Dignity in Childbirth
Introduction

Who we are and what we do

- Set up in 2013.
- Raise awareness about human rights in maternity care.
Factsheets available: birthrights.org.uk.
- Provide individual advice service to women and professionals.
- Undertake research, e.g. Dignity Survey 2013.
- Campaign on human rights in childbirth.
- Train health professionals.
Human rights in maternity care

“A woman’s relationship with her maternity providers is vitally important. Not only are these encounters the vehicle for essential lifesaving health services, but women’s experiences with caregivers can empower and comfort or inflict lasting damage and emotional trauma. Either way, women’s memories of their childbearing experiences stay with them for a lifetime and are often shared with other women, contributing to a climate of confidence or doubt around childbearing.”

White Ribbon Alliance, Respectful Maternity Care (2011)
Principles: dignity

‘Humanity itself is a dignity; for a man cannot be used merely as a means by any man but must always be used as an end.’ Kant, Metaphysics of Morals

‘All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.’ Article 1, Universal Declaration of Human Rights
Principles: dignity

Human dignity offers a **moral and legal basis** for:

A. Resisting degrading and abusive treatment  
B. Asserting autonomy

A pregnant woman remains human. She is not simply a means to producing a baby. Her humanity must remain ‘an end in itself’.

Recognising a pregnant woman’s humanity means that we must treat her as a person worthy of respect.
Principles: respectful treatment

‘No one shall be subjected to inhuman or degrading treatment’ Article 3, European Convention on Human Rights

Failure to provide care, including pain relief, which is needed to avoid preventable suffering can amount to inhuman or degrading treatment.

The Mid-Staffordshire public inquiry revealed the impact that failure to respect basic dignity had on patients. The labour ward at Stafford Hospital was implicated in the scandal. Human rights claims brought under Article 3 on behalf of over 100 of the Mid-Staffs patients have succeeded.
Principles: autonomy and consent

‘A competent woman, who has the capacity to decide, may, for religious reasons, other reasons, for rational or irrational reasons or for no reason at all, choose not to have medical intervention, even though the consequence may be the death or serious handicap of the child she bears, or her own death.’

Court of Appeal, Re MB (1997)
Principles: autonomy and consent

‘In our judgment, while pregnancy increases the personal responsibilities of a woman, it does not diminish her entitlement to decide whether or not to undergo medical treatment. Although human … an unborn child is not a separate person from its mother. Its need for medical assistance does not prevail over her rights. She is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it. Her right is not reduced or diminished merely because her decision to exercise it may appear morally repugnant.’

Court of Appeal, S v St George’s Healthcare Trust (1998)
Montgomery v Lanarkshire Health Board

Mrs Montgomery, a pregnant diabetic woman with a large baby, was not informed by her obstetrician of the chance of shoulder dystocia. Baby was damaged during birth, woman suffered serious perineal and pelvic trauma.

For diabetic women, the risk of the occurrence of shoulder dystocia is about 9-10% and the consequent risk of serious injury to the baby is less than 1%. Shoulder dystocia also poses a variety of serious risks to the woman’s health, including post-partum hemorrhage (11%) and 4th degree perineal tear (3.8%).
Montgomery v Lanarkshire Health Board

i) **Dialogue:** in order for a patient to make an informed decision, there must be a conversation between doctor and patient. The doctor must ‘ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision.’ The information cannot flow one way and the doctor’s advice must be ‘sensitive to the characteristics of the patient‘ (Montgomery, para 89). Hospitals cannot rely on printed information leaflets to provide information; there should always be a personal discussion.
ii) **Material risks**: a material risk is one to which a reasonable patient would attach significance. Statistics alone will not determine whether a risk is significant for a particular patient. For example, the risk of complications for future pregnancies after a c-section might be statistically small, but it would be more significant for a woman who wished to have multiple children than for a woman who did not.
Montgomery v Lanarkshire Health Board

iii) Consent forms: the Court emphasised that the doctor’s obligation will only be discharged if the information is imparted in a way that the patient can understand. ‘The doctor’s duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form’ (Montgomery, para 90).

Hospitals cannot rely simply on a completed consent form as evidence that a clinician has fully appraised a patient of the risks of a procedure.

What are the implications for documentation?
Human Rights Act 1998

Implements the rights in the European Convention of Human Rights in UK law. All public bodies and their staff, including hospitals and health professionals, are legally obliged to respect human rights.

Potential for legal action under the Human Rights Act for poor care, e.g. human rights claims brought under Article 3 by relatives of Mid-Staffs patients.
Principles: choice

Article 8 of the European Convention on Human Rights protects the right to private life. The European Court of Human Rights recognised in Ternovszky v Hungary (2010) that choices about childbirth are part of private life.

Health professionals are obliged by the Human Rights Act 1998 to respect women’s choices, subject to proportionate limitations.
Ternovszky v Hungary

The European Court of Human Rights held that women are entitled to choose to give birth at home and the state is obliged to ensure that health professionals can attend them at home without fear of criminal, civil or disciplinary sanction for doing so:

‘The Court considers that, where choices related to the exercise of a right to respect for private life occur in a legally regulated area, the State should provide adequate legal protection to the right in the regulatory scheme. … In the context of home birth, regarded as a matter of personal choice of the mother, this implies that the mother is entitled to a legal and institutional environment that enables her choice, except where other rights render necessary the restriction thereof.’
Dubska v Czech Republic

In 2014, the European Court of Human Rights seemed to reverse the position in *Ternovszky*. While recognising that Article 8 protected women’s right to make choices about childbirth, it found that the Czech government was entitled to decide whether or not to support women’s choice of home birth by allowing midwives to attend them.

Ms Dubska gave birth at home alone and yet the government claimed the prohibition on midwives attending home birth made birth safer for women and their babies.

The decision was appealed to the Grand Chamber of the European Court and a decision is expected imminently.
Konovalova v Russia

Is a woman’s consent necessary for the presence of medical students during labour?

“Article 8 encompasses the physical integrity of a person, since a person’s body is the most intimate aspect of private life, and medical intervention, even if it is of minor importance, constitutes an interference with this right.”

The Court held that Russian law did not contain adequate safeguards to protect patients from arbitrary interferences with their private life. There was no legal provision requiring patients’ consent for students’ participation in their treatment and the hospital’s information about students was ‘vague’ and did not specify the extent of their involvement in treatment.
Personalised care

The law demands that healthcare professionals provide personalised care.
Healthcare practices that violate human rights

**Physical abuse:** non-consented force, restraint, unnecessary procedures including episiotomy, failure to provide pain relief

**Disrespect:** verbal abuse, bullying, blaming, humiliation, reprimands, ‘shroud-waving’

**Non-confidential care:** unauthorised revelation of personal details, physical exposure

**Non-consented care:** procedures performed without adequate information or dialogue to enable autonomous decision-making, undue pressure to make specific clinical choices

**Misinformed care:** biased, non-transparent clinical information, disabling women from giving true informed consent

**Depersonalised care:** inflexible application of institutional policy, failure to take into account women’s individual circumstances, including around companionship of choice

**Discriminatory care:** unequal treatment based on personal attributes such as age, race and disability

**Abandonment of care:** refusal to provide care due to inability to pay or birth choices outside guidelines

(Draws on the White Ribbon Alliance, Charter for Respectful Maternity Care)
Foetal rights?

In the UK, there is no recognition of a separate legal right or interest that is capable of being used to override a woman’s consent to care: *Re MB* (1997), *S v St George’s Healthcare Trust* (1998).

However, social and reproductive changes, the development of sophisticated scanning technologies and the growing influence of the ‘foetus as patient’ movement conceived in the USA, contribute to a cultural conception of fetal separateness and even antagonism with its mother.

‘*[T]he physician and other obstetric providers have an independent obligation, as a matter of professional integrity, to protect fetal, and neonatal patients.*’ Chervenak et al, ‘Planned home birth: the professional responsibility response’ AJOG (2012)

‘*Women have the right to choose how and where to give birth, but they do not have the right to put their baby at risk.*’ Lancet (2010)
Do health professionals have a clear understanding of the legal framework in which they operate?

‘Maternity care professionals demonstrated a poor understanding of their own legal accountability, and the rights of the woman and her fetus. Midwives and doctors believed the final decision should rest with the woman; however, each also believed that the needs of the woman may be overridden for the safety of the fetus. Doctors believed themselves to be ultimately legally accountable for outcomes experienced in pregnancy and birth, despite the legal position that all health care professionals are responsible only for adverse outcomes caused by their own negligent actions.’ Kruske et al (2013)
How do human rights improve maternity care?

• Value-based approach improves care for women. Research has consistently shown that the two of the most important factors in ensuring positive experiences of childbirth are those promoted by the principle of dignity:

(i) supportive relationships with health professionals; and
(ii) sense of control over decisions made during birth.

(Hodnett, 2002; Waldenström, 2004; Stadlmayr, 2006)
How do human rights improve maternity care?

• (Most) rights are not trumps.

• Recognition of the right, and the values underpinning it, is the starting point for a conversation between a woman and a healthcare professional.

• Human rights law gives professionals a way to frame the process: at a policy level, evidence-based, proportionate decision-making; at an individual level, personalised care.

• Provides a framework in which ethical concerns – including obligations towards the wider community – can be considered.
How do human rights improve maternity care?

• Human rights approach to informed choice clarifies responsibility for the woman and professional.

• If woman is the decision maker in childbirth, she takes responsibility for decisions and subsequent harm, if it is causally connected to her choice.

• Professionals cannot be criticised if they have supported an informed choice regardless of whether that choice is ‘within guidelines’.
Additional resources

- Human Rights Guide for Midwives
- Training videos
- Updated factsheets
- I-Learn module with RCM