The age of consent

Gaining informed consent in O&G is not always straightforward, but with the right approach to consent women are more likely to be satisfied with their care

WHAT IS consent? A piece of paper with a signature? A nodded agreement to an emergency procedure? Or a process of dialogue leading up to a medical event?

In an ideal setting, it could be all three. "It's not a moment in time, it's a dynamic process," says Edward Morris, Vice President of Clinical Quality at the RCOG. "Consent is the process of thinking about performing a procedure or arranging a test, and being able to explain it to the woman so she's able, with the right information, to agree to move forward."

The issue of consent has come to the fore since the 2015 Montgomery ruling which, while it didn't introduce any new legislation, effectively shifted the 'test' of negligence from achieving accepted standards of practice (as deemed appropriate by 'a responsible body of medical opinion') to one of appropriate dialogue with the patient, ensuring they have made informed decisions about their care based on the information provided. If there has been no informed dialogue, this could amount to negligence. Informed consent is therefore extremely important in ensuring our care is centred on the woman – and on keeping her safe.

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To determine why consent is a thorny issue in O&G we would need to examine the very nature of the profession. Phil Owen, a Glasgow-based consultant obstetrician and member of RCOG Council, says: "I think it's because there's such a large element of unpredictability, particularly in maternity care. All obstetricians and midwives will confirm that you don't know how a pregnancy or labour is going to end – a happy, relaxed atmosphere can soon turn into an emergency situation. And parents' expectations are high. That's appropriate, but the reality is that pregnancy and labour are unpredictable. My work in the delivery suite is the management of uncertainty."

Negligence claims

There is also an element of doctors needing to make sure they have done the right thing. It is true that O&G is one of medicine's more litigious specialties when it comes to the size of negligence claims. In 2015–16 it ranked third (below orthopaedic surgery and A&E) in terms of total number of clinical negligence claims received, but the value of those claims outstrips any other specialty.

However, doctors needn't take the view that they need to cover their backs, "it's about enabling the woman to have the delivery she wants and supporting her to make the right

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choices," Phil says. "If you provide women with the appropriate information they're more likely to be satisfied with their care."

So, what are the barriers to obtaining good quality consent? In gynaecology, where most procedures are planned, the consent procedure is generally not complicated. "Gynaecology lends itself by its planned nature to providing adequate information," says Phil. "There's time for consideration and informed consent. And in my view," he adds, "there is really no justification for us to be pursuing any elective procedure without suitably informed patients."

When it comes to obstetrics, however, "then that's a different matter, particularly in an emergency situation". Phil continues, "All we can do is adopt the usual practice, explain the situation as best we can and obtain verbal or written consent. And at 4am, in that kind of emergency scenario, it could be argued that the woman isn't necessarily giving her informed consent."

Phil acknowledges that there's no easy solution. "One way to provide informed consent is to provide the woman with information beforehand," he says, emphasising that this is just one idea of how the future of consent could look. "So, you'd almost be asking her to consent to an instrumental delivery or a C-section if it becomes necessary before labour even starts. The argument against that would be that you're turning a normal physiological event into a potential emergency before anything happens."

Ongoing debate

There's nothing new about this dilemma. Most doctors navigate it successfully day in, day out. But Montgomery has prompted a re-examination of consent procedures among organisations such as the RCOG. "A lot of medical practitioners are probably doing extended versions of consent in that they're

Top tips for obtaining consent

- Have information leaflets and consent forms to hand
- Document that you have provided information and that the patient has understood it
- When writing your documentation, consider how it might be interpreted by a third party in two, five or even ten years from now
- If you feel your documentation has been brief due to time constraints, go back and complete it after the event
- Ensure all those involved in the procedure are noted and their involvement is documented
- Document the facts only – it's seldom helpful to write down speculation
- Rules change: make sure you keep up to date on the latest guidance

having long discussions with patients," says Edward Morris. "What we need to be sure about is how we document it. Doctors need to check that the patient has understood, confirm they've understood and that they've made appropriate note of that."

Over the next three to five years, the RCOG is overhauling its online content, and part of this transformation will be its patient information. "We have a rich vein of patient information leaflets, which are effective and liked by patients and doctors," says Edward. "Every time one of those comes up for review from now on it's going to be reconsidered for its digital and consent content. There's no point in giving information without considering consent; I want to build that in."

He says he'd like to see the development of a suite of tools that will help not only in the planning of gynaecological procedures weeks in advance, but also allow women to get even a small amount of information in an urgent situation.

"The thing is that in the delivery suite, if it is a true emergency, you're saving lives," Edward says. The risk of a claim of negligence through lack of consent is therefore low. "But in many cases, you've got half an hour to an hour to make a decision. It's still an emergency situation but there's a bit more time for the patient to understand what the risk might be and what options there are, if any." He adds, "The RCOG is looking at more innovative tools, for example short explainer videos that can be shown on a tablet in the delivery suite."

In the meantime, however, the professional duties surrounding consent have not changed. Montgomery simply highlighted the important aspects of it. The consent advice on rcog.org.uk remains relevant and Edward encourages doctors to continue to use it. "In the future, though, we plan to present it in a more modern way," he says.

READ MORE

- Chief Medical Officer for Scotland's Annual Report 2015-16, Realising Realistic Medicine: www.gov.scot/Publications/2017/02/3336
- Article in *The Obstetrician & Gynaecologist*: Cheung E, Goodyear G and Yoong W. Medicolegal update on consent: 'The Montgomery Ruling'. TOG 2016; 18: 171–172. doi:10.1111/tog.12303
- Consent advice on RCOG website: rcog.org.uk/consent