**Litigating Labour: Condoning Unreasonable Risk Taking in Childbirth?**

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**Abstract:** Given the enormity of obstetric litigation and all its associated complexities, in 2012 the National Health Service Litigation Authority (NHSLA) produced a report entitled ‘Ten Years of Maternity Claims: An Analysis of NHS Litigation Authority Data’ (the 2012 Report). This document identified, *inter alia*, a number of problematic areas in respect of litigation trends and illuminated a range of clinical situations in which claims are most likely to arise. It is against this backdrop that this article seeks to critically analyse a body of case law that has occurred since the publication of the 2012 Report. Focusing on breach of duty, the paper seeks to evaluate whether or not the weighing of risks and benefits, as advocated in the case of *Bolitho* as a means of assessing the question of breach, has been appropriately utilised by judges in recent childbirth cases. It is an important and original piece of research as it is the first of its kind to investigate how judges have dealt with specific aspects of childbirth identified as being contentious in the wake of the 2012 Report.

**Keywords:** Clinical Negligence; Childbirth; Breach of Duty; *Bolitho*; Doctors; Midwives.

**I. Introduction**

Cinema audiences across the world sat, mesmerised, as the gravel-voiced actor Oscar Isaac crooned his rendition of the old ballad folk song *The Death of Queen Jane* in the 2013 Coen Brothers’ film *Inside Llewyn Davis*.[[1]](#footnote-2) The harrowing lyrics tell the tale of the troublesome nine day labour of Queen Jane, in which she repeatedly asks her women and King Henry to ‘open her right side’ to find her baby. The song ends with a vivid juxtaposition between the celebratory emotions after the eventual successful birth and the mournful sorrow of the consequential death of the Queen.

 The stark message from the ballad transcends centuries’ worth of medical advancement. Childbirth is a risky business; it is fraught with danger for both mother and child. In a situation where so much can go wrong in a relatively short period of time, where decisions have to be made quickly and in the heat of the moment, and where errors can lead to the most severe consequences, it is unsurprising that this field of medicine attracts high levels of litigation.[[2]](#footnote-3)

 The reality is that not many childbirth cases actually make it as far as the courtroom.[[3]](#footnote-4) Nevertheless, given the intricate and delicate nature of the process, in those cases that do, judges have, justifiably to an extent, sought to constrain the legal exposure of healthcare professionals within the framework of the negligence action. This has been achieved principally through the development of the *Bolam* test, articulated by McNair J in *Bolam v Friern Hospital Management Committee*.[[4]](#footnote-5) Here it was stated that a doctor ‘is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art’.[[5]](#footnote-6) *Bolam* thus promulgated a standard of reasonableness in which the adequacy of a doctor’s conduct would be judged by reference to her professional peers. On one level there is nothing untoward about this approach as it does not depart from traditional principles of professional negligence, but *Bolam* has since been interpreted in a manner which arguably affords too much deference to expert medical testimony offered on behalf defendant doctors. This has caused particular problems in the context of maternity litigation.

 One only has to cast the mind back to the early 1980s in order to gain a snapshot of historical judicial attitudes towards allegations of negligence in childbirth. In *Whitehouse v Jordan*[[6]](#footnote-7), a case in which it was argued that a consultant obstetrician pulled too long and too hard during a trial of forceps delivery, Lord Denning, in the Court of Appeal, famously stated that ‘we must say, and say firmly, that, in a professional man, an error of judgment is not negligent’.[[7]](#footnote-8) Thus, even if the consultant had pulled too long and too hard with the forceps during the delivery it was only a mistake and, in the eyes of Lord Denning, this could never amount to negligence on the part of a doctor.[[8]](#footnote-9) His interpretation of the law was reined in when the case was appealed to the House of Lords where it was held by Lord Fraser that ‘the true position is that an error of judgment may, or may not, be negligent; it depends on the nature of the error’.[[9]](#footnote-10) If, therefore, the error was one that would not have been made by a reasonably competent doctor acting in accordance with a practice accepted as proper by a responsible body of medical opinion, it ought rightly to be regarded as negligent. Yet, regardless of the fact that Lord Denning’s view of the law was criticised, the outcome of the case in the House of Lords remained unchanged from the Court of Appeal and the claimant lost. Receiving approval for the first time from the then highest domestic court, *Bolam’s*[[10]](#footnote-11)star was in its ascendancy from that point on in terms of clinical negligence cases and served to inhibit claimants in establishing breach, an attitude which remained largely unchanged until the late 1990s when the House of Lords delivered its subsequent judgment in *Bolitho*.[[11]](#footnote-12) In this case, Lord Browne-Wilkinson sought to add a certain ‘gloss’ to the *Bolam* test by advocating an approach which allowed judges to consider the logicality of the medical testimony before them by weighing in the balance the relative risk versus benefit ratios of the evidence in question.

 The success of *Bolitho* in its attempt to clip the wings of *Bolam* has been fervently debated amongst scholars.[[12]](#footnote-13) Whilst in theory the *Bolitho* ‘gloss’ could benefit claimants in some cases, it only has that effect if it is consistently and rigorously applied. The evidence suggests that the added string to a judge’s bow by virtue of *Bolitho* has not always been deployed to useful effect, an issue which is particularly evident in respect of childbirth cases.[[13]](#footnote-14)

 Given the enormity of obstetric litigation and all its associated complexities, in 2012 the National Health Service Litigation Authority (NHSLA) produced a report entitled ‘Ten Years of Maternity Claims: An Analysis of NHS Litigation Authority Data’ (the 2012 Report).[[14]](#footnote-15) The driving force behind this report was to assess the nature and financial scale of harm reported from maternity units and to ascertain what lessons can be learned from litigation concerning maternity claims.[[15]](#footnote-16) The document identified, *inter alia*, a number of problematic areas in respect of litigation trends and illuminated a range of clinical situations in which claims are most likely to arise. Yet, one problem with the 2012 Report was that it proceeded to analyse maternity claims from a narrow standpoint, predominantly with risk management considerations in mind. Whilst the study was designed to ‘produce information to support learning to improve safety for women and their babies’,[[16]](#footnote-17) its main conclusion that ‘the most effective way to reduce the ongoing financial cost to the NHS, and the cost to patients and staff alike, is to continue to improve risk management in maternity care’,[[17]](#footnote-18) on the back of such a lengthy report, seems rather inadequate. The 2012 Report reveals little if anything about how maternity claims are assessed and dealt with from a substantive legal perspective, nor does it shed any light on how judges have come to interpret and apply the principles of negligence in the specific context of childbirth litigation.

 It is against this backdrop that this article seeks to critically analyse a body of case law that has occurred since the publication of the 2012 Report.[[18]](#footnote-19) Focusing on breach of duty, the paper seeks to evaluate whether or not the weighing of risks and benefits, as advocated in the case of *Bolitho* as a means of assessing the question of breach, has been appropriately utilised by judges in recent childbirth cases. It is an important and original piece of research as it is the first of its kind to investigate how judges have dealt with specific aspects of childbirth identified as being contentious in the wake of the 2012 Report.[[19]](#footnote-20) In order to set the scene, the piece begins by providing some background information and highlights some of the headline figures to emerge from the 2012 Report, and more recently from the NHSLA annual fact sheets.[[20]](#footnote-21) The narrative then seeks to provide context for the core of the paper’s analysis by exploring the existing academic literature concerning *Bolam* and *Bolitho.* From here the discussion progresses to critically analyse the developing case law. The focus of the critique hones in on three key issues which emerge as recurring themes throughout many of the cases and which are identified as pertinent issues in the 2012 Report. These include the interpretation of cardio-tocographic traces (CTG trace), the management of labour, and the impact of professional guidelines and protocols. From this an argument is constructed that suggests, in certain situations, that mothers and babies are being exposed to unreasonable risks in labour and that the law is perhaps being too quick to unquestioningly accept this behaviour.

**II. Background: The Scope of Childbirth Litigation**

Maternity claims represent the second highest number of clinical negligence claims reported to the NHSLA.[[21]](#footnote-22) Surgical claims represent the highest number of claims, but still maternity claims represent the highest value. At the time of the 2012 Report, between 1995 (when the Clinical Negligence Scheme for Trusts (CNST)[[22]](#footnote-23) first started) and the end of March 2011, the number of obstetrics and gynaecology claims reported to the NHSLA under the CNST amounted to 13,095.[[23]](#footnote-24) The total estimated value of these claims was in excess of £5.2 billion. In terms of overall value, this was more than double that of surgical claims, which were in second place.[[24]](#footnote-25) Significantly, when the 2012 Report was published, obstetrics and gynaecology claims accounted for 20% of the number of clinical negligence claims notified to the NHSLA and 49% of the total value.[[25]](#footnote-26) More recently, the up-to-date figures from the NHSLA indicate that, as of the end March 2013, the number of obstetrics and gynaecology claims since April 1995 stands at 16,262 with the total expenditure on these claims between the same dates totalling £7,096,927,000.[[26]](#footnote-27)

 The 2012 Report analysed 5,087 maternity claims on the NHSLA’s claims database as at the 1st April 2010 with an incident date in a ten year period between 1st April 2000 and 31st March 2010. The total value of these claims was £3,117,649,888.[[27]](#footnote-28) It comprised a primary and secondary level study. The primary level study showed that the three most frequent categories of claims were those relating to management of labour (14.05%); caesarean section (13.24%); and cerebral palsy (13.24%).[[28]](#footnote-29) The secondary level study undertook a detailed review of files for four specific categories of maternity claims including antenatal ultrasound investigations; CTG interpretation; perineal trauma; and uterine rupture.[[29]](#footnote-30) The figures from the 2012 Report clarified that CTG interpretation and management of labour (along with cerebral palsy) were the most expensive category of claims and accounted for 70% of the total value of all the maternity claims.[[30]](#footnote-31) Thus, as prevalent themes in the 2012 Report itself, and as frequent and recurring contestable issues in the subsequent case law, the two categories of CTG interpretation and management of labour were chosen for this research as the main platforms upon which to develop critical legal analysis pertaining to the question of breach.[[31]](#footnote-32) The cases selected for investigation therefore centred on these key issues. A further theme also included in the core of this paper’s analysis relates to the influence of professional guidelines. This was not identified as a significant factor in its own right in the 2012 Report, but, regardless, the use of professional guidelines has featured heavily in recent judicial reasoning and, as many of the post 2012 cases included reference to the use of professional guidelines, it was felt that it was important to include this as a head of discussion.

 Before the narrative progresses, it is perhaps worth noting at this point that, during the time period from 2000 to 2009, there were 5.5 million births in England. Accordingly, less than 0.1% of these births became the subject of a claim.[[32]](#footnote-33) It is clear that the vast majority of births do not result in clinical negligence claims. Yet, as one of the most frequently litigated areas of medicine, it is still useful to consider how judges deal with the issue of breach when it arises in court and to assess whether or not they are providing appropriate legal redress to those patients who have been injured during the course of a problematic labour. Before proceeding to analyse the case law which has followed the 2012 Report, in the next section the article locates the specific analysis of the recent childbirth cases in the context of the wider academic debate relating to the question of breach.

**III. From *Bolam* to *Bolitho*: Shiny Gloss or Invisible Shadow?**

As noted above, the aspect of *Bolam* that endorsed assessing a doctor’s conduct by reference to a responsible body of medical opinion was largely unproblematic. McNair J, however, did not leave it there. He also stated that ‘a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view’.[[33]](#footnote-34) It is this latter part that arguably allowed *Bolam* to spiral out of control and served to provide almost unqualified protection to medical professionals because of the manner in which it came to be interpreted. In reality all a doctor had to do in order to avoid liability was to adduce one body of medical opinion that supported her professional practice. It did not matter if there was equally, if not more, compelling evidence on the side of the claimant suggestive of the fact that what the defendant doctor did was negligent, nor did it matter that the opinion supporting the doctor was in the minority.[[34]](#footnote-35) Esteemed medical professionals were held in high regard by judges and there was a clear unwillingness to question expert evidence.

 The law of negligence should be concerned with the question of what ought to have happened in the circumstances, but the application of *Bolam* in practice conflated this key question with that of what was done in the circumstances.[[35]](#footnote-36) The test effectively prevented an appropriate assessment of the competing bodies of expert opinion from taking place and so the scope for a judge to reach a conclusion as to what was reasonable or not in the circumstances was considerably narrowed.[[36]](#footnote-37) This striking example of English law’s historical endorsement of the view that the ‘doctor knows best’ shaped the direction of clinical negligence case law throughout the 1980s and into to the late 1990s.[[37]](#footnote-38) Without doubt there are cogent reasons why judges ought to be cautious when it comes to questioning expert medical testimony. Medicine, by its very nature, is a discipline in which one will always encounter differences of professional opinion. Divergent views are unavoidable in a tradition which progresses, at least in part, by a certain amount of trial and error and the law has to take account of this. Being too hasty to hold one doctor negligent simply because she advocates a practice that another doctor may not, may be inappropriate. Similarly, judges ought to be slow to impose their own views over and above those held by distinguished medical professionals. However, to hold that a doctor can avoid a claim in negligence by simply adducing one expert in support of what she did provides too much respect to the medical profession, especially where there is convincing evidence in favour of the claimant that is indicative of the fact that what happened may have been unreasonable in a legal sense. This, of course, means that judges should take a broader, more holistic approach to assessing the reasonableness (or otherwise) of healthcare professionals’ conduct in clinical negligence cases.

 With the above in mind, to some commentators, the decision in *Bolitho* added much needed dilution to the heavily maligned *Bolam* test.[[38]](#footnote-39) It was decided that once a body of medical opinion is deemed ‘responsible’, it is still not open to a court to prefer one over the other.[[39]](#footnote-40) Yet, in *Bolitho*, Lord Browne-Wilkinson was concerned with how to reach that threshold. He stated in the case that before a body of medical opinion could be regarded as being responsible, it had to be capable of withstanding the logical scrutiny of the court and, in determining the ‘logicality’ of the evidence, a judge must have regard to the relevant risk versus benefit ratio of a particular decision.[[40]](#footnote-41) This attempt by Lord Browne-Wilkinson to regain some control for judges over medical decision making was certainly a step in the right direction, but to suggest *Bolitho* was the dawn of a new era for claimants in clinical negligence cases is to overplay its significance and underplay its problems.

 First, it has been rightly pointed out that the notion of ‘logic’ does not always sit easily with medical decision making. In the childbirth case of *C v North Cumbria University Hospitals NHS Trust* Green J appeared to indicate that logic and reasonableness were one and the same thing and that the terms could be used interchangeably.[[41]](#footnote-42) This is potentially problematic as they are different concepts. What is optimum for the patient in a given situation may not always be easily reconcilable with what is logical and being too quick to discount medical opinion on this basis alone could be inappropriate. Similarly, placing the emphasis on logic has the potential to detract from what ought to be the key consideration in all negligence cases, that of reasonableness.[[42]](#footnote-43) This problem was identified at a very early point by Teff, who accurately spotted that ‘to speak of logic in this context suggests an appeal to the internal consistency of the expert’s testimony, rather than a more extensive, pragmatic assessment of what the court deems reasonable’.[[43]](#footnote-44)

 Second, the aspect of *Bolitho* that could, potentially, be utilised to great effect is sometimes overlooked. The balancing of risks versus benefits could, if undertaken appropriately, lead to a more favourable outcome for patients in some cases. Yet, whilst there is evidence that the courts have indeed taken note of the ruling since *Bolitho*, it is how they have come to apply it in practice that is perhaps the more interesting question.[[44]](#footnote-45) With this important point in mind, Professor Mulheron’s recent paper, in which she identifies a number of scenarios that have attracted judicial consideration in English law post *Bolitho*, is particularly illuminating.[[45]](#footnote-46) The scenarios she identified included: where the peer professional opinion has overlooked that a clear precaution to avoid the adverse outcome for the patient was available; where there was a question of resources and conflicts of duty; where there was failure to weigh the comparative risks and benefits of the chosen course of conduct; where the accepted medical practice contravenes widespread public opinion; where the doctor’s peer medical opinion cannot be correct when taken in the context of the factual evidence; where the doctor’s expert medical opinion is not internally consistent; and where the professional opinion has adhered to the wrong legal test.[[46]](#footnote-47)

 The two factors relating to peer professional opinion overlooking a clear precaution that could have avoided the adverse outcome for the patient, and the failure to weigh the comparative risks and benefits of a particular course of action, are highly relevant to the proceeding analysis concerning childbirth litigation. As will be seen, whilst there may be some evidence of judges being mindful of these important considerations, they have sometimes failed to observe that *Bolitho* should bite and, even where they have ostensibly applied the gloss, they have not done so in a way that is conducive to answering the question of breach in the affirmative.

**IV. Contentious Issues in Childbirth Litigation: Exploring the Question of Breach**

***i. Interpretation of CTG Traces***

During labour, the health of a fetus is monitored by a CTG trace. This has a sensor attached to the maternal abdomen or the fetal scalp which gives a fetal heart rate (FHR) reading, and an abdominal belt (the tocograph) which records maternal contractions.[[47]](#footnote-48) Thus, it is an essential tool for monitoring the health and progress of both the unborn child and mother during the process of labour. Given their crucial role in identifying fetal distress, it is hardly surprising that many allegations of negligence in childbirth converge on the interpretation of CTG traces. Care needs to be taken when assessing the credibility of such claims for a number of reasons. First, given the length and complexity of some labours, it is not an infrequent occurrence to have a number of different medical personnel involved in the process at any one time.[[48]](#footnote-49) Deciphering a range of conflicting interpretations and ascertaining what, if anything, ought to have been done as a result of those readings is a far from straightforward task. Second, one has to bear in mind that the tort of negligence does not impose on healthcare professionals a standard of perfection. The law, predominately under the guise of *Bolam*, has therefore always tried to allow a generous margin of appreciation for professional discretion and differences of opinion in defining the threshold for establishing breach. This is especially important in terms of CTG interpretation because, whilst detailed guidelines now exist, there is scope for professional disagreement in terms of what a reading may indicate at any given time.[[49]](#footnote-50)

 At a glance, the question of CTG interpretation appears to demand a predominantly factual inquiry. Nonetheless, a concomitant question frequently arises which asks, based on the reading of the CTG trace, what ought to have happened in the circumstances. It is commonly suggested that further diagnostic procedures, such as a fetal blood sample (FBS), should have been performed at a prior point. Alternatively, it is often claimed that a decision should have been made to intervene by means of a caesarean section at an earlier stage. Faced with opposing experts, one suggesting that the CTG trace reading said one thing, and the other suggesting that it actually said something else, a judge is somewhat constrained in terms of what she can do to scrutinise the expert opinion. This is the paradigm situation in which the question of logic becomes naturally intertwined with the internal consistency of expert testimony. An almost inescapable consequence of this is that the most convincing expert triumphs and so the normative inquiry into the ‘reasonableness’ or otherwise of the conduct on the whole becomes lost and almost inseparable from the issue of witness credibility.[[50]](#footnote-51)

 In *Tippett v Guy’s & St Thomas’ Hospital NHS Foundation Trust* the allegation was made that a midwife had negligently interpreted and then discontinued a CTG trace, when, in fact, she should have called for a medical review of the reading because it showed two decelerations of fetal heart rate.[[51]](#footnote-52) The case itself fell at the first hurdle because Dingeman J found, on the balance of probabilities, that the mother herself had removed the CTG trace and not the midwife.[[52]](#footnote-53) In assessing what the CTG trace indicated before that point, Dingeman J, in evaluating the conflicting expert testimony, also concluded that the testimony of the claimant’s expert was inconsistent with the definition of a deceleration contained in the National Institute for Health and Clinical Excellence (NICE) guidelines relating to the use of CTG monitoring equipment.[[53]](#footnote-54) When analysed against this backdrop, the testimony of the defendant’s witnesses, one of whom was involved in drafting the guidelines, seemed more plausible, whereas the claimant’s expert testimony was not logical.[[54]](#footnote-55) Given that those two key findings were resolved in favour of the defendant, a number of residual issues fell away which are perhaps worthy of further consideration.

 Ruling that there was no evidence of decelerations on the CTG trace just before it was removed caused Dingeman J to conclude that the midwife was under no duty to call for a medical review, nor was she under a duty to tell the patient that the trace was not yet satisfactory during her previous checks.[[55]](#footnote-56) First, had there been any evidence of decelerations identified beforehand, because this was categorised as a high risk pregnancy, there almost certainly ought to have been a duty on the midwife to inform the patient about them. [[56]](#footnote-57) Beyond that it could even be argued that because of the recognition of the pregnancy as being high risk, even in the absence of decelerations, the midwife ought to have had a heightened sense of awareness in terms of what she communicated to the patient and how she said it. Had it been stressed to the patient that this was a high risk pregnancy, that the CTG trace was at present unsatisfactory, and that it was important to keep it running in order to get a clearer picture of variability and accelerations[[57]](#footnote-58), the patient may have been more alert to the dangers and less inclined to remove the CTG herself. This has to be considered in the context of a second issue, which brings the above more sharply into focus. Dingeman J found that, had the CTG trace not been removed when it was it would have continued to be unsatisfactory, and that this would have called for a further medical review some twenty-five minute later.[[58]](#footnote-59) This review, however, would not have triggered a more interventionist approach by way of caesarean section, it would only have led to a request for further CGT monitoring.[[59]](#footnote-60) It is difficult to discern from this a convincing explanation as to why the expectation of swifter intervention would have been so unreasonable, nor is there any persuasive justification for the proposition that not acting in a more assertive manner would have actually been responsible. Whilst these points are largely hypothetical given the primary findings of fact, when considered against the more extensive background of reasonableness in the circumstances,a slightly different picture begins to emerge concerning the professional conduct when one acknowledges the high risk nature of the pregnancy coupled with a CTG trace that was not wholly satisfactory.[[60]](#footnote-61)

 The plausibility of the lay witnesses was clearly the most influencing factor in *Tippett*, but *Chappell v Newcastle Upon Tyne Hospitals NHS Foundation Trust* reveals a similar attitude towards reliance on expert testimony that advocates what might best be described as a more cautious approach.[[61]](#footnote-62) The claimant alleged that a negligently administered Syntocinon infusion caused the mother’s uterus to contract too frequently with an inadequate recovery time between contractions.[[62]](#footnote-63) This, it was claimed, added to the decision to allow labour to continue for too long a period, exposed the baby to a sustained period of chronic partial hypoxia which ultimately led to extensive brain damage.[[63]](#footnote-64) Whilst it was admitted that the increased dose of Syntocinon was ‘probably not the correct decision’, there was no evidence that this error would have altered the overall outcome.[[64]](#footnote-65) The main point of contention was what the CTG indicated at a certain point and what should have happened as a result. The expert providing testimony on behalf of the claimant suggested that there were a number of factors that were indicative of the defendant being faced with ‘a very high risk scenario’.[[65]](#footnote-66) These factors, coupled with a trace reading suggestive of fetal tachycardia and reduced baseline variability, meant that the risk of hypoxia ‘couldn’t (sic) be ignored’.[[66]](#footnote-67) Due to the presence of these worrying signs, a repeat FBS should have been undertaken, a more senior doctor should have been involved at an earlier point in proceedings, and the labour should only have reasonably been allowed to continue if was possible to obtain reassurance from the FBS that the fetus was in a good condition.[[67]](#footnote-68) The defendant’s expert disagreed; in his view there was never any fetal heart abnormality illustrative of hypoxia on the trace. Despite the admission of visible periods of reduced variability and rising fetal heart baseline rate being evident, McKenna J had ‘no hesitation in preferring’[[68]](#footnote-69) the defendant’s expert and the claim failed.

 In view of Lord Scarman’s *dictum* in *Maynard v West Midlands Health Authority*[[69]](#footnote-70), this particular turn of phrase is, if nothing else, curious. Quite apart from that, though, the fragility of analysing matters from the perspective of logic once again becomes apparent. Admittedly it is possible to suggest that the defendant expert’s interpretation of the trace was not wholly illogical because he could attribute the presence of fetal tachycardia to the mother’s existing fever and could also support his conclusion as to the absence of hypoxia by reference to the lack recurrent decelerations being present on the trace.[[70]](#footnote-71) In the context of a routine labour, this evidence would perhaps have been convincing, but if one takes a step back from this scenario a different argument can be constructed.

 The claimant’s expert was right to consider the trace in the context of the surrounding circumstances. There were a number of features that were case specific and which marked out this pregnancy as being high risk. The mother was only seventeen; she was 42 weeks pregnant and hence overdue; she was being induced; she had a fever; and she had also dilated to 9cm two hours previously with no further progress.[[71]](#footnote-72) Add to these factors the evidence that the CTG trace reading was not entirely without concern, it is possible to suggest that the views of the claimant’s expert should not been have discounted so easily. Given the severity of consequence, it could be argued that it would not have been so ill-conceived of McKenna J to accept the cautious approach recommended by the claimant’s expert as representing a responsible body of medical opinion and the more risky approach as perhaps not. If, for example, the defendant in *Chappell* had ordered a repeat FBS, or indeed had summoned a senior colleague, it may have uncovered something sinister at an earlier point which, in turn, may have caused the medical team to reassess the need to provide some type of intervention, especially given the precarious circumstances of the mother. Whether or not this ultimately would have avoided the harm caused to the claimant is another matter, but, if the evidence pointed to the fact that it may have done, it does shed a different light on proceedings.[[72]](#footnote-73) To use Mulheron’s example, this certainly seems to be a situation in which professional opinion overlooked a simple precaution that could, potentially, have avoided the adverse outcome for the patient.[[73]](#footnote-74)

 An immediate criticism of this may reside in the fact that the law of negligence should not be too quick to endorse claimant expert testimony over and above that of the defence simply because it advocates a more cautious approach in a given situation. Holding doctors liable in childbirth cases because they do not opt to intervene at the first hint of anything untoward would be inimical to the exercise of professional discretion and would impose a duty beyond that of reasonableness. Furthermore, a higher risk option may carry with it a significantly greater benefit for the patient and so to say that the least risk option is always indicative of a responsible body of medical opinion, and that the higher risk approach can never meet that threshold, would be counter-productive in the law of negligence. As fair a point as this may be, it is not actually necessary to resort to the angle of the ‘least risk’ approach to produce a different and more patient-orientated outcome in many of these cases. Less tendentiously then, it is here where considerations in regard to the delicate balancing of risks versus benefits become incredibly important.

 A judge must bear in mind precisely what course of action the defendant’s witness is proposing and consider the inherent risks and benefits therein and she must then equally apply her mind in a similar fashion to the evidence presented on behalf of the claimant. It is insufficient though to suggest that a judge ought to confine her deliberations solely to whether or not an individual expert has given his mind to the risks and benefits in order to assess the internal consistency of *that* particular piece of opinion. The sting in *Bolitho’s* tail should reside in empowering a judge to *weigh for herself* the competing risks and benefits of each particular suggested course of action against each other. Clinical negligence cases that do in the end litigate will invariably comprise delicate risk benefit calculations and decisions will often have been made at the margins of acceptability. Some of these risk assessments may be difficult to comprehend for medically untrained judges, especially when their investigation is backward looking by nature. Thus, there may be an understandable over-reliance on expert testimony from judges. Sometimes, however, it is necessary for judges to take a step back in order to consider, and then balance, the risks and benefits in the context of the surrounding circumstances of a particular case to effectively assess the question of reasonableness in the totality of the situation. If this balancing exercise is undertaken, it may sometimes uncover a disproportionate risk to benefit ratio in the circumstances which has exposed the claimant, on one view, to an unreasonable risk. If defence expert testimony is supportive of this unreasonable risk taking, it must surely call into question the appropriateness of classifying it as a responsible body of opinion. Not infrequently this important facet of *Bolitho* goes unnoticed, and this seems particularly evident in cases that hinge on the interpretation of CTG traces.

 The Scottish case of *NM v Lanarkshire Health Board* is the epitome of a decision in which an extensive examination and weighing of the risks and benefits, in a more rounded and contextual sense, ought to have yielded a more favourable outcome for the pursuer.[[74]](#footnote-75) The allegation centred on negligent management of labour which resulted in severe and catastrophic injuries to the pursuer’s child at birth.[[75]](#footnote-76) The interpretation of a CTG trace was pivotal to the question of breach, a matter which was finally decided in favour of the defendant in both the Outer and Inner House of the Court of Session.[[76]](#footnote-77) The defendant obstetrician maintained throughout her testimony that, as the CTG trace did show some reassuring factors, that there was never any need to take a FBS or to intervene by means of a caesarean section.[[77]](#footnote-78) This view was supported by the defendant’s experts and, in light of the reassuring factors, this evidence passed the ‘logicality’ threshold.[[78]](#footnote-79) It was held that the reading of a CTG trace was a matter of clinical judgment in which there was always room for differences of opinion.[[79]](#footnote-80) The evidence offered on behalf of the pursuer was in sharp conflict with that of the defendant’s. It was acknowledged that there were four possible points at which the CTG trace indicated the *potential* for concern and the possibility of an underlying problem.[[80]](#footnote-81) With this in mind, it is possible to make a number of observations.

 First, in connection with the risks and benefits, it may well have been true that the defendant’s experts gave their mind to this question when forming their opinion, but there was very little if any evidence of *judicial* weighing of the risks and benefits of each proposed course of action, less still any convincing reason as to why, even if this exercise had been appropriately carried out, that the decision not to intervene at an earlier point could legitimately have been characterised as responsible. The main benefit of obtaining a FBS is the early detection of a potentially serious underlying condition, whereas the risk is that the procedure is painful and causes discomfort to the mother and fetus.[[81]](#footnote-82) The flip side to this coin is that the benefit of not taking a FBS is that the mother and fetus are saved from this mild pain and discomfort, but the risk is the missed opportunity to detect a serious condition at the earliest possible point in proceedings, which may result in catastrophic harm if missed. The reality is that the balancing exercise would be more complex than this in practice as there will undoubtedly be other risks and benefits to factor into the equation. That aside, one must still be able to point to a sufficiently convincing benefit to the course of action that advocates do nothing in order to trump the considerable and identifiable risk.

 Second, whilst admittedly this exercise becomes more challenging when the issue centres on the more medically complex procedure of a caesarean section, an important aspect of the tort of negligence needs to be borne in mind, which ought to have favoured the pursuer in this and other cases. Medical evidence indicates that there are clearly risks inherent in both a natural delivery and a caesarean section.[[82]](#footnote-83) The risks in one are not more obviously significant than in the other and so it is impossible to say that one is the more visibly safer option. Each labour is unique and the risks and benefits will alternate depending on the circumstances. Thus, healthcare professionals must remain alert to the individualities of each pregnancy. In a similar vein, judges must also remain cognisant of the subtleties of a particular case when determining the question of breach, for the correct legal test is negligence in the *surrounding circumstances.* In *NM,* given the associated risks, it may well have been inappropriate to move immediately to a caesarean section based on the first, and perhaps even the second, sign on the CTG trace that something untoward may have been happening. A certain amount of perseverance undoubtedly falls within the margin of appreciation afforded to the exercise of professional discretion, but there were *four* points at which the CTG trace indicated that there could potentially have been a problem developing. There were also very clear factors which signified that the pregnancy should be regarded as ‘high risk’.[[83]](#footnote-84) These particular features included the fact that the mother was diabetic, a condition which increases the risk of the fetus being macrosomic.[[84]](#footnote-85) Similarly, she was of short stature and was incredibly anxious about her pregnancy.[[85]](#footnote-86) Adding the far from perfect CTG reading to these additional factors, a justifiable question arises as to precisely how much leeway a judge should be permitted to give. All things being equal, the balancing of risks and benefits may have favoured continuing labour naturally, but all things were not equal here and seldom will they ever be in high risk pregnancies. There is cause to suggest in *NM*, as in other cases, that the signs from the CTG trace, coupled with the combination of wider case-specific factors, ought to have caused the risk benefit ratio to have tipped in favour of earlier intervention and that to argue otherwise was not representative of a responsible body of medical opinion.

***ii. Negligent Management of Labour and Systemic Fault***

A number of the recent childbirth cases unveil a combination of errors from different healthcare professionals involved at the various stages of the labour. The interesting question is the extent to which judges have seen fit to actively scrutinise, and disagree, with expert medical testimony in cases which appear to involve a multitude of sins. Where the issue is less concerned with matters that require a high degree of technical expertise, one may be forgiven for assuming that a judge may be more willing to apply the *Bolitho* gloss. Certainly in theory the less specialist knowledge that is required to understand the main issues, the more straightforward the objective weighing of risks and benefits ought to be. There appear to be mixed messages in this regard and much seems to rest on the precise course of action that could have been taken to avoid the harm complained of and by whom.

 In *C v North Cumbria University Hospitals NHS Trust*[[86]](#footnote-87)negligence was alleged in regard to a midwife who administered a second dose of Prostin to the mother during the course of her labour.[[87]](#footnote-88) The claimant’s experts suggested that because Prostin carries with it an acknowledged risk of uterine rupture, which can lead to the catastrophic consequences that eventually transpired in this case, a ‘highly precautionary’ approach should be taken. [[88]](#footnote-89) In justifying their approach the experts alluded to the fact that the risk of not administering the second dose or delaying to await events was very small. This was not an emergency case where time was of the essence. Similarly, if there was any ambiguity as to whether or not the labour was establishing, then a competent midwife should delay the second dose.[[89]](#footnote-90) Green J, whilst admitting that it would have been reasonable for the midwife to have adopted the highly cautious approach, said that to impose that standard would be setting the bar of reasonableness at ‘too high a level’.[[90]](#footnote-91) If ever there was a case in which *Bolitho* should have bitten, it was this one. Despite careful and reasoned evidence from the claimant’s experts, Green J failed to spot that, whilst the risk of uterine rupture was small, the consequences of that risk materialising were huge.[[91]](#footnote-92) It ought to be evident from the most rudimentary of balancing exercises that the benefit of delaying the second dose in a non-emergency case far outweighed the risk of severe adverse consequences inherent in administering it, notwithstanding the fact that the rate of occurrence of that risk was only slight. The rate of occurrence of a risk ought not to be confused with the severity of consequence should it materialise as being the more crucial question in any balancing exercise. All the midwife had to do was delay to see for herself how things developed, or, alternatively, seek a second opinion, and this would have exposed the patient to very little, if any, additional risk.[[92]](#footnote-93) To categorise the midwife’s approach as recklessness may be going too far, but in the same breath to classify her actions as reasonable, and to hold that the expert opinion supportive of that approach was responsible, seems equally inappropriate.

 The above attitude has not always been evident. In *Popple v Birmingham Women’s NHS Foundation Trust* the claimant suffered from severe dyskinetic cerebral palsy. It was argued on his behalf, by his Friend in Litigation, that two midwives were negligent in regard to their management of his mother’s labour.[[93]](#footnote-94) It was first claimed that there was a failure to provide effective continuous monitoring. Oliver-Jones J found in favour of the claimant on this point.[[94]](#footnote-95) Second, it was suggested that the situation demanded some further exploration of what else the midwives should have done. On the evidence, Oliver-Jones J was satisfied that the unfolding chain of events, which ought to have alerted the midwives to the fact that things were not proceeding as planned in the labour, should have caused them to summon obstetric assistance at an earlier point in proceedings, or, alternatively, should have led them to perform an episiotomy.[[95]](#footnote-96) If either of these things had happened, the claimant would have been delivered sooner and avoided the damage that he suffered.[[96]](#footnote-97) This is a refreshing attitude. It was not a case of suggesting that asking for help or performing the episiotomy were options that entailed the least possible risk and that to do anything else would automatically have been negligent, it simply recognised that more decisive action at an earlier point from the midwives may have caused the harm that was suffered by the claimant to be avoided. In other words, prompter decision making could well have avoided the unreasonable risk to which the patient was exposed. Summoning obstetric help at an earlier point, or indeed recourse to an episiotomy, could have been undertaken without the imposition of any significant risk, expense or burden to the patient (or indeed the midwives), but it would have yielded quite perceptible benefits.

 In another Scottish case, *MC v Borders Health Control*[[97]](#footnote-98)*,* two midwives were held to be negligent in relation to two separate telephone calls with the pursuer. The finding in relation to the first call was based largely on a factual inquiry. This was one of the rare occasions in which a judge, Lord Menzies, found the pursuer to be the more credible witness in relation to the inadequate advice that she was given on the phone. After the patient explained that she had suffered from a ‘sticky green discharge’ it was negligent of the first midwife to tell the patient that it was a ‘show’ and not to insist on her coming into hospital.[[98]](#footnote-99) In regard to the second call, Lord Menzies held the second midwife to be negligent in failing to take any details from the pursuer about her vaginal discharge.[[99]](#footnote-100) It was no defence that the pursuer did not volunteer this information. It was incumbent on the midwife to illicit this important information and it was not unreasonable to expect her to explore certain important issues with the patient by asking her direct questions which were relevant to assessing the overall health of the mother and status of the pregnancy. If these simple questions had been asked, which, apart from time, would have caused little if any imposition to the midwife and certainly would have not exposed the patient to any real risk, then the mother would have described the green sticky discharge in the course of that questioning, which in turn ought to have triggered an immediate insistence from the midwife that she should come into hospital.[[100]](#footnote-101) Irrespective of any accepted practice and agreed protocol in respect of telephone conversations with pregnant mothers, the basic exercise of common sense here could potentially have averted a crisis and Lord Menzies was correct to be unimpressed by this professional carelessness.

 The analysis of this decision should not end there. From start to finish this case unveiled a catalogue of errors that are typical of the type of collective fault that so often gives rise to problems in the management of labour. Absent the finding of negligence against the midwives, *MC* illuminates some of the problems faced by patients when the allegation of negligence hones in on the system as a whole rather than the sum of its parts. Two other averments were made by the pursuer, namely that an individual obstetrician was negligent in allowing the period of one hour to elapse between the decision to perform an emergency caesarean section and the actual performance of that procedure, and that the defendant Health Board was liable for failing to operate and maintain a proper system.[[101]](#footnote-102) Lord Menzies found for the defendants in relation to both of these arguments.

 The failure to find negligence on the part of the obstetrician is a little perplexing. Notwithstanding evidence of accepted medical practice, the delay of one hour between the decision to deliver the baby by what was classified as an ‘emergency’ caesarean section, and the actual performance of that procedure, seems patently unacceptable. The ‘benchmark’ or ‘ideal goal’ between the decision to deliver and the delivery itself was said to be thirty minutes, but, in the eyes of Lord Menzies, based on his interpretation of the evidence of one of the expert witnesses, this was not an absolute and there was some scope for slippage.[[102]](#footnote-103) The attending obstetrician was, at that point, the head of the team and whilst she was ‘scrubbed up and ready in the operating theatre’, there was no duty on her to leave the operating theatre to find out what was going on when the patient did not materialise in the expected time frame.[[103]](#footnote-104) In a slightly different context, this is akin to suggesting that if a Head Teacher of a school has been informed that one of her staff members is subjecting one of the school’s students to a significant risk and then summons that member of staff to her office to deal with that situation, that she is under no duty to do anything else if that member of staff fails to turn up. Any suggestion that imposing an affirmative duty to do something rather than nothing in this situation would be to impose a standard beyond that of reasonableness is surely questionable.

 In the case of the attending obstetrician, as in the hypothetical example of the Head Teacher, surely it would not be overly cumbersome to expect some further investigative steps to be taken by the person in charge when something is clearly amiss, especially when there is very little burden to them in doing so. It is somewhat troubling if findings of negligence are more frequently upheld against midwives when they fail to take an obvious precaution, expose the patient to an unnecessary risk, or perhaps do not show the basic exercise of common sense, when similar claims do not seem to be commonly upheld against doctors for doing the same thing. The conclusion in *MC*, at least in part, seemed to have been attributable to the manner in which this particular averment was pleaded, but for liability to be denied solely on this technical point seems a little disingenuous and one suspects that a slight re-wording of the statement of claim would not have produced an altogether different conclusion.[[104]](#footnote-105)

 Insofar as the allegation of ‘systemic’ fault was concerned, the patient failed because the manner in which the statement of claim was drafted was, again, too imprecise. There was nothing to indicate in what respect the system was unsafe and indeed how it could have been improved.[[105]](#footnote-106) The allegation of an ‘unsafe system’ was founded on the delay of over thirty minutes from decision to delivery. Lord Menzies suggested that, due to the allegation against the individual obstetrician in this regard as well, the passage of more than thirty minutes to delivery was not necessarily a result of an unsafe system but could, by implication, have been down to individual error.[[106]](#footnote-107) In the end, of course, the case against the individual was not made out and so here is a classic example of a situation in which the patient could have been left caught between two stools. If, on the one hand, it could not have been the fault of the system because, potentially, it could have been the fault of the individual obstetrician, yet, on the other, the individual obstetrician could not have been at fault because the ‘system’ did not deliver the patient to her on time when she was stood in theatre, scrubbed, and ready to operate, where should the responsibility have ultimately rested? As and between those two errors, presumably it should have rested somewhere. Holding the midwives liable at the earlier point in the proceedings was the more straightforward option, but it had the effect of concealing flaws in the reasoning which become apparent on closer inspection. Had it been impossible to make that finding against the midwives, would the pursuer have been unable to recover? To hold so would have been to completely ignore that something obviously went wrong that exposed the mother and her child to considerable and unnecessary harm. A judge should really not need recourse to specific examples of what a system should reasonably entail in order to reach a conclusion that it is, in fact, unreasonable in the circumstances. To suggest that it was impossible to investigate what was behind the catalogue of errors evident in *MC*, and that it was inappropriate to explore the inner-workings of a system in order to reasonably assess its overall safety and effectiveness without having a specific frame of reference against which that assessment could be measured, seems to overly constrict the powers of a judge in a negligence action. *Popple* and *MC* are also demonstrative of the fact that some judges seem more inclined to actively scrutinise the professional conduct of midwives and, where appropriate, deem their actions negligent, whereas they seem less enthusiastic to do the same in respect of doctors. One can only speculate as to why this may be the case. First, the error in question may well have been much more self-evident and easy to identify in a given case. Second, and potentially more problematic, judges may well feel they are better placed to assess the conduct of midwives as it is a role that demands less technical expertise than that of a doctor. In other words, judges may feel more comfortable in imposing their own views as to what amounts to reasonableness or otherwise. In the latter, if this attitude is adopted too frequently, it could become problematic. The job of a midwife is technically demanding and requires high levels of professional expertise; errors will sometimes not always be easy to identify and will indeed demand careful judicial scrutiny in order to determine the question of breach. Equally, it may well be the case that a doctor makes a very obvious error that should be visible to a judge on an objective assessment of the situation and to focus predominantly on the actions of midwives may detract from this. Where the allegation of negligence is made against various professionals who constitute of the delivery ‘team’, judges need to investigate carefully where the responsibility should actually lie and not be too quick to apportion blame based on the path of least resistance.

***iii. The Influence of Professional Guidelines***

Whilst professional guidelines were not a central feature of the 2102 Report insofar as being a major cause or principal focus of many childbirth claims, they were identified as being useful in improving professional standards moving forward and also as an effective risk-management tool.[[107]](#footnote-108) More importantly, reliance on professional guidelines was a common feature in the majority of cases analysed for the purposes of this study. They were used frequently by judges to assist them in answering questions relating to CTG interpretation and also as to the administration of certain drugs, such as Syntocinon.[[108]](#footnote-109) NICE has produced clinical guidelines in regard to childbirth[[109]](#footnote-110), so too the Royal College of Obstetricians and Gynaecologists.[[110]](#footnote-111) The Nursing and Midwifery Council has equally produced an array of publications[[111]](#footnote-112) and, moreover, some individual hospitals also issue guidance in respect of their own practices and protocols.[[112]](#footnote-113)

 First, there is a pragmatic difficulty worth noting that concerns the sheer number of guidelines that are currently being published. This increase could have the effect of confusing matters by creating a degree of overlap or contradiction. This, in turn, may make it extremely difficult for healthcare professionals and judges to decide on the reasonableness (or otherwise) of the course of action. That issue aside, two further points of curiosity reside in the degree to which the guidelines should be allowed to dictate the legal standard of care and how willing judges are to critically evaluate the content of the guidelines for themselves and, where appropriate, to disregard them.

 Obstetrics and gynaecology, in a manner not dissimilar to other fields, has favoured a move towards evidence-based practice in medicine.[[113]](#footnote-114) This trend has made the transition from medical practice into the courtroom as experts and judges will first look to whether or not there was a strong evidence-base in support of a healthcare professional’s practice. Guidelines are often constructed on the back of evidence-based practice and so these will frequently provide the benchmark against which the assessment of conduct can be carried out by a judge. To this end, albeit in a context other than childbirth litigation, Jones has quite rightly suggested that as professional attitudes change, patients will be entitled to a higher standard under *Bolam*.[[114]](#footnote-115) It is therefore possible to suggest that professional guidelines should be regarded as the baseline standard against which healthcare professionals should be judged because they are strongly representative of a ‘responsible’ body of medical opinion. However, even though they are a useful starting point, an awareness must remain that the legal standard of care, as defined by a judge, should not merely replicate without question the standard espoused by the guidelines.

 There seems to be a general reluctance from judges in England and Scotland to adopt a more proactive stance in terms of scrutinising the guidelines more carefully before admitting them into evidence. In terms of childbirth cases, this problem is amplified by the fact that a judge may be even more reluctant to subject to questioning elaborate and medically constructed guidelines that are intricate and heavily specialised. Whilst there is at least some evidence indicative of the fact that judges have, on occasion, been prepared to question professional guidelines, the examples are few and far between.[[115]](#footnote-116) Regardless of this, as hesitant as judges in England and Scotland may well be to hold that guidelines underpinned by a clear evidence-base are unreliable, it would seem that judges in other jurisdictions have been less circumspect in their approach.[[116]](#footnote-117) Thus, as Samanta *et al.* suggest, there is no reason why judges should not ‘apply an analytical framework to evaluate scientific evidence based on a range of factors before accepting guidelines as admissible evidence’.[[117]](#footnote-118)

 If the general attitude of unquestioningly accepting professional guidelines insofar as their admissibility and substantive content is cause for concern, there is evidence of an even more worrying trend developing in the specific context of childbirth litigation. The immense difficulty for a judge in having to balance out the risks and benefits in these cases has already been demonstrated. Despite this, Samanta *et al.* accurately point out that the use of professional guidelines may assist a judge in undertaking a *Bolitho* type risk versus benefit calculation.[[118]](#footnote-119) They suggest that ‘*Bolitho* might really take effect by assessing the validity of accepting the lack of use of guidelines and, more importantly, the validity of rejecting the competing position in terms of using the guidelines’.[[119]](#footnote-120) This recognises that professional guidelines can cut both ways in terms of their usefulness in apportioning liability. A healthcare professional is not bound by professional guidelines and in fact may justifiably depart from them on occasion, provided that she can point to a sufficiently convincing benefit in doing so that outweighs any associated risk. The converse is, of course, true. A healthcare professional should not be allowed to merely plead the defence that she acted in accordance with the professional guidelines and as a consequence she can never therefore be negligent. There will be some occasions in which healthcare professionals, having appropriate regard to the particular circumstances of the case, must be prepared act outside the scope of the guidelines, for not to do so would be unreasonable. They will need to be aware of this, but judges must also pay heed to the fact that, not only is it appropriate for them also to depart from the guidelines in certain cases, but that it is most definitely within their power to do so. This especially ought to be encouraged where the risk in sticking to the guidelines seems to have outweighed a clear benefit that could have accrued by doing something differently.

 There is also evidence to suggest that the guidelines are being used in a one-sided manner, supportive of the defendant and to the detriment of the patient. Where a defendant can point to the relevant guidelines in support of what she did, there appears in some instances to be clear reticence from judges to question the appropriateness of the guidelines themselves, much less depart from them.[[120]](#footnote-121) On the other hand, the case of *NM* illustrates that where the pursuer seeks to rely on an argument that the defendant acted contrary to the published guidelines at the time in support of imposing liability, there seems to be a greater judicial enthusiasm for disregarding the guidelines and holding that the issue was one that fell within the margin of appreciation that was afforded to the exercise of professional discretion.[[121]](#footnote-122) There is a tendency to treat the professional guidelines as a gold standard when the defendant is relying on them in support of their case, but when the claimant attempts to do the same thing, they are treated as nothing more than a mere guideline used to shape the contours of the legal standard, but not to categorically define it. Samanta *et al*. indicate that a range of factors need to be considered when using professional guidelines to assist in the performance of risk benefit analysis. This ought to include the magnitude of the risk, the comparative risk of using the guideline, the seriousness of the risk and the ease by which it might have been avoided and, interrelated, the implications of such avoidance in terms of finances and resources of healthcare.[[122]](#footnote-123) In the childbirth cases studied, consideration of these factors seems to have been fundamentally lacking in the judicial analysis, or, worse still, the factors only seem to have been contemplated from the perspective of the defendant, with little consideration as to the position of the patient. By way of example, the departure from the guidelines in *NM* exposed the pursuer to a significant risk which could have been avoided.[[123]](#footnote-124) The method of avoiding the catastrophic risk that materialised would not, admittedly, have been totally risk free, nor would it have had no impact whatsoever in terms of resources and cost.[[124]](#footnote-125) That being said, weighing everything in the balance in that particular set of circumstances, the departure from the guidelines was not, in this author’s view, defensible, nor could it be convincingly argued that it was reasonable. If this attitude towards professional guidelines in childbirth cases prevails, there is a danger that it will continue to leave claimants at a manifest disadvantage.

**V. Conclusions: Unreasonable Risk Taking in Childbirth Litigation?**

This paper has concentrated on a selection of negligent childbirth case law that has occurred since the publication of the 2012 Report. The research is therefore narrow in scope and clearly has its limitations. However, a number of emerging patterns have been identified and something of importance can undoubtedly be drawn from this analysis.

 The recent case law certainly makes it difficult to describe judicial attitudes in respect of the *Bolitho* gloss as being progressive. Liability has, in the odd case, been founded against midwives in situations where they have exposed patients to significant risks that could have been avoided with relative ease. These decisions do represent an example of balancing risk versus benefits, at least at a very superficial and basic level. Being held in breach, however, seems only to have happened in the most straightforward of cases and in many of these situations the mistake was so blatantly obvious that recourse to *Bolitho* in order to find the defendant negligent was not strictly necessary. Similarly, where the error does not focus solely on one individual, but on different members of the healthcare team, sometimes it appears that judges are more amenable to pinpointing errors made by midwives and to deem them negligent than they are when it comes to making similar findings against doctors. Whilst it is impossible to tell from the findings of this paper, if this attitude is representative of the majority of negligent childbirth claims across the board, there is perhaps some cause for concern. Where the error is more complicated to locate, and where the issue involves a greater amount of technical expertise to resolve, judges have adopted a ‘hands-off’ approach. Certainly in respect of CTG trace interpretation, which is a major issue in childbirth cases, judges seem to place heavy reliance on expert witness testimony and professional guidelines. Even where doctors have departed from those guidelines, there still seems to be a significant margin of appreciation afforded to them in the exercise of professional discretion.

 It also seems evident that, unless the error in question is easily recognisable, judges are unwilling to engage in the comprehensive risk benefit analysis that *Bolitho* invites of them. In such a specialist field of medicine, this is understandable to a point, but the objective powers of reasoning that should come naturally to every judge should not yield to highly distinguished medical experts, just because they are indeed highly distinguished. In the childbirth cases under investigation, judges have often ignored the surrounding circumstances of the case and therefore have frequently overlooked the fact that when risks are exacerbated by the individualities of the patient concerned, this often opens up a different perspective on the assessment of that risk. Whereas ordinarily there may be some benefit in allowing the labour to proceed naturally, there may be certain factors which call for a reassessment of the magnitude of that benefit when compared to any risk that may have been magnified. Prompter intervention may certainly have seemed to produce a more convincing benefit to risk ratio in some cases.

 In the past the courts have, from time to time, seen fit to engage more actively with expert opinion. For example, outside the domain of childbirth, there is evidence to support the fact that judges have been more willing to question the conduct of General Practitioners, especially where the exercise of due caution would have seemingly avoided a very obvious risk with relative ease.[[125]](#footnote-126) One possible reason for this is that judges may well feel more at ease in questioning what they perceive to be an area of medicine that is less complex than obstetrics and gynaecology. In a similar fashion though, prior to the 2012 Report, there is also some evidence of judges showing more initiative in respect of childbirth cases *per se*.[[126]](#footnote-127) It is only post 2012 that the picture becomes a little bleaker and it does cause one to question why in recent times judges seem so reluctant to engage more carefully with the weighing of risks and benefits in maternity cases. This may be reflective of a more widespread attitude of deference towards medical testimony which may, in part, be driven by policy-based concerns that healthcare professionals should not have to make medical decisions with the threat of a negligence action hanging over their heads like the sword of Damocles. Policy considerations aimed at protecting healthcare professionals are justifiable up to a certain point, but there are situations in which these can be legitimately overridden by recourse to equally, if not more, compelling factors affecting protection of patients. In response, I have argued elsewhere in respect of clinical negligence claims in general that the courts, after engaging in an objective assessment of the evidence from a risk benefit perspective, should ask the simple question: was the patient exposed to an unreasonable risk in the circumstances?[[127]](#footnote-128) This may only be met with a lukewarm response by some critics who will no doubt point out that judges may be unwilling to make decisions which give the impression that they may be encroaching on the views expressed by medical experts. Thus, it is important to remember that where there is competing evidence on both sides, a judge is not being asked to impose her own view over that of the defendant’s experts, she is simply being asked to objectively arbitrate between two conflicting factions. The argument is not that liability should be founded simply on the basis that what is suggested by the claimant’s experts seems *more reasonable*; the crucial point is that a judge must deem the evidence offered on behalf of the defendant to be *unreasonable*. Bearing in mind what is at stake in childbirth - the rights and interests of the mother, considerations pertaining to the health and wellbeing of the fetus, the severity of injury that is often suffered, and how this impacts on future lives care regimes - if ever there was a field in which the courts should be more receptive to the unreasonable risk approach it is here. At present, the evidence indicates that in some situations judges are oblivious to the fact that the patient, on an objective examination of the whole rather that the parts, was exposed to unjustifiable risk taking and this is something that the law of negligence should be slow to tolerate.

1. \* LLB (Hons); PhD. Reader in Medical Law, UEA Law School. R.Heywood@Uea.Ac.Uk. Thanks are due to my colleague, Dr Gareth Spark, and also to Dr Sebastian Peyer and Dr Sarah Devaney, for their useful comments on an earlier draft of this piece. Thanks are also due to the journal’s anonymous referees for their very helpful suggestions. The usual disclaimer applies.

 *Inside Llewyn Davis*. Written by Joel and Ethan Coen. Directed by Joel and Ethan Coen. Produced by Scott Rudin and Joel and Ethan Coen. Studio: Mike Zoss Productions, Scott Rudin Productions and Studio Canal. Distributed by CBS Films and Studio Canal. 2013. [↑](#footnote-ref-2)
2. See below n 26. [↑](#footnote-ref-3)
3. It is reported that, between 1/4/2003 and 31/3/13, out of 68,136 total files opened, 32,268 (47.36%) claims have been settled out of court. See ‘NHSLA Factsheet Number 3: Information on Claims’, July 2013. Written correspondence between the NHSLA and the author confirmed that of the 32,268 settled claims, 5,368 related to obstetrics and gynaecology. [↑](#footnote-ref-4)
4. [1957] 1 WLR 582. [↑](#footnote-ref-5)
5. Ibid at 587. [↑](#footnote-ref-6)
6. *Whitehouse v Jordan* [1981] 1 WLR 246. [↑](#footnote-ref-7)
7. *Whitehouse v Jordan* [1980] 1 All ER 650, 658. [↑](#footnote-ref-8)
8. See G Robertson, ‘*Whitehouse v Jordan* - Medical Negligence Retried’ (1981) 44 *Modern Law Review* 457. [↑](#footnote-ref-9)
9. *Whitehouse*, above n 6, 263. [↑](#footnote-ref-10)
10. *Bolam*, above n 4. [↑](#footnote-ref-11)
11. *Bolitho v City and Hackney Health Authority* [1998] AC 232. [↑](#footnote-ref-12)
12. See R Mulheron, ‘Trumping *Bolam*: A Critical Legal Analysis of *Bolitho’s* “Gloss”’ (2010) 69 *Cambridge Law Journal* 609; R Heywood, ‘The Logic of *Bolitho*’ (2006) 22 *Journal of Professional Negligence* 225; A MacLean, ‘Beyond *Bolam* and *Bolitho*’ (2002) 5 *Medical Law International* 205; M Brazier and J Miola, ‘Bye-Bye *Bolam*: A Medical Litigation Revolution?’ (2000) 8 *Medical Law Review* 85; J Keown, ‘Reining in the *Bolam* Test’ (1998) 57 *Cambridge Law Journal* 248; A Grubb, ‘Negligence: Causation and *Bolam*’ (1998) 6 *Medical Law Review* 378. [↑](#footnote-ref-13)
13. In order to conduct the research for this article, a search of Westlaw was undertaken. The keyword search terms comprised ‘clinical negligence’; ‘obstetricians’; ‘midwives’; ‘birth defects’. The range of dates searched spanned 1/1/2011 up until 3/6/2014. Whilst this piece does seek to focus on cases after the publication of the 2012 Report, the search was run from an earlier point in order to account for the fact that some of the returns in 2012 were appeal cases. Thus, it was important to also identify these cases in the court of first instance. Initially the author considered performing a pre-2012 and post-2012 survey. However, in the end this was avoided as maternity litigation is so vast, it would have extended the scope of the project beyond an appropriate level. [↑](#footnote-ref-14)
14. NHSLA, ‘Ten Years of Maternity Claims: An Analysis of NHS Litigation Authority Data’, October 2012. [↑](#footnote-ref-15)
15. Ibid. [↑](#footnote-ref-16)
16. Above n 14 at 6. [↑](#footnote-ref-17)
17. Above n 14 at 81. [↑](#footnote-ref-18)
18. See above n 13 for how the relevant cases were identified. The English cases included: *Tippett v Guy’s & St Thomas’ Hospital NHS Foundation Trust* [2014] EWHC 917; 2014 WL 1219296; *Sardar v NHS Commissioning Board* [2014] EWHC 38; [2014] Med LR 12; *C v North Cumbria University Hospitals NHS Trust* [2014] EWHC 61; 2014 WL 16538; *Chappell v Newcastle Upon Tyne Hospitals NHS Trust* [2013] EWHC 4023; 2013 WL 6537266; *Popple v Birmingham Women’s NHS Foundation Trust* [2012] EWCA Civ 1628; [2013] Med LR 47; *Spencer v NHS North West* [2012] EWHC 2142; *Croft v Heart of England NHS Foundation Trust* [2012] EWHC 1470; 2012 WL 1933467; *Reeve v Heart of England NHS Trust* [2011] EWHC 3901; 2011 WL 6329549. The Scottish cases included*: NM v Lanarkshire Health Board* [2013] CSIH 3; 2013 SC 245; *MC v Borders Health Board* [2012] CSIH 49; 2012 GWD 23-468. [↑](#footnote-ref-19)
19. Proving causation is another difficult obstacle for patients to overcome in negligent childbirth cases. The focus of this piece is exclusively on breach. [↑](#footnote-ref-20)
20. See below n 26. [↑](#footnote-ref-21)
21. The 2012 Report uses ‘maternity’ as a general term to include obstetrics and gynaecology claims. [↑](#footnote-ref-22)
22. The CNST is a risk pooling scheme administered by the NHSLA. It provides a means for organisations to fund the cost of clinical negligence claims. Despite being voluntary, all NHS organisations providing maternity services in England are members of the scheme. The total gross maternity contribution in 2011/12 was 571 million. (See above n 14 at 9). [↑](#footnote-ref-23)
23. Above n 14 at 7. [↑](#footnote-ref-24)
24. Ibid at 6. [↑](#footnote-ref-25)
25. Ibid at 6 and 8. [↑](#footnote-ref-26)
26. ‘NHSLA Factsheet Number 3: Information on Claims’, July 2013. [↑](#footnote-ref-27)
27. Above n 14 at 4 and 6. [↑](#footnote-ref-28)
28. Ibid at 4. [↑](#footnote-ref-29)
29. Ibid.

 [↑](#footnote-ref-30)
30. Ibid. [↑](#footnote-ref-31)
31. Cerebral palsy was omitted from this paper as a key theme of discussion because it is often a *consequence*, rather than a direct cause, of a breach of duty. [↑](#footnote-ref-32)
32. Above n 14 at 4. [↑](#footnote-ref-33)
33. *Bolam*, above n 4. [↑](#footnote-ref-34)
34. *See Defreitas v O’Brien* [1995] PIQR P281. [↑](#footnote-ref-35)
35. See JL Montrose, ‘Is Negligence an Ethical or Sociological Concept?’ (1958) 21 *Modern Law Review* 259. [↑](#footnote-ref-36)
36. See *Whitehouse*, above n 6; *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634. [↑](#footnote-ref-37)
37. See H Teff, *Reasonable Care: Legal Perspectives on the Doctor Patient Relationship* (OUP 1996). More recently see C Foster, ‘Autonomy in the Medico-Legal Courtroom: A Principle Fit for Purpose’ (2014) 22 *Medical Law Review* 48. [↑](#footnote-ref-38)
38. See Grubb, above n 12. [↑](#footnote-ref-39)
39. *Maynard*, above n 36, per Lord Scarman, 639. [↑](#footnote-ref-40)
40. *Bolitho*, above n 11, 242. [↑](#footnote-ref-41)
41. *C v North Cumbria*, above n 18 at [25]. [↑](#footnote-ref-42)
42. See Heywood, above n 12. See also N Castle, ‘Applying *Bolitho*’ (1998) *Journal of Personal Injury Law* 278; N Glover, ‘*Bolam* in the House of Lords’ (1995) 15 *Journal of Professional Negligence* 42. [↑](#footnote-ref-43)
43. See H Teff, ‘The Standard of Care in Medical Negligence - Moving on From *Bolam*?’ (1998) 18 *Oxford Journal of Legal Studies* 473 at 481. See also M Jones, ‘The *Bolam* Test and the Reasonable Expert’ (1999) 7 *Tort Law Review* 226. [↑](#footnote-ref-44)
44. See Heywood, above n 12 at 234. [↑](#footnote-ref-45)
45. Mulheron, above n 12. [↑](#footnote-ref-46)
46. Ibid at 620 - 637. [↑](#footnote-ref-47)
47. *Chappell*, above n 18 at 22. [↑](#footnote-ref-48)
48. Above n 14 at 41. [↑](#footnote-ref-49)
49. See the expert testimony in the case of *Tippett*, above n 18 at [37]. [↑](#footnote-ref-50)
50. Teff, above n 43. In terms of witness credibility, see also *Croft*, above n 18. [↑](#footnote-ref-51)
51. *Tippett*, above n 18 at [5]. [↑](#footnote-ref-52)
52. Ibid at 82. [↑](#footnote-ref-53)
53. Ibid at [85]. See NICE, *Intrapartum Care: Care of Healthy Women and Their Babies During Childbirth*, September 2007. [↑](#footnote-ref-54)
54. Ibid at [86]. [↑](#footnote-ref-55)
55. Ibid at [87]. [↑](#footnote-ref-56)
56. Ibid at [23]. It was designated as high risk due to the patients PPRM (premature rupturing of membranes). [↑](#footnote-ref-57)
57. It was acknowledged that this was what the midwife wanted to do. Ibid at [87]. [↑](#footnote-ref-58)
58. Ibidat [88]. [↑](#footnote-ref-59)
59. Ibid at [89]. [↑](#footnote-ref-60)
60. For a similar CTG case see also *Reeve*, above n 18. The case of *Sardar*, above n 18, illustrates the enormous weight that judges place on the credibility of expert witnesses outside the domain of CTG interpretation. [↑](#footnote-ref-61)
61. *Chappell*, above n 18. [↑](#footnote-ref-62)
62. Syntocinon is used to induce labour whilst avoiding hyper-stimulation of the maternal uterus. See ibid at [5]. [↑](#footnote-ref-63)
63. Ibidat [4]. [↑](#footnote-ref-64)
64. Ibid at [48]. [↑](#footnote-ref-65)
65. Ibid at [74]. [↑](#footnote-ref-66)
66. Ibid. [↑](#footnote-ref-67)
67. An earlier reassuring FBS was taken at 01.55. See ibid at [75]. [↑](#footnote-ref-68)
68. Ibid at [85]. [↑](#footnote-ref-69)
69. *Maynard*, above n 36. [↑](#footnote-ref-70)
70. *Chappell*, above n 18 at [75]. [↑](#footnote-ref-71)
71. Ibid at [74]. [↑](#footnote-ref-72)
72. The claimant had a persistent fever throughout labour and after her son was born. A subsequent diagnosis of Chlamydia was confirmed. Given that the finding of breach was resolved in favour of the defendant, there was technically no need for McKenna J to consider the question of causation. He did proceed to analyse the point and concluded that it was more likely than not that the claimant’s injury had actually been caused by the mother’s existing infection. Thus, even if the claimant had managed to successfully argue that there had been a breach, the case may still have been lost on causation. [↑](#footnote-ref-73)
73. Mulheron, above n 12. [↑](#footnote-ref-74)
74. *NM v Lanarkshire*, above n 18. At the time of writing, this case is currently under appeal before the Supreme Court. The controversial aspect of the decision is more concerned with information disclosure and breach. However, it will be interesting to see what their Lordships say in respect of the actual treatment decision *per se* and the question of breach. See UKSC 2013/0136. For discussion of the decision of the Outer House of the Court of Session see R Heywood, ‘Negligent Antenatal Disclosure and Management of Labour’ (2011) 19 *Medical Law Review* 140. See also A MacLean, ‘From *Sidaway* to *Pearce* and Beyond: Is the Legal Regulation of Consent Any Better Following a Quarter of a Century of Judicial Scrutiny?’ (2012) 20 *Medical Law Review* 108. [↑](#footnote-ref-75)
75. *NM v Lanarkshire*, above n 18 at [55]. [↑](#footnote-ref-76)
76. The Scottish courts are not technically bound to follow the English House of Lords’ decision in *Bolitho*. However, there is no indication that Scottish law wishes to travel in a different direction. [↑](#footnote-ref-77)
77. *NM v Lanarkshire*, above n 18 at [60]. [↑](#footnote-ref-78)
78. Ibid at [66]. [↑](#footnote-ref-79)
79. Ibid at [59]. [↑](#footnote-ref-80)
80. Ibid at [55]. [↑](#footnote-ref-81)
81. See L Liljeström *et al*., ‘Experiences of Fetal Scalp Blood Sampling During Labor’ (2014) 93 *Acta Obstetricia Et Gynecologica Scandinavica* 113. [↑](#footnote-ref-82)
82. See J Villar *et al*., ‘Maternal and Neonatal Individual Risks and Benefits Associated With Caesarean Delivery: Multicentre Prospective Study’ *BMJ Online First* doi: 10.1136/bmj.39363.706956.55; JL Ecker, ‘Cesarean Delivery and the Risk-Benefit Calculus’ (2007) 356 *The New England Journal of Medicine* 885; J Villar *et al*., ‘Caesarean Delivery Rates and Pregnancy Outcomes: The 2005 WHO Global Survey on Maternal and Perinatal Health in Latin America (2006) 367 *Lancet* 1819. [↑](#footnote-ref-83)
83. *NM v Lanarkshire*, above n 18 at [2]. [↑](#footnote-ref-84)
84. Ibid. A macrosomic fetus is a larger than average baby. [↑](#footnote-ref-85)
85. Ibid at [2] - [3]. [↑](#footnote-ref-86)
86. *C v North Cumbria*, above n 18. [↑](#footnote-ref-87)
87. Prostin is a drug that stimulates natural contractions in the uterus. [↑](#footnote-ref-88)
88. The mother tragically died and the child was born with cerebral palsy. [↑](#footnote-ref-89)
89. *C v North Cumbria*, above n 18 at [75]. [↑](#footnote-ref-90)
90. Ibid at [78]. [↑](#footnote-ref-91)
91. Ibid at [37]. [↑](#footnote-ref-92)
92. *Spencer*, above n 18, is another decision in which liability was denied on a similar basis.

 [↑](#footnote-ref-93)
93. *Popple*, above n 18. [↑](#footnote-ref-94)
94. See *Popple* in the High Court [2011] EWHC 2320, p 60 at [D] (b). [↑](#footnote-ref-95)
95. An episiotomy is an incision through the perineum and perineal body. Its main aim is to speed up the delivery where there is evidence of fetal distress. See ibid at [78]. [↑](#footnote-ref-96)
96. Ibid, p 65 at [j]. The decision was appealed to the Court of Appeal on a point of causation (*Popple*, above n 18). Oliver-Jones J’s initial finding of negligence was no longer challenged at this stage. The appeal was dismissed in favour of the claimant. [↑](#footnote-ref-97)
97. *MC*, above n 18. [↑](#footnote-ref-98)
98. [2011] CSOH 73 at [127] - [128]. The case was initially heard in the Outer House of the Court of Session in 2011. The case was then appealed to the Inner House in 2012 and the appeal in relation to the negligence of both midwives was dismissed in favour of the pursuer (*MC*, above n 18). [↑](#footnote-ref-99)
99. Ibid at [132]. [↑](#footnote-ref-100)
100. Ibid. [↑](#footnote-ref-101)
101. Ibid at [3] and [47]. [↑](#footnote-ref-102)
102. Ibid at [140]. [↑](#footnote-ref-103)
103. Ibid at [137]. [↑](#footnote-ref-104)
104. Ibid at [133] and [137]. [↑](#footnote-ref-105)
105. Ibid at [150]. [↑](#footnote-ref-106)
106. Ibid at [151]. [↑](#footnote-ref-107)
107. Above n 14 at pp 77 - 81. [↑](#footnote-ref-108)
108. See *Tippett* and *Chappell* above n 18. [↑](#footnote-ref-109)
109. See above n 53. [↑](#footnote-ref-110)
110. See Royal College of Obstetricians and Gynaecologists, *Shoulder Dystocia:* Green-Top Guideline No. 42, 2nd edn, 2012. [↑](#footnote-ref-111)
111. See Royal College of Midwives, *Evidence Based Guidelines for Midwifery-Led Care in Labour: Supporting Women in Labour*, 2012. [↑](#footnote-ref-112)
112. See *Chappell*, above n 18. [↑](#footnote-ref-113)
113. See K Cornthwaite *et al*. ‘Reducing Risk in Maternity by Optimising Teamwork and Leadership: An Evidence-Based Approach to Save Mothers and Babies’ (2013) 27 *Best Practice & Research: Clinical Obstetrics and Gynaecology* 571; SL Clark *et al*., ‘Improved Outcomes, Fewer Cesarean Deliveries, and Reduced Litigation: Results of a New Paradigm in Patient Safety’ (2008) 199 *American Journal of Obstetrics and Gynecology* 105. [↑](#footnote-ref-114)
114. M Jones, ‘Informed Consent and Other Fairy Stories’ (1999) 7 *Medical Law Review* 103 at 125. [↑](#footnote-ref-115)
115. In the specific context of childbirth, see *Rich v Hull and East Yorkshire Hospitals Trust* [2014] EWHC 1978 in which a judge allowed expert testimony to be admitted that called into question the interpretation of clinical guidelines. In contrast, and in a different context than childbirth, see *Jones v Conwy and Denbighsire NHS Trust* [2008] EWHC 3172 QB; 2008 WL 6036247. [↑](#footnote-ref-116)
116. *See Daubert v Merrill Dow Pharmaceuticals Inc.* 509 US 579 (1993).

 [↑](#footnote-ref-117)
117. A Samanta *et al.*, ‘The Role of Clinical Guidelines in Medical Negligence Litigation: A Shift from the *Bolam* Standard?’ (2006) 14 *Medical Law Review* 321 at 364. [↑](#footnote-ref-118)
118. Ibid at 361. [↑](#footnote-ref-119)
119. Ibid. [↑](#footnote-ref-120)
120. See *Tippett*, *Reeve* and *Chappell*, above n 18. [↑](#footnote-ref-121)
121. *NM v Lanarkshire*, above n 18 at [58] - [59]. [↑](#footnote-ref-122)
122. Samanta *et al.*, above n 117 at 361. [↑](#footnote-ref-123)
123. *NM v Lanarkshire*, discussed above at pp 15 – 17. [↑](#footnote-ref-124)
124. Ibid. [↑](#footnote-ref-125)
125. See *Marriott v West Midlands Heath Authority* [1999] Lloyd’s Rep Med 23; *Hucks v Cole* (1968) [1993] 4 Med LR 393 (CA). [↑](#footnote-ref-126)
126. See, for example, *Kingsberry v Greater Manchester Strategic Health Authority* [2005] EWHC 2253 (QB); [2011] Med LR 334; *Hunt v NHS Litigation Authority* [1998] Lloyd’s Red Med 425; *Wiszniewski v Central Manchester HA* [1998] P.I.Q.R. P324. In particular, for an example of the weighing of risks v benefits, see the decision of the High Court in *Wiszniewski* [1996] 7 Med LR 248. [↑](#footnote-ref-127)
127. Heywood, above n 12. [↑](#footnote-ref-128)