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## Medical Law

**Topic 7** (of 10). **Lectures 1 & 2** (of 2):

# Maternity Care and Liability for a Child Born With Congenital Disabilities

**Aim:**
To outline some medico-legal issues which may arise during ante-natal care and at, or after, childbirth – particularly when a child is born with congenital disabilities.

**Objectives:**
After carefully studying the following notes, and other prescribed readings for this lecture, you will be able to:

1. Discuss selected legal issues that reportedly have arise from the use of ultrasound scans and in the 'home vs. hospital-childbirth' debate;
2. Clearly distinguish between a cause of action for wrongful disability and for wrongful life;
3. Discuss the circumstances under which a child born disabled has a cause of action, and against whom, in respect of both pre and post conception occurrences.

## (I) Legal Issues Arising From Monitoring Foetal Development

Various methods of ante-natal screening (or monitoring) may provide information on the growth and development of the foetus and may detect deformities such as spina bifida. Screening may be of a non-invasive nature, such as where the pregnant woman is subjected to an ultrasound scan; or invasive, such as amniocentesis or chorionic villus testing. It's not the *detection of deformities* which is the issue here: it's the potential the monitoring, or diagnostic, tests have for *contributing* to the birth of babies with congenital deformities.

### 1. Non-invasive monitoring of foetal development: ultrasound scanning

The use of ultrasound scanning now appears to be part of routine ante-natal care. Frequently, however, there is no 'medical' reason for a scan: it has been reported that scans are often used for 'social' reasons – to introduce prospective parents to their new baby – as well as to check for abnormalities. In an article entitled 'Unanswered questions' in the *Western Mail*, 29 December 1993, ***Michael van Straten*** stated that whereas:

> Doctors who specialise in ultrasound claim that there have been no adverse effects from using this technique in the past 30 years, …others are more sceptical. Doctor ***Michel Odent***, a pioneer of gentler approaches to pregnancy and childbirth, was worried about these scans 15 years ago. As a hospital consultant in France he outlawed the use of routine scans because at that time there was not enough evidence to prove that they were safe. After all, *ultrasound waves are not neutral and do have powerful biological effects.*
>
> In the light of recent evidence he's even more adamant that they should be used only when there is an obvious medical need for more information about the growing baby.

However, interpretation of evidence appears confused though, it is submitted, some cause for concern does seem justified. Results of studies conducted in Australia, Norway and America have been as follows.

## Australia

Here, 'Results of a study of women who had five or more ultrasound examinations during pregnancy show that they were more than twice as likely to have babies with restricted growth as those who had just one ultrasound'. (***The Times***, 8 October 1993).

## Norway

In September 1993, ' … a Norwegian study found a link between ultrasound and left-handedness, suggesting a possible effect on the developing central nervous system'. (***The Times***, 8 October 1993).

## America

Here there was a comparison of two groups. 'In the first group there was no routine use of ultrasound and scans were only performed if there was a serious medical reason. The second group were routinely scanned at around 20 and 32 weeks. There were nearly four times as many stillbirths in the second group as in the others, so what is the value of routine screening[?].' (***Western Mail***, 29 December 1993).

Also, a much smaller scale study carried out in Canada appears to yield a result that is a cause for concern. When 72 children with speech defects were compared with another group of children without speech defects it was discovered that 'the majority of the problem youngsters had been exposed to ultrasound scans, but those with normal speech had not'. (***Western Mail***, 29 December 1993).

By contrast with the above, however, 'an analysis of four trials of 16,000 pregnancies published in the *British Medical Journal* [in July 1993] concluded that ultrasound had no effect on parents' chances of having a healthy baby'. ((1993) *The Times*, October 8th).

Five years later, in ***1998***, 'a six-year study [by doctors at Oxford's John Radcliffe Hospital] of prenatal ultrasound, published in *The Lancet* .. found that it can detect 68% of congenital

abnormalities which could lead to miscarriages or other problems'[1]. The news item continued by noting that:

> 'The researchers studied more than 30,000 babies, of whom .. 2% were deemed abnormal on delivery.
>
> "Another 174 foetuses had signs suggesting abnormality, but went on to be normal at birth. These are known as "false positives". [It was also said that:] "The Oxford study shows that ultrasonography is increasingly sensitive for the detection of many serious anomalies and therefore capable of providing good information to allow parents to make important decisions about their unborn child.
>
> "Unfortunately, it also shows that ultrasonography may also provide information that is confusing or even misleading."

In 1998, then, it appeared that, overall, ultrasound scans were a safe, non-invasive form of monitoring foetal development and generally effective in detecting foetal abnormalities.

## 2004: safe or some cause for concern?

Results were published in *The Times* of nearly 3,000 children whose mothers had been randomly assigned to receive *either* five ultrasound scans from 18 to 38 weeks gestational age *or* a single scan at 18 weeks. The children were monitored from birth to 8 years of age. Whereas it was reassuring that no difference was found after the age of one year between groups in terms of physical size, speech, language, behaviour or neurological development, the potential for concern was in discovering that *at birth*, *the length of newborns in the '5 ultrasound scans' group was 'significantly less' than in the 'single ultrasound' group*. This appears very similar to the Australian results published in 1993: indeed, restricted growth is the single condition common to a couple of published results.

## February 2007: New causes for concern?

Whereas the results of the tests published in 2004 (noted above) seemed to suggest that there is no discernible risk associated with ultrasound scans, a report published in the British Medical Journal (BMJ) in February 2007 has again cast doubt on their safety. Commenting on the report, CBC news[2] said:

> While non-medical ultrasound scans offer parents an irresistible sneak peek, *the practice may not be entirely benign*, ..
>
> Dramatic improvements in technology, from the fuzzy polaroids of the past to the current 3-D photographs, have shifted ultrasound from its original medical intent, ..
>
> But the report notes that the U.S. Food and Drugs Administration, the American Institute of Ultrasound in Medicine and the French Academy of Medicine have all

[1] BBC News, Friday November 13th 1998: 'Abortion risk of prenatal scans' – available on the internet.
[2] http://www.cbc.ca/technology/story/2007/02/06/ultrasound-scans.html?ref=rss

> expressed reservations about ultrasound for non-medical purposes. The FDA suggests that casual exposure to ultrasound should be avoided, *particularly during pregnancy*.
>
> Health Canada also cautions parents, saying ultrasounds should only be performed for diagnostic purposes. The federal agency also suggests *fetal ultrasounds should only be performed when the expected medical benefits exceed any foreseeable risks*.

The concerns relate to what is now being called “4-D ultrasonography” or “boutique ultrasonography” – the ‘4th dimension’ being the movement of the developing foetus - and the increasingly rapid expansion of the provision of commercial scans for ‘social’ purposes.

### Preliminary Conclusions on Ultrasound Scans

A number of results have suggested foetal development has been adversely affected when the mothers of the children have been subjected to multiple scans, but that no long-term adverse effects have been experienced by the mothers or by the growing children. Yet, it seems too simplistic to suggest that foetal ‘problems’ simply disappear with age. However, unless a specific adverse condition is positively linked to the use of ultrasound scans, it seems as if the practice will remain an acceptable, convenient diagnostic tool with the added bonus of promoting ‘parental bonding’.

Given the apparently safe nature of the scans, despite concern expressed over some of the results, it would appear that if a disabled child alleged that ultrasound scans caused his disabilities he would be met with a number of major obstacles, viz;

i. if a responsible body of medical practitioners would recommend the use of ultrasound scans then a *Bolam* standard would be challenged;
ii. a causal link between the use of the ultrasound and the disability would have to be established; and, presumably,
iii. the child’s mother would have to establish that had she been informed of the risk multiple ultrasound scans might have on her ability to have a healthy child, then she would have refused to have them.

## 2. Invasive Diagnostic Testing Procedures

## (i) Amniocentesis

By contrast with ultrasound scans, amniocentesis is an invasive procedure involving the insertion of a needle through the mother’s abdomen and the uterine wall into the sac surrounding the foetus. The object of the procedure is to remove a small volume of amniotic fluid and test it for substances which indicate abnormalities such as spina bifida and Down’s syndrome. It is estimated that amniocentesis is more than 99% accurate in identifying chromosome abnormalities and the test may be used from 15 weeks of

pregnancy onwards. If an abnormality is indicated, it would permit an abortion under (***s.1***(***1***)(***d***)) ***Abortion Act 1967***.

In terms of legal action: first the pregnant woman would have an action in battery against the health authority / NHS Trust if her consent had not been obtained. Secondly, amniocentesis carries about a 1% risk of causing a miscarriage. Accordingly, (and as for (iii) above) the woman would have to establish that had she been informed of the risk of miscarriage she would not have consented to the procedure. Thirdly, if the procedure is carried out negligently and the woman is not informed that there is a probability of her giving birth to a disabled child, then, if she can prove that she would seek an abortion had she been given the correct information, then she would have an action in negligence. The effect of the ***Abortion Act 1967*** as amended by ***s.37 Human Fertilisation and Embryology Act 1990*** is to reverse the decision on this point as decided in <u>*Rance v Mid Downs Health Authority*</u> (1991). In *Rance*, the result of tests negligently carried out were not available until such time as it would be unlawful for Mrs Rance to seek an abortion because by then, under the provisions of the ***Infant Life*** (***Preservation***) ***Act 1929***, the foetus/child would be 'capable of being born alive'. (See notes on Abortion)

### (ii) Chorionic Villus Sampling (CVS)

This test may be carried out from 10 weeks gestation. Here, ultrasound is used to guide a needle through the mother's abdomen into the developing placenta of the foetus. A small sample of tissue is extracted via suction and a preliminary result is available within 48 hours with the final result being available within two weeks. CVS testing carries a slightly higher risk of miscarriage when compared to amniocentesis.

The legal issues that may arise in respect of CVS are the same as for amniocentesis. As to which test may be offered to the pregnant woman is likely to be dependent on procedures adopted in the hospital where she intends to give birth (presuming, of course, it's not going to be a home birth: see *infra*).

## (II): Medico-Legal Aspects of Childbirth

### (a) Home Births

Not all women wish to give birth to a child in a hospital: some would prefer to undergo the delivery in their own home. With regard to the merits of the 'hospital v home' choice, ***Margaret Brazier*** (<u>*Medicine, Patients and the Law*</u>, 3/e, p391) contends that: 'The debate is largely medical and social'. Whereas this contention is not disputed it must be emphasised that the significance of the legal issues is such that breach of certain statutory provisions may lead to those parties present at a home birth, including the mother, facing criminal liability.

Currently, ***Art.45 Nursing and Midwifery Order 2001*** (***SI 2002/253***) provides that it is a **<u>criminal offence</u>**[3] for a person other than a registered midwife or a registered medical

[3] An offence previously enacted in ***s.16 Nurses, Midwives and Health Visitors Act 1997***.

practitioner to attend a woman in childbirth except 'in a case of sudden or urgent necessity'. The strictness of the last-but-one of this provision's predecessor (***s.17*** of the ***Nurses, Midwives and Health Visitors Act 1979***), was demonstrated when, in August 1982, Brian Radley from Wolverhampton was convicted and fined £100 for attending and delivering his own wife! Furthermore, and subject to ***s.16*****(*****2*****)** of the successor to the 1979 Act (the **1997 Act**), should a pregnant woman seek the assistance of an unqualified attendant, but not a doctor nor a midwife, then she risks being accused of counselling and procuring a criminal offence.

The stark reality is, then, that avoidance of criminal liability may only be assured either by the pregnant woman seeking the assistance of a midwife or doctor; or giving birth alone. Bearing in mind the complications that might arise in childbirth, legal action, perhaps by way of a charge of manslaughter, according to Brazier, could also be brought against the unattended woman if the child should die. However, it is submitted that Brazier's contention that 'the mother may face prosecution for manslaughter' is at least debatable: the issue is uncertain depending, perhaps, on the interpretation of whether *an omission* to act (i.e., in the circumstances in question, an omission to seek the assistance of a midwife and/or doctor) could constitute manslaughter; and that point is probably dependent on whether *Senior* (1832) or *Lowe* (1973) is authority on this point.[4]

Many doctors try to discourage women from giving birth in their own home. Indeed, it is known that a GP who has taken a 'strong stand against home births has, in fact, struck from her list 'a pregnant woman [who] want[ed] to have her baby delivered at home'. (See the *Western Mail*, 29 October 1993). For many women, then, there is virtually no practical alternative to giving birth in hospital. Nevertheless, a Maternity Charter published in April 1994 and based on the Department of Health's document, *Changing Childbirth*, published in 1993, included amongst the rights and standards it said women should have, the right to choose where their baby is born, in hospital or at home.

## (b) Childbirth in Hospital

In essence, the legal issues relate to precisely what it is that a woman consents to by deciding to have her child born in a hospital; and whether the standard of care owed to her has been breached, causing her and/or the child harm.

The well-established basic principle is that both in moral and legal theory there is a rebuttable presumption that the individual has the capacity to make her own decisions, i.e.,

> "Over [her] self over [her] own body and mind, the individual is sovereign," per ***Mill***, from his essay, '*On Liberty*'.

[4] See *Attorney-General's Reference* (*No.3 of 1994*) [1997] 3 All ER 936 in relation to criminal activities (unlawful act type manslaughter) following the death of a child born alive.

This moral principle was given the force of law in the American case of *Schloendorff* (1914) where ***Cardozo J*** said that:

> 'Every human being of adult years and sound mind has the right to determine what shall be done with [her] own body.'

That the common law has adopted this persuasive precedent and that it respects the principle of respect for a patient's autonomy was asserted in *Re T* (1992), *Bland* (1993) and reaffirmed in *Re MB* (1997) and *St George's Healthcare NHS Trust v S* (1998). Accordingly, any non-consensual touching may give rise to a civil action for trespass to the person.

## Consenting(?) to Drugs to Kill the Pain of Childbirth

To combat the pain of going through labour, many women are given epidurals, i.e. an injection of anaesthetic into the base of the spine in order to numb the lower half of the body. It has been recorded that:

> 'Thirty per cent of first-time mothers in Britain are routinely given epidurals.' *Sunday Express* 23 January 1994.

Apart from the fact that some women find this 'unnatural', research in Kansas City, Missouri, USA, by ***James Thorp***, has found that

> … those who had been given an epidural were four times more likely to have a caesarean birth. Labour also lasted longer and was more difficult.

Thus, if a woman wishes at all costs to avoid a caesarean section, then, according to Dr Thorp: 'It is imperative that women are told that an epidural increases the chances of a caesarean'. If they are not, then they may argue that they've not given real consent because they've not been informed in 'broad terms of the nature of the procedure intended': *Chatterton v Gerson* (1981). Equally, if a woman had avoided an epidural but is then advised at the time of labour that she should undergo a caesarean section, even though she had previously made her objections known, there is a strong case for contending that any consent she gives to the procedure is not real: that is, she might be incapable of full and free consent because of the pain and ordeal of the delivery. An Area Health Authority has been found negligent in attempting to obtain a woman's consent to subsequent sterilisation when she was on her way into theatre to give birth to her second child: *Wells v Surrey AHA* (1978). The woman was a Roman Catholic and it was held that she had not been adequately counselled as to the implications to her. She was awarded £3,000 in damages.

## Caesarean Sections: Why Have Them & Who Decides?

That an undeniable tension has arisen in respect of performing caesareans over the past decade, there is no doubt. For example, in (1993) *The Times*, October 21st in '*Doctors claim legal fears affect births*' it was said that: "Obstetricians are being driven to perform caesareans on women in childbirth because they are more likely to be sued for negligence

if they do not [it was claimed by the ***Medical Defence Union***]". The article continued by noting: "More than 90,000 women have a caesarean each year in Britain and the rate, 13% of all births, is nearly three times higher than 20 years ago. But women are more likely to sue because they have not had one than because they were not given one they did not need".

In support of the increasing popularity of caesareans, by 1998, it was reported in (1998) *The Times*, August 14th that: "Over 100,000 women in Britain have a caesarean every year and it is now the most commonly performed operation on women". In this article, it was claimed that: "Healthy women must be allowed to have their babies by caesarean section if they want, however foolish or irrational their decision may seem to their doctors, according to two leading specialists. … While any request for one has traditionally been refused, there is a growing belief that the procedure can no longer be seen as clinically unjustifiable". The changes in attitudes "had been brought about by advances in making caesareans safe, by evidence of 'substantial morbidity' with normal births, and by changes in the attitude of society which has become intolerant of risk".

However, earlier in 1998, in '*Curb on caesarean births to save costs*', (1998) *The Times*, March 6th, it was reported that: "A Health Authority [Wiltshire Health Authority] has become the first in the country to ask its doctors to carry out fewer births by caesarean section because they are too expensive". The news reporter, ***Ian Murray***, noted that: "The operation costs £2,500, five times more than a natural birth, and the Health Department is already looking into reasons why the proportion of cases has trebled in the past 20 years. Nationally, about 26% of babies are now born this way, compared with 5% in the early 1970s". The article went on to quote a consultant working in a Wiltshire Health Authority hospital as saying: " … our ultimate objective has always been the safety of mother and baby" and another consultant from a Scottish hospital as saying that: "Mothers if anything are healthier than they used to be, and there is no logical reason why more of these [caesarean] operations should be performed … [especially since] there is no evidence to suggest that a caesarean birth is any safer than a normal delivery".

## Defence(?) to performing a caesarean section

If a woman hasn't consented to a caesarean section, or the validity of her consent is in doubt, then the hospital /health authority / NHS Trust may put forward the defence of necessity. 'Necessity was widely defined by ***Lord Brandon*** in *Re F* (1989) where his Lordship, in relation to a proposed sterilisation, said that the treatment would be in the best interests of a patient: ' … if, *but only if*, it is carried out in order to either save life *or* to ensure improvement *or* prevent deterioration in physical or mental health'.

A moot point until1997 was whether it could be construed as being 'necessary' for a pregnant woman in labour to be directed against her will to undergo a caesarean section to save the life of her 'child' which was capable of being born alive. This point was raised by ***Lord Donaldson MR*** in *Re T* (1992). It had to be borne in mind, however, that, until birth, English law does not accord legal personality to a foetus: *Burton v Islington Health Authority* (1992); *St George's Healthcare NHS Trust v S* (1998).

Whereas in _Re S_ (1992), a pregnant woman was ordered to undergo a caesarean section, even though the decision was against persuasive precedents and against the principle of respect for autonomy, this decision will no longer be followed as it was disapproved by the Court of Appeal in _Re MB_ 1997.

## Episiotomy

Episiotomy, which ***Margaret Brazier*** regards as 'One of the most controversial issues of hospital birth' (3/e, p392) and one she regards as unlawful unless expressly consented to, could almost certainly be justified, if necessary, by the defence of necessity. It is difficult to see the need for *express consent* being required to make the procedure lawful if the procedure would be followed by a responsible body of medical practitioners making their decision on a logical basis: _Bolam_ and ***Bolitho***.

## Water Births

It is submitted that one of the most controversial issues of hospital birth is one to which many commentators make no reference, i.e. a woman undergoing labour and birth in a birthing pool where this option is available.

In 1992, ***The Winterton Report*** (House of Commons Health Committee) called for more choice for mothers at the time of childbirth. As noted above, the basic choice has been between home birth, if *available*, and hospital birth; and in hospital there may be vaginal delivery or caesarean section. Genuine 'choice' has been notable for its absence.

However, water births were not something new to report in 1993 when the Report, '_Changing Childbirth_' was published. Indeed, the concept of water births was pioneered by ***Igor Tjarkovsky*** in Russia in the 1960's and recommended for pain relief during labour, rather than birth, by the French doctor, ***Michel Odent*** in the 1970's.

It was reported in the _British Journal of Midwifery_, November/December 1993, Vol.1, No.6, p264 that " … pioneer Igor Tjarkovsky performed his first water delivery after seeing the benefit of warm water in the treatment of his premature daughter … Tjarkovsky believed that delivery into water was less dramatic for the baby than being subjected to a cold world where the force of gravity 'strikes like a blow from a club'".

Indeed, the benefits of a water birth to the baby were described in the following terms:

> Having spent 9 months in fluid, protected from the harshness of light, sound, and touch, what could be more natural than to extend these features past the moment of birth? The characteristics of the pool water are very similar to those in the womb, so a delivery into this environment is surely less traumatic than the sudden, combined experience of a drop in temperature, gravity, bright lights and noise. …

> The baby does not attempt to breathe under water, taking the first breath only when brought into contact with air (Balaskas and Gordon, 1990). Despite recent concern, there have been no reports of babies drowning in this country. ((1993) 1BJM 265).

It is reported that there are also a number of benefits to the mother in the use of a birthing pool, viz;

> Th[e] [buoyancy afforded by the water in the birthing pool] together with the non-supine position, reduces the strain on the heart and spine; women with back problems find this particularly helpful. (ibid)

In addition the use of pain-killing drugs, such as pethidine has been reduced, or eliminated (as it has been at the Garden Hospital, London). Consequently, there has been a cost saving on analgesics in general. Furthermore, 'Of the 100 births reported by Odent (1983), 29 women tore. [However] No episiotomies were performed' (ibid).

Whereas the editorial in (1993) 1BJM 249 noted that: 'published information [on the experience of water birth] is relatively scarce. … One common feature [of the accounts that have been published] appears to be the *safe* outcome'. Nevertheless, the editorial pointedly asks: 'Is this bias in the data? Have fatalities occurred in the last 30 years or more without being reported? We may never know, but we should ask what, if anything, is different in these recent cases [relating to the deaths of three babies] from those in the past'.

The reference to fatalities in the editorial (on p249) appears to question the claim of 'no babies [having been] drown[ed] in this country'. (p265)

If it is accurate that thousands of births have taken place in/under water, then this would undoubtedly appear to be, *prima facie*, a practice adopted by a responsible body of medical practitioners. However, with the lack of good research data, any reported death by drowning of a baby in a birthing pool could surely lead a court to declare that it is not an acceptable practice: the courts' right to overrule a '*Bolam*' standard, as declared in *Sidaway*, could be invoked. (& See now the Australian case of *Rogers v Whittaker* (1993)). This might well be the case, especially if the expectant mother had not been informed of any risks to the life of the child she was about to deliver. As this technique is still undergoing considerable research, then there appears to be a case of a practitioner having to gain the woman's *informed consent* if he is to avoid an action in negligence.

**References** } **See Lecture 2, pp16-17**

**Workshop Questions** }

**Lecture 2**

## (III): Congenital Disabilities; Possible Causes, Potential Liabilities

That medical research 'into the growth of the foetus in the womb has established the crucial importance of good ante-natal care' there is no doubt (per ***Brazier & Cave,*** *Medicine, Patients and the Law* 4th edn., 2007, p291). What appeared to be at least strong circumstantial evidence of the need for good ante-natal care resulted from the severe disabilities suffered by children whose mothers, during their pregnancy, had taken the drug Thalidomide to help them sleep. Distillers, the manufacturers of Thalidomide, had claimed that it was non-toxic and safe for pregnant women and nursing mothers. It was never proved that this was incorrect, i.e. legal causation was never established, as out-of-court settlements were reached.

Whereas, at common law, the parents of children who were mentally or physically disabled by (say) a drug regime prescribed by a GP for the use of the woman when she was pregnant, could sue the GP in negligence, there was no authority to suggest either that doctors (GPs or hospital doctors) or drug companies could be sued by children for injuries they suffered before their birth. This *lacunae* was filled by enacting the ***Congenital Disabilities*** **(*Civil Liability*)** ***Act 1976***[5] (hereafter: ***CD*****(*CL*)*A 1976***).

The ***CD*****(*CL*)*A 1976***, which applies to all births, from the time it came into force in July 1976, 'governs the child's rights only' (***Brazier***, *op cit*., p291). Moreover, it:

> "purports to protect children against *pre-conception injury*, not just injury *in utero*. This could happen where the father or mother is affected by radiation or drugs so that the sperm or egg carries a serious defect. Or the child may be damaged if doctors mismanage a previous pregnancy, for example if they fail to take note of and treat Rhesus incompatibility in the mother, a second child could be born brain damaged." (per ***Brazier***, *op cit*., p300).

That ***s.4*****(*5*)** provides that 'This Act applies in respect of [all] births after (but not before) its passing' means that the statutory provisions replace, and not supplement, the common law.

The Act is short: it consists of only six sections. Of those, ***s.4*** is 'the interpretation, etc' section; ***s.5*** provides that: 'This Act binds the Crown'; and ***s.6*** provides for the citation and extent of the Act. By far the most significant issues provided for by this Act are contained in ***s.1***. This section, in part, reads as follows:

**Civil liability to child born disabled**

1. (1) If a child *born* disabled as a *result* of such an *occurrence* before its birth as is mentioned in subsection (2) below, and a *person* (other than the child's own mother) is under this section *answerable to the child* in respect of the occurrence, the child's

[5] ***N.B.:*** This Act has been amended by the ***Human Fertilisation and Embryology Act 2008***

disabilities are to be regarded as damage resulting from the wrongful act of that person and actionable accordingly at the suit of the child.

2. An occurrence to which this section applies is one which –
   (a) affected either parent of the child in his or her ability to have a normal, healthy child; ***or***
   (b) affected the mother during her pregnancy, or affected her or the child in the course of its birth, so that the child is born with disabilities which would not otherwise have been present.

The ***Human Fertilisation and Embryology Act 1990*** has extended s.1 to cover infertility treatments by inserting ***s.1A*** into the ***1976 Act*** which provides that:

(1) In any case where –

   (A) a child carried by a woman as the result of the placing in her of an embryo or of sperm and eggs or her artificial insemination is born disabled,
   (B) the disability results from an act or omission in the course of the selection, or the keeping or use outside the body, of an embryo carried by her or of the gametes used to bring about the creation of the embryo, and
   (C) a person is under this section answerable to the child in respect of the act or omission,

the child's disabilities are to be regarded as damage resulting from the wrongful act of that person and actionable accordingly at the suit of the child.

## Employing Provisions of the 1976 Act

If the provisions of the Act are to be successfully employed, then first of all, the child must be born alive and must live for at least 48 hours: ***ss.4(2)(a)*** and ***4(4)***. Secondly, the child, via his next friend, must establish that his disabilities resulted from an occurrence which is provided for in ***s.1(2)(a)*** and ***(b)*** (supra). An occurrence is a tortious, usually negligent, act. Accordingly, for the tortfeasor to be answerable to the child it must be proved that: (i) the tortfeasor was negligent; and (ii) that the tortfeasor breached the duty of care he owed to the affected parent. The rights of the child to sue arise from this relationship, i.e. the child's rights are derivative only: ***s.1(3)***. Clearly, (iii) causation is the major hurdle which has to be overcome if the plaintiff/claimant is to discharge the burden of proof.

## Prescribed Drugs and Consequential Damage to the Foetus

If a drug prescribed for the child's mother during her pregnancy is alleged to have caused the child's disability, then it must be decided who, if anyone, is to be sued for damages: for example, should it be the doctor who prescribed the drug(s) and/or the manufacturer(s) of the drug(s)?

## Suing Doctors

That a doctor owes a duty of care to his patient is a well-established duty. In _Sidaway_, ***Lord Templeman*** said at [1985] 2 WLR 480, 508E:

> 'The relationship between doctor and patient is contractual in origin, the doctor performing services in consideration for fees payable by the patient.'

Nevertheless, the common law has also long recognised a doctor as having a duty of care towards his patients independent of contract. In _Pippin v Sheppard_ (1822) it was said that: 'To hold to the contrary would be to leave such persons in a remedyless state'; and in _Gladwell v Steggall_ (1839) ***Tindal CJ*** said that in spite of the absence of a contract between a 10 year old girl and a clergyman who "practised as a medical man" … this is an action ***ex delicto***.

For the child to succeed in his claim, he must prove, *inter alia*, that (1) the doctor knew that his (the child's mother) was pregnant at the time he prescribed the drug(s) for her or at least he ought to have known; and that (2) the doctor should have been aware of the risk posed by the drug. Whereas the doctor has no defence in claiming that the drug regime he prescribed was beneficial for the mother if he then failed to take into account the possibility of harm to her developing foetus, the doctor does have a defence if he acted in accordance with the practice of a responsible body of medical practitioners. A statutory equivalent of the *Bolam* standard is provided for in ***s.1*(*5*)** of the **1976 Act**, i.e.:

> The defendant is *not answerable to the child*, for anything he did or omitted to do *when responsible in a professional capacity* for treating or advising *the parent*, if he took reasonable care having due regard to *the then received professional opinion* applicable to the particular class of case; but this does not mean that he is answerable *only* because he departed from received opinion.

That a claimant has the onus of discharging the burden of proof, i.e. he has to overcome, *inter alia*, the *Bolam* standard and establish causation, is a difficult task. That an out-of-court settlement might be reached is, perhaps, as much as can be expected – as was the case when Distillers were sued in respect of the 'Thalidomide disabilities' (remember: causation was not established): _S v Distillers_ (1970).

## Suing Drug Companies

***s.1*(*1*) *CD*(*CL*)*A 1976*** refers to a person who is answerable to the child in respect of an occurrence. The 'person' answerable is not confined to a natural person: a juristic person, or corporation, may be answerable. Indeed, as a general point, many drug companies have been sued in respect of various injuries to a range of plaintiffs.

Liability of drug companies is now governed by the provisions of Part 1 of the ***Consumer Protection Act 1987*** (***CPA 1987***) providing the drug in question has been marketed since 1 March 1988 when the 1987 Act came into force. Part 1 was enacted to implement the EEC (now EC) ***Product Liability Directive 85/374***. The principal point is that the reports

which were at the basis of this Directive recommended that manufacturers' liability for injury caused by defective products should be strict liability; i.e. that liability should not depend upon any proof of fault or negligence. However, ***s.2*(*1*) *CPA 1987*** places the onus on the plaintiff to prove that: (a) the drug was defective; and (b) it caused the relevant injury to the foetus. If causation is established via application of standard tort principles of causation, then, as noted, liability is strict. ***s.3*(*1*)** provides that there is a defect in a product if the safety of the product is not such as persons generally are entitled to expect. Bearing in mind that a drug may have a particularly beneficial effect on some people the fact that it may promote serious side effects on a few others does not, of itself, mean that the drug is defective. When all the relevant factors (of, for example, the cost involved in eliminating the risk – assuming that it is known – and the urgency of the situation for which the drug was required) are taken into account, then it may be that persons generally are not entitled to expect the drug to be safer than it is actually is. Indeed, ***s.4*(*1*)(*e*)** provides that it is a defence for a drug company to show:

> That the state of scientific and technical knowledge at the relevant time was not such that a producer of products of the same description as the product in question might be expected to have discovered the defect if it had existed in his products while they were under his control.

## What is the disabled child permitted to seek damages for?

For those who believe in the quality of life being at least of equal importance, if not more important, than the sanctity of life, there are many states of physical and mental health that they would regard as being worse than death. However, the Court of Appeal has decided that a disabled child cannot seek damages on the basis that she would have been better off not being born at all, i.e., a claim for 'wrongful life' has not been entertained: <u>McKay v Essex A.H.A</u>. (1982). In this case, the Court of Appeal said that no such cause of action was available at common law (the girl was born in 1975 – the year before the ***CD*(*CL*)*A 1976*** was enacted) nor, indeed, under the Act itself. The reason for a claim falling outside the scope of the Act is that the 'occurrence' referred to in ***s.1*(*2*)(*b*)** is one that affected the mother in her pregnancy 'so that the child is *born* with disabilities which would not otherwise have been present' per ***Ackner LJ***. Accordingly, a child's claim is limited to wrongful disabilities, i.e. a claim against a defendant whose conduct has caused the child's disabilities, and a claim for 'wrongful life' would be dismissed.

## Pre-Conception and Post-Conception Occurrences

A child's ability to sue a doctor in respect of wrongful disabilities caused by the doctor negligently prescribing drugs to the child's mother during her pregnancy, or suing a drug company in respect of a defective drug, might seem indicative of there being a limited number of defendants and, perhaps, limited to events at the post-conception stage. This is incorrect. A child may seek damages in respect of pre-conception occurrences. He may also have, in particular circumstances, a cause of action against his mother, though only rarely against his father.

If (say) a man's reproductive capacity is damaged by the negligence of his employers and, as a consequence, he has a much reduced likelihood of fathering a normal child, then the employer is answerable to the child even if the father appeared to suffer no actionable injury: ***s.1(3) CD(CL)A 1976***. The general rule is, however, that if either of the parents knew of the risk of begetting an abnormal child, then the employer would not be answerable to the child: ***s.1(4)***. In essence, this means that the only time liability is likely to attach to the father is if he has been responsible for assaulting the mother. Knowledge on the father's part does not then preclude his liability to the child.

It is unlikely that a cause of action could be founded on a pregnant woman's decision to have a baby on the basis that she was aware that she would have a child with a high predisposition to a particular genetic defect or that her personal life style was such that there was an increased risk of harm to the child, e.g. by way of the mother being a drug addict/heavy smoker. Amongst the pitfalls of trying to attach liability to the mother would be almost certain infringement of ***Article 12*** of the ***European Convention on Human Rights and Fundamental Freedom*** which provides for the right to marry and found a family.

At present, English law does not permit for protection to be given to a foetus by way of making it a ward of court: *Re F* (*in utero*) (1988). This is because English law does not recognise the foetus as having legal personality separate from its mother: *Burton v Islington Health Authority* (1992); *St George's Healthcare NHS Trust v S* (1998). It would appear that the only protection that can be afforded to the foetus in respect of its mother's life style would be based either on the mother's criminal activities or on her coming within the provisions of the ***Mental Health Act 1983*** and, accordingly, being 'sectioned' i.e. being compulsorily admitted to hospital under Part II MHA 1983 either for admission and assessment or for admission and treatment. Other than the aforementioned possibilities, it would appear that English courts have very little jurisdiction to restrict women's civil liberties – especially since the court of appeal decision in *Re MB* (1997) disapproved *Re S* (1992) where a woman in labour was ordered to undergo a caesarean section as it was in her vital interests and those of 'the child she is carrying'. *Re MB* has made it clear that if a woman is deemed to be competent then she may refuse any treatment that would save her life and that of her unborn baby.

It is important to note, however, that if (say) the baby is born to a registered drug addict, then that baby (now a separate person) could be taken into care on the basis that the mother's lifestyle had avoidably impaired the baby's health *in utero*: *D v. Berkshire CC* [1987] 1 All ER 20.

There is also one particular post-conception event specifically provided for in ***s.2 CD(CL)A 1976*** where the mother is made liable for her child being born with disabilities which, apart from her breach of duty, would not otherwise be present. ***s.2*** provides that:

> A woman driving a motor vehicle when she knows (or ought reasonably to know) herself to be pregnant is to be regarded as being under the same duty to take care for the safety of her unborn child as the law imposes on her with respect to the

safety of other people; and if in consequence of her breach of that duty her child is born with disabilities which otherwise would not have been present, those disabilities are to be regarded as damage resulting from her wrongful act and actionable accordingly at the suit of the child.

Thus, the specific duty referred to in ***s.2*** provides an exception to the general rule in ***s.1*** of the mother having no liability in respect of her disabled child. The specific reference to 'motor vehicle' thereby excludes liability for disabilities if the mother had had an accident when riding a bicycle or a horse.

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## References


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**N.B.:** Remember that the ***Congenital Disabilities*** **(*Civil Liability*)** ***Act 1976*** has been amended by the ***Human Fertilisation and Embryology Act 2008*** **–** but the amendments have NO significant impact on the issues discussed in *these* lecture notes.

## Potential Examination Questions

1. Critically evaluate the assertion that the ***Congenital Disabilities*** **(*Civil Liability*)** ***Act 1976*** "is ambitious, complex and largely irrelevant".

(Quotation taken from: ***Brazier, M***, ***& Cave, E.*** *Medicine, Patients and the Law*, 4th edn, 2007. London: Penguin).

2. Jill, a 17-year-old unmarried girl, is pregnant and likely to give birth very soon. The number of cigarettes she has smoked during her pregnancy has increased significantly as she has got nearer to term. She has also 'experimented' with soft drugs and her consumption of alcohol has also increased. Nevertheless, her ideas on childbirth have remained clear throughout her pregnancy: she wants her child delivered by Jack, her boyfriend, at their place of residence. Friends of Jill have expressed concern over this as Jack is a volatile character, frequently aggressive and with a previous conviction for assault. Nevertheless, Jill says she doesn't want anyone else present as 'Jack can phone anyone he wants – including my mother - if we experience any problems'. Jill doesn't anticipate any problems because (as she has said):

> "I'll have about half-a-dozen ultrasound scans, including one of the new 4D type, to make sure everything is OK. Anyway, when my mother was pregnant with me, she experienced almost exactly the same lifestyle and habits I'm experiencing now: and as I'm OK, there's no need to think things will be any different for me or my baby, is there? Besides, there's no way I'm going into hospital for the birth of my baby: I want a natural birth – it's my right to choose that – and I'm not even going to give anyone the opportunity to get me to have a caesarean section. No one's going to interfere with my body. I know what I want and no one's going to change my mind."

Discuss the legal issues that may develop from this scenario and advise Jill of the actions that could be invoked following the birth of her child.