Midwives Protection Program

RISK NOTE

SUBJECT: Informed Choice for Midwives

By JT Beck BA, JD Candidate, Law Co-op Student, Risk Management Branch

The midwifery model of care places a special emphasis on clients' rights to make informed choices.[1] Informed choice is a cornerstone of all health care, which recognizes every individual's right to self-determination and bodily autonomy. Within informed choice, individuals have the right to decide whether to consent to a particular treatment or care, and to have that right respected by their health care providers.[2] This right is carefully protected in both legislation and case law.

The following are key aspects of gaining and documenting informed consent and refusal. Midwives should remain aware of these and strive to document them fully.

Informed Choice and Legal Liability

Informed choice allows the client to be the primary decision-maker in their care, guided and facilitated by the midwife's non-authoritarian knowledge and expertise.[3] Of course, the process of informed choice will result in a client either consenting to or refusing treatment or care. This can be standard or routine care offered to all clients, or it can be specific care recommendations the midwife makes based on the client's risk factors or circumstances.

Providing informed choice can leave midwives and other care providers with a concern of increased ethical and legal liability, especially when clients refuse either routine or recommended care.[4] This can be particularly difficult to navigate when balancing the autonomy and values of the client, the clinical concerns the midwife may have, and the regulatory or professional standards the midwife must remain aware of.

Midwives can be reassured that, when informed choice discussions are conducted thoroughly and documented carefully, the client's choice can be respected without increasing liability. The following highlights the important areas to ensure are clearly met in order to reduce or minimize liability risk.

---

[1] BC College of Nurses and Midwives (BCCNM) (2017 & 2018). *Policy on informed choice* and *Midwifery scope and model of practice.*
https://www.bccnm.ca/Documents/standards_practice/rm/RM_Policy_on_Informed_Choice.pdf
https://www.bccnm.ca/Documents/standards_practice/rm/RM_Scope_and_Model_of_Practice.pdf

[2] Kotsaka, A. (2017). *Informed consent and refusal in obstetrics: A practical ethical guide*. Birth: 2017; 1-5.

[3] BCCNM (2017), *supra*, *Policy on informed choice.*

[4] Kotsaka, A. *supra*, pg 1.

Forms of Consent

Consent can be *implied* or *express*. Consent is implied when a client cooperates with care offered, such as when a client rolls up their sleeves to a midwife holding a blood pressure cuff, or arriving at hospital in active labour asking for assistance. In implied consent, a provider must have a reasonable belief that the client consents to the care, and should be able to demonstrate that belief if asked. If unsure, seek express consent, which can be either oral or written, and leaves no doubt as to the client's consent.

In most jurisdictions the healthcare provider proposing the procedure or treatment is also the practitioner responsible for having the informed consent and choice discussion with the patient or legal substitute decision-maker.

Elements of Consent

In order to defend an allegation that consent was not given the midwife must be able to show that all elements of consent were met prior to treatment. There are four key principles of consent:

1. **The consent discussion must be complete.** The legal test is whether the discussion included all information a "reasonable person in the client's shoes would want to know",[5] including the:
    a. Cause of the ailment,
    b. Nature of proposed treatment;
    c. Risks of proposed treatment;
    d. Special or unusual risks relevant to the particular client;
    e. Alternatives to treatment including no treatment;
    f. Opportunity to ask questions and have them answered in full.

    In determining how much information to share, keep in mind the standard of the 'reasonable person' and provide enough to allow another person in a similar circumstance enough information to make a decision.[6] In addition to these elements of consent, the BC College of Nurses and Midwives' (BCCNM) *Policy on Informed Choice* adds additional requirements: [7]
    a. Relevant research evidence including any deficiency of clear evidence;
    b. Relevant community standards of care and practices;
    c. Considerations according to *Indications for Discussion, Consultation and Transfer of Care*;[8] and
    d. Recommendation for the client; supported by evidence, BCCNM standards and community standards.

    These additional elements highlight the responsibility placed on midwives to provide recommendations to their client where they determine a particular recommendation for care is "in the best interest of their client".[9]

---

[5] *Reibl v Hughes*, [1980] 2 SCR 880
[6] Healthcare Insurance Reciprocal of Canada (HIROC) (2017). *Strategies for Improving Documentation*. At 14. https://www.hiroc.com/getmedia/9b3d1ed1-b2e1-45fc-ae18-bfc998177d15/Documentation-Guide-2017.pdf.aspx
[7] BCCNM (2017), *supra*, *Policy on informed choice.*
[8] BCCNM (2020) *Indications for Discussion, Consultation and Transfer of Care.* https://www.bccnm.ca/Documents/standards_practice/rm/RM_Indications_for_Discussion_Consultation_and_Transfer_of_Care.pdf
[9] BCCNM (2017), *supra*, *Policy on informed choice.*

2. **Consent must be voluntary.**[10] It must be gained without any undue influence or coercion, wherein the provider talks the client into a specific choice or treatment. In cases where a complainant can show a health care provider, such as their midwife, coerced them into accepting a treatment or intervention, the consent they provided is negated. This could make a case very difficult to defend as it would be hard to show true consent.

   Voluntary consent is especially important in high risk circumstances and procedures. Feeling coerced may lead clients to not trust their provider, and make unsafe choices with potentially tragic consequences.[11] Coercion can consist of magnifying risks, exaggerating benefits or withholding risks of treatments, demeaning a client for their choices, or threatening to withdraw care if they refuse recommendations.[12] It is important to the trust and safety of the professional relationship to ensure that the client receives courteous, professional care, regardless of their choices.[13]

3. **The client must have capacity to consent**. Capacity can be influenced by age and disability. Should the client be too young, or mentally disabled, they may not be capable of consenting to medical care. In this case they may require a proxy decision maker. However, this should not be an issue with the majority of midwifery clients. Even teenagers old enough to reproduce will likely have capacity to consent. However, if you are unsure please seek MPP advice.

4. **Consent must be to a specific treatment and to the person providing the care.** Clients must be able to understand what they are consenting to specifically, and who will perform that care.

If any of these elements are not met, consent may be deemed invalid by a court. High risk scenarios require extra documentation to ensure that these elements are reflected. If you feel that a client could say, *"If I had known… I would have chosen otherwise"*, that would be evidence they did not have a fulsome consent discussion at the time.

Consent can Change or Need to be Repeated

Think of consent as a process. It is not a one-time blanket statement; it can change or need to be repeated as situations change, care recommendations change, or circumstances arise requiring new procedures or treatments. For instance, an implied consent to treatment such as a labouring client arriving at hospital, or an express consent through a blanket consent form on admission, does not confer consent to any treatment a client may require. Should complications or new risks arise, new consent would be required for the resulting treatments, such as epidurals, forceps, IV starts, etc. These changes require documentation.

Even routine care requires consent. This process does not always need to be arduous, nor does it always require written documentation; however it is important to ensure that whenever a patient's bodily integrity or autonomy is affected, consent has been

[10] *Norberg v Wynrib*, [1992] 2 SCR 226
[11] Kotsaka, A. *supra*, at 2.
[12] *Ibid* at 3.
[13] *Ibid* at 3.

received. In routine procedures where consent has been hesitant or equivocal, document the response and action taken.

Consider Whether an Offer or a Recommendation is Needed

It is important to recognize the difference between offering *choices* and making specific *recommendations*.[14] Each of these plays a different role in the informed choice process. At different points in care, midwives may need to offer a choice, make a recommendation, or both.

When providing informed choice, clients often ask what the midwife recommends. In non-urgent situations, or when there is no best option because choices offer a "similar risk-benefit ratio",[15] it is appropriate to offer two or more options and allow the client to make their own best choice. For example, a discussion of newborn eye prophylaxis in a low-risk client is usually a situation where choices are presented neutrally, with current evidence-based research presented.

However, informed consent "does not preclude recommendations for the best course of care… as the experts, [midwives must] make clear recommendations during informed choice discussions."[16] When one course of action is in the client's best interest, based on their risk factors or circumstances, the clinician is responsible to make it clear to the client what their recommendation is. As per the BCCNM *Standards of Practice*, informed choice requires that "the midwife advises the client of their professional standards and recommendations with respect to safe care".[17]

Recommendations should be evidence-based, and supported by professional standards of care or guidelines.[18] In the example above, if the client had an acute gonorrhea infection, the midwife would be responsible to recommend newborn eye prophylaxis. At that point a client can choose to consent to the treatment, or refuse the recommendation. If the client was to refuse the recommended eye prophylaxis, the midwife should carefully document the informed refusal. For more detail see "Documenting Informed Refusal" below.

Use of Informed Choice Handouts

While informed choice handouts can be helpful in demonstrating that some of the elements of consent were met, such as risks, benefits, and alternatives, they do not meet the standard for documentation or for gaining consent.[19] Document when the handout was given, whether it was reviewed with the client, including discussion of risks, benefits and alternatives of treatment, as well as the clients specific personal risk factors, and that the client had opportunity to ask questions.

Documenting Informed Consent

To be defensible, all elements of informed choice/consent must be documented. In the case of specific recommendations, be sure to document clearly what recommendations

[14] Kotsaka, A. *supra*, pg 2.
[15] *Ibid.*
[16] Quoted from a recent BCCNM inquiry panel decision.
[17] BCCNM (2020). *Standards of Practice policy*. At Standard Five: 5.6 https://www.bccnm.ca/Documents/standards_practice/rm/RM_Standards_of_Practice.pdf
[18] BCCNM (2017). *Policy on Informed Choice*.
[19] HIROC, *supra*, at 15.

were made and why they were made, along with the other elements of informed choice provided to the client as listed above in "*Elements of Consent*". This documentation applies equally to situations where clients accept or refuse recommended care as a part of the informed choice process.

The higher acuity of a situation, or higher risk the procedure, the more detailed the chart notes should be. Other than in medical emergencies, consent must be gained prior to treatment, otherwise it may result in unfavourable legal outcomes for health care providers including allegations of medical battery and negligence.[20] Even when care was appropriate and consent was properly gained, failure to document the discussion can make it difficult to prove the patient was fully informed of the risks prior to the treatment or procedure.

The Right to Refuse Treatment

As with all health care patients, midwifery clients have a right to refuse treatment. Even when the recommendation is clearly toward one choice, the client may have their own reasons to refuse that recommendation. In all situations, clients should receive courteous, professional care without threat of abandonment.[21]

> "By refusing a caregiver's recommendation, a pregnant person's choice may put her and the fetus at increased risk of harm*. In continuing to care for her, it must be clear to everyone that her clinician is respecting her right to choose, and not endorsing her choice.* … Patients, families, caregivers, risk managers, indemnity providers, lawyers, and judges all need to be aware that a patient is ethically and legally responsible for any adverse outcome that results from their refusal." [22] [emphasis in original]

For further information, please review the BCCNM's Policy on Requests for Care Outside Standards.[23]

Documenting Informed Refusal

If a client refuses recommended or offered routine care, a midwife should ensure that all of the same criteria for providing informed consent has occurred and is fully documented. [24]

If the client is making choices outside of recommended care, it is crucial to document that all elements of consent were discussed, and that the client chose to refuse the treatment. Be sure to document:

- ✓ The recommend treatment or procedure, including its risks, benefits, and alternatives;
- ✓ That the client was advised of the risks of refusal of the treatment or procedure;
- ✓ That they know what to return to care for should they be leaving care against medical advice.

---

[20] *Malette v Shulman,* [1990] (Ont. H.C.J.), 1987 CanLII 4096 (ON SC)
[21] Kotsaka, A. *supra*, at 4.
[22] Kotsaka, A. *supra*, at 4.
[23] BCCNM (2020). Policy on Requests for Care Outside Standards. https://www.bccnm.ca/Documents/standards_practice/rm/RM_Policy_on_Requests_for_Care_Outside_Standards.pdf
[24] HIROC (2017), *supra*, at 14.

In situations where midwives are concerned about liability or potential poor outcomes, it can be helpful to have a second midwife or consultant physician counsel the client. In these situations however, the second opinion must be respectful and must be careful not to coerce the client to make an alternate choice.

The standard can be higher when a client is refusing care, especially in high risk situations. As the risk increases, the need for detailed charting increases as well.[25] This can be most important in informed refusal situations where:

- ✓ The midwife is not following the hospital guidelines or policies for a clinical issue, by either their clinical judgement, or by the client's choice.
- ✓ The client's choice goes against evidence-based guidelines or BC College of Nurses and Midwives' standards of practice or clinical practice guidelines.
- ✓ A refusal of recommended treatment increases the risk to maternal or fetal status.
- ✓ A refusal of care impacts the midwife's ability to provide safe care to a client.

For further information, please review the BCCNM's Policy on Requests for Care Outside Standards. [26]

Test Your Knowledge

A client who'd had a prior C-section discussed options for delivery with her midwife, and elected to try for a Vaginal Birth After C-Section (VBAC). The midwife obtained and reviewed the client's prior records and operative report and conducted a risk assessment based on her personal circumstances. The midwife's practice group protocol used a 'VBAC consent form', which the client signed when the midwife conducted an informed consent discussion during which she reviewed the risks, benefits, and alternatives of VBAC, and conducted a personalized risk assessment.

Spontaneous labour was reported at term. Early labour was monitored for five hours at home then transferred to hospital in active labour. Six hours after admission, an obstetrical consult for oxytocin was obtained for labour dystocia, and oxytocin was commenced. Full dilation was achieved four hours later. Severe bradycardia occurred during second stage. The midwife paged the on-call obstetrician and paediatrician stat, and the infant was delivered by forceps soon after. The patient was found to have had a uterine rupture. The infant was severely acidotic and was transferred to a tertiary facility. Long-term neurological sequelae occurred, and a lawsuit was filed claiming a lack of informed choice, and that the patient would not have chosen a VBAC had they known the risks of attempting VBAC.

The midwife's overall management during pregnancy and labour was considered by expert reviewers to be reasonable and defensible. At trial, the court found that the care provided was not negligent, largely supported by the detailed documentation of the

[25] HIROC, *supra*, at 14.
[26] BCCNM (2020). Policy on Requests for Care Outside Standards. https://www.bccnm.ca/Documents/standards_practice/rm/RM_Policy_on_Requests_for_Care_Outside_Standards.pdf

informed choice discussions the midwife had with the client in pregnancy.[27]

Questions:

1. Should a practice have a consistent way of conducting and documenting informed consent discussions?

2. If your practice group or hospital requires the use of consent forms for certain types of births or routine care, can you rely on the signed consent form alone as evidence of informed consent?

Answers:

1. *Yes. The most defensible practice is one which is routinely used in all circumstances. In the case where documentation is not performed well, a court may rely on evidence of standard practice of a midwife (i.e. what a midwife would tell every client in a given situation). If the entire practice conducts the same type of discussions and documents in similar ways, it will make evidencing the discussion easier should a legal issue arise in future.*

2. *No. While a signed consent form does provide helpful evidence that elements of consent such as risks, benefits and alternatives were communicated to the client, it does not prove as well as a chart note would that a conversation occurred or that the client had opportunity to ask questions and have them answered. Additional documentation is required to show these elements. This is more important in the case of high risk scenarios or patient-specific concerns*.

July 2018

January 2021: CMBC to BCCNM update (name change occurred September 1, 2020)

[27] Adapted from: HIROC (2017), *supra*, at 14.