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Medical Negligence in Obstetrics and Maternal Autonomy

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I. INTRODUCTION

Medical negligence in obstetrics is especially complicated, because of the dual patient-hood that is unique to this area.[1] This dual patient-hood model persists especially where the child can sue the obstetrician. This model is however, limited to the mother's rights and interests. The obstetrician operates under the "dual patient-hood" model insofar as there are no maternal-foetal conflicts. While the mother and child usually share a set of congruent interests, these sometimes diverge when the pregnant mother puts her choice above fetal outcome. In such cases of maternal-foetal conflict,[2] it is important to preserve the best interests of the child, but this cannot circumvent the mother's autonomy. The obstetrician faces the competing interests of both mother and child and the law should provide an answer to this dilemma. This paper will explore the various legal issues that arise in the birth of a baby, and where there are maternal-foetal conflicts, seek to find a balance between the various competing interests of the mother and unborn; and how the obstetrician should respond to such a dilemma. The obstetrician should place the mother's interests above the

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[1] The development of the dual patient-hood, can be attributed to obstetric advancements. Mattingly has suggested how advanced technology has allowed obstetricians to directly observe and treat the foetus, therefore changing the maternal-foetal relationship from one of 'unity' to 'duality'. See Susan S. Mattingly, "The Maternal-Fetal Dyad: Exploring the Two-Patient Obstetric Model" in Sheila McLean, ed., *Medical Law and Ethics*, (Aldershot, Hants, England; Burlington, VT: Ashgate/Dartmouth, c2002) at 325.

Specifically, the model adopted in this paper is largely similar to the "not-one-but-not-two" model, where the rights of the unborn are inchoate and instead crystallizes upon birth. See John Seymour, Childbirth and the law, (Oxford; New York: Oxford University Press, 2000) at 201.

[2] Mair suggests that there are two types of maternal-foetal conflicts. The first is where the maternal conduct is contrary to the interests and healthy development of the foetus. The second concerns Court-enforced Caesarean on parturient women, who have indicated refusal to such treatment despite medical recommendation of such for the foetus' interests. See Jane Mair, "Maternal-Foetal Conflict: Defined or Defused?" in Sheila A.M. McLean, ed., *Contemporary Issues in Law, Medicine, and Ethics*, (Aldershot; Brookfield, USA: Dartmouth , c1996) at 80; Jane Weaver, "Court-ordered Caesarean Sections" in Andrew Bainham, Shelley Day Sclater and Martin Richards, eds., *Body Lore and Laws* (Oxford: Hart Publishing, 2002) at 238. The focus of this paper is on the latter conflict, which will involve the obstetrician intimately.

Also see Frances H. Miller, "Maternal-Fetal Conflicts: Narrowing the Controversy" in Eric Matthews, Michael Menlowe, eds., *Philosophy and Health Care* (Aldershot, Hants, Eng.; Brookfield, Vt. USA: Avebury, 1992) at 117. This article proposes a interesting 6-stage test in the obstetrician's approach to maternal-foetal conflicts, namely, whether the proposed treatment

i) is experimental, or if not,
ii) can be omitted with insignificant harm or easily reversible after birth, or if not,
iii) poses significant danger to the foetus, or if not,
iv) there is a significant chance of failure, or if not,
v) poses significant danger to the pregnant woman, or if not,
vi) is highly invasive to the pregnant woman.

child and provide treatment according to her wishes, especially where the mother clearly refuses a particular treatment. This is especially so because it is illogical to deprive the mother of her right to self-determination by virtue of her pregnancy. Although such deprivation seems unjustifiable, it has occurred in the UK and this paper will criticize recent US developments that seek to do the same. Although recent UK decisions have resiled from this position, the common law should never allow such injustice to resurface. This paper advocates that the Singapore courts must protect women's autonomy in obstetrics and refrain from developments in the US that are contrary to such.[3]

II. TO ESTABLISH MEDICAL NEGLIGENCE IN A DOCTOR-PATIENT RELATIONSHIP

To establish medical negligence, there must be first a doctor-patient relationship. It is this doctor-patient relationship that gives rise to the duty of care, which when in breach, attracts a claim in medical negligence.

a) Duty of care

In a negligence action against the doctor, a patient must first establish that the defendant owed her a duty of care. A doctor-patient relationship certainly has the potential to create such a duty, because doctors must assume some professional responsibility to their patients.[4] However, it does not follow that the very act of taking advice from a doctor would create a doctor-patient relationship. Consequently, a pregnant woman who calls an obstetrician for advice would not be deemed to have a doctor-patient relationship with the obstetrician even before the first consultation. The determination of such is a matter of law,

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On the ethical and policy issues from the medical perspective, see Wayne R. Cohen & Ruth Macklin, "Maternal-Fetal Conflicts: Ethical and Policy issues" in Amnon Goldworth, William Silverman, David K. Stevenson & Ernle W. D. Young, *Ethics and Perinatology*, (New York: Oxford University Press, 1994) at 10.

[3] Where possible, this paper has examined the law in Singapore on obstetrics cases, but such opportunities are few and far between. Therefore, this paper would be looking closely at developments in the UK, US and Australia where appropriate.

[4] On the doctor-patient relationship between the obstetrician and the mother, the duty of care owed to the mother should not only be in relation to physical injury but also should include psychological harm or nervous shock which may be suffered when a mother gives birth to a damaged baby or a stillborn.

from the landmark case of *JU*,[5] which decided against the claimant in accordance with the *Bolam* test.[6] *JU* exemplifies such a failure to establish a doctor-patient relationship, where telephone advice was considered insufficient to create a duty of care before the first consultation. The doctor had no duty to schedule an appointment at the earliest time possible because such a duty should have fallen on the plaintiff herself instead. As Lai Siu Chiu J stated, "It would place an onerous and unfair burden on medical practitioners and specialists alike, if the law was to decree that their duty of care to patients began even before the first consultation, and extended to cover telephone advice and/or opinions sought by callers who might not even become their patients later."[7] It is clear the patient must cross a certain threshold before the obstetrician could be considered responsible for the management of her birth, so that the obstetrician would not attract undeserved liability.

b) Duty of care to both the mother and child

The doctor-patient relationship in obstetrics is not as clear-cut and is unique, as there is more than one patient who could be foreseeably affected by acts or omissions. The obstetrician's potential duty to the unborn naturally affects his treatment of the mother. If the obstetrician has a duty towards a foetus that may not be born alive, such limitless liability might result in defensive obstetric practice.[8] Conversely, if it is foreseeable that the baby can appreciate the impact of the obstetrician's practices, he should be held liable. However, the obstetrician may face a dilemma when faced with the mother's right of choice and refusal of treatment. Although the obstetrician has to bear in mind the child's interests, these should be secondary when juxtaposed against the mother's wishes.

In UK, the doctor-patient relationship between the doctor and the foetus has come a long way. In 1971, *Distillers*[9] indicated how it was possible to owe a duty of care to the foetus

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[5] *JU v See Tho Kai Yin* [2005] 4 SLR 96 at 119. Margaret Fordham, "A Life without Value?" (2005) Sing J. L. S. 395.
[6] *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.
[7] *Supra*, note 5 at Para 87.
[8] Specifically, foetuses that are not even viable yet.
[9] *Distillers Co (Biochemicals) Ltd v Thompson* [1971] AC 458.

later born disabled. Even before we consider an obstetrician's duty to the foetus, there has been authority establishing the possibility of owing a general duty the foetus in tort.[10]

Later, the House of Lords (HL) decided in *Whitehouse v Jordan*,[11] that there was an implicit assumption that the child, who was alleged to have been injured as a result of occurrences both immediately before and during birth, was owed a duty of care. Specifically, under the *Whitehouse v Jordan* model, the court did not have to consider if a foetus had rights. It was not a question of whether a foetus could sue; rather, it was whether a child could sue for occurrences immediately before birth.

Finally, in 1992, it was firmly established that the same doctor-patient relationship between the mother and the obstetrician is also present between the foetus and the doctor. *Burton v Islington*[12] accepted that the factual matrix of prenatal treatment gave rise to a potential relationship between the foetus and the obstetrician that would later manifest into a complete duty of care upon birth. Therefore, it implies that it is possible to sue for injuries suffered by the child before birth, because the doctor's duty crystallizes upon birth.[13] In coming to this conclusion, the Court of Appeal (CA) had referred to various precedents from other jurisdictions, which found a duty of care in negligence in such cases.[14]

The position in UK from *Burton v Islington* finds its origins from in the Australia case of *Watt v Rama*,[15] a case on antenatal injuries caused in a vehicular accident. In *Watt v Rama*, the defendant motorist contended that he owed no duty of care to the foetus because it did not exist and was only a part of the mother. However, the Victorian Supreme Court dismissed this contention and held that it was possible to owe a duty towards the foetus.

Other than a general duty towards the foetus, the Australian position is also similar to that in UK, recognizing that the doctor owes a duty of care to both the mother and the foetus

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[10] Prior to *Distillers*, there was previously no direct statutory authority in UK that laid down the duty of care owed by the obstetrician, until the Congenital Disabilities (Civil Liability) Act 1976. Therefore, the Act serves as a good benchmark before further development of cases on the doctor-patient relationship between the obstetrician and the unborn child.
[11] [1981] 1 All ER 267.
[12] *Burton v Islington Area Health Authority* and *De Martell v Merton and Sutton Area Health Authority* [1992] 3 All ER 833.
[13] A. Whitfield, "Common Law Duties to Unborn Children" 1993, 1 Med. L. Rev. 28.
[14] Vivian Harpwood, *Legal Issues in Obstetrics*, (Dartmouth: Brookfield USA, 1996) at 142.

and goes further to define the standard of disclosure. In referring to *Whitehouse v Jordan*, *Howarth v Adey*[16] held that, once it is accepted that the obstetrician owes a duty of care to both the mother and the child, the scope of this duty must extend to disclosures as to material risks affecting the potential well-being of the infant. In *X & Anor v Pal & Ors*,[17] a doctor was held liable for a child born with syphilis, as the child was a foreseeable victim of the doctor's failure to screen the mother for the disease.

In the US by 1946, *Bonbrest v Kotz*,[18] allowed an action in negligence for prenatal injury. It emphasized that a viable child, having a capacity to survive, is not a part of the mother.[19] In finding a doctor-patient relationship between the obstetrician and the child, the law is giving the foetus a legal personality that is capable of suing and enforcing its rights. Such actions are not limited to injuries that were sustained before it became viable. In *Smith v Brennan*,[20] it was held that "an unborn child is a distinct biological entity from the time of conception… [and] that the viability distinction has no relevance to the injustice of denying recovery for harm which can be proved to have resulted from the wrongful act of another."

Most importantly, the issue of enforceability against the obstetrician turns on whether or not the foetus has acquired a legal personality. The position differs across jurisdictions as to when liability can be incurred as against a foetus.[21] From *Burton v Islington*,[22] it would seem that the child's legal personality is not recognized until birth. As the duty of the obstetrician crystallises upon birth, a stillbirth would have removed the possibility of such

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[15] [1972] VR 353, 359. Also see note 1, Seymour at 162.
[16] [1996] 2 VR 535.
[17] (1991) Aust Torts Reports 81-098, 23 NSWLR 26.
[18] 65 F Supp 138 (1946).
[19] 65 F Supp 138 (1946), at 140.
[20] 157 A 2d 497(NJ 1960), at 504.
[21] There is substantial debate on the status of the foetus, attempting to demarcate a moment when the foetus becomes a person. *Supra*, note 1, Seymour at 135.

The focus of this paper is not on the debate of the status of the foetus and will instead examine the legal distinction between a child born alive and a stillborn, as the former is more relevant in the abortion context. See Boonin, David, *A Defense of Abortion* (Cambridge: Cambridge University Press, 2003) Chapter 4; Finnis, "The Rights and Wrongs of Abortion" 2:2 (1973) *Philosophy and Public Affairs* 117; Hershenov, "Abortions and Distortions" 27:1 (2001) *Social Theory and Practice* 129; Patrick Lee & Robert P. George, "The Wrong of Abortion" in Andrew Cohen & Christopher Wellman, eds. *Contemporary Debates in Applied Ethics*. (Oxford: Blackwell, 2005); McMahan Jeff, *The Ethics of Killing*, (New York: Oxford University Press, 2002); Schwarz Stephen, *The Moral Question of Abortion* (Chicago: Loyola University Press, 1990) Chapter 8; Bonnie Steinbock, *Life Before Birth: The Moral and Legal Status of Embryos and Fetuses*. (Oxford: Oxford University Press, 1992); Thomson, "A Defense of Abortion" 1:1 (1971) *Philosophy and Public Affairs* 47; Thomson, "Rights and Deaths" 2:2 (1973) *Philosophy and Public Affairs* 146.

duty. This is contrary to *Smith v Brennan*, that could potentially recognize a legal entity right from conception. The former view welds more strength, because only a child that is born alive would have to suffer the damages that have been inflicted before birth. If we were to take the *Smith v Brennan* position, a stillborn could sue even if it did not have to live through the pain and suffering of birth injuries. It is logical not to allow the child's action if he or she were a stillborn, because this foetus never acquired a living legal personality to attract rights against the obstetrician.[23] Consequently, it would be illogical to subjugate the mother's interests below that of the unborn because there is no sense in reducing the woman's interests for the sake of an uncertainty. This argument is reinforced by *Vo v France*,[24] which stated *obiter dictum* that, even where the foetus could have a right to life under Art.2,[25] such a right would be limited by the mother's rights and interests. Clearly, the doctor must place the mother's wishes first.

Further, in *Vo v France*, the European Court of Human Rights affirmed that the foetus was not a person and did not enjoy the protection of Art.2 directly. Therefore, a stillborn cannot sue, because the child had never lived in the world to experience the suffering that he or she would have if alive. The foetus does not constitute an entity that can enforce rights as against the obstetrician, it merely has rights that are latent in nature and such crystallizes upon birth.[26]

With the above establishing a potential duty towards the unborn, the potential for a conflict of interests between the mother and child arises. As the obstetrician could owe a duty to both the mother and child, he would have to make a choice as to whose interests to give priority to. It is advocated that the obstetrician must follow the mother's wishes to consent or refuse treatment, because she is his primary patient and the duty to the unborn is only a secondary duty. This might offer an appropriate balance to both mother and child and prevent defensive obstetric practice.

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[22] *Supra*, note 12.
[23] There is much ethical debate on the life and rights of the foetus, which this paper cannot belabour upon unfortunately.
[24] [2004] 2 FCR 577.

III. STANDARD OF CARE

After establishing the obstetrician's duty of care to the mother and potentially the foetus, we must examine the standard of care required by this duty. This paper advocates that the appropriate standard of care is one that optimises maternal objectives.

a) General standard of care in medical negligence

The common law standard of care is found in *Bolam*,[27] which establishes the criteria for competent medical practice. In *Bolam*, McNair J 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."[28] *Bolam* has since been criticised enormously for effectively sanctioning any practice that is supported by a body of medical opinion, possibly "reducing medical negligence to being determined by the lowest standard of care (accepted by the medical profession) rather than reasonable contemporary standards (expected by the community)."[29]

Bolam was later modified by *Hucks v Cole*,[30] that requires the defence opinion to have a rational or logical basis and that the body has reached a defensible conclusion for the matter at hand. In the words of Sach LJ:

"When the evidence shows that a lacuna in professional practice exists by which risks of

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[25] Article 2 of the European Convention.
[26] *Supra*, note 12 and the accompanying main text.
[27] *Supra*, note 6. The standard of care in *Bolam* is similar to that required in the Congenital Disabilities (Civil Liability) Act 1976, is found in section 1(5), that "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." See Rodney Nelson-Jones & Frank Burton, *Medical Negligence Case Law*, 2nd edn (Butterworths: London, Dublin & Edinburgh, 1995) at 53. Also see Harvey Teff, "The Standard of Care in Medical Negligence – Moving on from Bolam?" (1998) Oxford Journal of Legal Studies 473.
[28] *Supra*, note 6.
[29] Kumaralingam Amirthalingam, "Judging Doctors and Diagnosing the Law: Bolam Rules in Singapore and Malaysia" (2003) S. J. L. S 125, at 129. Also see Lord Woolf, "Are Courts Excessively Deferential to the Medical Profession?" (2001) 9 Medical Law Review 1 at 15; Margaret Brazier and J. Miola, "Bye-Bye Bolam: A Medical Revolution?" (2000) 8 Medical Law Review 85; Margaret Fordham, "The Bolam test lives on" (1998) Sing J. L. S. 140; A. Maclean, "Beyond Bolam and Bolitho" (2002) 5 Medical Law International 205 at 217. Dato' G Sri Ram, "The Standard of Care: Is the Bolam principle still the Law?" [2000] 3 Malayan Law Journal lxxxi.

Keown suggested that *Bolitho*, although expressedly qualifying the *Bolam* test, is only as significant to the extent that it reins in the Bolam test. See John Keown, "Reining in the Bolam Test" (1998) Cambridge Law Journal 248; "Doctor Knows Best?: The Rise and Rise of the Bolam Test" Sing. J. L. S. 342.
[30] [1993] 4 Med.L.R. 393.

grave danger are knowingly taken, then, however small the risk, the court must anxiously examine that lacuna—particularly if the risk can be easily and inexpensively avoided. If the court finds, on an analysis of the reasons given for not taking those precautions that, in the light of current professional knowledge, there is no proper basis for the lacuna, and that it is definitely not reasonable that those risks should have been taken, its function is to state that fact and where necessary to state that it constitutes negligence."

Although *Hucks v Cole* was considered at the CA in *Bolitho,* its significance was greatly reduced in the HL, where *Bolam* was emphasised again. The court went further and stated that "if, in the rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible."[31]

The above test was applied in the obstetrics case of *Smithers v Taunton*,[32] where it was again emphasized that, the "[c]ommon practice… cannot be and is not conclusive of the question of negligence."

Further, in *French v Thames*,[33] it was held that if the obstetrician had acted in accordance with a practice accepted as proper for an ordinarily competent obstetrician by a responsible body of medical opinion, the next question is whether the practice survives the *Bolitho* scrutiny, which examines if the practice is 'responsible' or 'reasonable'.[34] Separately,

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[31] *Bolitho v City and Hackney Health Authority* (1997) 39 BMLR 1, [1997] 4 All ER 771.
[32] *Smithers (A minor by his father and litigation friend Aaron Smithers) v. Taunton and Somerset NHS Trust* [2004] EWHC 1179. In the US Georgia, *McDaniel v Hendrix* 260 Ga. 857 held that the general standard of care was the appropriate standard in malpractice cases. In US Carolina, the court in *The Estate of Lynch v Nash Day Hospital* 167 N.C. App. 194 found that the doctor established his knowledge of the standard of care in a similar community, as required by the *N.C.Gen.Stat. §90-21.12*. This position was also reflected in Rhode Island, where the court in *Kayla Buja v Howard Morningstar* 688 A.2d 817 held that the expert witness had the necessary prerequisite knowledge, skill, experience, training, or education in the field of the alleged malpractice, as required by *R.I. Gen. Laws §919-41 (1956)*. In Texas, *Eckert v Smith* 589 S.W.2d 533 followed a test largely similarly to the *Bolam*, holding that the standard for physicians in the county was equal to the state standard, which excluded liability when a physician undertakes a mode or form of treatment which a reasonable and prudent member of the medical profession would undertake in the same or similar circumstances. In the District of Columbia, *Robbins v Marvin Footer* 179 US App DC 389 found that the standard of care for obstetricians was based on a uniform national examination. As a national board of examiners did the certification process, the specific practice profession should determine the appropriate standard nationally.
[33] *French v Thames Valley Strategic Health Authority* [2005] EWHC 459.
[34] *Ibid*, at para 8-12.

in *DA v North East London*,[35] the endorsement of *Bolam* and *Bolitho* was adopted without modification or discussion on its suitability.[26]

In the case of *Kingsberry v Greater Manchester*,[37] it was held that the obstetrician should have employed the trial of forceps technique.[38] The court found that such a technique was an accepted, established obstetric management technique. A failure to adopt this was not in accordance with proper practice, and the obstetrician was therefore negligent in delivering the baby by manual rotation and forceps delivery. On the basis of *Bolam*, the court found a breach of duty. In interpreting *Bolam*, the court reminded itself that it should not be "tempted to put itself in the surgeon's shoes".[39] Effectively, it relied upon expert evidence, and did not give preference for one responsible body of opinion over another. However, it also accepted the *Bolitho* qualification and went further to note that the *Bolitho* qualification of *Bolam* has now become a "commonplace within the assessment of whether or not a doctor's act or omission is or is not negligent."[40]

Locally, the development of the law on the standard of care in obstetrics proceeds in similar vein. *F v Chan Tanny* followed *Yeo Peng Hock Henry v Lily Pai* in adopting the *Bolitho* reformulation of *Bolam*, without any reconsideration.[41]

b) Necessary modification to the general standard of care in obstetrics

The standard of care in obstetrics is unique when contrasted with other areas of medical practice, because of the unpredictable nature of labour. It is the obstetrician's duty to provide a standard of care that would sufficiently manage such cases if it were to arise suddenly. This unique area of law would certainly require a modification of the current adoption of *Bolam* with *Bolitho* in the determination of the standard of care. Using *Bolitho* as

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[35] *DA v North East London Strategic Health Authority* [2005] EWHC 950.
[36] *Ibid*, at para 2.
[37] *Kingsberry v Greater Manchester Strategic Health Authority* [2005] EWHC 2253.
[38] *Ibid*, at para 46.
[39] *Sidaway v Governors of Bethlehem Royal Hospital* (1985) 1 BMLR 132, [1985] 1 All ER 643.
[40] *Supra*, note 37 at para 11. See *Marriot v West Midlands Health Authority* [1999] Lloyd's Rep Med 23 at 27-28 and *Reynolds v North Tyneside Health Authority* [2002] Lloyd's Rep Med 459 at 463-463, 475.
[41] [2003] SGHC 231; [2001] 4 SLR 571.

a mode of modification, the standard of care should be one that optimises maternal objectives in the labour process.

As it is necessary to modify the general standard of care applicable to obstetrics, there is a growing trend in the use of clinical guidelines to determine the applicable standard. In English case of *DF v St George's Healthcare*,[1] Gray J with guidance from the Royal College of Gynaecologists and Obstetricians, held that the instrumental delivery done by the senior registrar was not acceptable medical practice. In finding against the defendant, the court was effectively using the guidelines as a benchmark of what the obstetrician should have done.

The US courts practice a strict approach in interpreting guidelines. In *Jewett v Our Lady of Mercy Hospital*,[1] the defendant appealed against liability in the failure to monitor during labour, which resulted in the child's death. The court agreed with the plaintiff's expert witness that the standard of care complied with those of the American College of Obstetricians and Gynaecologists, but such a standard was the minimum standards and that more should have been done. Clearly, guidelines may be useful, but should be necessarily modified.

IV. INFORMED CONSENT

The obstetrician faces a unique decision making process, because of the dual patient-hood in this area. The doctor is effectively providing treatment to two patients, while one is "within and dependent upon the other."[44] In the challenge of balancing interests of the mother and child, it is emphasized that the mother's wishes should prevail, especially if she is competent to decide. The right of refusal in obstetrics is essential because the mother retains as much autonomy as a reasonable person would, despite the pain and momentary stress of labour. Her competence to give an informed consent is not vitiated by the mere fact of her

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[42] *DF (by her litigation friend and mother CF) v. St George's Healthcare NHS Trust* [2005] EWHC 1327. For a comprehensive study of the role of clinical guidelines in medical negligence litigation, see Ash Samanta, Michelle M. Mello, Charles Foster, John Tingle & Jo Samanta, "The Role of Clinical Guidelines in Medical Negligence Litigation: A Shift from the Bolam Standard?" (2006) 14 Medical Law Review 321.
[43] 82 Ohio App 3D 428; 612 NE 2d 724 (Ohio 1992).

parturient state. As *Re MB* dictated, where a woman is competent, she has the absolute right to refuse or accept recommended treatment irrespective of the consequences of her choice.[45] Her competence is presumed until and unless it is rebutted.[46]

a) The encroachment into the mother's right of refusal and consent to treatment

When there are complications the doctor may be faced with maternal interests competing against fetal outcome. The mother may oppose medical intervention for religious reasons or simply desire a natural childbirth. For instance, she may insist on walking around during labour, but this is opposed to mainstream clinical practice of constant electronic fetal monitoring.[47]

In critical situations, the doctor may be faced with a patient who may not want to save her baby if it means that the baby will be retarded. If the mother believes that abnormality is worse than death, while the doctor regards death as worse than disability, there is a clear conflict. The doctor might feel compelled to intervene, for fear of legal liability towards the baby. However, the doctor cannot impose such medical opinions on the patient. It is trite law that the mother's autonomy prevails, as per *Re MB*.[48] The law is silent on whether the child may sue the obstetrician, if he followed the mother's instructions and the baby is born damaged as a result. If there is indeed an action against the doctor for negligence in failing to preserve the baby, the mother should be liable as well. It may arguable that the mother should be liable as against her child, but the action against the mother is unenforceable due to maternal immunity.[49] The doctor, having given advice and offered his recommendations, should not be made to suffer for the willful decision of the mother.

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[44] Nancy K. Rhoden, "Informed consent in Obstetrics" 9:67 (1987) Western New England Law Review 67, at 76.
[45] [1997] 2 FLR 426.
[46] *Ibid*, at 436.
[47] MOH Clinical Practice Guidelines 4/2000, for Induction of Labour and MOH Clinical Practice Guidelines 4/2000, for Preterm Labour, at 16.
[48] *Supra*, note 45.
[49] Maternal immunity as against the unborn child has been given legislative force in section 1(1) of the UK Congenital Disabilities (Civil Liability) Act 1976. As a result, a child will not be able to enforce an action against his or her mother for injuries sustained through the birth even as a result of the mother's negligence or willful conduct. The only exception occurs where the mother had drove negligently, and it has been suggested that this is so because the compulsory road insurance will eventually pay damages towards the mother for the care of the injured child. See Emily Jackson, *Medical Law: Text, Cases, and Materials* (Oxford University Press: Oxford, 2006)

Furthermore, the mother's pregnant state does not in any way influence her competence to consent, as shown by a line of authorities such as *Re MB*,[50] and *St George's NHS Trust v S*,[51] overturning the decision in *Re S*.[52] Most importantly, the stress and pain of a woman in labour, does not in any way compromise her intellectual ability to consent. This cannot be emphasized further, and the decisions of *Rochdale v C* and *Re S* are clearly wrong.[53]

Rochdale cannot be right, as it makes it too easy to find a woman in labour to be incompetent. In the words of Johnson J:

> "The patient was in the throes of labour with all that is involved in terms of pain and emotional stress. I concluded that a patient who could, in those circumstances, speak in terms which seemed to accept the inevitability of her own death, was not a patient who was able properly to weigh-up the considerations that arose so as to make any

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Effectively, this is a strong recognition of the woman's autonomy over her body and allows her to take a choice that could potentially cause damage to the child. The UK Law Commission had explained that allowing a child's claim against the mother would give rise to tension in the family. Although this is true, it is more important that such an action be disallowed because it is necessary to recognize the woman's autonomy in pregnancy. The child should not be able to sue his or her mother, because the woman should be free to decide on issues pertaining to her physical self. It is arguable that it is unfair to put the unborn child's interests before the mother, because the child's legal personality is insufficient to warrant such a tremendous obligation from the mother. While *in utero*, there is still a possibility for the unborn child to be a stillborn and its legal personality could have never been materialized eventually.

Locally, *JU* briefly considered the mother's contribution to the loss. As a matter of fact, the mother had lied about her age and alleged ignorance of the risks of her carrying a Down's Syndrome child due to her age. The court found that it was by her deliberate choice that she had chosen not to perform an amniocentesis test, which would have revealed any abnormalities.

To prove that the mother is liable to her child for decisions that she makes through the course of a pregnancy, the law of torts will require us to show that she had a duty of care to her child. However, it is clear, at least in English law, that the mother will not have such a duty of care, as per the Congenital Disabilities (Civil Liability) Act. It is possible that the law in Singapore may proceed along these lines, because imposing an obligation on mothers to decide according to their unborn child's interests might deter women from having children.

In the US, the law differs between states, but the general sentiment is that the mother does not have any civil liability towards her child. See Sheena Meredith, *Policing Pregnancy: The Law and Ethics of Obstetric Conflict* (Ashgate: Burlington, 2005) at 25. However, there are some decisions in the exception that have allowed such a claim. In *National Cas. Co. v Northern Trust Bank* 807 So.2d 86, the child succeeded in a claim against the mother for injuries sustained in utero in a motor vehicular accident due to the mother's negligence. However, the claim was limited to the mother's insurance cover. This is similar to the British statutory exception to maternal immunity that recognizes the child's claim against the mother in cases of motor vehicle accidents.

It is arguable that a mother should be equally liable to her present living children and her unborn child. If there is no maternal immunity for maternal negligence after the birth of a child, there is no extenuating reason for such exception before the child was born. It is arguable that insurance coverage would ease direct conflict if there were to be an action against the parent for negligent acts committed before birth. However, to impose obligations on the mother is certainly unfair, because it will limit her freedom of choice. On the issue of maternal liability, see Rosamund Scott, *Rights, Duties and the Body: Law and Ethics of the Maternal-Fetal Conflict* (Oxford: Hart Publishing, 2002) at 312.

[50] *Supra*, note 45.

[51] [1999] Fam 26.

[52] *Re S (Adult: Refusal of Treatment)* [1992] 4 All ER 671.

> valid decision, about anything of even the most trivial kind, surely still less one which involved her own life."

If *Rochdale* is taken literally, any woman who feels the stress and pain of a labour process would have been incompetent. With due respect, it is illogical to judge a person's ability to comprehend and retain medical information by the amount of pain and stress inflicted on her. Further, it is most strange why the judge would have deemed the patient to be incompetent, especially when the obstetrician was satisfied that the patient was competent to consent.[54]

In *Re S*,[55] although S had objected to a Caesarean on religious grounds, the doctor had made an emergency application that was granted despite her competence to refuse such a treatment. This is a gross violation of patient autonomy, because S had never been incompetent. Although her choice may not optimize fetal outcome, she should have the final authority over her physical self. Ironically, the baby died and S was severely traumatized. Effectively, the court had sanctioned an act that should have been constituted as a trespass.

With due respect, *Re S* is a most puzzling case. The court referred to *Re AC*,[56] allegedly to have supported intervention for Caesareans.[57] Such a position was taken at the Superior Court, which held that there was a legitimate state interest in protecting the potential life of the foetus. However, on appeal, *Re AC* had in fact reversed such a trend of intervention.[58] When AC was pregnant, she was unfortunately plagued with cancer. While AC was unconscious, the hospital sought a declaration from the court for a Caesarean to save the foetus although this would kill AC. AC regained consciousness and refused to consent. Her appeal against the declaration was not successful and both mother and baby died as a result of the Caesarean. On further appeal by the estate, the court held that such interventions were "virtually never" justified. As Barbara Hewson aptly puts, such were "indefensible practices in the name of defensive medicine".[4] Additionally, she warned of the abusive ramifications of court ordered Caesareans, that it violates basic rights to bodily integrity, a fair trial and equal treatment.[5]

[53] *Rochdale Healthcare NHS Trust v C* [1997] 1 FCR 274.
[54] Sabine Michalowski, "Court Authorised Caesarean Sections – The End of a Trend?" Modern Law Review at 117.
[55] *Supra*, note 52.
[56] 533 A.2d 611 (DC 1987).
[57] *Supra*, note 52, at 672.
[58] 573 A.2d 1235 (DC App, 1990)

in the name of defensive medicine".[59] Additionally, she warned of the abusive ramifications of court ordered Caesareans, that it violates basic rights to bodily integrity, a fair trial and equal treatment.[60]

The line of authorities after *Re S* began to give greater eminence to the mother's right of choice. In *Re MB*, Butler-Sloss LJ stated that "A competent woman who has the capacity to decide may, for religious reasons, other reasons, for rational or irrational reasons or for no reason at all, choose not to have medical intervention, even though the consequence may be the death or serious handicap of the child she bears, or her own death."[61] Although a bold pronouncement of patient autonomy, MB was curiously found incompetent due to her needle phobia. It may be argued that if irrationality was not an indication of incompetence, MB's needle phobia should not have rendered her incompetent. If *Re MB* had indeed allowed irrational reasons to refuse treatment, the court would have respected her phobia for needles unless she was already insane with or without the pregnancy. However, *Re MB* must be read closely to its facts. MB had in fact agreed to the Caesarean, but was unable to consent. Therefore, the court was effectively declaring her incompetent so as to give consent on her behalf.

Finally, *St George's NHS Trust v S* clarified the position, where it was held that an emergency Caesarean that was imposed on S despite her objections was unlawful. It was held that the procedure was effectively an act of trespass as S was competent to refuse such a treatment. From the child's perspective, this could be a denial of his or her interests. He or she may argue for a right to life and that the mother should have an obligation to provide a reasonable quality of life after birth. However, the mother's autonomy is sufficient to rank above any such arguments, because the foetus' legal personality is still an uncertainty. It would be unfair for her competence to be diminished by the fact that she is carrying a baby.

The pregnant mother's patient autonomy should be supported by society's obligation and authority to guard this autonomy. It is essential to prevent any possible interference with

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[59] Barbara Hewson, "When 'no' means 'yes'", Law Society's Gazette, 1992.
[60] *Ibid*.

personal liberty. As the CA has emphasized in *St George's NHS Trust*, such protection of a person's personal liberty has been cast in its social and political context in *S v McC*. [62]

However, the courts have shown inclination to impose some checks on such autonomy. The complete autonomy is limited by the woman's capacity to give consent or refusal. This position in *Re MB* has been reiterated in *Bolton v O*,[63] where it was held that the patient was temporarily without capacity due to her overwhelming fear and anxiety when she went to the operating theatre. As a result, she lost the capacity to consent or refuse the surgery proposed, or to refuse the anesthesia, which was an essential prerequisite to the surgery.

From *Re MB* and *Bolton v O*, it was clear that the autonomy enjoyed by the woman is not unrestricted. The parturient woman in both cases had consented to the Caesarean before entering the theatre, but both had panicked at the theatre itself. It is probably because of their prior consent to Caesarean, that the court can declare the operation lawful, even as they lose the capacity to decide. Conversely, in a case where the woman has indicated clear refusal to a Caesarean before labour, and shows fear and anxiety in the labour ward later, she should not be found incompetent for the purposes of enforcing a Caesarean on her. The two cases must be distinguished, because the latter has made clear refusal and unless she withdraws such refusal, it should continue into the course of labour. Otherwise, it would have defeated the purpose of her advance refusal to the treatment.

The US position imposes the state's interests in maternal-foetal conflicts. Upon the doctor's application to the court to save the viable foetus, courts has ignored the rights of competent women to decide on their bodies. In *Raleigh v Anderson*,[64] the Supreme Court upheld the order of the New Jersey Supreme Court requiring a woman to submit to a blood transfusion to save the life of her foetus.

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[61] *Supra*, note 45.
[62] Refer to Rebecca Bailey Harris, "Pregnancy, Autonomy and Refusal of Medical Treatment" (1998) 114 Law Quarterly Review 550-555. See Lord Reid's comments in *S v McC* [1972] A.C. 24, at 43, that "We have too often seen freedom disappear in other countries not only by coups d'etat but by gradual erosion: and often it is the first step that counts. So it would be unwise to make even minor concessions".
[63] *Bolton Hospitals NHS Trust v O* [2002] EWHC 2871.
[64] *Raleigh Fitkin-Paul Morgan Mem Hosp v Anderson* 201 A 2d 537 (New Jersey 1964).

Later, in *Jefferson v Griffin Spalding*,[65] the Supreme Court of Georgia denied a woman's right to refuse medical treatment and dismissed a stay on the court order that mandated a Caesarean on the mother. The mother refused to follow the doctor's advice of a Caesarean, that the child would certainly die and she would probably die if she continued to try for a natural birth. The court found that the medical interests of both mother and child would be optimal if a Caesarean was ordered. Effectively, the court was deciding against the mother's will for the sake of the child, relying upon the doctor's recommendation. Here, the doctor should not even have applied to court at all. He should have respected his patient's wishes. This is borne out in the fact that the mother eventually gave birth to a healthy baby via natural birth. Even if the results were to be adverse, it would have had been the course of action that the mother wanted to take. The right to self-determination should have prevented the doctor and the court from attempting to force a Caesarean on the mother.[66] A most graphical illustration is how women refusing Caesareans have been restrained to their hospital beds or fled the hospital.[67]

While there are no reported cases of Caesareans forced upon parturient women in Singapore, *JU* has possibly encroached into the mother's right of choice to treatment.[68] Although *JU* was a claim for wrongful birth, it is relevant to consider it with regards to the court's comments on the plaintiff mother's ability to choose a treatment when it is no longer legally available in Singapore. The court had stated that "(a) doctor in Singapore is not duty-bound to, and indeed should not, recommend treatment outside Singapore when Singapore law prohibits such treatment." While it may be true that the doctor should not be obliged to advise patients to seek abortion elsewhere when Singapore no longer allows it; it is wrong to deprive a patient of a treatment that is necessary. The plaintiff in *JU* should be free to abort an

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[65] *Jefferson v Griffin Spalding County Hosp Authority* 274 S.E.2d 457 (Georgia 1981). For earlier literature, see Bowes & Selgestad, "Fetal versus Maternity Rights: Medical and Legal Perspectives" 58 (1981) Obstetrics & Gynecology 209, at 211-212.

[66] See E P Finamore, "*Jefferson v Griffin Spalding County Hosp Authority*: Court ordered Surgery to protect the life of an unborn child", 9 American Journal of Law & Medicine 83-101 (1983). Cf, LJ Nelson, BP Buggy & CJ Weil, "Forced Medical Treatment of Pregnant Women: "Compelling each to Live as seems good to the Rest"", 37 (1986) Hastings LJ 703-763. The right to self-determination as a justification of refusal to treatment is also explored in Supra, note 49, Scott at 218.

abnormal foetus in another jurisdiction where abortion is still legal at a late stage of pregnancy for foetal abnormality, such as the UK.[69]

b) Emergency Obstetrics Procedures

In an emergency situation where the doctor does not have the privilege of consulting the patient, the question could arise as to whose best interests he should consider in the course of administering emergency obstetric procedures. If the mother had the foresight to make an advanced medical directive, the doctor would have had a better indication of her wishes. However, if there is no such indication from the mother, the obstetrician's consideration of the patient's best interests is those of the mother and not the child. The mother's interests must be first in priority, even without regard to the child.

In UK, *Wilson v Pringle* stated that public policy would demand that it is to the public's benefit that unconscious patients who require emergency treatments should be able to receive it.[70] In the same vein, the doctors providing such emergency treatment should not be liable in tort. However, this was subjected to the "best interests" test, in *Re MB*, where it was held that the obstetrician may only intervene if the patient lacked capacity and the treatment was in her best interests.[71]

It seems that such a position would be taken in other jurisdictions as well. In *Marshall v Curry*,[72] the Canadian CA stated that it is the surgeon's duty to act in order to save lives or preserve the health of the patient; and that in the honest execution of that duty he

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[67] More philosophical criticism of the US cases in A. Maclean, "Now you see it, now you don't: Consent and the Legal Protection of Autonomy" (2000) 17(3) Journal of Applied Philosophy 277, at 285.
[68] *Supra*, note 5.
[69] In UK, section 1(d) of the Abortion Act, as amended by the Human Fertilisation and Embryology Act, makes provision for a termination of pregnancy for foetal abnormality, even at a late stage. In Singapore, it is unfortunate that termination of pregnancy is not allowed at a late stage, even where there is foetal abnormality. Termination of pregnancy is currently prohibited "unless the treatment is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman," as per s.4(1)(a) of the Termination of Pregnancy Act (Cap. 324, Rev. Ed. Sing.), s.4(1)(a). See Rosamund Scott, "Prenatal Screening, Autonomy and Reasons: The Relationship between the law of Abortion and Wrongful Birth" (2003) 11 Medical Law Review 265. Also see Elizabeth Wicks, "Late Termination of Pregnancy for Fetal Abnormality: Medical and Legal Perspectives" (2004) 12 Medical Law Review 285.
[70] [1987] QB 237.
[71] *Supra*, note 45.
[72] [1933] 3 DLR 260

should not be exposed to legal liability.[73] In this case, it laid down the doctor's duty to act in the best interests of the patient and this duty was held to be over and above the patient's right to his body. To gain an exception to the patient's autonomy and for the emergency immunity to apply, the treatment must be, (i) necessary to meet the emergency, and (ii) required to be carried out before the patient regains consciousness to decide. In this case, the surgeon was found to be liable, for tying the patient's tubes to prevent future pregnancy hazards as fibroid tumor was discovered on the uterus during the Caesarean. Although this act was possibly in her best interests, it was unnecessary at that point of time. Further, Neill J excluded and deemed it unnecessary to consider an important set of circumstances in which the doctor is entitled to give treatment to preserve the life of a competent patient who chooses to forsake life.

Other than the common law, we must consider the Law Commission Report on Mental Incapacity as well, which almost seem to encroach into the pregnant woman's autonomy. It suggested that there should be a presumption of inapplicability if the advanced refusal was given by a pregnant woman endangers the life of her foetus. However, it mentions that the Law Commission did not intend to deprive women of their rights to make an advanced refusal which could compromise the foetus' life. Instead, if she had wanted her advance refusal to continue into her pregnancy, she must make expressed provision for such to the obstetrician. The Law Commission Report stated that, "We do not, however, accept that a woman's right to determine the sorts of bodily interference which she will tolerate somehow evaporates as soon as she becomes pregnant"[74] Clearly, it is against the principles of patient autonomy to allow the foetus' viability to circumvent the woman's autonomy.

Therefore, in taking the best interests approach in the course of an emergency treatment, the mother's wishes must be taken into consideration. If the doctor were to make a choice between the best interests of the woman or the child, the doctor should consider those of his primary patient, the mother. Although the concept of dual patient hood prevails, the

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[73] *Ibid*, at 275.
[74] Law Commission No. 231 at para. 5.25.

doctor's duty is primarily to the mother, who has employed him to provide treatment for her. However, he is faced with a dilemma as he is also liable to the foetus (if the child is born alive) and does not enjoy any exception that is comparable to the maternal immunity.[75]

V. WHAT TYPE OF DAMAGE IS TO BE PROTECTED?

The doctor clearly has a duty to not cause physical harm in the care of the mother and child before or after pregnancy. This duty to avoid causing physical harm to the mother is particularly important in maternal-foetal conflicts, where the proposed treatment may be harmful to the mother, such as in *Re AC*. Other than this basic duty, there are various additional damages that he would want to avoid. Especially of significance is the duty to avoid psychiatric harm, particularly where the mother has raised her refusal, indicating the potential psychiatric damage that such treatment may pose to her.

a) Not to cause psychiatric harm

A duty not to cause psychiatric trauma while delivering the baby should include not causing distress to the mother by imposing treatments on her. Nervous shock claims are based on psychiatric trauma that is long term in nature and extends beyond the immediate temporary shock or grief in the labour ward. Before examining the obstetrician's duty in this area, nervous shock claims were first established in UK by *Dulieu v White*.[76] There, it was held that it was "unreasonable" not to recognise nervous shock where physical injury is directly produced by it.[77] In setting proper limits for such claims, the court went further to state that the shock must arise from "a reasonable fear of immediate personal injury to oneself."

Later, *McLoughlin v O'Brian* and *Alcock v Chief Constable of South Yorkshire Police*,[78] established that the test for the determination of nervous shock pivoted on the requirement of a close relationship, proximity to a tortious event, and the means by which the

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[75] *Supra*, note 49.
[76] [1901] 2 KB 669. *Dulieu v White* has since been applied in *Abramzik v Brenner*, (1967) 65 D.L.R. (2d) 651 (CA (Sask)).
[77] *Ibid*, at 673.

shock is caused. The shock must come through actual sight or hearing of the event or of its immediate aftermath. In a birth, it is with no doubt that the mother has a close relationship with the child. In fact, some goes as far as to suggest that the mother and child are very much fused as one entity. Such is the epitome of close relationships and it is difficult to see why such a relationship would not satisfy the first requirement.

Further, in *Farrell v Merton*, the principles from *Alcock* in assessing damages for a secondary victim were reinforced.[79] The court found that, in addition to the "natural and presumed emotional tie between mother and child", the birth of the baby in traumatic circumstances made the child all the more precious and special to the mother. Therefore, the defendant Authority was liable to compensate for the psychiatric illness suffered as a result.[80]

Locally, in *Pang Koi Fa*,[1] it was found that there existed a strong bond in relationship of the mother and child, and the court held that such fulfilled the first requirement of a close relationship. Further, the court found that the plaintiff was witnessing the consequences of the defendant's negligent diagnosis, negligent operation and negligent post-operative treatment of her daughter. Specifically, the court held that the plaintiff was a percipient witness in relation to the elements of immediacy, proximity of time and space, visual and aural perception. Although this was a case of a mother's shock over an adult daughter's suffering, this reasoning is easily applied in the labour ward, where the mother is actually undertaking a major surgical procedure for the sake of her child, placing her in the same event as her child. Her interest in having optimal fetal outcome puts her in a vulnerable position should there be any shock.

Such a position is mirrored in Australia, where a woman who suffers shock in the immediate aftermath of giving birth to an abnormal child will have a claim in negligence if there has been a fault on the part of the obstetrician or hospital treating the plaintiff during

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[78] [1982] 2 WLR 982; [1992] 1 AC 310.
[79] *Farrell v Merton Sutton & Wandsworth Health Authority* (2000) 57 BMLR 158.
[80] It is noted that, where maternal decisions to refuse treatment result in a baby born damaged, the mother and child should not be able to claim for such risk that has been assumed in making that decision, unless it was not an informed decision.
[81] *Pang Koi Fa v Lim Djoe Phing* [1993] 3 SLR 317.

pregnancy and childbirth. In *Veivers v Connelly*,[82] it was found that the serious risk to the plaintiff's mental health crystallized with the birth of a terribly disabled child. In this case, the mother was not screened to determine whether or not she had rubella while she was pregnant. As a result, the child was born severely disabled with rubella embyropathy. It was held that the fact that nervous shock was foreseeable in this situation provided justification to terminate the pregnancy in its early stages. Clearly, the doctor had breached his duty to screen the mother and properly advise her of the effects that rubella may have on a pregnancy. Had he done so, she would have had an option to terminate the pregnancy and would have avoided the costs of bringing up a disabled child.

Similarly, in *X v Pal & Ors*, the CA awarded the plaintiff $15,000 after she suffered nervous shock having given birth to a disabled child as a result of the doctors' omission of a syphilis screen during her pregnancy.

Finally, in *Strelec v Nelson*,[83] the doctor had failed to give the patient the option to proceed to birth by Caesarean. Instead, he proceeded to deliver the baby and evidence suggested that he had exerted too much force while delivering the infant. As a result, the infant suffered from a spinal injury which continued and enlarged as more force was used. Smart J held that the plaintiff suffered from sensory shock after receiving the news that her son was terminally ill. She was further traumatized when the decision was made to not resuscitate the infant when he suffered a further respiratory arrest. But for the doctor's failure to inform her of the possibility of a Caesarean and the doctor's use of inappropriate traction, the mother would never had to witness such a tragic end to her newborn's life.

b) Damages for a stillbirth

In assessing damages for a stillbirth, the physical injury could be identified as the unnecessary "prolongation of labour beyond the appropriate point."[84] It was suggested that the ancient common law principle that no person has an interest in the life of another would

[82] (1994) Aust Torts Reports 81-309, [1995] 2 QdR 326.
[83] No 12401 of 1990. (unreported) 13 December 1996 (NSWSC).

imply that the mother should not be compensated for the death of her child, where the child was not born alive. However, the mother should be compensated for the nervous shock of having to deliver a stillborn caused by negligent acts, instead of a healthy baby. But for the negligent acts of the obstetrician, the mother would have been able to experience the joy from the time and energy that she had invested for the birth of her child. Therefore, in the context of a stillbirth caused by negligent acts, the obstetrician has a duty to compensate for such damages that he has inflicted.

As shown earlier, the stillborn is incapable of suing because he or she did not live to experience the pain and suffering. Hence, there is no enforceable action on behalf of the stillborn. There are a few cases that illustrate the scope of damages awarded for a stillbirth. In *Bagley v North Herts*,[85] damages were awarded for the loss of satisfaction in carrying the baby to full term, for the disappointment of unfulfilled family plans, and for being deprived of the joy in raising an ordinary healthy child. In *Kralj v Mcgrath*,[86] the mother was awarded general damages after a gross obstetric procedure that resulted in the stillbirth of the second twin. Woolf J expressed that if her grief had aggravated the injury to herself, such aggravation could be reflected in the damages. However, Woolf J took care not to award aggravated damages in a medical negligence case, despite the expert opinion that the treatment on the plaintiff was "horrific".[87] Later, in *Grieve v Salford*,[88] damages were awarded for the initial prolongation of labour, some additional pain, loss of the stillborn child, deprivation of the satisfaction of successfully carrying the baby to full term and the stillbirth.

c) Economic loss

Additionally, there should be compensation for economic loss arising as a consequence of injury inflicted by obstetric negligence. Infants born brain-damaged as a result of negligence should be awarded adequate compensation to cover special education and

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[84] Charles J Lewis, Clinical negligence: a practical guide, 5th edn (Butterworths: London, Edinburgh & Dublin, 2001) at 234.
[85] *Bagley v North Herts Health Authority* [1986] NLJ Rep 1014.
[86] [1986] 1 All ER 54

special care required for their maintenance which would not have been necessary had they been born without their disabilities. Other than the above traditional damages, consideration of wrongful birth claims is necessary as more parents are now claiming for the costs of raising an unexpected child.[89]

In *Kralj v Mcgrath*, Woolf J also awarded damages for the economic loss in the event that the parents would try for a larger family.[90] In the situation that the parents did not try for a larger family, such further award would have covered the disappointment in having been unable to achieve that objective. At first instance, this head of damages seem to be stretching the extent of the obstetrician's liability. Although the obstetrician had unfortunately caused the child's death, it is arguable that damages for the economic loss in the parents' efforts for a larger family are too remote. However, but for the obstetrician's negligent act that caused the death of the baby, the parents would not have had to try for another baby to fulfill their familial objective of a particular number of children.[91]

Veritably, the damages obtainable from a claim against the obstetrician, however, can never replace the joy that the mother could have had from having a healthy baby. The damages may only ameliorate the pain and suffering of losing a child or having to raise a

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[87] Guy Carpenter, "What's the difference? The UK versus the US Legal System" (Guy Carpenter & Company: London, 2003) at 26.

[88] *Grieve v Salford Health Authority* [1991] 2 Med. L.R. 295.

[89] Specifically, the controversial wrongful life action deserves mention. Typically, the child is born with disabilities resulting from medical negligence and but for such negligence, would have been aborted as a foetus. *McKay v Essex Area Health Authority* [1982] QB 1166 has demonstrated the courts' reluctance to allow such claims on moral grounds. Locally, *JU* echoes such similar sentiments. See Margaret Fordham, "Blessing or Burden? Recent Developments in Actions for Wrongful Conception and Wrongful Birth in the UK and Australia" (2004) Sing J. L. S. 462. *Supra*, note 5.

[90] [1986] 1 All E.R. 54.

[91] Conversely, a mother should also be entitled to damages when sterilization procedures were negligently performed and resulted more children to the already burdened family. The mother will need to show that the failed operation resulted in the pregnancy. The obstetrician may argue that it is the sexual intercourse that caused the pregnancy instead of the failed operation. However, this argument may not succeed, unless the claimant was aware that the sterilization had failed at the time of the intercourse, as per *Sabri-Tabrizi v Lothian Health Board* [1998] BMLR 190. The woman who becomes pregnant also does not have a duty of care to have an abortion and such a decision not to have an abortion cannot bar her from suing, as per *Emeh v Kensington, Chelsea and Fulham Area Health Authority* [1984] 3 All ER 1044; *McFarlane v Tayside Health Board* [1999] 4 WLR 1301. While the woman may sue, the damages obtained are purely those for the medical expenses to compensate the pain and suffering associated with pregnancy and childbirth, *Walkin v South Manchester Health Authority* [1995] 1 WLR 1543. The costs of raising the child are not recognized as a head of damages, as per *McFarlane*. Such reluctance has been affirmed in *Rees v Darlington Memorial Hospital NHS Trust* [2004] AC 309, compensation was given not for the cost of raising the child, but for the loss of the woman's "opportunity to live in the way she wished and planned." However, if the child was born disabled, the claim for expenses required to raise the child is allowed, as per *Parkinson v St James and Seacroft University Hospital NHS Trust* [2001] EWCA Civ 530 and *Farraj v King's*

damaged child. Such damages are not only limited to the mother, and the father should also sue for trauma inflicted upon him as a result of the mismanaged birth.[92] Furthermore, where the damage was caused by the obstetrician in imposing a treatment against the mother's wishes, the damages ought to be increased.

VI. MOVING AHEAD IN MATERNAL-FOETAL CONFLICTS

a) Preserving the mother's autonomy over and above the foetus' interests

The preservation of patient autonomy for pregnant women is essential.[93] Her pregnancy in no way subjugates her interests below that of her foetus. There cannot be any implicit consent to risks associated with treatments for the unborn, in the mother's choice of pregnancy.[94] The fact that she chose to continue the pregnancy instead of opting for an abortion does not in any way diminish her capacity to consent or refuse treatments that the foetus may need. When the pregnant woman falls ill, she may need treatment that is known to carry a risk of injury to the child. For instance, in a car accident, the mother might need to undergo a surgical operation and such could require anesthetic, which is potentially harmful to the foetus.[95] If the mother would rather save herself than to sustain the foetus, the doctor

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Healthcare NHS Trust [2006] EWHC 1228. For a US decision, see *McCullough v Hutzel Hospital* 88 Mich. App. 235.

[92] *Withington v Central Manchester Health Board*, *The Times* 2 July 1954 (QBD). It is arguable that extending the obstetrician's liability to the father is unnecessary because the father is never involved directly in the treatment of the pregnant woman and the unborn child. Although there is no direct doctor-patient relationship between the father and the obstetrician, the father should be able to sue the obstetrician for a negligently managed birth because the father would also have been deprived of the joy in raising an ordinary healthy child and would have also suffered the disappointment of unfulfilled family plans; all but for the obstetrician's negligent act. The father may not be involved directly, but is clearly foreseeable and proximate.

However, the father's claim as a secondary victim was very restricted in *Tan v East London and the City Health Authority* [1999] Lloyds's Rep Med 389, where the court had distinguished *Tan* from *Tredget v Bexley Area Health Authority* [1994] 5 Med LR 178. *Tredget* held that incidents comprising the negligent delivery and the child's death, could be view as one single horrifying event. However, the father in Tan, who had received a call informing him about his child's death in utero, and subsequently traveled to witness the stillbirth of his child three and a half hours later, was not recognized to have any claim.

[93] *Supra*, note 1, Seymour at 207.

[94] Cf, Mattingly's view that the mother in most cases "expect to assume reasonable risks to improve the chances of deliverying a healthy baby. Willingness to do so is ideally implicit in the choice of pregnancy, and indeed the argument that the pregnant woman increases her responsibility for the fetus's well-being by choosing not to have an abortion is often cited to support the medical duty to provide fetal therapy." *Supra*, note 1. See also, H Tristram Engelhardt, Jr., "Current Controversies in Obstetrics: Wrongful Life and Forced Fetal Surgical Procedures," American Journal of Obstetrics and Gynecology 151 (1985): 313-318.

[95] Margaret Brazier, *Medicine, Patients and the Law*, 3rd edn, (England: Penguin, 2003) at 373.

ought to respect her wishes.[96] In this scenario, notwithstanding that the treatment may cause harm to the foetus, it is a necessity. Furthermore, she still commands the full capacity to determine her choice of medical treatment.

Conversely, if the mother elects to forgo the treatment in order to preserve the foetus, the doctor must not force the treatment on her.[97] Even if the mother is opting for a treatment that is clearly detrimental to her own health, she has the full legal right to do so.[98] Her choice, although out of the ordinary, is still a free choice within the bounds of her capacity to consent. The ethical motivation for such practice is recognized by UK Ethics Committee, reinforcing the obstetrics profession's attitudes to such issues.[99]

The emphasis on maternal welfare is clear even from statutory provisions on abortion in Singapore and UK. Ss.1(b) and (c) of the UK Abortion Act, makes provision for abortion at any stage where the pregnancy is harmful to the mother.[100] Locally, abortion can be at any stage, where "the treatment is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman," as per s.4(1)(a) of the Termination of Pregnancy Act.[101] Inferring from the legislature intent to continue protecting the welfare of the mother, such motivations should be mirrored in maternal-foetal conflicts. Although maternal-foetal conflicts may not necessarily involve a life-threatening situation for the mother, an obstetric intervention against her wishes could possibly cause much damage to her mental health.

The above analysis culminates in the argument that the obstetrician should be immune from maternal decisions that is contrary to the child's interests, as the mother's refusal rendered intervention unlawful. The current law in UK is silent as to the obstetrician's liability as against the foetus for withholding necessary treatment as per the mother's wishes.

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[96] The religious argument to preserve the baby for the sake of assuring it of a Christian baptism to save the baby from hell cannot be imposed on the general society. This religious view was first advanced in 1773, when doctors consulted Sorbonne theologians on the choice between the mother and unborn child if only one of them can be saved. *Supra*, note 2, Weaver at 237.
[97] *Supra*, note 45 and 63.
[98] *Ibid*.
[99] Royal College of Obstetricians and Gynaecologists, *A Consideration of the Law and Ethics in Relation to Court-ordered Obstetric Intervention* (Royal College of Obstetricians and Gynaecologists, 1994).
[100] UK Abortion Act, as amended by the Human Fertilisation and Embryology Act.

However, it may be implied from *Re MB* and *Bolton*,[102] that if the mother should be free to choose a treatment despite knowing that it is contrary to her life or the foetus' interests, it is unfair to hold the obstetrician liable for such maternal decisions. Implied within both *Re MB* and *Bolton*, is the obstetrician's duty to intervene when the mother is incompetent, and the best interest approach must be taken. Here, the obstetrician faces the most problematic dilemma, whether to take the best interests of both mother and child, or solely that of the mother or solely that of the child. As aforementioned, the obstetrician should first follow any advanced medical directive written by the mother. Otherwise, he should consider the best interests of the mother, well above that of the child. Between the two patients, the mother is still the primary patient.

b) US developments

Further, US judicial developments denying maternal autonomy should neither be adopted in UK, nor Singapore. Such development infringes maternal autonomy, and invades parents' rights to decide for their child. It is most ironic that these judicial developments are in fact contrary to the general obstetric attitudes in the US, where the Ethics Committee had expressedly stated that obstetricians should not impose procedures on pregnant women when they have refused to consent.[103] The US decisions' erroneous emphasis on the viable foetus is encouraging defensive obstetric practice. As Rhoden has aptly put it, "if the infant is impaired and the doctor has just stood by, the doctor may face legal liability, whereas if he has done a C(a)esarean, the doctor has the strong [104] defense of having done everything."[105]

The US cases of *Raleigh* and *Jefferson* are erroneous in recognizing the foetus' right to immediate protection under the court's *parens patriae*.[106] However, Illinois cases have

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[101] (Cap. 324, Rev. Ed. Sing.), s.4(1)(a).
[102] *Supra*, note 45 and 63.
[103] American College of Obstetricians and Gynaecologists, Patient Choice: Maternal-Foetal Conflict (Committee on Ethics, American College of Obstetricians and Gynaecologists, 1987).
[104] Bridget Taylor, "Parental Autonomy and Consent to Treatment" (1999) 29(3) Journal of Advance Nursing 570.
[105] *Supra*, note 44 at 79. Also see Marieskind, Cesarean Section, 7 Women & Health 179, 188 (1982) on the fear of legal liability as a motivating factor for obstetrician to deliver by Cesarean.
106 An influential decision of interest is *Roe v Wade* 410 U.S. 113, where the state's interests in protecting human life could be inferred. However, it did not state that such interests could override those of the mother. *Roe v Wade*

recognized the mother's right of refusal, such as *Re Baby Boy Doe* and *Re Fetus Brown*.[107] Curiously, in *Pemberton v Tallahassee,*[108] the court held that the mother's personal constitutional rights did not outweigh the interests of the state in preserving the life of the foetus. The US development is in a clear state of flux, varying across states.[109] However, it is submitted that the position taken in the Illinois courts is the preferable direction, for it recognizes the fundamental right of every person to refuse treatments, especially parturient women.

VII. CONCLUSION

It is crucial that the UK courts avoid adopting the US position of denying the right of refusal to treatment, because it is not only problematic, but furthermore an encroachment into the mother's autonomy. Re MB and Bolton are promising trends that respect maternal autonomy and subsequent decisions should follow such a direction. It is illogical to subsume the mother's interests under those of the child, whose rights and interests remain inchoate till he or she is born alive and capable of enforcing those rights and interests. The obstetrician operates under the dual patient-hood model, limited by the mother's rights and interests. In fact, maternal-foetal conflicts are rare because the majority of mothers would have elected the best for their unborn child. However, such norms should not restrain the right of every woman to decide for her own body. In conclusion, a pregnant woman retains the same rights of refusal to treatment when she was not pregnant.

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is useful for the purpose of understanding the value of the foetus, but this paper will not belabor on this case as it is more relevant to the context of abortions.

[107] 260 Ill. App. 3d 392 (App, Illinois 1993); 294 Ill. App. 3d 159 (App, Illinois 1997). Some, such as Rosamund Scott has labeled this case as a sign of "regression" in the jurisprudence in this area. *Supra*, note 49, Scott at 187.

[108] *Laura Pemberton v Tallahassee Memorial Regional Medical Center* 66 F. Supp. 2d 1247 (Florida, 1999).

[109] Rosamund Scott has suggested that this issue seem to remain open in the United States and that numerous states have yet to consider the issue. *Supra*, note 49.

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