Obstetrics and gynaecology and the law

Alec Samuels

Abstract
Litigation over medical mishaps – NHS Resolution – extent of damages and costs – the relationship between doctor and midwife – celebrated or notorious cases, Mid Staffs, Morecambe Bay, Northwick Park – informing patient of risks – meaning of wrongful birth – contemporary tests for negligence.

Keywords
Obstetrics and gynaecology, doctor, midwife, risks, informed consent, disasters, negligence, wrongful birth

In legal terms obstetrics and gynaecology represent high risk medicine (along with anaesthetics and misdiagnosis). Something like 10% of the legal claims against the NHS are “obs and gyn”, usually injuries suffered at birth, and up to something like 65% of the amount of the payments are for maternity claims, £3,650,000 in one birth injury case, and the payments may run over a remaining lifetime. Over £8bn has been paid annually in recent years, and a further £2.3bn in costs in 2019–2020 and £2.1bn in 2020–2021.

Not many trials
Although there are a good many claims, and also a good many mishaps which look likely to lead to a claim, the number of actual trials is small, surprisingly small, 0.6% of claims. The reasons for this are manifold:

The case (for both sides) would be complicated, lengthy, costly, of uncertain outcome. Liability may have to be separated from quantum.

The judge, impartial though he is, will inevitably be sympathetic towards the claimant baby, a damaged baby, and the mother and family.

Legal aid or a conditional no win–no fee arrangement may not be possible.

A protective order for costs may not be possible.

An inquest may turn out to be revealing, and promote settlement.

In a number of cases there is a public enquiry, which hopefully gives a clear exposition of the facts and a clear indication of liability, and this induces settlement. In any event, because of the inherent problems of a trial, a settlement or withdrawal is a common outcome.

Relationship between doctor and midwife
The relationship between doctor and midwife is critical. Many problems have arisen because of a deficiency in their vital relationship. The midwife is present at the birth, the doctor not (usually). Good medicine requires “one voice and a shared purpose”. Mutual respect and co-operation are truly essential. Multi-disciplinary training can only be beneficial. In simple terms mishaps can occur from too much intervention or too little intervention, or too soon or too late.

Home birth is less common than in former times. It may go perfectly smoothly, and does not occupy the hospital bed. However, the risk factors are inevitably greater than in the hospital or maternity unit, and may call for careful assessment and decision.

Toxic maternity: Mid-Staffordshire
Toxic maternity, toxic culture, were the phrases that emerged from the reports on the Mid-Staffordshire
Hospitals by Chairman Sir Robert Francis QC (24 February 2010 and 6 February 2013). There were an unusually large number of stillbirths, deaths during pregnancy, deaths of babies shortly after delivery, deaths of mothers. The use of excessive force led to broken bones and fractured skulls. There were multiple brain injuries. Cerebral palsy went unrecognised. Caesareans were well below the national average. Parents were not informed that the maternity units were stand alone midwifery units. Families were not involved. The babies were starved of oxygen. There was substandard care. There was a failure to learn lessons from experience. There was even a lack of kindness and compassion.

Morecombe Bay

A damning indictment of maternity services appears in The Report of the Morecombe Bay Investigation, Dr Bill Kirkup CBE, March 2015, paras 1–26. “Clinical competence was substandard, with deficient skills and knowledge; working relationships were extremely poor, particularly between different staff groups, such as obstetricians, paediatricians and midwives; there was a growing move amongst midwives to pursue normal childbirth ‘at any cost’; there were failures of risk assessment and care planning that resulted in inappropriate and unsafe care; and the response to adverse incidents was grossly deficient, with repeated failure to investigate properly and learn lessons” (Executive summary, para 4). Particular problems included shortage of oxygen, untreated high blood pressure, unrecognised infection, undetected amniotic fluid embolism, over-pursuit of normal childbirth, poor clinical competence, insufficient recognition of risk, a failure of team working, and denial of the problem.

Northwick Park Hospital East Kent (October 2019)

The mother of the long-labour new-born baby suspected that something was wrong. The midwives tried to reassure her that everything was fine. It emerged that the baby had a collapsed lung, pneumonia, septicemia and a kidney and liver infection. The mother was a carrier of Group B streptococcus (GBS). Oxygen levels were low, and an X-ray at once disclosed the collapsed lung. There was a catalogue of criticisms, general criticisms of the hospital: Preventable deaths. Failure to spot infection. Misreading of a cardiotocography machine. Panic in difficult circumstances. Staff out of their depth. No CTG training attendance. Reliance upon out-of-date clinical guidelines. Doctors determined to “do their own thing”. No detection or expectation of death or serious brain injury. Poor forward planning. Poor ward round practice. Poor teamwork. Lack of staff.

Wrongful birth

Wrongful birth is a curious phrase, which seems to cover negligent advice or assistance or treatment by the doctor or nurse or midwife involved before or at the birth. Situations include a failure of conception, pregnancy care, and delivery. The duty on the doctor is to so advise the patient that she is able to make a fully informed decision as to whether or not to consent to whatever is proposed. This means that the risks which a competent doctor would expect to be material to the patient, including any risks specifically raised by the patient, are fully and properly understood by the patient.1

The claimant3 was having an anxious pregnancy. She was very concerned that her unborn child was or might be subject to haemophilia. The doctor tested her and thought not, and so advised her, so she proceeded with a pregnancy. The child was born with haemophilia and autism. A “wrongful birth”. The mother claimed damages for having the child, losing the opportunity of termination, and the substantial extra cost of upbringing brought on by the haemophilia and the autism. The doctor accepted liability for the extra cost brought on by the haemophilia, but denied liability for the autism. In what might be seen as a decision which could have gone the other way, the Supreme Court unanimously held that the patient specifically raised haemophilia, the GP referred her to the appropriate specialist on haemophilia, who was found to be liable. The GP’s duty extended no further, no liability for the autism, the additional costs brought on by the autism. Advice on autism was not within the scope of the legal duty. Their unanimous lordships indicated the questions to be raised in analysing the place of the scope of duty principle in the tort of negligence (para 28, likely to be much applied in future):

1. Is the harm (loss, injury and damage) actionable in negligence?

Not negligent

The claimant bore a child, all was normal. Quite soon after the birth the claimant was found to carry Group B streptococcus infection which caused her some brain damage. She claimed that the infection could and should have been identified and treated whilst in the hospital for the birth. The judge held that the probable cause of the brain damage could not be identified, and even if it had been identified the treatment would not have been any different.1
2. What are the risks of harm to the claimant against which the law imposes on the defendant a duty to take care?
3. Did the defendant breach his or her duty by his or her act or omission?
4. Is the loss for which the claimant seeks damages the consequence of the defendant’s act or omission?
5. Is there a sufficient nexus between the harm and the duty of care?
6. Is a particular element of the harm irrecoverable because it is too remote or because there is a different effective cause or because the claimant has mitigated his or her loss or failed to avoid loss which he or she could reasonably be expected to avoid?

What then are the lessons for the medical professionals in the obstetrics and gynaecological world? The GP should answer all the questions posed by the patient, and refer to the consultant where appropriate. The consultant must comply with the standards of competence and expertise rightly to be expected of him in his position. Depending upon the understanding capacity of the patient and her family all the medical professionals should seek to ensure that the patient is fully informed of the likely or reasonably possible risks in pregnancy and childbirth, not so as to alarm the patient but so as to fully inform her and to gain and maintain her confidence. Depending upon status and experience, the medical professional would do well to be familiar with patient concerns, contemporary literature, local practice, and local statistics.

The pregnant woman was having difficulties, abdominal pains and such like. At 31 weeks she was prescribed Nifedipine, a tocolytic drug designed to prevent premature birth. The child was born with brain damage. The claim alleged that the drug was only experimental at the time (the relevant time being well over 20 years before the trial), caused a fall in blood pressure and a hypoxic episode. The claim failed on the basis that administration of the drug was reasonable and acceptable (and indeed had been vindicated in recent times, though the claim had to be judged on the state of medicine at the time).

During the pregnancy the doctor and/or nurse or midwife notices something which gives them reason to think that “something may be wrong”. They do not tell the mother or her family. The child is born with a serious medical problem. The mother could have opted for a termination had she known. She sues for wrongful birth. The doctor owes a duty to the mother patient, especially to keep her informed so that she knows the options open to her.

The mother may sue on her own behalf, and the child may sue, by next friend namely mother, on his or her own behalf, under the Congenital Disabilities (Civil Liability) Act 1976. Damages are not available at common law for the benefit, such as it may be, of non-existence. The child was born with a congenital development defect with limited mobility and double incontinency. The claim was that the mother’s GP had failed to advise her of the association between folic acid intake and spina bifida and to prescribe folic acid supplements, so that she would have avoided the problem, or even not have conceived. The judge accepted jurisdiction in the claim.

**Contraception**

The best and cheapest remedy for women worldwide is contraception, and contraception or good contraception is all too often not available. Any deficiency is harmful to women and existing families; and over-population is damaging to the world at large. Problems such as violence, marriage and relationship breakdown, infertility, abortion, child neglect and suicide stem from the contraception deficiency. The incidence of obstetric and gynaecological problems would be much reduced. In modern times women 35–45 are particularly vulnerable.

**Notes**

1. Ludwig v Oxford Radcliffe Hospitals NHS Trust [2012] EWHC 90, QB.
2. Montgomery v Lancashire Health Board [2015] UKSC 11, [2015] AC 1430, [2015] Med LR 149.
3. Khan v Meadows [2021] UKSC 21, [2021] Med LR 523.
4. Manchester Building Society v Grant Thornton UK LLP [2021] UKSC 20.
5. Jones v Taunton and Somerset NHS Foundation Trust [2019] EWHC 1408 QB, [2019] Med LR 384.
6. Scuringa v Powell (1979) 123 SJ 406 and McKay v Essex Area Health Authority [1982] QB 1166, [1982] 2 All ER 771, CA.
7. Toombes v Mitchell [2020] EWHC 3506 QB; [2021] Med LR 220, and with valuable commentary by Dr Simon Fox QC.

**General background information**

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Women’s Health Strategy, Dame Lesley Regan (RCOG, 2019).
Labour ward negligence, GG Buttigeg and K Micallef-Stafrace (2021) 89 MLJ 34.
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Wellbeing of Women, charity – cradle to grave. Obstetrics and Gynaecology, Peter J Huntingford, chapter 31, pp. 678–735, in Medicine Negligence, Michael Powers and Nigel Harris (Butterworths, 1990).
Simms v Birmingham HA (2001) 58 BMLR 66.

What can be done to reduce the damages, costs and fees paid out by the NHS for claims for clinical negligence?, Alec Samuels (2018) 86 MLJ 132.

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