member at the fertility clinic the couple had been attending. Mrs U was unsuccessful in her action and the decision is *U* was applied in *Evans v Amicus Healthcare Limited and Others* [2005] Fam 1; [2004] 3 All ER 1025. See also Pattinson, "Undue Influence in the Context of Medical Treatment" (2002) 5 *Medical Law International* 305.

[23] Para 32.

[24] Lord Donaldson also stated that "some relationships more readily lend themselves to overbearing the patient's independent will than do others."

[25] Para 41.

[26] The consequence of what the Supreme Court found to be a negligent failure to disclose relevant information to her was that her son was born with severe disabilities following a very traumatic birth.

[27] The court noted that "shoulder dystocia is itself a major obstetric emergency, requiring procedures which may be traumatic for the mother, and involving significant risks to her health. No woman would, for example, be likely to face the possibility of a fourth degree tear, a Zavanelli manoeuvre or a symphysiotomy with equanimity." Para 94. See also Lady Hale at para 111 "In this day and age, we are not only concerned about risks to the baby. We are equally, if not more, concerned about risks to the mother. And those include the risks associated with giving birth, as well as any after-effects. One of the problems with this case was that for too long the focus was on the risks to the baby, without also taking into account what the mother might face in the process of giving birth."

It is worth noting that the clear and strongly worded principle set out by the House of Lords in *Airedale NHS Trust v Bland* that "it is unlawful, so as to constitute both a tort and the crime of battery, to administer medical treatment to an adult, who is conscious and of sound mind, without his consent…. Such a person is completely at liberty to decline to undergo treatment, even if the result of his doing so will be that he will die"[28] has on many occasions wavered in cases involving pregnant women.[29] This was acknowledged by Lady Hale in *Montgomery* when she stated "[g]one are the days when it was thought that, on becoming pregnant, a woman lost, not only her capacity, but also her right to act as a genuinely autonomous human being."[30] The strong statement in *Montgomery* that pregnancy does not dilute existing autonomy rights was particularly significant because it co-existed with a recognition of the uniqueness of pregnancy. Unlike many other healthcare decisions that people are required to make, deciding not to choose any of the options presented to you is generally not a possibility. Lady Hale succinctly captured it as follows "[o]nce a woman is pregnant, the foetus has somehow to be delivered. Leaving it inside her is not an option."[31]

Part II: Decision-making in labour and childbirth

The core issue then is how to best protect the autonomy of pregnant women in labour while recognising that pregnancy is different to other healthcare contexts and decision-making in labour is complicated by factors such as pain and pressure. This Part first briefly outlines the factors that might give rise to questions about the validity of consent in labour and broadly categorises the women affected. It then moves on to problematise the existing model of consent. This is followed by a discussion on caesarean section case-law which illustrates the stereotypes and narratives which complicate any discussion of decision-making in labour. Finally, the decision of the High Court in *ML* will be considered in detail because, while it was not concerned with vaginal examinations, it did specifically consider the impact of pain in labour on capacity, decision-making and communication.

What factors impact on the validity of consent?

Where consent has been provided by a woman in labour but there is a concern regarding the validity of that consent there are a number of factors that can give rise to that concern. In reality these factors can be interlinked, but they are unpacked here for the purposes of analysis. The first is that inadequate information was provided to the woman or there was a failure to effectively communicate adequate information to her. While acknowledging that it can be challenging to clearly and effectively communicate what may be quite complex information in the dynamic context of labour and childbirth, as noted in *Montgomery* one of the purposes of legal obligations in relation to informed consent is to ensure "that even those

[28] [1993] AC 789.
[29] See discussion of caesarean section cases below and also Halliday, *Autonomy and Pregnancy: A Comparative Analysis of Compelled Obstetric Intervention* (Routledge, 2016).
[30] Para 116.
[31] Para 110.

doctors who have less skill or inclination for communication, or who are more hurried, are obliged to pause and engage in the discussions which the law requires."[32]

The second is that the woman's decision-making capacity *may* be in question. This can be for reasons unrelated to labour, for example because she has an intellectual disability[33] or a pre-existing serious mental illness, where labour and the associated pain exacerbate the underlying issues. The final factor is that the pain of labour, perhaps in addition to pressure or persuasion, leads the woman to consent to something that she perhaps was not completely happy with. This includes women whose decision-making capacity was not in question up until the point of labour.

Troubling consent

As noted above, a valid consent must be informed, voluntary, and provided by someone with capacity. From these requirements the current model of consent has been built around a series of binaries: capacity/incapacity, voluntary/involuntary, and informed/not-informed. Some of these binaries are more rigid than others – the boundary between informed consent and not-informed consent is perhaps the most porous as it relies so much on communication and circumstances. The capacity/incapacity binary, in contrast, is quite rigid, and this is very significant in the context of this paper. For some healthcare decisions this binary model of consent is workable – standard consent to routine medical procedures where there are limited risks, plenty of time to consider the decision, good information sharing and communication, and no pre-existing conditions that would raise considerations about capacity.[34] However, as the situation becomes more complex the model is less effective.

The uniqueness of pregnancy and labour must be recognised here, because by considering consent through the prism of labour we begin to identify shortcomings in the current model. Labour is both natural and normal, and simultaneously dangerous for women and babies.[35]

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[32] Para 93.

[33] For further discussion on the challenges for women with intellectual disabilities in the context of reproduction see Kong, "Constructing feminine sexual and reproductive agency in mental capacity law" (2019) 66 *International Journal of Law and Psychiatry* (https://doi.org/10.1016/j.ijlp.2019.101488) and Arstein-Kerslake "Gendered Denials: Vulnerability created by barriers to legal capacity for women and disabled women" (2019) 66 *International Journal of Law and Psychiatry* (https://doi.org/10.1016/j.ijlp.2019.101501), both pieces in a Special Issue: Gendering Mental Health and Capacity Law. For a discussion of capacity and sexual agency see Series, "The use of legal capacity legislation to control the sexuality of people with intellectual disabilities" in Shakespeare (Ed), *Disability Research Today: International Perspectives*, London: Routledge, 2015) and Arstein-Kerslake, "Understanding sex: the right to legal capacity to consent to sex" (2015) 30(10) *Disability and Society* 1459–1473.

[34] That is not to suggest that these types of situations do not also give rise to issues in relation to consent, but in general the model is a better fit for these kinds of scenarios.

[35] The following is a very small selection of recent cases illustrating some of the risks associated with childbirth. It is important to note that in some of these cases there was no finding of negligence on the part of the healthcare providers, and the negative outcome was understood as being as a result of the ordinary risks of childbirth. See *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 (finding of negligence); *DS v Northern Lincolnshire and Goole NHS Foundation Trust* [2016] EWHC 1246 (QB) (no finding of negligence); *Re (A Minor) and Others v Calderdale and Huddersfield NHS Foundation Trust* [2017] EWHC 824 (finding of negligence); *ML v*

The pain of labour is very real, but not necessarily incapacitating. Women in labour are both powerful and vulnerable. Because pregnancy and labour occupy a space like no other, when we consider the pregnant woman in labour, she may not always sit clearly within one or other side of the binaries which underpin the legal framework for consent. In some cases she may occupy the unexplored spaces in-between the binaries. However, because we are familiar with the existing binary model of consent it is difficult to concede that pain or pressure might have an impact on decision-making because to do so *feels like* defeat and *appears to be* accepting that pregnant women in labour are less autonomous than other subjects. This is because within the current model it moves the woman from the capable to the incapable category. The challenge is to begin to look beyond the binaries and to explore those in-between spaces where we can perhaps recognise that pain and pressure impact on decision-making ability without that equating to a finding of incapacity. This paper is intended as one response to that challenge.[36]

The pregnant woman as a less than autonomous subject

The lack of fit between the model of consent and the reality of the pregnant woman in labour is further complicated by a stereotypical perception that pregnant women refusing treatment are not thinking clearly, because if they were they would do what is best for the baby. The narrative here is of the pregnant woman as a less than fully autonomous subject, and also an unreliable subject who cannot be trusted to make the "correct" decisions.[37] These narratives and stereotypes are apparent in many of the enforced caesarean section cases.[38] Clearly a caesarean section performed on a woman without consent is a profound violation of bodily autonomy and yet the courts have, and continue to, regularly sanction such interventions.

Caesarean section case-law

There is a significant body of case-law in this area and so the discussion here is focused on a selection of cases, beginning with an older case which foregrounded the role of pain and/or pressure in the finding that the woman lacked capacity. This is followed by a brief discussion of *St George's* as this is the clearest illustration of the narratives around pregnant women and autonomy in action. The post *St George's* case-law is then briefly outlined.

In *Norfolk and Norwich NHS Trust v W*[39] W was in arrested labour, but denying that she was pregnant. She had a previous history of mental illness, but at the relevant time she did not

Guy's and St Thomas's National Healthcare Foundation Trust [2018] EWHC 2010 (QB) (no finding of negligence)*; YAH v Medway NHS Foundation Trust* [2018] EWHC 2964 (QB) (finding of negligence).

[36] See also Villarmea Requejo and Fernandez Guillén, "Fully Entitled Subjects: Birth as a Philosophical Topic" (2011) 11 *Ontology Studies* 211-230.

[37] For a thoughtful analysis of this issue see Villarmea "When a uterus enters the door, reason goes out the window" in this volume.

[38] For further discussion on stereotypes of women in the context of reproductive rights and childbirth see Zampas "Negation of Women's Autonomy in Reproductive Healthcare Settings: stereotypes and international human rights standards and national level cases in the context of childbirth" in this volume.

[39] [1996] 2 FLR 613.

satisfy the criteria to be detained under the Mental Health Act 1983. The hospital sought a declaration to permit a forceps delivery, or if necessary a caesarean section, and permission to restrain W in order to do so. This approach was deemed necessary "to preserve the life of the foetus, which was in danger of suffocating, and also to avoid the risk of the patient's earlier caesarean scars reopening and so endangering the life of the foetus. There was also a risk to W's own life."[40] W was found to lack competence because she didn't satisfy the third step of the *Re C*[41] test as, according to the psychiatrist, she was unable to weigh information in the balance to arrive at a choice. The court noted that "she was called upon to make that decision at a time of acute emotional stress and physical pain in the ordinary course of labour, made even more difficult for her because of her own particular mental history."[42]

St. George's Healthcare NHS Trust v S

In *St George's*[43] the Court of Appeal awarded damages in trespass (alongside declaratory relief) to a woman who had a caesarean section performed on her without her consent. The complex circumstances of this case involved S being involuntarily admitted for the purpose of assessment to a psychiatric hospital under the Mental Health Act 1983, transferred to the maternity ward of the hospital to have the caesarean section against her wishes, then returned to the psychiatric hospital and subsequently discharged. At no point did she receive any treatment for a mental illness.

This case was also significant because the court held that the existence of a judicial declaration permitting the caesarean section in this case did not provide a defence to the claim of trespass because the circumstances in which the declaration had been obtained were unacceptable. Donnelly describes the declaration being obtained "in circumstances of startling procedural inadequacy, due largely to the behaviour of the healthcare trust."[44] This included the court being advised that S had been in labour for 24 hours at the time of the application, when in fact labour had not yet begun. The court was therefore mistakenly under the impression that it was an urgent life and death situation. There was no discussion of the issue of S's capacity or competence in the hearing, including the fact that there were no concerns about S's capacity prior to her admission for assessment or that S was thought to have capacity throughout. The court was also not informed that S had instructed solicitors and that neither she nor the solicitors were aware that the application was taking place. What occurred in this case appears to have been a complete overriding of the autonomy rights of a pregnant woman because she was not complying with medical advice. While there was no issue around pain or pressure impacting on capacity in this case, S was not in labour, the

[40] Halliday, note 29 at p. 48.
[41] *Re C (refusal of medical treatment)* [1994] 1 FLR 31.
[42] Note 39 at 616. In some of the early cases the finding that the woman did not have capacity to refuse the caesarean section was complicated by pre-existing mental health issues, see *Tameside and Glossop v CH* [1996] 1 FLR 762; *Re L (Patient: non-consensual treatment)* [1997] 2 FLR 837 and *Re MB* [1997] 2 FLR 426 both of which involved needle phobias.
[43] [1998] 3 ALL ER 673. For discussion of the decision see Bailey-Harris, "Pregnancy, Autonomy and the Refusal of Treatment" (1998) 114 *Law Quarterly Review* 550.
[44] Donnelly, note 12 at p. 56. For further detail see p. 682-683 of the judgment.

significance of the case lies in the clear violation of autonomy in the actions of the hospital[45] and the strong response from the Court of Appeal reiterating the continuation of autonomy in pregnancy.[46] Judge LJ stated "while pregnancy increases the personal responsibilities of a woman it does not diminish her entitlement to decide whether or not to undergo medical treatment."[47]

Post St George's

The caesarean section cases post *St. George's* have come before the courts by way of a variety of legal frameworks: the Mental Health Act 1983, the Mental Capacity Act 2005, and the inherent jurisdiction of the High Court. Each of these is problematic, but detailed consideration is outside the scope of this discussion.[48] There does appear to be a recurring thread in the more recent case-law of orders being sought to permit caesarean sections to be performed on women with underlying mental health issues or learning difficulties.[49] In some instances the woman is not being treated for her mental illness while pregnant and her condition is deteriorating. In many others the suggestion appears to be that caesarean delivery would ensure safe delivery of the baby and this is important for the mental health and recovery of the woman (even in circumstances where she is resisting a caesarean delivery). There also appears to be a move away from emergency applications (which was recommended by the Court of Appeal in *MB*[50]) and so most of the findings of incapacity are not related to pain and pressure in labour.

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[45] The consequences of such an approach are encapsulated in the following extract from the Court of Appeal judgment in *St George's* at p. 684 outlining the aftermath of the caesarean section"[S] was very angry that the hospital had gone against her wishes and complained of physical assault. When she was told that it was done for her benefit and that of her baby she remarked that is was 'a matter of opinion.'"

[46] Judge LJ in the Court of Appeal encapsulated the narratives underpinning the approach of the hospital at p.692 "[t]he prohibited reasoning is readily identified and easily understood. Here is an intelligent woman. She knows perfectly well that if she persists with this course against medical advice she is likely to cause serious harm, and possibly death, to her baby and to herself. No normal mother-to-be could possibly think like that. Although this mother would not dream of taking any positive steps to cause injury to herself or her baby, her refusal is likely to lead to such a result. Her bizarre thinking represents a danger to their safety and health. It therefore follows that she must be mentally disordered and detained in hospital in her own interests and those of her baby. The short answer is that she may be perfectly rational and quite outside the ambit of the Act, and will remain so notwithstanding her eccentric thought process."

[47] P. 692.

[48] For a detailed discussion see Halliday, *Autonomy and Pregnancy: A Comparative Analysis of Compelled Obstetric Intervention* (Routledge, 2016).

[49] *Re AA (Mental Capacity: Enforced Caesarean*) unreported 24 August 2012; *Re P* [2013] EWHC 4581 (COP); *Great Western Hospitals NHS Foundation Trust v AA, BB, CC & DD* [2014] EWHC 132 (Fam); *Royal Free NHS Foundation Trust v AB* unreported 31 January 2014; *The NHS Acute Trust & The NHS Mental Health Trust v C* [2016] EWCOP 17; *NHS Trust v JP* [2019] EWCOP 23; *Guys and St Thomas' NHS Foundation Trust v X* [2019] EWCOP 35. For a discussion of the role of mental illness in cases of court-ordered obstetric intervention see Halliday, 'Court-ordered obstetric intervention: insight and capacity, a tale of loss' in Pickles and Herring (eds) *Childbirth, Vulnerability and Law: Exploring Issues of Violence and Control* (Routledge, 2019).

[50] [1997] 2 FLR 426.

Impact of pain in labour on decision-making

In *ML v Guy's and St Thomas' National Healthcare Foundation Trust*[51] a minor (ML) took a case (by his Litigation Friend and mother, SL) on foot of the circumstances surrounding his birth in 2010. In the minutes before delivery he suffered deprivation of oxygen to the brain and this left him with devastating brain damage and profound disability – the judgment of the court notes that he is tube fed, will always need 24 hour care, has no prospect of independent living and his life expectancy is limited.[52] The judgment relates to the trial of a preliminary issue, namely liability and causation.

According to the judgment SL experienced a spontaneous rupture of membranes (SROM) and went to the hospital. She was initially sent home but then returned and was admitted. She was induced and was actively monitored throughout labour because there were some pathological CTG readings. On two occasions foetal blood samples were taken, because of the CTG readings, and the results of these samples were normal. On this basis, and because there were other indications of satisfactory progression of labour,[53] the plan was to proceed to a vaginal delivery. Unfortunately there was a sudden deterioration in ML's condition (most likely as a result of cord occlusion) and a decision was made to perform an emergency caesarean section. There was a slight delay in transferring SL to theatre as both theatres were already occupied with caesarean deliveries.[54] During this period ML was deprived of oxygen and suffered brain damage. SL contended that she asked for a caesarean section at an earlier point in labour because she was worried about the safety of ML and had a caesarean section been carried out shortly after she requested it the injuries to ML would have been avoided.

Spencer J identified two issues for consideration: first, whether the plaintiff's mother, SL, had requested a caesarean section during labour, and secondly, if the hospital responded appropriately to that request.[55] SL's evidence was that at a particularly painful moment in labour she requested a caesarean section. Her account of the circumstances around the request was that she said "I was worried and in pain and I clearly remember saying, Please, just chop me, what are you waiting for? Meaning that I wanted a caesarean section."[56] The response of the staff attending to her in labour was to give her an epidural. This appeared to provide her with considerable relief and in a statement provided in the course of litigation she said "after about 20 minutes I felt much more coherent and relaxed as the pain disappeared and I started talking and joking with my husband and sister."[57]

Spencer J found that it was most likely that SL was motivated by pain in making the request for a caesarean section at the point she did, rather than from concern for the wellbeing of the baby. He stated that this finding was supported by evidence which demonstrated that shortly before she requested the caesarean section a foetal blood test had been conducted which

[51] [2018] EWHC 2010 (QB).
[52] Para 1.
[53] Para 22.
[54] Paras 30-33.
[55] Para 52.
[56] Para 36.
[57] Para 36.

showed that the baby's condition was not a cause for concern at that point.[58] In those circumstances he found that the correct course of action was to address the issue of pain, which was done, and if after that SL had continued to request a caesarean section then the healthcare practitioners would have been required to discuss this with her further. This did not arise in this case, as once SL was given the epidural she relaxed and did not raise the issue of a caesarean section again.

His comments on pain and decision-making in labour are worth setting out in some detail. He first drew a distinction between a request for a caesarean section in the ante-natal period and one made in the "throes of labour pain." In the first instance such a request should be "considered carefully and fully by the obstetric staff with the risks and benefits being fully discussed and with time for thought and reflection being given."[59] However where the request comes when the woman is in labour and in pain "the appropriate response, as here, is to deal with the pain and then review the matter and see whether the request was or was not 'serious.' By that I do not intend to suggest that any request for a caesarean section is not serious but an obstetrician or midwife would be failing in their duty to both mother and baby if they simply took every such request at face value without exploring and addressing the underlying reason."[60] A lot of weight was attached to SL's account that after the epidural she felt more "coherent." Spencer J interpreted this as "a tacit admission that, before the epidural and given the pain she was in, she was less than coherent and I suspect this will be the case for many women undergoing labour for the first time or, indeed, not for the first time."[61] On the basis that SL was less than coherent at the relevant time, as a result of the usual and expected pain of labour, the court found that it would be inappropriate to have the kind of conversation which would be necessary to ensure that she made a voluntary and informed choice as to whether to have a caesarean section. "It would in fact be impossible to have the kind of discussion of risk and benefit envisaged by…the NICE guidelines with a woman who is not wholly coherent and thinking straightforwardly and logically because of the extreme pain she was in and could be regarded as irresponsible for a midwife or obstetrician to attempt to have such a discussion with a woman before her pain had been addressed."[62]

The decision in *ML* is to be welcomed in so far as it recognises that the existing rules on informed consent and information communication can prove challenging in the context of labour where the woman is in pain, perhaps feeling vulnerable, and therefore may not be in a position to engage in the same kind of reasoning or questioning as she would be in a different context. This acknowledgment of the gap between the theory of consent and practice is important. However, this is something of a double edged sword because at the same time this characterisation of the pain of labour as somehow rendering a labouring woman less competent can be seen as feeding into the broader narratives of pregnant women

[58] This finding does not appear to consider the possibility that SL's concern for the wellbeing of the baby would not be completely alleviated by the results of the foetal blood tests in circumstances where the foetal CTG trace was repeatedly assessed as "suspicious" and the midwives were calling for doctors to review the trace throughout the labour.
[59] Para 90.
[60] Para 90.
[61] Para 90.
[62] Para 90.

as inherently incapable. The use of the word "coherent" by SL in her evidence was unfortunate in this context as it provided a hook for the court to focus the discussion on competence and capacity. Perhaps a more useful approach by the court would have been to recognise that the pain SL was experiencing impacted on her decision-making ability without framing that in terms of competence. Also, having recognised the impact of pain in labour on decision-making, the court then placed the onus on SL, once her pain had been addressed, to raise the issue of a caesarean section again. An argument could be made that those involved in caring for SL should have checked in with her again, once the pain relief had taken effect, to see if the possibility of a caesarean section was something that she still wished to discuss. Such an approach would be more in line with a model of childbirth that prioritised and respected the autonomy of labouring women and supported them in decision-making.

Conclusion: Challenges and Solutions

The issue of vaginal examinations in labour without consent requires us to consider the legal framework on consent from a new perspective. The focus on the impact of pain in labour on decision-making ability and consent shines a light on some of the troubling issues with the current model of consent. Because the legal framework for consent is constructed around a series of binaries, any suggestion that the decision-making ability of women in labour might be affected by pain and pressure has the potential to be fraught. This is because of the implication that it moves labouring women from the capable to the incapable category, and all of the consequences for autonomy that are associated with that shift. It also appears to affirm the existing stereotypes and narratives of the pregnant woman as a less than fully autonomous subject. The cause of the difficulty here is not that pregnant women in labour do not fit the otherwise serviceable model of consent, but rather that the model of consent on which the legal framework is based is not sufficiently flexible to be effective for women in labour. This needs to change because the shortcomings of consent in this context apply in respect of all interventions in labour, including vaginal examinations, and while this model remains women will continue to experience a range of harms in pregnancy and childbirth, particularly in relation to autonomy.[63]

Stretching the temporal context

One potential solution is a more flexible legal model of consent that moves away from the rigid binary divisions that underpin the current framework. For consent to be meaningful for women in labour the temporal context for consent needs to be stretched. One aspect of this would be more clear and effective communication in advance of labour about all aspects of

[63] For a discussion of harm in childbirth and the importance of developing vocabularies of harm in response to systemic experiences of violation see Fionnuala Ní Aoláin ""On Being the Subject of Law: Feminist Reflections on Gender, Harm and Violence in Northern Ireland" delivered as the Stephen Livingstone Lecture 2018 available at: https://www.youtube.com/watch?v=yb92m12_hus.

labour and birth.[64] This is in accordance with the emphasis in *Montgomery* on the importance of communication in ensuring effective consent. This should include an open discussion about the possibility of vaginal examinations during labour,[65] the purpose of these examinations, what is involved, any potential downsides to not having a vaginal examination, and the fact that this is something that the woman can refuse if she so wishes, even if she has consented to a vaginal examination at an earlier point in labour. The importance of clear communication about vaginal examinations was highlighted by Stewart who notes that "midwives need to consider how they discuss vaginal examinations with women during pregnancy in order to inform them of their purpose and rationale so that women, in turn, can become involved in decisions about how and when they should be done."[66]

Such an approach would allow women to have the space and time needed, away from the intensity of labour, to make decisions, if they wish with the input of others, and to indicate preferences at this earlier stage.[67] This is closely linked to the importance of effective and realistic birth planning, which again should include references to vaginal examinations in labour if this is something that is important to the woman.[68] Outside of the labour context the benefits of advance healthcare planning are recognised in situations where there is a concern that decision-making may be affected in the future.[69] None of the above is to ignore the reality that complications can arise in labour and emergency situations can develop which may require reassessment of previously expressed preferences in challenging circumstances, but that does not undermine the value of those earlier discussions and planning which are crucial to a woman-centred model of childbirth. Increased continuity of care throughout

[64] O'Donovan and Madden, in the context of a discussion on the difficulties faced by members of the public who submit complaints to medical professional regulators in having those complaints taken seriously and referred on for further inquiry, note that "[t]ime and time again, poor communication with patients and their families has been found to be at the core of what goes wrong in medicine." O'Donovan and Madden, "Why do Medical Professional Regulators Dismiss Most Complaints from Members of the Public? Regulatory Illiteracy, Epistemic Injustice, and Symbolic Power" (2018) 15 *Bioethical Inquiry* 469-478 at p.477. They reference the Report of the Parliamentary and Health Service Ombudsman, *Listening and learning: The Ombudsman's review of complaint handling by the NHS in England 2010-11* (2011: London, The Stationery Office) in support of this.

[65] It is worth noting that in some instances the term vaginal examination is not even used when healthcare professionals are attending women in labour, with phrases such as "an internal" or "a v.e." being used instead. Stewart, "'I'm just going to wash you down': sanitizing the vaginal examination" (2005) 51(6) *Journal of Advanced Nursing* 587-594, conducted a study which included interviews with midwives and at p. 592 suggested that "they might feel uncomfortable using terminology that makes explicit reference to women's genitalia and use abbreviations as a means of overcoming this discomfort." This contributes to women being unsure exactly what is involved in the proposed examination.

[66] Stewart, "'I'm just going to wash you down': sanitizing the vaginal examination" (2005) 51(6) *Journal of Advanced Nursing* 587-594 at p. 593. While some failures in communication on this topic may be attributable to embarrassment discussing vaginas, there is a more worrying explanation as well, with Stewart at p. 592 suggesting that failure to communicate clearly can also sometimes be an example of power strategies "where midwives decide what information will be given to women and what will be withheld."

[67] For a discussion of a 'rich' understanding of consent, which recognises the relational nature of consent and highlights the importance of understanding consent within context, see Herring, 'Implied consent and vaginal examination in pregnancy' in this volume.

[68] This may include advance refusals of vaginal examinations, or the woman may wish to outline the circumstances in which she is willing to consent to a vaginal examination in labour.

[69] See discussion in Donnelly, "Developing a framework for advance healthcare planning: Comparing England and Wales and Ireland" (2017) 24(1) *European Journal of Health Law* 67-84.

pregnancy and labour is also important in building relationships of trust which are helpful in ensuring effective communication during periods of labour which may be more challenging for the woman.[70]

From the judgment in *ML* we see the importance of ensuring that whenever possible decision-making in labour should occur at times where the woman is not in significant pain. That may require those caring for women to pay close attention to the rhythms of labour and where possible discuss interventions or seek consent during lulls in pain.[71] In some cases, as in *ML*, pain relief may need to be provided before other requests or options are discussed.

Before concluding it is important to recognise the risks associated with the arguments outlined above. Acknowledging the impact of pain and pressure on decision-making in labour in isolation, without also rejecting the binary model of consent, has the potential to further reinforce the existing stereotypes of pregnant women as not fully autonomous subjects. This occurred to an extent in *ML*. It also risks labour being characterised as an unusually traumatic or damaging process, which is unhelpful in respect of the normalisation of the pregnant subject.[72] The process of reimagining consent is not something that can be achieved in the short term and is unlikely to occur without set-backs and challenges. However, it is important to begin to have these kinds of conversations if the ultimate objective is a legal framework on consent that works in practice for pregnant women in labour.

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[70] Dixon et al, "Women's perspectives of the stages and phases of labour" (2013) 29 *Midwifery* 10-17 at 15 noted that in the New Zealand context where women have a midwife they know and who provides all of their intrapartum care women were less anxious and unsure in relation to the onset of labour. The women involved in this study also did not express any negative feelings towards vaginal examinations, in contrast with other studies. See Dahlen, Downe, Duff and Gyte, "Vaginal Examination During Normal Labor: Routine Examination or Routine Intervention?" (2013) 3(3) *International Journal of Childbirth* 142-152 and Lewin et al., "Women's experiences of vaginal examinations in labour" (2005) 21 *Midwifery* 267-277. For the importance of continuity of care see also Clement, "Unwanted vaginal examinations" (1994) 10 *British Journal of Midwifery* 368-370 and RCM note 2.

[71] RCOG note 2 at p. 6 states "[w]hen consent has to be obtained from a woman during painful labour, such as to perform a vaginal examination, episiotomy, operative delivery or to site an epidural, information should be given between contractions."

[72] See the judgment in *Re (A Minor) and Others v Calderdale and Huddersfield NHS Foundation Trust* [2017] EWHC 824 where, in the context of a claim for psychiatric injury by a mother and grandmother resulting from a birth where the baby suffered injury, childbirth was characterised as a sudden, shocking and horrifying event. Lindsey, "Psychiatric Injury Claims and Pregnancy: *Re (A Minor) and Others v Calderdale and Huddersfield NHS Foundation Trust* [2017] EWHC 824" (2017) 26(1) *Medical Law Review* 117-124, at p.122 notes that "[c]haracterisations that frame childbirth as shocking and horrifying could have a wider impact on how pregnant women are treated and undermine the struggle to ensure a pregnant woman's autonomy is respected."