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# Informed consent to breech birth in New Zealand

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## ABSTRACT

The authors note significant room for improvement in facilitating informed consent in the management of breech presentation. New Zealand maternity care providers, including midwives, general practitioners and specialist obstetricians, have legal duties to provide full and unbiased information about risks and benefits of all relevant treatment options. In the case of breech presentation, such options include the interventions of external cephalic version or planned caesarean section, as well as the option to decline intervention and proceed with a planned vaginal breech birth. Information should be presented in a balanced and accessible way and not limited to the provider's personal preferences. Women have legal rights to make an informed choice, to give or refuse consent, to a second opinion and to co-operation among providers. The right of competent persons to refuse medical treatment, including the right to refuse caesarean section, is well established. Clinical policies therefore should include appropriate and non-coercive care for women who choose to birth their breech-presenting baby vaginally, compliance with such policies should be the norm, and consideration should be given to any institutional reforms or educational priorities needed to achieve this.


Current practice in obtaining informed consent in managing a breech-presenting foetus in late pregnancy needs significant improvement. The authors all regularly interact with women who have experienced care that fails to meet the legal requirements for informed consent. Our observations are consistent with others published in international literature, reflecting a cultural acceptance of minimal choice and coercive consent practices within many maternity services.[1-3]

Anecdotally, it appears that in New Zealand, Australia and the UK, some women are given no realistic choice other than 'elective' caesarean section and some women are given unbalanced information about the risks and benefits of vaginal breech birth (VBB) and caesarean section. This quote (and others in this article) is taken from an Antipodean internet support group for women with breech-presenting foetuses (quoted with permission):*

> *"The [obstetrician] for my first breech pregnancy told me that no-one offered VBB or [external cephalic version] ... because it was not safe for the baby or the mother ... He didn't go into any detail about the risks..."*

Women also describe feeling coerced into attempting external cephalic version (ECV) (quoted with permission):

> *"ECV felt like the only way we could get VBB on the table. Nevertheless, it felt wrong to agree to the ECV for the sake of the hospital's birth policy."*

This anecdotal evidence is consistent with research suggesting that women's perceived control over decision-making in childbirth is surprisingly low[4] and that maternity care providers' (providers) understanding of women's legal rights in maternity care is poor.[5]

This article considers the legal duties of New Zealand providers, including independently practising midwives and

* The support group includes a range of mothers, midwives and obstetricians. Pregnant women are supported whether they plan to birth vaginally or by caesarean section and discussions relate to a wide-range of concerns specific to breech: for instance discussions include positive experiential anecdotes about caesarean section and questions about developmental hip dysplasia.


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District Health Board midwifery and obstetric staff, to give information and to obtain consent in the management of breech presentation.

# Legal framework

New Zealand's maternity arrangements and health law framework are both unique. General legal principles about information and consent are similar to other common law jurisdictions, such as Australia and England. However, in New Zealand, the Code of Health & Disability Services Consumers' Rights (Code) adopts the concept of 'informed consent', which has been rejected in England[6] and Australia.[7] The Code can be breached even if no injury or damage has been caused. In addition, the accident compensation scheme (ACC) provides fault-free compensation to victims of personal injury, including injuries caused by medical treatment. Medical negligence litigation is almost non-existent in New Zealand because the Accident Compensation Act 2001 prohibits damages for personal injury covered by ACC (section 317).

In New Zealand, almost all pregnant women are registered with a Lead Maternity Carer (LMC), usually a midwife, who provides primary antenatal, intrapartum and postnatal care. LMC midwives are legally required to comply with the Guidelines for Consultation with Obstetric and Related Medical Services (Ministry of Health, 2012) (Guidelines). District Health Board clinical policies and College statements have no legal status and are subject to the Code and the common law. However, they are relevant in determining a provider's compliance with professional standards. Breach of the Code does not necessarily constitute a disciplinary offence.[9]

# Consultation and cooperation

The Guidelines confirm that "the woman should have continuity of maternity care … regardless of how her care is provided" (p2). This is important because breech presentation, whether diagnosed before or in labour, engages an obligation on the LMC midwife to recommend consultation with an obstetrician. Guideline 4.2 suggests that a three-way conversation should take place between the woman, the LMC midwife and the obstetrician.

The Code also recognises that "[e]very consumer has the right to co-operation among providers to ensure quality and continuity of services" (Right 4.5). If disagreements arise about the care plan, it is important to maintain communication so that emergency care can be provided if necessary. The Health & Disability Commissioner emphasised the importance of communication in a case in which a baby died after a VBB.[10] The woman became disillusioned with medical staff after their insistence upon a caesarean section. Interpersonal tensions meant that the midwives did not inform medical staff that the woman was in labour and when problems arose, it was too late to help.

# Information

The Code protects the right to be fully-informed (Right 6) and the right to make an informed choice and give informed consent (Right 7).

The importance of providers providing information to allow women to make their own choices was recently emphasised by the Supreme Court of the UK in *Montgomery v Lanarkshire Health Board* (para 81):[11]

> *"social and legal developments … point away from a model of the relationship between the doctor and the patient based upon medical paternalism. … What they point towards is an approach to the law which, instead of treating patients as placing themselves in the hands of their doctors (and then being prone to sue their doctors in the event of a disappointing outcome), treats them so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices."*

Although the therapeutic privilege to withhold information for a patient's own benefit is recognised in law, this is a very narrow exception and only applies in cases

where disclosure would be "seriously detrimental to the patient's health" (para 88).[11] It is unlikely to apply to a competent woman choosing antenatally how to deliver her breech baby.

The Code requires information to be provided about the following:

### *The options available, including an assessment of the expected risks, side effects, benefits and costs of each option* (Right 6(1))

This includes ECV, planned VBB, planned pre-labour caesarean section and planned caesarean section when labour commences. These options should be discussed even if they necessitate a referral to another provider. Health & Disability Commissioners have interpreted Right 6(1) to require information to be based on objective data and, where no such data exist, to disclose this fact.[12]

The authors have observed that woman commonly need to be assertive to discuss the option of VBB (quoted with permission):

> *"I believe if I had not known to ask I would not have been given the option [of VBB] … I felt that the [obstetricians] gave a lot of statistics about the 'average' … but not … me and my pregnancy."*

As well information relevant to the current pregnancy, the consequences of a woman's choices for future pregnancies should be discussed. These include the chances of recurrent breech presentation,[13] the increased likelihood of this following a caesarean section[14] and the risk of morbidity and mortality for the woman and her future babies following a caesarean section.[15]

In disciplinary proceedings for failure to obtain informed consent, the fact that other providers would have provided the same level of information is not a determinative defence.[9,11] The duty is to provide the information that "a reasonable consumer in that consumer's circumstances" would expect to receive or would need to make an informed choice or give informed consent. Although this is ostensibly an objective standard, these "circumstances" will vary from patient to patient and include the woman's beliefs, fears, and desires[9] and the level of information the woman desires to receive.[7]

### *Open and honest answers to questions about providers available to care for the woman* (Right 6(3))

This includes the provider's identity and qualifications, recommendations and how to obtain a second opinion. Health & Disability Commissioners have interpreted this requirement to extend to risks associated with the provider.[12] Ideally, providers or services should present their particular statistics about relevant outcomes.

### *The right to express a preference as to who will provide services and to have that preference met where practicable* (Right 7(8))

This right, combined with the right to have services provided with reasonable care and skill (Right 4(1)), is pertinent given the common understanding that most obstetricians and midwives do not have sufficient skills and experience to safely support a planned VBB.[16] The presence of an experienced provider is the only factor that has ever been shown to improve outcomes for vaginal breech deliveries (VBD),[17] although there is currently a lack of agreement about how much practical experience is required for a provider to be sufficiently 'experienced' to safely support a VBB.

Accordingly, a woman may express a preference to be under the care of somebody who has expertise in supporting VBB. This will not always be practical—a provider's duty is to take reasonable actions in the circumstances to comply with the Code (Right 10(3)). Similarly, a provider will not be in breach of their duty of care by failure to provide care which is outside their power to provide.[9] District Health Board structures that facilitate access to medical and midwifery staff with breech expertise would assist in fulfilling Right 7(8), as well as maximising the chances of a good outcome in a planned VBB.

### *A written summary of information, upon request* (Right 6(4))

Written information can be prepared in advance and annotated for a woman's clinical circumstances. This is already practised at some services (quoted with permission):

> *"I received an information sheet recapping all that we had discussed*

*so I could take it away and have further conversations with my partner and family. It had been printed out and personalised ...”*

## Discussing the Term Breech Trial

The Term Breech Trial (TBT)[18] may sometimes be presented to women as ‘determinative’ of the choice they should make. This approach potentially breaches the woman’s right to make an informed choice.

In order to present balanced information, if the TBT is directly discussed (which depends on the level of detail a woman wishes to hear), providers should also discuss (with an explanation about their comparative evidential value):

- the two-year follow up study of infants finding no significant long-term differences between planned caesarean section and planned VBD[19]
- epidemiological studies demonstrating a decrease in neonatal mortality associated with increased caesarean section at population level but with much less difference than that observed in the TBT (1.6/1000 vs 6/1000)[20] and
- retrospective cohort studies showing that with good clinical support and in some places, planned VBD brings no significant greater risk to the infant than planned caesarean section.[21,22]

## Presenting risks

The National Institute for Clinical Excellence and the Royal College of Obstetricians and Gynaecologists (RCOG) provide guidance on the presentation of statistical information to patients (1.5.24).[23, 24] Although clinical studies such as the TBT[18] compare the relative safety of planned caesarean section and planned VBD, this approach is aimed at population-based policy-making and not at counselling women.

The TBT analysed overall incidence of ‘severe neonatal morbidity and mortality’.[18] However, presenting risks of different sorts together to a woman gives the misleading impression that the risk of long-term morbidity or mortality is more common than the evidence suggests. The TBT showed:

- no statistically significant difference in the risk of the three most serious birth traumas (intracerebral or intraventricular hemorrhage, spinal cord injury and basal skull fracture) between the planned vaginal and planned caesarean groups[18]
- a similar incidence of the most common birth trauma, clavicle fracture (6/1000)[18] to the incidence of clavicle fracture in cephalic presentation (5/1000)[25]
- that the risk of neonatal death after a planned VBD is 6/1000 in countries with low perinatal mortality.[18] In a recent study in the Netherlands, which had a 20% vaginal breech rate in the relevant period, the risk of death after a planned VBD was as low as 1.6/1000[20]
- that the most common adverse outcomes after a planned VBD are tube feeding for >4 days (31/1000), 5 minute Apgar of <7 (30/1000), and admission to neo-natal intensive care for >4 days (30/1000).[18]

Women may not necessarily want this level of detail and providers are not expected to provide information that a woman does not wish to hear. However, information on specific risks should be offered because it counteracts the common misunderstanding that the risk of mortality from VBB is high. It also enables the woman to make an autonomous decision about which risks she is willing to take.

Women should be told about risks specific to caesarean section and VBB in absolute rather than relative terms. RCOG recommends the term ‘uncommon’ to describe a risk of between 1 in 100 and 1 in 1000,[24] which applies to most relevant risks. Natural frequencies, consistent denominators, and combining positive and negative framing are best practice.

Women and clinicians may perceive risk differently.[26] Although the immediate risks to the current pregnancy should be discussed, women may be concerned about a broader range of factors than short-term adverse clinical outcomes, such as their ability to care for other children

or relatives, their partner's ability to take time off work, and plans for future children. Research shows that women are particularly concerned about the long-term outcomes for their child, and partners are most concerned about risks to the woman.[27]

## Timing and transfer

Decision-making requires discussion, an opportunity to ask questions, and time to reflect.[3] This is facilitated in New Zealand by the LMC model. As the availability of clinical expertise in managing VBB may be a factor in a woman's decision about whether or not to attempt ECV, a discussion about mode of birth should not be delayed until after ECV.

Although, in most cases, after consultation, women will choose to transfer care, in New Zealand the obstetrician does not automatically assume responsibility for ongoing care. Some women will make a legally supported choice to remain in the care of their LMC midwife.

## Undiagnosed breech presentation

Although rates vary, a reasonable proportion of breech presentations are diagnosed in labour (25–33%).[29] There is a lack of evidence that a caesarean section in active labour offers the same benefits to the foetus as it may have prior to or in early labour.[29] Caesarean section in active labour also brings increased risks for both mother and baby.[30] The Royal Australian & New Zealand College of Obstetricians' & Gynaecologists (RANZCOG) College Statement 'Delivery of the Fetus at Caesarean section' (C-0bs 37; current July 2010) specifically addresses the difficulties of caesarean section for breech in active labour.

For a breech diagnosed in labour, without evidence of lack of progress, compromised wellbeing of mother or baby, or lack of experienced provider,[30] a vaginal birth should be assumed and supported. Extensive risk-based discussion about intervention should be reserved for situations in which the provider observes an increase in risk for which a caesarean section is known to improve outcomes.

## Consent and refusal

The Code and the common law (applicable in other jurisdictions too),[6,31] confirm the right of patients to refuse consent to medical treatment, even if the implications are serious. Although this should be obvious, the Australian Medical Association recently reaffirmed that a "pregnant woman has the same rights to privacy, to bodily integrity, and to make her own informed, autonomous healthcare decisions as any competent individual"[32] and the UK Supreme Court has confirmed that "[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" (para 116).[11]

Although a provider cannot be compelled to provide care that they believe is clinically inappropriate, this does not extend to requiring a competent woman to undergo surgery to 'avoid' a natural process.[11] Neither may a provider refuse care simply because they disagree with the woman's decision or because of factors unrelated to the woman, such as personal beliefs about the merits of caesarean births or previous bad personal experiences. In the absence of another provider who can take over the woman's care, the ethical and legal duty is to continue to provide care.

Consent may be undermined by:

- clinical policies which make no allowance for VBB
- providing misleading information about risks, and
- threatening to withdraw care if a woman disagrees with advice.

This is an example of coercive behaviour, which is in breach of the Code and could lead to a complaint to the Health & Disability Commissioner or to disciplinary action (quoted with permission):

> *"The hospital midwives had to transfer me to the [obstetricians] who threatened to call child protective services and get a court order to perform a cesarean and then remove my child from my and my husband's care if I didn't "consent" to an elective cesarean..."*

In one of the first British forced caesarean cases, a woman brought legal action for battery after being coerced into agreeing to a caesarean section for breech, although the case settled out of court (p270).[33] (In New Zealand there are no compensatory damages for any injury caused by battery because of ACC. Declaratory relief or exemplary damages may be available.)

The common law also recognises that 'undue influence' may undermine consent. The High Court of Australia has held that (para 40):[34]

> *"What appears to be a valid consent given by a capable adult may be ineffective if it does not represent the independent exercise of person's volition: if … the person's will has been overborne …"*

Factors which make a woman more susceptible to undue influence include:[6]

- pain
- being tired
- being on medication, and
- the relationship with the persuading party (which could include any power-imbalance in a doctor-patient relationship or pressure from family members).

Particular care should be taken to ensure that a woman's consent to medical intervention in labour is freely given. Consent is not required to birth vaginally.

## Clinical policies, compliance and costs

Patient-centred, legally-sound, evidence-based and non-coercive clinical policies are critical to safe maternity care. In one well-known New Zealand example, a baby died (due to placental abruption) after a planned breech homebirth[35] and the Coroner criticised a clinical policy allowing no realistic alternative to caesarean section because it influenced the choice of the woman to birth at home where emergency care was sub-optimal.

The quotes presented in this article and the authors' interaction with pregnant women both suggest that, in practice, VBB is rarely a choice that is open to women. A legal compliance review of current breech presentation clinical policies in New Zealand and Australia would be worthwhile as it is unclear whether the issue is a failure to comply with clinical policies or the policies themselves.

The RANZCOG College Statement 'Management of Breech Presentation at Term' (C-Obs 11; current March 2013) could also be improved by including a sounder evidence-base for recommendations, a wider range of information about the risks of caesarean section, particularly the risks for future pregnancies, and acknowledgment that the role of the obstetrician is to advise the woman, not to make the decision.

Whatever the reason, the authors have noted that whether or not a woman is offered support for a VBB often depends upon luck. Women should not rely on luck to determine whether or not they have a caesarean section (quoted with permission):

> *"I felt 'lucky' that I was given the option to attempt VBB. On reflection though, how sad that a woman should feel 'lucky' to birth her child the way she instinctively wishes. She should only feel supported in her decision."*

It is well recognised that New Zealand's health services are stretched.[9] There are financial implications of providing real choice to women because this requires the availability of 'experienced' staff to support a VBB at any time. There is also a lack of consensus about how much practical experience is sufficient to count as 'experienced'. Counselling should therefore include provider and location specific experience and outcome data, so that women can judge for themselves what level of experience they find acceptable.

Although all specialist obstetricians *should* have the ability to safely support a VBD, a core component of RANZCOG obstetric training, it appears that not all are currently confident in doing so.[16] It is therefore inevitable that providing real non-coercive choice to women may require additional training for midwives and obstetricians and a reconsideration of institutional and supervision arrangements.[9] The costs of providing 24/7 specialist support for VBB may potentially be partially offset by the costs saved on unnecessary caesarean sections and

resultant complications, including in future pregnancies. The status quo is unacceptable from a medico-legal perspective and so the resource implications and educational needs (such as simulation training)[36] should be considered as a matter of public health policy. The provision of specialist breech-services, such as that offered at John Hunter Hospital in Newcastle, New South Wales,[23] is worth further exploration as a way to facilitate safe care for VBB.

Ultimately, a woman's informed choice to birth vaginally should be respected. As stated in *Montgomery v Lanarchshire Health Board* (para 115):[11]

> *"A patient is entitled to take into account her own values, her own assessment of the comparative merits of giving birth in the ... traditional way and ... by caesarean section, whatever medical opinion may say, alongside the medical evaluation of the risks to herself and her baby. She may place great value on giving birth in the natural way and be prepared to take the risks to herself and her baby which this entails. The medical profession must respect her choice, unless she lacks the legal capacity to decide."*

# Conclusion

Given apparent inadequacies in current practice, this article considered the legal duties of New Zealand providers to give information and to obtain consent in the management of breech presentation. The provider must give information about the risks and benefits of ECV, planned VBB and planned caesarean section (either before or during labour). Women have the legal right to refuse consent to caesarean section, in which case providers must deliver reasonable care in the circumstances. In order to respect women's legal rights, consideration should be given to any necessary changes to educational requirements and institutional arrangements to facilitate real choice for women and safe care for VBB in the New Zealand maternity care system.

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