Research Open

Archives of Women Health and Care

Volume 6 Issue 2

Editorial

Reflections on Women's Medical Autonomy in the 21st Century

George Gregory Buttigieg[1]* and Kirill Micallef-Stafrace[2]

[1]Department of Obstetrics and Gynaecology University of Malta, Department of Obstetrics and Gynaecology, Plovdiv Medical University and Hospital St George, Bulgaria

[2]Visiting Professor, Medico-legal Studies, Department of Pharmacy, University of Rome, Tor Vergata, Italy

Corresponding author: George Gregory Buttigieg, Department of Obstetrics and Gynaecology University of Malta, Department of Obstetrics and Gynaecology, Plovdiv Medical University and Hospital St George, Bulgaria

Received: June 09, 2023; **Accepted:** June 16, 2023; **Published:** June 20, 2023

Editorial

One of the fiercest and most pragmatic of women's battle was their right of medical autonomy vis-a- vis full information and right of acceptance/ refusal of any treatment offered. One of the most celebrated of these medico-legal battles and one which proved a page-turner was the case of *Montgomery (Appellant) v Lanarkshire Health Board (Respondent) [2015] UKSC 11.* It is time to take a reality check on the situation arising in this case, for it is becoming amply clear that in daily obstetric practice, women's rights are far from being respected for one reason or another.

Montgomery (Appellant) v Lanarkshire Health Board (Respondent) [2015] UKSC 11 revolved about a pregnant mother's request for an elective caesarean section was completely rejected by the obstetrician. The mother, a PhD graduate, repeatedly and persistently informed her obstetrician about her fears of a vaginal delivery. Her request for a CS was not unreasonable, for she, a primigravida, would be delivering a baby presenting by the breech. In addition,

(i)She was of a short stature.

(ii)She was a diabetic.

(ii)She was carrying a clinically large baby (4.25kg).

Subsequently, at birth the baby experienced severe shoulder dystocia and developed cerebral palsy of the spastic quadriplegic dyskinetic form consistent with underlying Hypoxic-Ischaemic Encephalopathy. At the Appeals Court, the defendant obstetrician was deemed negligent and the Appellant was awarded the sum of £5.25 million in damages. The ruling is widely held to have displaced the previous "Bolam test" in matters of consent.

There is no doubt that the hefty sum awarded in Montgomery was impressive as was indeed the now doubly underlined warning that that the doctor does not know all and the patient *must* be informed of all that has to happen to him/her and has the right to accept or reject any medical treatment proposed. This principle of disclosure in itself had been long a-brewing, but *Montgomery* pushed it to the fore not only in the Anglo-Saxon world but also across the ocean. Not that, anyone needed to be advised to explain managements to patients and listen to *their* side of the coin.

There was and is a danger with Montgomery that the medical practitioner just listens to what the patient wants and simply concedes. This is not a rare occurrence especially with caesarean sections in private practice. That is not the spirit of the *Montgomery* judgement which, above all, requires that the physician *explains* the suggested treatment and any alternatives to it, the pros and the cons, what potential complications may be entailed etc. *This* is Montgomery and it seeks to elicit the charity, the compassion and the 'loving father image' rather than the now rejected paternal aspect of "I know best". A loving father explains to a child and helps in the right choice. In the great majority of cases, medical practitioners across all disciplines are cut of the "loving father" cloth, but, by no means, does this apply universally so.

I have recently been greatly disturbed by a patient of mine, whose daughter in Germany had had a breech presentation and was repeatedly and forcefully refused a caesarean section. The obstetrician could not be a person well versed with recent obstetric developments nor with modern medical ethics in general. Having confirmed all the details, I was both much amazed and greatly pained at such dictatorial remnant behaviour in 2023. Perhaps this is even commoner than I thought. And in this case, we speak of a woman who was tertiary educated - a PhD, in fact. Imagine what an uneducated woman, a non-English speaker or a refugee goes would to through, at this obstetrician's hands and his ilk.

The battle for woman's rights is by no means over. I firmly believe that before such rights can be fought for, their existence must surface, be noted and registered. Taking obstetric care as one example, the mode of delivery, especially and particularly in complicated cases, must be *actively* discussed with the parents, with an end scope of truly answering their questions. If the mother's choice is for a particular mode of delivery, the only solid element to bring out and defend against would be maternal and child safety. In a breech delivery, for example, the greatest potential danger in a vaginal delivery, would be fetal intra-partum obstruction with subsequent intra-partum hypoxia and its resultant damage such as cerebral palsy. The inherent surgical and anaesthetic risks in a modern-day caesarean section especially with regional anaesthesia would be far less than the previous situation as discussed.

In Medicine, where one must practice *secundum artis,* depending on challenge and circumstance, no one can write a book of magical solutions. However, as modern medicine broadens its scientific horizons and new legal and ethical reins regulate behaviour, it is now clear that just as important as the tenets of science that we must be informed about, are the obligations of behaviour, imposed by the continuously evolving principles of law and medical ethics.

Citation:

Buttigieg GG, Micallef-Stafrace K (2023) Reflections on Women's Medical Autonomy in the 21st Century. *ARCH Women Health Care* Volume 6(2): 1-2.