

CONSENTING TO TREATMENT

Summary

Pregnant women – like everyone else – have the right to make their own decisions about their bodies.

It is against the law to give medical treatment to a pregnant woman unless she agrees to it. This is known legally as giving her consent.

Basic principles

Every person has the right to make decisions about their body for themselves. This is known as the principle of autonomy. It is protected under the common law of England and Wales and Article 8 of the European Convention on Human Rights. See our factsheet, [Human Rights in Maternity Care](#).

Pregnant women are entitled to make autonomous decisions in the same way as any other person, and their decisions must be respected, regardless of whether health professionals agree with them.

The principle of autonomy creates a legal requirement to obtain a person's consent whenever they are given any medical treatment.

The only exceptions to this are in rare cases: either when a person does not have the capacity to make their own decisions; or in an emergency when a person cannot consent because of their physical condition.

If a person's consent is not obtained, the medical treatment will be against the law on several counts. It will constitute the crime of battery, and a civil wrong of trespass to the person and/or negligence, and it will violate Article 8 of the European Convention. If the harm that occurs as a result is serious, it will also breach Article 3 of the European Convention prohibiting inhuman and degrading treatment.

When is consent required?

Consent is required for every medical procedure.

Consent must be obtained before any examination or investigation is carried out, or any care or treatment is provided.

The fact that a woman has consented to a particular procedure in the past does not mean that she consents automatically to the same procedure again. Consent must be sought each time a procedure is performed.

If circumstances change or new information becomes available and the benefits or risks of the treatment change as a result, then fresh consent should be sought.

Sometimes, a healthcare professional may ask for advance consent to treat problems that could arise while the woman is unable to give further consent. For this reason, consent forms for caesarean section will often list other procedures which the woman is asked to 'pre-authorise' in case they should become necessary during the operation and the woman is unable to give her consent because she is under general anaesthetic or lacks capacity. Any procedure not mentioned on the form may only be carried out if it will prevent death or serious harm.

What counts as consent?

For consent to 'count' in the law, a person must genuinely agree to receive treatment.

This means that the woman must be well-enough informed about the treatment, and cannot have been put under undue pressure or bullied into receiving the treatment by healthcare professionals or family members. These requirements are explained in detail below.



What information should I be given?

You must be given information about any proposed procedure in advance. The information should cover any significant risks, any alternative treatments which are available, and the risks of doing nothing. However, the law does not require that doctors and midwives give women all the information within their knowledge. They must provide enough information so that the general nature and purpose of the treatment is properly understood.

Giving misleading information about your medical condition or the proposed treatment, or not giving you relevant information, may mean that consent was not valid. The failure to provide appropriate information may also leave the healthcare professional open to a successful claim of negligence where the woman suffers harm as a result of the treatment.

If a woman asks specific questions, it is good practice for a healthcare professional to give full, honest and objective answers. The [GMC guidance](#) advises doctors to encourage their patients to ask questions.

The healthcare professional regulators, the [General Medical Council](#) (GMC) and the [Nursing and Midwifery Council](#) (NMC), produce guidance on consent explaining in detail what information doctors and midwives are expected to provide as well as how consent should be recorded.

The Royal College of Obstetricians and Gynaecologists also provides advice on consent, and on specific procedures and the risks associated with those procedures, including [caesarean section](#), [operative vaginal delivery](#), and [participating in research while in labour](#).

What is undue pressure?

A healthcare professional must explain the risks of a procedure to a woman, including risks to her unborn child, and may recommend a particular clinical option. However, they must not put 'undue pressure' on the woman to accept their advice.

'Undue pressure' could include physical restraint, threats to withdraw care, repetitive and unwanted discussion of risks, imposing an arbitrary time limit for a decision, and putting pressure on other family members.

A threat to refer a woman to social services would constitute undue pressure. Such a threat should never be used to intimidate, bully or coerce a woman into accepting a particular medical procedure for her or her unborn child. Consent that is given on this basis may not constitute valid consent, and the healthcare professional may be legally liable if they performed the medical intervention. See our fact-sheet, [Facing Criticism](#).

Should consent be recorded in writing?

Consent does not need to be recorded in writing. Consent may be given verbally or even with a gesture, for example by holding out your arm for blood pressure to be checked.

It is usual practice to sign a consent form for surgical procedures.

Where there has been a discussion about a procedure, the medical records should include details of the discussion including information given and any questions asked by the patient.

A signed consent form and/or medical notes are evidence of consent but not proof: they may be contradicted by other evidence that consent was not well-enough informed or freely given.

The [GMC's guidance](#) and [Department of Health's reference guide](#) contain further information on the form consent should take.

What happens in an emergency?

In an emergency, the general principle is that if a patient is unable to make their wishes known, treatment can be given without their consent in order to



save their life or prevent serious deterioration in the patient's condition.

If there is time, the patient's next-of-kin should be involved in decisions about their care.

Can I refuse treatment?

Yes. The English courts have upheld the rights of patients 'to make important medical decisions affecting their lives for themselves: they have the right to make decisions which doctors regard as ill advised' (*Re MB (Adult, medical treatment)* (1997)).

A mentally competent patient has an absolute right to refuse medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death.

A mentally competent woman may refuse treatment even where that might lead to death or serious harm to her or her baby (*St George's Healthcare NHS Trust v S* (1997)).

The [Royal College of Obstetricians and Gynaecologists ethics committee guideline on court-authorised Caesarean section](#) provides further details on the very limited circumstances in which the court can authorise Caesarean sections.

Can I withdraw consent?

Yes. Once given, consent remains valid for the relevant procedure unless it is withdrawn.

Consent can be withdrawn at any time. It may not always be possible to stop a procedure immediately, but if the healthcare professional has any doubts about whether a woman has withdrawn her consent, they should stop as soon as possible and check whether or not she still consents.

What is mental capacity?

It is always assumed that a woman has the mental capacity to consent to treatment (or to refuse it) unless it can be shown otherwise. This principle is enshrined in the [Mental Capacity Act 2005](#) which governs decisions about whether a person lacks capacity and how they can be treated if they do.

In order to lack capacity under the law, a woman must be unable to make a decision for herself because of a problem in the functioning of her mind. She might lack capacity in relation to some decisions and not others.

The fact that a woman may have made a seemingly irrational decision that clinicians believe is not in her best interests is not a reason by itself to decide that she lacks capacity.

If a woman is deemed to lack capacity, decisions about her treatment must be made in her best interests. The Mental Capacity Act sets out the factors that should be taken into account in deciding someone's best interests. This includes taking account of any written statement of preferences or wishes, which could include a birth plan.

Where there is serious doubt or dispute about a person's capacity or best interests, the Court of Protection can be asked to make a ruling. It may make a binding decision regarding treatment or may appoint a deputy to make decisions on behalf of the patient.

The [Mental Capacity Act 2005 Code of Practice](#) gives further detail on how the Mental Capacity Act should be applied.

If a woman is being treated for a mental disorder under the [Mental Health Act 1983](#), that does not necessarily mean that she lacks capacity in relation to decisions about her maternity care. She should be treated in the same way as any other woman unless she has been assessed to lack capacity.



Will giving birth affect my capacity to consent?

Extremely rarely. The experience of giving birth will not affect whether you have capacity to consent to treatment, except in very exceptional circumstances where capacity is completely destroyed by drugs, fatigue, pain or anxiety.

[Royal College of Obstetricians and Gynaecologists guidance](#) and [guidance on consent from the Association of Anaesthetists of Great Britain and Northern Ireland](#) state that special care must be taken when obtaining consent from women who are in labour, particularly if they are under the influence of narcotic analgesics (opiate-derived painkilling drugs).

What happens if I lose capacity?

If you suffer from a condition that may cause you to lose capacity during your pregnancy or labour, you could make an 'advance decision' about your maternity treatment under the Mental Capacity Act 2005.

An advance decision will have the same effect as a decision made in labour and must be followed by healthcare professionals. This advance decision can be withdrawn at any time.

An advance decision must meet certain criteria set out in the Mental Capacity Act 2005. It must, for example, make it clear which treatments the person is refusing and it must be signed and witnessed. If an advance decision refuses life-sustaining treatment when life is at risk, it must clearly state this. An advance decision cannot request specific medical treatment, it can only refuse treatments.

A written statement of wishes or preferences, such as a birth plan, that does not qualify as an advance decision under the Act, does not legally bind a healthcare professional like an advance decision would. However, it should be used to guide any decisions if a woman loses capacity.

What is the legal status of a birth plan?

A birth plan is a statement of a woman's preferred plan of care during labour and postnatally. It does not have any formal legal status, but it ought to be respected by healthcare professionals unless the woman gives her consent to a different plan of care.

A birth plan may be used as evidence of consent or lack of consent if a woman later challenges the treatment that she has received.

If treatment that a woman has requested in her birth plan is clinically contra-indicated (i.e. there are medical reasons for not providing the treatment), she should be told the reasons for refusing to provide the treatment.

Healthcare providers have a duty to prevent avoidable suffering, and so refusal of pain relief, access to a birth pool or other forms of support during labour should be considered with reference to each woman's individual circumstances and not solely on the basis of a guideline or policy.

Can I decide what treatment my baby receives?

Yes. Consent for any medical treatment or procedure, including the administration of a drug, must be sought from a person with 'parental responsibility' for the baby. This always includes the baby's mother, but the baby's father has parental responsibility only if certain criteria are met. You can find a summary of parental responsibility on the [NHS Choices website](#).

If parents refuse treatment for their child, healthcare professionals should respect their decision. In some circumstances, including if parents disagree about treatment, healthcare professionals may approach the High Court for an order declaring that treatment is in a child's best interests and should be carried out.

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