Protecting human rights in childbirth

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Union House
111 New Union Street
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2nd July 2020

Dear Ms Greenwood,

We write to you from the human rights in childbirth charity Birthrights, regarding the discussion due to be held by the Clinical Ethics Advisory Group on the 3rd July on the ongoing policy of Oxford University Hospitals NHS Foundation Trust (OUH) to refer women seeking a maternal request caesarean to Gloucester Hospitals NHS Foundation Trust.

We recognise the remit of the Clinical Ethics Advisory Group is to advise clinicians on their practice and not to make decisions. However we strongly urge the ethics group to:

- urge obstetric colleagues to reflect on the legal and ethical basis of their own individual position on maternal request caesareans and on the impact this has on women,

- recommend that the obstetric body of consultants revisit their collective decision to uphold their existing policy of not offering maternal request caesareans at OUH on the basis that the way the decision was taken was unethical.

Legal/ethical basis for maternal request caesareans

1. **The law is clear on a woman's right to decide what happens to her body during pregnancy and birth even when her own life or that of her baby depends upon it.**

Montgomery v Lanarkshire (2015) centred on a patient's right to choose, and concluded that the role of the clinician was to facilitate a patient to make an informed decision about what was right for her (or him) as an individual. It was not to make that decision on her behalf. The judgment stated:

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"[Societal changes suggest] 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."*

Dominic Wilkinson, Professor of Medical Ethics and consultant neonatologist at OUH, argues in his discussion of the Montgomery case here that if Montgomery leads to an increase in requests for elective caesarean *"that is the price we have to pay for respecting the autonomy of women and their right to make important decisions about their health."*

The position in the Montgomery case reflects the right to make reproductive choices protected by Article 8 of the European Convention of Human Rights. [1]

The concept of individual's autonomy and the right to choice is upheld by the NHS Constitution and runs through national guidance from NHS England, the Royal College of Obstetricians and Gynaecologists, the Nursing and Midwifery Council, and the General Medical Council.

Therefore where a woman wishes to choose caesarean as mode of birth, the Trust has a duty to respect and facilitate her choice unless they have a good reason not to.

2. National guidance should be followed unless there is an evidence based reason not to follow it

NICE guideline CG132 contains the following guidance on maternal request caesarean:

[1] Further discussion of this can be found in *Childbirth, Vulnerability and the law: Exploring Issues of violence and Control, eds Camilla Pickles and Jonathan Herring, chapter 7 "Human rights law and challenging dehumanisation in childbirth" by Elizabeth Prochaska, and Chapter 8 "Leaving women behind: the application of evidence-based guidelines, law, and obstetric violence by omission" by Camilla Pickles.*

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1.2.9 Maternal request for CS

1.2.9.1 When a woman requests a CS explore, discuss and record the specific reasons for the request. **[new 2011]**

1.2.9.2 If a woman requests a CS when there is no other indication, discuss the overall risks and benefits of CS compared with vaginal birth and record that this discussion has taken place (see box A). Include a discussion with other members of the obstetric team (including the obstetrician, midwife and anaesthetist) if necessary to explore the reasons for the request, and ensure the woman has accurate information. **[new 2011]**

1.2.9.3 When a woman requests a CS because she has anxiety about childbirth, offer referral to a healthcare professional with expertise in providing perinatal mental health support to help her address her anxiety in a supportive manner. **[new 2011]**

1.2.9.4 Ensure the healthcare professional providing perinatal mental health support has access to the planned place of birth during the antenatal period in order to provide care. **[new 2011]**

1.2.9.5 For women requesting a CS, if after discussion and offer of support (including perinatal mental health support for women with anxiety about childbirth), a vaginal birth is still not an acceptable option, offer a planned CS. **[new 2011]**

1.2.9.6 An obstetrician unwilling to perform a CS should refer the woman to an obstetrician who will carry out the CS. **[new 2011]**

Sir Jonathan Montgomery states in his own assessment of the Montgomery v Lanarkshire case that: "Within the NHS, the work of the NICE also seeks to establish guidance on best practice. In the absence of particular issues suggesting that a particular woman's circumstances made the guidelines inapplicable, following them would seem responsible practice providing that they are not followed 'slavishly' and do not exclude the exercise of the professional's clinical judgment"

It was also accepted in ***R (Rose) v Thanet CCG*** [2014] EWHC 1182 (Admin) that NICE recommendations have the status of public law relevant considerations.

NICE guidelines are the accepted guidance of best practice within the NHS, and should be followed unless an individual obstetrician can show that there is a good reason not to apply them in an individual case, or where a Trust can show that local circumstances deem them inapplicable.

3. OUH has been unable to give any evidence of a practical reason why it cannot support maternal request caesareans, particularly given the recent expansion

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of theatre capacity. The evidence on caesareans which does not support taking a different view to NICE and we urge obstetricians to reflect on this evidence on an individual basis.

Sir Jonathan Montgomery's letter to Birthrights of the 17th June 2020, argued that OUH's position was in line with FIGO and WHO guidance. This is disingenuous on a number of levels:

- Firstly, NICE guidance and not FIGO and WHO is the correct point of reference for the NHS.

- Secondly, the FIGO/WHO guidance referenced does not recommend restricting access to maternal request caesarean. The FIGO guidance states that women should be informed properly on the benefits and risks of a c-section, and this recommendation is already reflected in NICE guidance. As the FIGO guidance makes clear, WHO has said that decisions on caesareans should be made on **an individual basis** rather than being driven by a target caesarean rate, even when at a population level there may be a case for trying to reduce *unwanted* caesareans. This view was echoed by the CQC in September 2018 when they confirmed to Caesarean Birth that if a Trust's caesarean rate rises due to an increase in maternal request, and NICE recommendations were being followed, this is an acceptable reason. *"CQC don't believe that targets for caesarean section should be in place and therefore don't inspect against targets."*

- There are many issues with unnecessary and unwanted caesareans around the world that are not applicable to the UK. The FIGO paper highlights problematic financial incentives for example. However, this large systemic review and meta-analysis published in the PLOS journal in 2018 quoted evidence from NICE to conclude that "the short-term adverse associations of caesarean delivery for the mother, such as infection , hemorrhage, visceral injury, and venous thromboembolism, have been minimised to the point that cesarean delivery is considered as safe as vaginal delivery in high-income countries". It is crucial that the clinical safety of caesarean births **in the UK** is considered and that a distinction is made between the safety of planned caesareans as opposed to unplanned caesareans.

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- This article by UK obstetricians explains why resource constraints are not an adequate reason for withholding caesareans and this article by respected obstetricians argues that when litigation costs are taken into account, planned caesareans are actually much more cost effective than vaginal births.

- The risks and benefits of caesarean vs vaginal birth will vary with each individual both in terms of the likelihood of clinical outcomes but also how strongly they feel about it, and whether these feelings could change. However it is crystal clear that the evidence does not support a blanket refusal to carry out maternal request caesareans. As many of the risks related to caesarean birth relate to future pregnancies, a 42 year old woman pregnant for the first time and only intending to have one baby, faces a significantly different set of risks to a woman in her 20s expecting her first baby and wanting a large family. Whilst individual obstetricians are permitted to decline to undertake a caesarean in an individual case, it is unethical not to consider individuals on a case by case basis, and for a doctor to have already made up their mind not to offer maternal requests caesareans to any woman who requests one.

4. **Evidence about the impact of the current policy on women and their families has been missing from obstetricians' analysis to date. It is unethical for individuals (as well as the consultant obstetric body as a whole) to have reached a position on maternal request caesarean birth without understanding the impact on a woman's physical and psychological health, and that of her family, as well as understanding the impact of having to travel to another Trust.**

Our report on maternal request caesarean published in 2018 explored the reasons women contacting our advice line wanted to have a caesarean.

A third of enquirers (33%) over the period analysed wanted a caesarean birth due to a previous traumatic birth. The second most common reason (28%) for wanting a caesarean birth was an underlying medical condition such as symphysis pubis dysfunction (SPD) - a common problem with the pelvis during pregnancy -, vaginismus or fibroids. These conditions do not always meet the threshold of requiring a caesarean for medical reasons but the impact of these conditions on the

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women affected is significant, and the thought of having their condition exacerbated by a vaginal birth can be a cause of huge anxiety. It is not clear what the ethical basis is for obstetricians deciding they know best for women in these cases.

The remaining third is made up of women who simply believe it is the right option for them (16%), often after extensive research into the evidence, or who have primary tokophobia (8%) or who have experienced other trauma in their lives such as sexual assault (6%). 10% did not give their reason for making this request.

It is startling to note that according to this data a third of requests are driven by psychological trauma caused by maternity services that did not meet that woman's needs. It is has been noted that if someone was suffering PTSD as a result of fighting in a war, they would not be sent straight back to the battlefield. The current set up of maternity services means that many women who never wanted a caesarean end up with one, and Birthrights has consistently argued that any efforts to reduce caesareans should be focused on preventing unwanted caesareans, rather than the very small numbers of women who feel that a caesarean birth would be best for them.

These women have repeatedly told us of the judgement, and hostility and the lack of understanding they have faced from healthcare professionals at OUH when making a request for a caesarean, and we urge clinicians to consider the stories below, or even better reach out to women who have been affected by this policy in order to reflect on how the maternal request caesarean ban at OUH fits with their professional and ethical obligations to their patients.

A. *I had my 20 week appointment with Obstetrician Dr. X at J. Radcliffe hospital Oxford two weeks ago and it was awful experience. Dr. X was nearly an hour late for the appointment. The consultation lasted less than 15 minutes. He spoke to me about the fibroids and how they pose no risk to my VB delivery. I asked about risks of VB with fibroids Dr. X said there aren't any. When I asked him if we could discuss mode of delivery he stopped me mid-sentence and said my best option is vaginal birth. I said to him that I would like to explore other options such as elective caesarean. The conversation turned very quickly after this and I was unable to finish explaining my reasons or concerns. I was quickly stopped mid sentence and Dr. X told me that they do not follow NICE guidelines and that I will*

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never get elective CS in John Radcliffe hospital for non-medical reasons. The word 'never' was stressed to me.

I felt like a child being told off for doing something wrong and found Dr. X's attitude appalling. I was extremely shaken after this appointment and had to sit in my car for 15 minutes before I was able to drive back home."

B. *"I have just moved to Oxfordshire and if I were to have a second baby I would be assigned to the John Radcliffe hospital. I have read that they have a staunch policy not to offer c sections other than for medical emergencies. This worries me deeply as I had a traumatic birth with an emergency epidural, forceps and episiotomy. Without the option for real support and the potential for a planned c section I cannot see myself coping with the prospect of a second vaginal birth. I also have friends who have been cared for by this trust who felt judged, pressured and misunderstood when declining a VBAC."*

C. *"My Maternal Request for Caesarean Section has arisen due to a deeply ingrained and long term fear of natural childbirth. My fear is rooted in the birth of my brother, who sustained birth injury following a traumatic birth and severe oxygen deprivation. My brother has suffered with severe learning disabilities his whole life due to his birth. My fear of natural childbirth is due to my first hand family experience, I have always been acutely aware of the real risks of natural childbirth and injury babies can sustain from this, which can result in handicap.*

I had my first meeting with Dr Y. Dr Y turned up about 2 hours late for the meeting, and made a comment about how he had been in a clinic dealing with women with "real problems".

(Second meeting with Dr Y) After this discussion, I questioned Dr Y on OUH's stance on Maternal Requests for Caesarean Sections, which is in clear contravention of NICE guidelines.. I asked Dr Y why OUH considers its policy to supersede the NICE guidelines, and at this point, Dr Y threatened to terminate the meeting as it was a "waste of his time" to listen to me "making pot shots" at OUH's policy and that "a woman has lost her baby", the clear implication, yet again, that some women have "real problems", and I am a burden to him and a drain on his

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resources. Feeling extremely upset by this comment, I then asked him directly "do you consider this meeting to be a waste of your time?" he remained silent."

The above was subject to a formal complaint – the response made no reference whatsoever to the doctor's behaviour.

D. *"It is hard to put into words how disgusting it is to be shown in black and white that the best I can hope for from the Oxfordshire NHS trust is to be sent somewhere else so that I can be someone else's problem. At my booking in appointment with the Midwife I was presented with a letter stating your policy on maternal request C-sections. I did not discuss my fears regarding childbirth with the Midwife because it was clear there was no point in doing so. The message could not be clearer; regardless of how valid my reasons might be, vaginal birth is the only option. The fact that your policy on C-sections has meant that I no longer feel able to discuss my fears with the midwives illustrates just how toxic it is.*

   A C-section is not my idea of an ideal birth; it's the option that I find least terrifying, the lesser of two evils. In this day and age, with the medical resources and practices available to us, a fear of childbirth should not be a barrier to having a child. I know for a fact that my case is not unusual and that there are many other women in my situation who feel let down by Oxfordshire NHS trust. While it is clear some health care professionals within Oxfordshire NHS trust are sympathetic to women in my situation; the organisation they work for appears to consider their existence inconvenient, their rights non-essential, and their wishes best ignored."

E. *"I have recently given birth to my fourth baby. I have suffered severe SPD with all of my pregnancies each one getting worse. I've delivered all of my children vaginally after being induced at around 39 weeks but after speaking with my physio, she believed that the treatment during my last delivery may have prolonged my recovery.*

   At 36 weeks I had an appointment with the consultant at the John Radcliffe to discuss my birthing plans. I put across to them that I was considering a caesarean to be my best option but was told that they wouldn't offer me one as it was not an obstetric need.

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I also tried to discuss the option of having an early induction, again I was told no, this did not follow their policies. I reminded the Dr that I was taking daily Fragmin injections due to my lack of mobility to stop blood clots forming and I was aware that if I went into spontaneous labour within a certain time frame after having an injection I'd be left unable to have an epidural should I feel I needed one, it also meant that should something go wrong and I needed to have an emergency caesarean I'd be unable to have any form of spinal block meaning I would need a general anaesthetic. The Dr I was speaking to only offered her sympathies and repeated that it was against their policies and I would not be offered either an early induction or a planned caesarean.

I feel that my concerns were not listened to, my knowledge of SPD with my own body and the previous trauma my body had suffered along with the recovery time were ignored.

Because my unborn child was thriving inside me they weren't prepared to listen or help me. I felt that I was seen as being selfish for requesting help rather than suffering both physically and mentally."

F. *"I think there is an issue regarding the perception of 'anxiety' around childbirth. I am not frightened of the pain or uncertainty per se and it is not the inherent indignity, vaginal examinations or lack of control which especially worries me, which as I understand it is what making a birth plan with the midwives seeks to address. My reasons for requesting a caesarean are to do with the inherent risks of vaginal birth (namely third and fourth degree tears, subsequent genital tract prolapse and incontinence, changes to my sexual function and risks to my baby resulting from an assisted birth) none of which I believe is adequately addressed in the leaflet and these known risks cannot be reduced with 'reassurance'. The consultant who will perform the operation has agreed that my "rational and logical reasons" justify pursuing what is generally an extremely safe surgery noting in addition that as a spontaneous vaginal birth cannot be guaranteed indeed my safest option overall is for a caesarean under regional anaesthesia. "*

Issues with the Gloucester referral pathway

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To our knowledge the impact of the Gloucester referral pathway on women, compared to the alternative of offering maternal request caesareans at OUH, has never been assessed, and we would argue that continuing this pathway without that assessment is unethical.

The pathway via Gloucester is not secure. We know that it was not available for a period around May 2019 when we were alerted to the fact that Gloucester was not accepting new referrals, and that it hasn't been available since the outset of the current pandemic (with no reinstatement date), which means that maternal request caesarean is not available consistently to women served by OUH.

Furthermore, no assessment has been done on the impact on women being referred to Gloucester and whether this is consistent with the Trust's public sector equality duty and human rights obligations. A woman who contacted us in December 2019, decided not to go to Gloucester because of the cost of accommodation for her partner. Another woman who had lost a baby and then had a traumatic birth where she experienced significant injuries told us:

"However neither me nor my partner drive (I have autism / dyspraxia - the latter which effects my ability to judge speed and distance effectively) I've been told it's best for me not to and my partner has just not learnt yet, with a 7 month old and no family around that are able to watch her and look after her it's not possible for us to keep going backwards and forth to a hospital that is much further away and definitely very difficult if I were to have a prolonged stay."

This woman ended up having a further traumatic vaginal birth at OUH because she had no other option.

In addition, we know that many of these women go through their entire pregnancy living with the anxiety of deciding whether they have enough time to make the drive (over an hour in many cases to Gloucester) or to go to OUH where their request for a caesarean will not be honoured:

"Driving to Gloucester three times for my antenatal appointments and then the birth, arranging for accommodation nearby for my husband and family and the worry that, should I go into labour spontaneously prior to my scheduled section at 39 weeks, I will have to ring the JR and see whether they are prepared to honour the Gloucester consultant's position or face the one hour drive to Gloucester when I live ten minutes from a hospital."

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5. **Finally we believe that the way the recent decision was taken to continue the current policy was unethical.**

Sir Jonathan's letter of the 17th June advises that Ms Greenwood met with 13 of the Trust's 16 consultant obstetricians recently to discuss the current maternal request caesarean policy and that all 13 present were in favour of maintaining the current policy (we would be very interested to hear the views of the final 3). Frankly, given the evidence outlined above we find it amazing that there was such a consensus of views and therefore question whether this was a safe environment given for anyone to voice a different view without risking censure from colleagues. We are also concerned about what this says about the culture at OUH and the example this sets for doctors in training. Our concern has been amplified after having been contacted by a doctor at OUH (not an obstetrician) who wanted a maternal request caesarean but was very concerned about the professional repercussions of her choice. We urge the Clinical Ethics Group to urgently explore ways of developing a culture whereby obstetricians are free to form and express their own professional judgement and that "group think" is avoided particularly when the outcome is so damaging to patients. We strongly believe this decision needs to be revisited and taken in a different way where obstetricians are free to listen to their own consciences. We would also urge OUH to urgently undertake steps to secure more diversity and independence in the views of its obstetric body.

We also note that as far as we aware there was no involvement of the Maternity Voices Partnership or any other service user involvement in this decision.

Finally, although OUH claim **that that take the same approach as other Trusts in the Local Maternity System, Birthrights gets far more complaints about OUH's policy that other Trusts in the area (or in the country)**. For example in the financial year ending March 2020, we received 10 enquiries about OUH, compared to 2 regarding Royal Berkshire and 1 regarding Buckinghamshire. Anecdotal evidence suggests that the policy is more strictly applied at OUH than elsewhere. We are not aware of Royal Berkshire or Buckinghamshire consistently referring to another Trust.

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We ask the Clinical Ethics Advisory Group to take account of the points above, and to urge individual obstetricians to reflect on the legal and ethical basis for their own position on maternal request caesarean, and to ask the obstetric body of consultants to revisit their unethical and damaging decision.

We look forward to hearing the outcome of the Clinical Ethics Advisory Group discussion following Friday's meeting.

Yours sincerely,

Maria Booker

Programmes Director – Birthrights

Cc
Sir Jonathan Montgomery – Chair, OUH NHS FT
Meghana Pandit – Chief Medical Officer, OUH NHS FT
Oxfordshire Maternity Voices Partnership
James Kent – Executive Lead of BOB ICS
Kiren Collison – Clinical Chair, Oxfordshire CCG
Rosalind Pearce - Healthwatch Oxfordshire
Anneliese Dodds – Member of Parliament for Oxford East
Matthew Jolly – Clinical Director, NHS England
Stephen Anderson – Maternity Transformation Programme, NHS England
Karen Kennedy – Maternity Transformation Programme, NHS England
Eddie Morris – President, Royal College of Obstetricians
Matthew Miles – Royal College of Obstetricians