SECOND DIVISION, INNER HOUSE, COURT OF SESSION

[2019] CSIH 20
A306/13

Lord Justice Clerk
Lord Brodie
Lord Drummond Young

OPINION OF THE COURT

delivered by LORD BRODIE

in the reclaiming motion

LT (as guardian of RC)

Pursuer and Reclaimer

against

LOTHIAN NHS HEALTH BOARD

Defenders and Respondents

Pursuer and reclaimer: Milligan QC, Bell; Digby Brown LLP
Defenders and respondents: Ferguson QC, Doherty QC; NHS Central Legal Office

3 April 2019

Introduction

[1] The pursuer is the mother and guardian of RC, a son who was born by spontaneous vaginal delivery in the defenders' hospital on a date in 2005. The time of birth was recorded as 2327 hours on that date. The pursuer avers that at about the age of three years RC was

diagnosed as suffering from severe cerebral palsy and that he has very serious associated disabilities. She further avers that RC's condition is the result of a period of significant hypoxia-ischaemia and consequent brain damage which occurred immediately before his birth and, in particular, in the period of about 45 minutes before his birth. The pursuer seeks reparation from the defenders on behalf of RC for his injury and damage on the ground of alleged fault and negligence for which the defenders are liable.

[2] The reclaiming motion, which is at the instance of the pursuer, is against the interlocutor of the Lord Ordinary (Lady Wolffe), dated 3 April 2018, repelling the pleas-in-law for the pursuer, sustaining the second and third pleas-in-law for the defenders and assoilzing the defenders from the conclusions of the summons.

[3] The interlocutor of 3 April 2018 was pronounced after a three-week proof restricted to the question of negligence; questions of causation and quantification of damages having been left over for later determination if necessary.

The scope of the reclaiming motion

[4] In large part the pursuer's case is concerned with the interpretation of the results of the electronic foetal monitoring ("EFM") of the pursuer using a cardiotocograph machine during the pursuer's labour and, in particular during the last two hours of that labour (after 2126 hours). This period was when labour was in its second stage, in other words the cervix was fully dilated and the foetus was being pushed through the vaginal canal.

[5] As the Lord Ordinary records at para [7] of her opinion and as is very familiar, EFM of a woman in labour using a cardiotocograph machine is common. It is carried out by affixing sensors to the mother which are intended to record, among other things, the uterine activity (ie contractions) of the mother and the foetal heart rate ("FHR"). These recordings

are printed out in real time in a continuous manner onto a scroll of paper, which may be referred as a foetal trace ("a trace") or a cardiotocograph ("CTG"). A CTG records the level of FHR at particular points of time and the pattern of its increase ("acceleration") and decrease in speed ("deceleration") from the mean level ("the baseline") over a period of time in parallel with uterine contractions. Decelerations may be "early" or "late". Early decelerations are repetitive uniform decelerations whose onset is early in a contraction and which return to the baseline at the end of the contraction. Late decelerations are repetitive uniform decelerations with onset mid to late in a contraction with a nadir more than 20 seconds after the peak of the contraction and whose end is after completion of the contraction. Comparison of FHR at different points of time indicates the extent to which it fluctuates ("variability"). Assessment of these readings allows suitably qualified clinicians to come to a view as to the condition of the foetus during labour and, in particular, whether it may be suffering from hypoxia. Such an assessment is an exercise in interpretation in the sense that suitably qualified clinicians may come to different conclusions from a consideration of the same CTG. In the present case the expert witnesses led for the pursuer interpreted the relevant portion of the CTG differently from the way in which it was interpreted by the expert witness led for the defenders. A particular point of difference was where the baseline should be located. As will be apparent, the location of the baseline determines whether an excursion or change in FHR falls to be regarded as an acceleration or a deceleration.

[6] Again as is recorded by the Lord Ordinary (paras [9] to [17] of her opinion), at the relevant time guidance on the use and interpretation of cardiotocography in intrapartum foetal surveillance had been provided by the Royal College of Obstetricians and Gynaecologists by way of *Evidence-based Clinical Guideline Number 8 of 2001, The Use of*

Electronic Foetal Monitoring ("the Guidelines"). The Guidelines incorporate a clinical practice algorithm or flow chart, with recommended actions depending on the results of auscultation or CTG during labour ("the Algorithm"). Excerpts of the Guidelines and the Algorithm were lodged in process by the defenders and extensive use was made of them by parties in leading evidence and by the Lord Ordinary in evaluating that evidence. They were taken to be an indicator of standard obstetric practice at the time of RC's birth.

[7] The Guidelines provided definitions and descriptions of a number of individual features of FHR (table 2.1). At paragraph 2.5 and table 2.3 they set out four FHR features: (1) baseline FHR expressed in beats per minute (bpm); (2) variability of FHR (expressed in bpm); (3) decelerations; and (4) accelerations. In relation to each of these features the table sets out parameters which enable the feature to be categorised as "reassuring", "non-reassuring" or "abnormal". In the same paragraph, table 2.2 provides for the categorisation of FHR traces. A CTG where all of the table 2.3 features are reassuring is categorised as "normal"; a CTG one of whose features fall into the non-reassuring category is categorised as "suspicious"; and a CTG where two or more of the features fall into the non-reassuring category or one of the features falls into the abnormal category is categorised as "pathological".

[8] When considering the pleadings and the evidence of witnesses as recorded in the transcript and the submissions made by counsel, where words are used which are defined in the Guidelines it is to be assumed that the words have been used in the sense of the definitions. Thus, for example, "normal", "suspicious" and "pathological" are all to be regarded as terms of art, the definitions of which are as set out in the preceding paragraph of this opinion.

[9] As pled, the pursuer's case alleges fault and negligence on the part of both the midwife who attended the pursuer from 1915 hours on the day of RC's birth and the obstetrical registrar who was in attendance at about 2230. During the course of the proof before the Lord Ordinary the case against the midwife was abandoned as were some of the grounds of fault directed against the registrar. At the point of submissions to the Lord Ordinary the pursuer relied on three grounds of fault on the part of the registrar following her assessment of the CGT trace at 2230, each of which arose from her failure to take action other than allowing the pursuer's labour to proceed with a view to spontaneous vaginal delivery. The Lord Ordinary referred to these three grounds of fault as "the CTG interpretation case", "the failure to expedite delivery case" and "the consent case".

[10] The Lord Ordinary records at para [219]of her opinion that when counsel addressed her he explained that while the CTG interpretation case and the failure to expedite delivery case depended on a finding that the CTG trace was pathological as at 2230 that was not so with the consent case. It required merely that the trace was "unusual" (para [219] of the opinion). "Unusual" is not a term of art, in the sense that it is defined in the Guidelines.

[11] The Lord Ordinary found none of the three cases insisted in against the registrar to have been established. The pursuer acquiesces in the Lord Ordinary's decision as far as the CTG interpretation and failure to expedite delivery cases are concerned. However, before this court she maintains that the Lord Ordinary erred in fact and law in holding that the registrar was entitled to proceed with labour without obtaining the pursuer's informed consent after about 2230 on the relevant date; what the Lord Ordinary described as the consent case. The Lord Ordinary discusses that case at paras [317] to [330] of her opinion.

The consent case

[12] For what is now the sole ground of alleged fault maintained against the defenders the pursuer relies on the law as it is found to be in *Montgomery* v *Lanarkshire Health Board* 2015 SC (UKSC) 63. In a judgment with which all members of the UK Supreme Court agreed, Lords Kerr and Reed stated the relevant principles in relation to the risks of injury involved in medical treatment at para [87] as follows:

> "An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it."

It was not disputed by counsel that this is the authoritative statement of the applicable law. No point is taken by the parties to this case in relation to "interfering with …bodily integrity". It is accepted that the same principles apply where the relevant treatment option is not to intervene or not further to intervene but rather to allow a previously determined management plan to continue notwithstanding the fact that further information has emerged which bears on the risks and benefits of the previously decided upon treatment.

[13] What is impugned here is a failure by the registrar to obtain the informed consent of the pursuer before continuing with the then current management plan which was to proceed to spontaneous vaginal delivery notwithstanding what should have been apparent to the registrar on consideration of the CTG trace at 2230.

[14] The registrar gave evidence of what would appear to have been a brief attendance on the pursuer at about 2230 (she had also provided an affidavit which the Lord Ordinary

quotes from at para [59] of her opinion). The Lord Ordinary describes that evidence as being, at times, confused and difficult to follow. However, after the registrar's evidence was concluded, parties to an extent superseded it by agreeing by way of a fourth joint minute that: (1) following assessment at about 2230 the registrar did not form a management plan to the effect that if the delivery was not achieved within 10 to 15 minutes, the midwife should call her back and (2) did not inform the midwife to call her back if delivery was not achieved within 10-15 minutes. As the registrar had maintained was the case when giving evidence, the Lord Ordinary held that the registrar was likely to have classified the CTG trace as normal when assessing it at 2230 and that the care provided to the pursuer thereafter proceeded on that basis (opinion para [259]).

[15] The pursuer's consent case is premised on the propositions that the registrar was wrong to classify the CTG trace as normal, that she should have classified it as suspicious (the pursuer's note of argument also describes it as "unusual and indeterminate") and that in classifying it as normal the registrar was negligent. The pursuer indeed avers that the trace was pathological. However, evidence of that proposition having been rejected by the Lord Ordinary, the submission for the pursuer has become that even if the trace is classified as merely suspicious, a registrar of ordinary competence exercising reasonable care would have appreciated that it demonstrated a small but nevertheless material risk of ongoing foetal compromise due to hypoxia-ischaemia which might result in brain damage in the event of labour being allowed to proceed to spontaneous vaginal delivery and that that fact gave rise to a duty on the registrar to (1) advise the pursuer of the risk demonstrated by the CTG trace, (2) advise the pursuer of the reasonable alternative options of assisted delivery by forceps or ventouse suction or facilitation by episiotomy, and (3) offer the pursuer the choice as between continuing towards spontaneous delivery and one of the available

alternatives. In failing to provide the pursuer with that advice and offer these alternatives it is submitted that the registrar failed in her duty of care towards the pursuer and RC which was identified in *Montgomery* at para [87] ("the *Montgomery* duty").

The Lord Ordinary's opinion

[16] As we have foreshadowed, at proof the pursuer's principal cases (the CTG interpretation case and the failure to expedite delivery case) were not to the effect that the trace was and should have been interpreted by the registrar at 2230 as suspicious and that that should then have been discussed with the pursuer. Rather, they were to the effect that the trace was and should have been interpreted by the registrar at 2230 as pathological and that delivery should have been immediately expedited. That latter proposition was based on what had been the evidence of all three of the pursuer's experts, summarised in the first two sentences of paragraph 36 of the pursuer's proposed findings-in-fact: "By this time (2230) the baseline had risen to 170-180 beats per minute with late decelerations to 130 beats per minute. Such a trace was pathological and delivery should have been expedited" (Lord Ordinary's opinion para [222]).

[17] The Lord Ordinary rejected the evidence of the pursuer's experts and their interpretation of the CTG as demonstrating a baseline tachycardia with decelerations for the reasons she gives, preferring that of the defenders' expert, Professor Murphy, which was that it had been open to the registrar to interpret the CTG as one with a normal baseline FHR, with marked accelerations with each contraction and ongoing variability (Lord Ordinary's opinion paras [310], [314] and [315]).

[18] Having found that the pursuer's principal cases failed because the CTG was not pathological, the Lord Ordinary turns to consider the consent case. She records that counsel

for the pursuer presented it on the basis that an ordinarily competent registrar exercising reasonable skill and care could not rule out "the material risk that the baby was in danger". She notes that for the *Montgomery* duty to obtain, there must be a relevant risk and that the identification of such a risk was a matter falling within the expertise of the medical profession. In the Lord Ordinary's opinion this gave rise to difficulties for the pursuer's case. First, the Lord Ordinary had found that the registrar was likely to have classified the CTG as normal and that, in the opinion of Professor Murphy, classifying the CGT as no more than suspicious was an available, non-negligent interpretation. Given the rejection of the pathological interpretation, the pursuer had to have some basis in the evidence about the risk posed (if any) in the event of a suspicious/non-reassuring CTG before it could be said that the duty to obtain consent arose. A second difficulty for the pursuer was that none of her expert witnesses had addressed the issue of consent in their reports or in their oral evidence. They had not expressed any view as to what the registrar should have said to the pursuer, much less what options she should have discussed. Nor had they expressed any view as to the nature or degree of risk (if any) that could be said to be posed by a CTG categorised as normal or suspicious or unusual. What had been said about material risk by counsel for the pursuer had been no more than assertion; there was no evidence to support the argument that there was an increased risk of brain damage when a trace was normal, suspicious or unusual. Such evidence as there was militated against such a finding. Without evidence of risk, the duty founded upon by the pursuer simply did not arise. The only expert who had been asked about patient consent had been Professor Murphy. Her evidence about this had come just after her concession that the CTG might have been classified as (no more than) suspicious, rather than normal. Even in that context, her position had been that, given that the current management plan was for watchful waiting, it

sufficed for the registrar to introduce herself to the pursuer, to assure her that she was making good progress and that the registrar would be called back if there were any concerns. There was accordingly no breach of the *Montgomery* duty and the pursuer's consent case accordingly failed.

The grounds of appeal

[19] The pursuer submits the Lord Ordinary erred in fact and law in rejecting the consent case. In ground of appeal 2 the pursuer particularises the Lord Ordinary's error as:

(a) Finding that the CTG trace could, reasonably and without negligence, be interpreted as normal, rather than suspicious, at about 2230.

(b) Failing to find that the trace as at about 2230 was both suspicious and unusual.

(c) Treating a normal trace and a suspicious trace as carrying the same degree of risk.

(d) Failing to hold that a suspicious trace posed a material risk.

(e) Holding that there was no obligation on the registrar, in the face of a suspicious and unusual trace, to obtain the pursuer's consent to proceed with labour without discussing the alternative of an expedited delivery.

(f) Failing to find that there was an obligation on the registrar, when faced with a suspicious trace and a baby that could easily be delivered with forceps, to inform the pursuer of the options available to her.

(g) Holding that consent obtained at the outset of labour continued even when there was a change in the status of the trace.

Submissions of parties

Pursuer and reclaimer

[20] *Montgomery* v *Lanarkshire Health Board* represented a fundamental shift from a paternalistic approach to the management of labour to a patient-driven approach where the decisions are taken by the mother rather than the doctor: *Montgomery* generally and at para [81] in particular; *Webster* v *Burton Hospitals NHS Foundation Trust* [2017] Med LR 113 at paras [31] and [35]. While the existence of relevant risk is a matter for medical evidence, the evaluation of whether a risk is material and whether the available alternatives are reasonable in the circumstance is a matter for the courts and not medical experts: *Montgomery* at para [83]; *Duce* v *Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307 at paras [33] to [35]. A woman giving birth was entitled to receive the information necessary to enable her to take a proper part in the decision-making relating to her care. Going into labour was not to be regarded as a roller-coaster ride on a pre-determined track. Rather it was a journey which, depending on changing circumstances, might be taken on one of a number of available paths.

[21] At the time that the registrar was examining the reclaimer at around 2230 the CTG trace should have been interpreted as being suspicious, on the basis of the evidence of the defenders' expert, Professor Murphy (Mr Milligan QC, who appeared on behalf of the pursuer, accepted that as the Lord Ordinary had rejected the evidence of the pursuer's experts and preferred that of Professor Murphy, a decision that was not challenged, and further accepted that Professor Murphy's was accordingly the only available evidence upon which he could rely in relation to interpretation of the trace). Mr Milligan submitted that the Lord Ordinary had incorrectly held (at paras [259], [310] and [325] of her opinion) that the trace was and could reasonably be interpreted as normal. There was no evidence to support

that conclusion. Furthermore, the Lord Ordinary's finding was irreconcilable with other of her findings at para [194] of her opinion. That the trace was normal was not the interpretation that Professor Murphy would have arrived at. Professor Murphy considered the trace to have been suspicious at 2230.

[22] Because of these errors as to what were the facts, the Lord Ordinary had failed to address what the registrar should have done in terms of advising the pursuer as to (1) material risks; and (2) reasonable alternative treatments in the face of a suspicious as opposed to a normal trace. As a consequence of the Lord Ordinary's error the issue was at large for the appellate court to determine as had been the position in *Webster*. On consideration of the evidence this court should find that there had been a breach of the *Montgomery* duty and the reclaiming motion should accordingly be granted.

[23] A suspicious trace indicates a small risk of foetal compromise (including cerebral palsy) due to hypoxia-ischaemia. Moreover, according to Professor Murphy, the possibility of foetal compromise in the second stage of labour is heightened if a midwife has called for a second opinion. In light of this the question became whether the risk was "material". This question is for the court. In making its assessment the court must take account of the odds of the risk materialising; the nature of the risks; the effect its occurrence would have on the life of the patient; the importance to the patient of the benefits sought to be achieved by the treatment; the alternatives available; and the risks associated with them: *Montgomery* at para [89] and *Duce* at para [35].

[24] In terms of the Algorithm, the advice, in the face of a suspicious trace, was to "Ensure that the mother is informed of concerns and included in management plan". This was an indication of the risk of foetal compromise to which a suspicious trace pointed. The Lord Ordinary failed to address this point in her opinion.

[25] The Lord Ordinary held that the uncontested evidence was that the alternative methods of delivery, by forceps, ventouse or episiotomy, posed a low risk (opinion at para [2]). The availability of these low risk alternatives was key to the question of materiality of risk to the foetus. The correct approach was that taken by Lord Brailsford in *KR* v *North Lanarkshire* [2016] CSOH 133 at [133]. The pursuer should have been advised of these alternatives and should have been included in the discussion as to whether to continue with the current birth management plan. That this is what should have happened was accepted by the registrar and is confirmed by what appears in the Algorithm. Despite this, the pursuer was not advised of the available alternatives to unassisted vaginal delivery, was not afforded the opportunity to decide the course of the second stage of her labour, and was not included in the management plan contrary to the terms of the Algorithm.

[26] When assessing materiality, although the risk of hypoxia-induced damage was small, the potential consequences of it were devastating in contrast to the alternatives which were virtually risk free in comparison, and which would have expedited labour and reduced the suffering of the reclaimer and RC. In the *Montgomery* sense the risk of foetal compromise was plainly material in that a reasonable person in the pursuer's position would have attached significance to it. The alternative methods were not options available to the pursuer at the time that she originally consented to spontaneous delivery. As and when they became available they should have been made available to her.

[27] The registrar's failure to advise of the alternative options was a breach of the duty of reasonable care. Professor Murphy's evidence that it was only necessary to obtain consent when intervention was being considered and not when what was in issue was simply progressing with labour, was contrary to the ethos of *Montgomery* and *Webster.*

Defenders and respondents

[28] At the outset of his argument, Mr Ferguson QC, who appeared for the defenders and respondents, submitted that the short answer to the reclaiming motion was that even if the Lord Ordinary had been wrong in finding that the registrar had not been negligent in finding the CTG trace to have been normal at 2230 (which was not conceded) the Lord Ordinary simply could not have found that there was a duty incumbent on the registrar to provide information to the pursuer with a view to allowing her to decide on whether or not she should continue with her labour unassisted by the suggested alternative means of delivery in the absence of evidence that a suspicious or unusual trace indicated a risk of hypoxia-ischaemia and consequent brain damage. There had been no evidence of such a risk. Neither had it been put to the registrar that she knew of such a risk nor was there evidence that she ought to have known of such a risk. The fundamental error on the part of counsel for the pursuer was that he started with the proposition that the risk of brain damage could not be ruled out. This, as the Lord Ordinary had observed at para [318] of her opinion, was to invert the test for the existence of the relevant duty.

[29] Turning to the propositions set out in the pursuer's note of argument, Mr Ferguson responded as follows:

(1) It was accepted that the law on the duty to obtain consent was as set out in *Montgomery* at paras [87] and [82] to [83].

(2) The pursuer was wrong to assert that there was no evidence to support the Lord Ordinary's conclusion that the CTG trace could reasonably be interpreted as normal at about 2230. The pursuer was also incorrect to say that the Lord Ordinary's finding was irreconcilable with her earlier findings at paras [194] to [195] of her opinion. The evidence of Professor Murphy required to be read as a whole.

(3) It was not accepted that a trace which was properly categorised as suspicious indicated a risk (small or otherwise) of foetal compromise due to hypoxia-ischaemia. This had not been explored in the evidence. It was to be borne in mind that whether a state of foetal compromise exists is not a binary question. Foetal compromise is of the nature of a spectrum of conditions. It cannot necessarily be equated with hypoxia.

(4) Contrary to what was suggested by pursuer's counsel, the availability of alternative treatments (here alternative methods of delivery) did not inform the question as to whether there was a risk such as to trigger the *Montgomery* duty.

(5) It was not correct to say that the pursuer had not previously been involved in the management plan (she had) and it was not correct to say that the registrar had accepted that the pursuer should have been advised of alternative methods of delivery at 2230 (she had not).

(6) The assertion that the registrar accepted that the pursuer had not been included in the management plan was also incorrect (the Lord Ordinary had also been incorrect to say at para [319] of her opinion that it was agreed by joint minute that the registrar never discussed the management plan with the pursuer). The registrar's evidence was that, in accordance with her usual practice, the pursuer was included when formulating the management plan. The terms of the fourth joint minute were not that the reclaimer was not included in the management plan, but rather that following the 22.30 assessment the registrar "… did not form a management plan to the effect that if delivery was not achieved within 10-15 minutes the midwife should call her back".

[30] The defenders' response to the reclaiming motion could be encapsulated in five submissions:

(1) The Lord Ordinary did not err in finding that the CTG at 2230 could be interpreted as normal or as no more than suspicious; the evidence entitled her to reach that conclusion. It had not been demonstrated that she was plainly and obviously wrong or indeed simply wrong about that matter.

(2) It was axiomatic that a risk of brain damage must have, in the circumstances, been a known risk in order for the duty to inform to arise. The existence and magnitude of that risk were matters for medical evidence. In this case there had been no such evidence and therefore the Lord Ordinary had no basis to find that the *Montgomery* duty had been incumbent on the registrar.

(3) It had not been established that the registrar knew or ought to have known of a risk of brain damage where a trace was interpreted as being no more than suspicious.

(4) If the trace was suspicious the legal duty to advise the mother of the risk of brain damage could only arise if it was known that a suspicious trace indicated a higher risk of brain damage than that which was otherwise consequent on the second stage of labour.

(5) In the absence of a known material risk there was no legal duty to advise of "concerns" (whatever that might mean) or alternative means of delivery or new options for delivery or to obtain the pursuer's agreement to continue with the existing management plan.

[31] The extent of the relevant duty and the considerations on which it is based are explained in *Montgomery*. It was a duty to take reasonable care to ensure that the patient is

aware of any material risks involved in any recommended treatment and of any reasonable alternative or variant treatments. The duty to inform of a material risk presupposes that obstetricians were or should have been aware of the relevant risk: *Duce* at paras [29], [30], [33], [42] to [43]. Thus, the first hurdle to be surmounted for there to be a duty involves a two-fold test: (1) is there a risk and (2) did the relevant clinician know or ought to have known of the risk. To determine whether each part of the test had been met required evidence. The opinion in *KR* v *Lanarkshire Health Board* at paras [125], [130], [132] and [133] illustrates circumstances where the duty did and did not arise. In the present case there had been no expert evidence as to what was the risk associated with an "unusual" CTG or one classified as "suspicious" or described as "indeterminate". Thus no duty to inform the pursuer of a risk of foetal compromise which would result in brain damage could arise. As in *Taylor* v *Dailly Health Centre and others* [2018] CSOH 91, in the absence of an identified risk that was or should have been known to an obstetrician, the registrar's decision as to the management of the labour fell within the exercise of professional skill and judgement. No issue had arisen that required discussion of the possible alternatives with the reclaimer.

[32] The legal duty to discuss risks did not extend to "concerns" (the word found in the Algorithm). A concern was not necessarily a risk. Similarly, the duty identified in *Montgomery* did not arise merely because additional options as to the means of delivery emerged in the course of labour. The duty arises because of the existence or the emergence of risk; not otherwise.

[33] The Lord Ordinary had accepted the evidence of Professor Murphy that the classification of the CTG as normal, or at least as no more than suspicious was an available non-negligent interpretation (opinion at paras [315] and [325]). Given the totality of Professor Murphy's evidence the Lord Ordinary had been entitled to do so. Her conclusion

was not irreconcilable with her other findings. Her finding was not one that this court should displace. In the absence of an identifiable error the Inner House can only interfere with the findings in fact of the Lord Ordinary if it is satisfied that the decision at first instance cannot reasonably be explained or justified and so is plainly wrong : *Henderson* v *Foxworth Investments Ltd* 2014 SC(UKSC) 203 at [66] to [67]; *McGraddie* v *McGraddie* 2014 SC (UKSC) 12; *Royal Bank of Scotland PLC* v *Carlyle* 2015 SC (UKSC) 93; *AW* v *Greater Glasgow Health Board* [2017] CSIH 58.

[34] The pursuer's consent case depends on the proposition that a suspicious CTG trace gives rise to a small (but material) risk of there being foetal hypoxia. Variants upon that proposition had been asserted by the pursuer's counsel: that a suspicious trace takes a clinician out of the comfort zone; that a suspicious and unusual trace increases the risk of harm to the brain; and that it was untenable to suggest that a clinician would not be aware of the risk of brain damage in the circumstances of a suspicious trace. None of these propositions were supported by any evidence. The Lord Ordinary had addressed this at paras [326] and [327] of her opinion. She had been correct to conclude that there was no evidence to support the pursuer's argument that there was an increased risk of foetal compromise which would result in brain damage when a CTG was normal, suspicious or unusual. Mr Milligan had conceded before the Lord Ordinary that a suspicious CTG did not require delivery to be expedited; rather, conservative measures should be used. The knowledge that a risk of injury exists is a matter for the medical profession and thus was a matter on which expert evidence was required. Neither the Guidelines nor the Algorithm suggested that a CTG classified as normal or suspicious gave rise to a risk of foetal compromise which would result in brain damage.

[35] The Lord Ordinary had correctly concluded that such evidence as there was militated against a finding that a suspicious CTG posed a material risk of foetal compromise which would result in brain damage. In particular the Algorithm provided that if a CTG remained suspicious there should be continued observation of FHR but nothing more. It did not mandate intervention for a suspicious CTG. The pursuer sought to rely upon the terms of the Algorithm which stated that where a CTG was classified as suspicious using the criteria in the Guidelines, steps were to be taken to "Ensure that mother is informed of concerns and included in management plan." It was important to note that the wording used in the Algorithm differed from the legal duty in *Montgomery* at [87]. There is no legal duty to inform the reclaimer of "concerns"; the duty is to inform of known material risks and no doubt for that reason the pursuer's pleadings rely on risk rather than concerns. By equating concerns with risks the pursuer sought to give the word "concerns" a status that it did not have or at least one for which there was no support for in the expert evidence. The meaning of "concerns" was not explored in evidence. It was very dangerous for a lawyer to interpret a document such as the Guidelines without hearing from a witness in one of the professions to which it is directed. That had not happened in the present case. For all that is known, ensuring that "mother is informed of concerns and included in management plan", which the Algorithm recommends as an action in the event of a suspicious trace, might mean advising the mother that there was one non-reassuring feature on the trace the significance of which is not known but which would be kept an eye on.

[36] The reason that the CTG trace was unusual was because it showed a pattern of persistent accelerations during the second stage of labour. That took the pursuer no further forward. Professor Murphy had given evidence that the standard resources used throughout the United Kingdom, even to the present day, do not flag up anywhere that

persistent accelerations during the second stage of labour might be a worrying phenomenon.

[37] In conclusion, it was submitted the Lord Ordinary was entitled to find the trace at 2230 normal or at worse suspicious; but even if that is not accepted it does not matter because there was no evidence of risk in the light of a suspicious trace or that the registrar knew or ought to have known of risk. What is relevant is risk not concerns. One does not get to the issue of materiality unless the existence of a risk is established and knowledge or deemed knowledge of it is brought home against the relevant grade of doctor. The Algorithm does not fill the gap. Lack of evidence is the determinative factor. The reclaiming motion should accordingly be refused.

Decision

The issue: did the Montgomery duty arise?

[38] The issue in this reclaiming motion is whether the pursuer has established, on the basis of the evidence led at proof, a breach of the duty, identified in *Montgomery*, to ensure that the patient has given properly informed consent to treatment. If breach was established, determining its consequences is a matter for another day, but the reclaiming motion succeeds and must be granted. If it was not established, the pursuer accepts that she has no other claim. That being so, the reclaiming motion against the Lord Ordinary's grant of absolvitor must therefore be refused.

[39] For there to be breach of a duty it must of course first be established that, in the circumstances of the case, the duty in fact existed. It is on that question that the defenders take their stance in responding to the reclaiming motion.

[40] Medical treatment is uncertain and may involve the risk of more or less adverse outcomes depending upon whether a particular course of action is or is not taken or, where more than one course of action is available, which of these is chosen. The judgment of the Supreme Court in *Montgomery* proceeds upon the basis that an adult patient understands that and, moreover, that a patient is entitled, as a matter of law, to decide whether or not to incur a risk: *Montgomery* at paras [81] and [82]. In other words, a patient is entitled to choose what happens, choice being exercised by giving or not giving consent to a particular course of treatment. For the choice and consequential consent to be real, in other words to have been arrived at after consideration of all the relevant circumstances, the patient will require information and, to the extent that that is different, advice from her doctor on the potential benefits of a good outcome and the potential risks of an adverse outcome. It is part of the doctor's duty of care to provide that advice. However, just as the decision is for the patient so it is for the patient to determine the weight to be given to the medical advice when coming to that decision.

[41] The UK Supreme Court articulates the duty on the doctor which is the counterpart of the right of the patient in a passage from para [87] in *Montgomery* which we have already quoted but will repeat:

> "The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it."

As we have indicated, this is a duty which arises and indeed only arises when the patient is required to make a decision or choice which involves incurring risk. We would suppose

almost every sort of medical treatment, in the sense of an intervention of some kind, to involve some degree of risk. Equally, not treating may involve risk. The *Montgomery* duty will therefore arise in very many clinical interactions between doctor and patient and certainly at the beginning of any course of treatment. However, its logical underpinning depends on there being a decision to be made in circumstances where there is a risk of injury to the patient associated with one or other of the available options. If there is no risk or no risk additional to what has previously been discussed and taken into account in consultation with the patient, then there is no duty because there is no further decision which the patient requires to make.

[42] As Mr Ferguson submitted under reference to *Duce* at paras [33], [42] and [43], in this context there are two steps to be taken in identifying whether there is a risk or additional risk such as to trigger the Montgomery duty. The first step is determining whether, as a matter of contemporary medical knowledge, there was a risk. The second step is determining whether the relevant clinician (here the registrar) knew or ought to have known of that risk. Whereas the materiality of the risk is something which the court may ultimately have to determine, the existence of the risk and whether the relevant clinician ought to have known about it are exclusively medical matters and therefore require to be established by expert medical evidence.

[43] In this case there is no criticism made of the initial plan for the management of the pursuer's labour, which was to allow it to proceed to spontaneous vaginal delivery. We suppose that to be the preferred course for most mothers notwithstanding the fact, as Professor Murphy said in evidence, that there is a possibility for compromise for every foetus in the second stage of labour (MS 748). That the *Montgomery* duty was fulfilled in respect of the initial management plan is not of course an end to the matter. A clinical

picture can change and that is certainly so during labour. Such a change may be associated with additional or enhanced risks for the mother or the baby. That is what the pursuer avers happened here: that at 2126 the CTG trace pattern changed rapidly and abruptly and that this indicated the onset of significant foetal compromise, possibly due to intermittent cord compression. The pursuer's principal case was that at that point the CTG had become pathological, in other words so strongly indicative of a risk of hypoxic-ischaemic brain damage occurring that good practice mandated immediate expedited delivery. The pursuer now accepts that that case failed; the Lord Ordinary found that the pursuer's experts were simply wrong in their proposed interpretation of the trace. However, the pursuer maintains that the altered appearance of the CTG presented sufficient of a risk (because if not pathological it was at least suspicious) to require that risk to have been discussed with the pursuer and her consent obtained to the continuation of an unassisted labour, if that is what was decided on. This is the consent case.

Was the Lord Ordinary wrong to find that the registrar had not been negligent?

[44] The first hurdle facing the consent case is the Lord Ordinary's finding that as a matter of fact the most likely interpretation reached by the registrar when she was called on to consider the trace at about 2230 was that it was normal, and the Lord Ordinary's further finding that at the relevant time a registrar of ordinary skill and competence was entitled to classify the trace as normal or as no more than suspicious (opinion paras [309] and [310]). Such a trace does not indicate a risk over and above the inevitable risks associated with the second stage of pregnancy. On that view of matters the *Montgomery* duty did not arise and therefore there was no basis upon which the consent case could succeed.

[45] On behalf of the pursuer Mr Milligan sought to surmount the first hurdle by displacing the Lord Ordinary's findings and substituting for them a finding that the only non-negligent reading of the CTG trace at 2230 was that it was at least suspicious.

[46] Mr Ferguson's preliminary response to this attack on the findings of the Lord Ordinary was to remind us, under reference to *AW* v *Greater Glasgow Health Board* at paras [38] to [58] about the limitations on an appellate court's ability to review the findings of a court of first instance on matters of fact.

[47] We do not intend to innovate upon or add to what appears in *AW* v *Greater Glasgow Health Board*. We merely observe that, while it is not a matter for the application of dogmatic or hard-and-fast rules, the extent to which a first instance decision is open to review by the Inner House will depend on the nature of the decision and the nature of the material upon which the decision was based. Here Mr Milligan proposes that we should review the decision of the Lord Ordinary that an interpretation of the CTG trace as normal at 2230 was not negligent. With a view to persuading us that the Lord Ordinary was wrong in the conclusion that she reached Mr Milligan proposes that we should look at the evidence of only one witness, the defenders' expert, Professor Murphy. The proposition that he seeks to make out is that the Lord Ordinary, who accepted Professor Murphy as a reliable witness, failed to understand her evidence. We would see the exercise which Mr Milligan invites us to embark on as a legitimate one for an appellate court. If, on the relevant evidence, the Lord Ordinary can be shown to have been wrong, there is no reason why this court cannot so decide, with the consequences that follow from that. However, in coming to a view as to whether the Lord Ordinary has been shown to have been wrong, as was said by the court in *AW* at para [48], an appellate court should not come to a different conclusion from the trial judge on the basis of the printed evidence unless it is satisfied that any advantage enjoyed

by the trial judge through having seen and heard the witnesses could not be sufficient to explain or justify his or her conclusion.

[48] We turn then to Professor Murphy's evidence.

[49] As we have already explained, the pursuer's principal case was based on the proposition, spoken to by her three experts, that, as a matter of fact, as at 2230 the baseline of the CTG had risen to 170-180 beats per minute with late decelerations to 130 beats per minute. The Guidelines categorise a baseline of 170-180bpm as non-reassuring. They categorise late decelerations as abnormal. In contrast, they categorise a baseline of 110-160, the presence of variability and the absence of decelerations as all being reassuring features. A CTG where all four features fall into the reassuring category is classified as normal. If one of the features is non-reassuring but the others are reassuring then the CTG is suspicious. If two or more features are non-reassuring or one is abnormal then the CTG is pathological. The pursuer's case was therefore that the trace was pathological. Professor Murphy's reading of the trace was very different. She states her position in her report of 25 March 2015 at para 5.5 as follows:

> "A vaginal examination was performed shortly after 20.50 confirming cervical dilatation of 7cm. There was a short sharp deceleration during the vaginal examination followed by an acceleration, normal baseline heart rate of 125bpm, as before, and good FHR variability. Between 21.00 and 21.20 the contractions continue at a rate of 4-5 in 10. The baseline heart rate is 130-140bpm and there is good variability. There are accelerations and no decelerations. There is a deceleration just before 21.30, coinciding with a change in maternal position to the woman's right hand side. The FHR recovers to 140bpm."

At para 8.6 she describes this presentation as:

> "The foetal heart rate was apparently normal right up until the moment of birth. There was no loss of variability, no decelerations, no tachycardia and no bradycardia."

By the time of preparing her Supplementary Report of 15 February 2017 Professor Murphy had had sight of the reports prepared by the pursuer's experts, Drs Smith, Hanretty and Walkinshaw. At page 24 of that report, at the end of a section considering the interpretation to be placed on the CTG, she provides a summary which includes the following:

> "In summary, it is my view that the CTG has an unusual appearance for the late first and second stage of labour. The presence of accelerations with contractions in the second stage of labour is uncommon. The baseline heart rate, however, is relatively easy to define. The midwife paid close attention to the timing of the contractions and accelerations. She questioned her own interpretation of the CTG and sought a second opinion from the registrar who expressed no concerns and confirmed that the vertex was visible. Having confirmed that the CTG was normal, reassuring or no more than suspicious, the midwife continued to manage the patient in a standard way for a nulliparous woman who was showing steady progress with pushing. … Neither the midwife nor the registrar considered that this might be a very unusual CTG pattern with a reversal of the usual features of hypoxia. This is not surprising given that such a pattern is not highlighted in standard teaching materials or practice guidelines, nor has it been recognised as such by most of the experts who have expressed an opinion on this case."

At para 5.3 in the section of her report reviewing the standard of care in the case, Professor Murphy has this:

> "5.3 Unfortunately in this case there was a very unusual but not entirely unknown CTG pattern with a reverse of the usual features of hypoxia. Instead of a rising baseline or tachycardia, late decelerations or bradycardia, and reduced or absent variability, there was a CTG with a normal baseline heart rate, marked accelerations with each contraction and ongoing normal variability. Any midwife or obstetrician of ordinary skill and competence was entitled to interpret these features as normal, reassuring or no more than suspicious …even experienced obstetricians struggle to interpret this type of CTG in a consistent manner."

When giving her evidence in chief Professor Murphy confirmed that she classified the trace as normal (MS518). She was asked, if the evidence was that the registrar had interpreted the trace as normal or reassuring, whether that was an interpretation that she would take issue with. Her reply was that that interpretation was "entirely acceptable" (MS549). Later, she was asked about her interpretation of the trace under reference to what had appeared in her

Supplementary Report and, in particular, at page 24 of that report. She explained that "the difficult time period to interpret, 2210 and 2230" could either be interpreted as "normal or indeterminate" (MS567). She confirmed what appeared at page 24 of the Supplementary Report and that she was not critical of either the registrar or the midwife for failing to identify (as very unusual) the reversal of the pattern of features which one would expect to see with a foetus enduring hypoxia (MS571).

[50] In cross-examination Professor Murphy was asked whether the trace should have been interpreted as suspicious. She replied that "I think it would be cautious to classify it as suspicious" (MS665). She had no difficulty in defending the actions of the registrar (MS666). It was put to her that the registrar at 2230 could not possibly have said with any reasonable confidence that the trace was reassuring. Her response was that the registrar "could have said, with reasonable confidence, that it is no more than suspicious, and that it requires ongoing observation" (MS685). Professor Murphy accepted that if the registrar had interpreted the trace as pathological she should "stay in the room and deliver by vacuum or forceps" (MS687). It was then put to her that the registrar could not, with confidence, rule out a pathological interpretation. Professor Murphy's response was that the registrar had ruled out a pathological interpretation with apparent confidence and that it was acceptable for her to have done so (MS687).

[51] On behalf of the defenders, Mr Ferguson relied on these passages in Professor Murphy's reports and the transcript of her evidence as supporting the Lord Ordinary's findings at paras [310] and [325] of her opinion that a registrar of ordinary skill and competence was entitled to classify the trace at 2230 as normal or no more than suspicious. Mr Milligan, on the other hand, relied on what he submitted was the concession that he had extracted from Professor Murphy towards the end of her cross-examination. The context

was questioning on the conclusion to Professor Murphy's Supplementary Report which is in these terms (at page 28 of report, MS305, in transcript MS739):

> "[RC] is likely to have sustained significant cerebral injury in the peripartum period that has resulted in his disabilities. It has been suggested by several experts that the intrapartum CTG was unequivocally pathological in the final two hours of labour and that delivery should have been expedited earlier. The cerebral damage has been attributed to this time period. It is my opinion that the CTG was unusual but technically the features entitled the midwife and obstetrician to interpret it as normal, or no more than suspicious. There are likely to be some midwives and obstetricians who would have been uncertain or concerned about the CTG, and in such circumstances, had they made the decision to deliver by vacuum or forceps this would be entirely justified. … Equally, there are likely to be obstetricians and midwives who would have interpreted the CTG as no more than suspicious, particularly where a second opinion confirmed the interpretation, and in such circumstances, had they made the decision to aim for a spontaneous vaginal delivery this would also be justified. I am not at all convinced that I would have taken the interventionist route if interpreting this CTG as a junior registrar, and consider it entirely possible that I may have opted for expectancy with the vertex visible near the perineum. On that basis, I do not consider the care [the pursuer] received in labour to be negligent ..."

In his role as cross-examiner, Mr Milligan put to Professor Murphy the part of the sentence in her conclusion which reads "there are likely to be obstetricians and midwives who would have interpreted the CTG as no more than suspicious". He followed up with the proposition that no one could be more confident than that; it was a suspicious trace.

Professor Murphy answered:

> "Well the suspicious CTG would be fairly commonplace in the second stage of labour. Very few CTGs have all three features, or indeed four features in the second stage of labour. The majority of second stage CTGs are suspicious. You always, virtually always, get an occasional variable deceleration or early decelerations, they're really common in the second stage CTG." (MS742)

Mr Milligan pressed his point: "You couldn't say it was better than suspicious, could you?"

Professor Murphy answered:

> "Oh, I think they could've used the classification normal. Normal baseline, normal variability, accelerations, no decelerations. So, for the, certainly the last hour, you

> would … they would have been entitled to classify it as normal. … The previous hour they would have been entitled to classify it as normal." (MS743)

There then came what Mr Milligan submitted to us was the concession by Professor Murphy upon which he founded. In response to his prompt: "… at 2230, somebody looking at the trace 2230 …", Professor Murphy said: "Suspicious". Mr Milligan then completed his question: "… should have classified it as suspicious", to which Professor Murphy responded: "Correct" (MS743).

[52] Mr Milligan pointed to another answer by Professor Murphy in which he submitted she had repeated or reinforced her concession. In response to the question:

> "… do you accept that … no ordinarily competent registrar acting with reasonable skill and care could have interpreted this trace as reassuring at 2230 or thereby?"

Professor Murphy had replied:

> "I would have expected them to interpret it as suspicious. Reassuring is a different word. Suspicious, I would expect that interpretation." (MS746)

That answer was not followed up; Mr Milligan moved on to another topic.

[53] There are a number of things to be said about what is to be made of this evidence, taken as a whole. The first is that the person best placed to understand it was the Lord Ordinary. She had heard all the oral evidence in the case and read the documentary productions. She appears to us to have mastered the relevant technical material. She has provided a very detailed analysis. She was therefore able to place particular passages of evidence and particular answers within the context of the totality of what had been put before her. Even if one was to take Professor Murphy's evidence in isolation, the Lord Ordinary not only had the opportunity of considering everything the professor had said and had written in her reports, but she had had the experience of listening to her and observing her in court. She had heard the professor' explanations for her answers and had been able to

consider their internal logic. Moreover, the Lord Ordinary was able to observe Professor Murphy's demeanour as she answered questions. The word demeanour is often used to refer to the various non-verbal clues which may assist a fact-finder in determining whether a witness is to be believed or not, but the importance of the way in which a witness gives her evidence goes beyond that. Communication of meaning, whether in court or otherwise, is only partly achieved by the words used. Tone, emphasis, gesture and other aspects of body language have a contribution to make. None of that is captured on the printed pages of a transcript. In some cases that may not matter. The words used may be sufficiently unequivocal to make the meaning that was intended to be conveyed quite clear. This is not such a case, or at least it not such a case if the suggestion is that the meaning which Professor Murphy intended to convey in two brief exchanges with counsel was that the only non-negligent interpretation of the CTG trace was that it was suspicious.

[54] In her reports and in her oral evidence Professor Murphy clearly expressed her opinion that, on the assumption that the registrar interpreted the trace as normal, she could not be said to have been negligent. Professor Murphy gave her reasons for considering that a trace which she would classify as suspicious might be classified as normal by the registrar without that leading to the conclusion that the registrar had been negligent. This was an unusual trace which had been difficult to interpret. Indeed, the pursuer's experts had been unable to do so successfully (as the Lord Ordinary accepted). Of the four features of a CTG that are of particular importance, three (a baseline that was normal; normal variability; and marked accelerations) were reassuring. Only one feature, the presence of some early decelerations, was non-reassuring. However, the decelerations were only occasional and decelerations are common in the second stage of labour. Moreover, as the Lord Ordinary records at para [209] of her opinion, Professor Murphy had explained: "This is how one was

trained to behave. To eyeball it. If normal, it was ok. If not, one applied the features to have a standard classification." Thus, interpreting a trace is to an extent a matter of impression depending on how the clinician perceives the pattern revealed by the CTG. Where the pattern appears to be normal, a clinician may not go on to check on each of the four features.

[55] Given how categorical she had been in previous answers and the reasons she had provided, if Professor Murphy had indeed intended to depart from her reasoned opinion that the registrar was not negligent one might expect her to have given something by way of an explanation. Mr Milligan did not suggest that this is what had happened. He had not explored the matter. He relied on no more than the two exchanges which we have reproduced above.

[56] When one turns to these exchanges, it is not clear to us just what Professor Murphy is conceding, if indeed anything. The Lord Ordinary may have shared that view. In the first exchange Mr Milligan puts to the professor that "somebody looking at the trace … should have classified it as suspicious". Now at this point there were, or may have been (the question does not make it clear), at least two concepts in play. The first is what the trace in fact shows. For present purposes, that is the same thing as the interpretation that Professor Murphy would put on it. Because she identified occasional decelerations the professor accepted that, in terms of the Guidelines, the trace fell to be classified as suspicious. In responding "Correct" to the proposition that "somebody looking at the trace…should have classified it as suspicious" Professor Murphy may have been saying no more than that: this is how she would classify the trace. The second concept is whether a classification of the trace as other than suspicious would be negligent. If that was the proposition Mr Milligan intended to put to Professor Murphy, it cannot be said to have been put very clearly. In the second exchange Mr Milligan did deploy the appropriate test for negligence by phrasing his

question as "do you accept that no ordinarily competent registrar acting with reasonable skill and care could have interpreted this trace …" However, he rather confused the issue by choosing as his next word "reassuring". If he was intending to use "reassuring " in a technical sense, that is in the sense in which it is used in the Guidelines, then he misused it. In terms of the Guidelines, a feature of a trace may be categorised as reassuring but a trace is not categorised as reassuring; the categorisations of a trace are normal, suspicious or pathological. This use or misuse of technical terms and the need to clarify how they should be employed then became the focus of Professor Murphy's reply: "I would have expected them to interpret it as suspicious. Reassuring is a different word. Suspicious, I would expect that interpretation."

[57] Given the ambiguous nature of Professor Murphy's responses in the two exchanges founded on by Mr Milligan and her unambiguous answers to the questions to which Mr Ferguson drew our attention, this court would be slow to construe her evidence as supporting a finding that the registrar was negligent but, as is explained in *AW* v *Greater Glasgow Health Board*, while an appellate court can interfere with the trial judge's decisions on fact for a number of reasons, it can only do so if it is satisfied that the trial judge, in his or her role as fact-finder, has in some way got it wrong. Where some aspects of the evidence point one way and others point another way, even if that evidence is that of a single witness, it is open to a fact-finder to select what are the aspects which are to be given more or less weight and where the evidence is of the nature of opinion what are the aspects which are based on convincing reasoning and what are the aspects which lack such a foundation. Here it was for the Lord Ordinary, as primary fact-finder, to assess the meaning and effect of Professor Murphy's evidence. We have not been satisfied, on the basis of the passages of the

professor's evidence which have been brought to our attention, that the Lord Ordinary got that exercise wrong.

[58] We would add this. Mr Milligan talked of Professor Murphy having made a concession, in the sense of an alteration of her position in response to his questioning. In judging whether that that had indeed happened, it was open to the Lord Ordinary to have regard to what if any, in the opinion of the witness, were the consequences of the apparent alteration. If there are no consequences, in other words if it does not really matter, a witness might accede to a proposition more readily than if she sees the alteration in position as being of importance. Here, and this is to anticipate what we have to say later in this opinion, for Professor Murphy whether the trace was classified as normal or as suspicious was of very limited clinical significance. In either case the proper clinical response was close monitoring but not intervention (MS664 to 665, 743). Thus, even if no registrar of ordinary competence exercising reasonable care would have classified the trace as normal (which is not how the Lord Ordinary understood the evidence) the fact that the registrar in the present case did classify it as normal did not lead to a negligent act or omission.

[59] Had the Lord Ordinary understood Professor Murphy to have made a concession on the issue as to whether the registrar should be regarded as having been negligent in interpreting the trace as normal, that would not of course have been an end to the matter. Important as her evidence may be, an expert does not bind the party who calls her. Here the onus was on the pursuer to establish that the registrar had been negligent. Before so finding the Lord Ordinary would have had to accept that there was a reasoned basis for that conclusion. As is very familiar, the *ipse dixit* of an expert has little weight. The same might be said about a few words of doubtful meaning uttered in an exchange with counsel which

were not followed up by an examination of the basis upon which they may have articulated a considered opinion.

Was there a risk of which the pursuer should have been informed?

[60] As we have explained, the pursuer's case is premised on there having been at 2230, a risk, over and above that which is inherent in the second stage of labour, which by virtue of the *Montgomery* duty, should have discussed with the pursuer in order to allow her to decide whether she was content to proceed with labour with a view to an unassisted delivery. The indicator of risk founded on by the pursuer is the appearance of the CTG trace, as classified by the Guidelines. The pursuer accepts that a normal classification is not an indication of risk. On the other hand, as it is put in her note of argument, the pursuer contends that "A suspicious trace indicates a small risk of foetal compromise (including cerebral palsy) due to hypoxia".

[61] In any particular case, without there being a risk which has not previously been discussed with the patient the *Montgomery* duty does not arise and therefore there can be no breach of duty. As Mr Ferguson submitted, determining whether such a risk was indeed present involves asking two questions: first, was there a risk? and second, was the relevant clinician aware of the risk or, if she was not, should she have been aware of the risk? Only if there was a risk and the relevant clinician was or should have been aware of it, does the *Montgomery* duty arise. Where there is a dispute about the matter the first question will require expert medical evidence in order to answer it, the issue being, given the clinical presentation what were the reasonably likely risks in the light of the available treatment options? In the event that there was a risk but the relevant clinician was not aware of it, the second question will also require expert medical evidence in order to answer it, the issue

being whether a clinician of ordinary competence exercising reasonable care would have been aware of the relevant risk at the relevant time.

[62] The final preliminary point that we would make in this part of our opinion is that the *Montgomery* duty is about protecting the patient's right to personal autonomy. The importance of the existence of a risk of which the clinician is aware is to do with the emergence of a situation in which a decision has to be made as to whether a particular course of treatment should be followed or not followed. For a decision or choice to have to be made there must of course be more than one choice which is available and as to which a decision must be made. The availability of choice in any particular case is again a matter for medical evidence.

[63] In the present case, the registrar, who was the relevant clinician, considered the trace to be normal. It follows that she was not aware of the emergence of any additional risk beyond that which may be taken already to have been discussed. The Lord Ordinary found that interpreting the trace as normal was not negligent. It follows from that that unless the Lord Ordinary can be shown to have been wrong in her understanding of the evidence on which she came to her conclusion, the *Montgomery* duty did not arise. We do not consider that the Lord Ordinary can be shown to have been wrong. On that basis the reclaiming motion falls to be refused. However, in our opinion, that must also be the fate of the reclaiming motion even if a different view were to be taken on whether the registrar had been negligent in interpreting the trace as she did. We shall give our reasons.

[64] If it is supposed that interpreting the trace as other than suspicious was negligent the question would come to be what should the notional competent registrar have made of a trace properly classified as suspicious and, in particular, whether the notional registrar would have considered that the CTG demonstrated "a risk of foetal compromise (including

cerebral palsy) due to hypoxia". On behalf of the pursuer Mr Milligan argued that to the extent that the matter was not simply self-evident, that a suspicious trace was indicative of a risk (perhaps small but, having regard to the potential consequences, sufficiently material to merit discussion with the pursuer) was demonstrated by or at least could be inferred from the terms of the Guidelines, including the Algorithm, and what Professor Murphy had said about the possibility of foetal compromise in the second stage of labour. We disagree.

[65] In the passage in Professor Murphy's cross-examination founded on by Mr Milligan (MS747 to 748) it had been put to her that the appearance of the CTG was unusual and that the midwife was unlikely to have seen a trace like it before. Professor Murphy accepted that. It was then put to her that, at a point prior to her calling on the registrar, the midwife would have had at least to consider whether the baseline was high (tachycardia) or indeterminate. Professor Murphy rejected tachycardia with late decelerations as something she would have expected the midwife to consider because the CTG did not have these features, but she accepted that the midwife would at least have to consider whether the baseline was indeterminate. Mr Milligan, in his role as cross-examiner, then asked: "And in that case, she would have had to consider that at least a possibility that there was a risk of foetal compromise?" to which Professor Murphy replied:

> "Certainly. There is a possibility of foetal compromise for every foetus in the second stage of labour. If a midwife calls you for a second opinion, that means there is a heightened concern about the possibility of foetal compromise."

That is saying no more than, first, that there is always a risk of foetal compromise during the second stage of labour, that it is inherent and inevitable; and, second, that clinicians are aware of that and in the event that a CTG is difficult to interpret their concern will be heightened. In the present case it was because of her uncertainty over interpretation of the

trace that the midwife called on the registrar for a second opinion. The criticism that Mr Milligan makes of the registrar is in not interpreting the trace as suspicious. Assuming that to be a good criticism the question would then arise as to whether a suspicious trace should be taken to indicate a known risk over and above or additional to the inherent risks associated with the second stage of labour. Mr Milligan may be entitled to say that if there was a risk it was a risk of foetal compromise (albeit to what extent is uncertain) but in order to succeed at this stage of his argument he must be able to point to evidence that there was a risk indicated by a suspicious trace of which the registrar should have been aware. The passage to which Mr Milligan drew attention does not support that.

[66] The Lord Ordinary concluded that such evidence as there was militated against a finding that a CTG classified as suspicious posed a material risk of foetal compromise which would result in brain damage (opinion para [327]). On the basis of the passages of evidence which were drawn to our attention, we would agree with that assessment. In chief Professor Murphy explained that a CTG "may be suspicious, which requires observation, or it may be normal, which requires observation anyway because we are in the second stage of labour, but there is no indication for an obstetric intervention at this moment in time" (MS552). In other words, a suspicious trace implies no more risk than a normal trace and both merit observation but nothing more. In cross-examination Professor Murphy confirmed her understanding that the midwife had recorded the registrar's assessment of the trace as "happy with CTG, or happy to continue something to that effect" (MS663). That meant that the registrar's classification must have been normal or suspicious (MS665); "it was one of two things, either of which the correct management is close monitoring, which was the management that was implemented, so I have no difficulty defending her signing the CTG on that basis" (MS66). In Professor Murphy's opinion the decision of the registrar

that it was satisfactory to continue with labour in the light of a normal or suspicious trace was not unreasonable. At that point if she spoke to the mother, who would at that point have been very busy pushing, she should have told her "I have reviewed the CTG. You appear to be making good progress. We'll keep a close watch on things and the midwife will call me back if she needs me" (MS666 to 669). The appropriate plan, independent of whether the trace was interpreted as normal or interpreted as suspicious was simply ongoing observation or "watchful waiting" (MS685, 688, 690, 752). Although very limited reference was made to his evidence, it would appear that this is also the approach that the pursuer's expert, Dr Walkinshaw, would have taken. When asked by Mr Milligan in re-examination what, if anything, he would have done if he had interpreted the trace as no more than suspicious he replied:

> "it would depend precisely which feature or features were of concern, what you knew about the foetus up until that point and the labour progress. Generally speaking, you might observe for a period of time when it's suspicious, even in the second stage … it would be usual to observe for a period of time" (MS487).

[67] As an indicator of there being a risk of foetal compromise associated with a suspicious trace which warranted discussion with the mother Mr Milligan pointed to the Algorithm which stated that where a CTG was classified as suspicious using the criteria in the Guidelines, steps were to be taken to "Ensure that mother is informed of concerns and included in management plan." Agreeing with what was submitted by Mr Ferguson, we do not consider that this piece of text goes the distance of establishing that there was a risk. As Mr Ferguson emphasised, the wording used in the Algorithm differed from the legal duty in *Montgomery* at [87]. There is no legal duty to inform the reclaimer of "concerns"; the duty is to inform of known material risks. The meaning of the word "concerns" was not explored in evidence. There is no basis for equating it with risk. The Algorithm is not entirely easy to

understand but it appears to recommend only conservative measures in the light of a suspicious trace: "ensure that the mother is not lying supine, encourage mother to adopt left lateral position, check blood pressure, give 500ml crystalloid [a fluid replacement] if appropriate". That recommendation is not suggestive of an increased risk of foetal compromise and it does not point to any decision which the mother might require to make. However, a more critical point was made by Mr Ferguson when he submitted that it was very dangerous for a lawyer to interpret the Algorithm and the Guidelines of which the Algorithm forms part, without hearing from a witness in one of the professions to which these documents were directed. This, in our opinion, must be correct. The Guidelines were published by the Royal College of Obstetricians and Gynaecologists in order to provide guidance for those who required to use and to interpret cardiotocography in intrapartum foetal surveillance. They are of the nature of a specialised medical text aimed at a specialised medical audience. Mr Milligan sought to construe part of that text as inferring that the classification of a trace as suspicious would or should have indicated a risk of foetal compromise, but that was Mr Milligan's construction alone; it had not been elicited from any of the expert medical specialists who had given evidence at the proof. With all respect to Mr Milligan, it is not the role of counsel to embark on an exposition of a technical text which has not been the subject of the evidence of an appropriately qualified witness. A somewhat similar, if perhaps more elaborate, exercise was attempted before an Extra Division in *Gerrard* v *Royal Infirmary of Edinburgh NHS Trust* 2005 1 SC 192. It provoked a response from Lord Osborne, giving the opinion of the court, at para [81], which we would see to be apposite to the circumstances of the present case:

> "[81] In the course of the hearing before us much use was made by counsel for the pursuers of extracts from textbooks on medical practice. Indeed, at times, the submissions made to us came to resemble lectures on medical practice. We think it

> right to emphasise certain points regarding the use of textbooks in the context of a case relating to medical negligence. In the first place, it has to be recognised that a medical textbook, dealing with accepted medical practice, however authoritative it may be and however distinguished the author or authors may be, of itself, possesses no evidential value. Its subject-matter will not be within judicial knowledge. However, a passage from such a book may acquire evidential value to the extent that it is adopted by a witness as representing his opinion, or otherwise dealt with in the evidence of a witness. In the second place, as a result of what has just been said, in the context of an appeal from a decision of a judge of first instance, it is vain to attempt to make use of textbooks which have not been put to witnesses in the case before that judge, so that they may thus acquire evidential status. In the present case, while certain passages from textbooks were put to certain witnesses, others were not, yet they were sought to be relied upon. In the third place, in the course of the hearing before us, discussion developed even in relation to the interpretation of certain passages in these textbooks. We consider that it would be utterly wrong for us to embark upon the business of interpreting the meaning or scope of propositions to be found in medical textbooks. Such matters as that must be the exclusive responsibility of expert medical witnesses, to whom the passages concerned have been put in evidence."

The use that Mr Milligan sought to make of the Algorithm, unsupported as it was by any expert testimony, was not legitimate. What he put forward as evidence from which an inference might be drawn was simply not evidence.

[68] By way of summarising his argument, Mr Ferguson submitted that the Lord Ordinary was entitled to find the trace at 2230 normal or at worse suspicious; but even if that were not to be accepted it did not matter because there was no evidence of risk in the light of a suspicious trace or that the registrar knew or ought to have known of risk. What is relevant is risk, not concerns. The *Montgomery* duty had not been shown to have arisen in this case. One does not get to the issue of materiality unless a risk is established and brought home against the relevant grade of doctor. The Algorithm did not fill the gap. Lack of evidence was the determinative factor. We would agree with all of that.

[69] The reclaiming motion must therefore be refused.

Postscript: Professor Murphy's understanding of the law

[70] The final paragraph of the pursuer's note of argument included the proposition that

Professor Murphy's evidence that it was only necessary to obtain consent when intervention was being considered and not when what was in issue was simply progressing with labour, was contrary to the ethos of *Montgomery* and *Webster.* Had Professor Murphy said that and had she meant it as a general statement of the principles of good medical practice which informed the decision of the Supreme Court in *Montgomery* then we would consider her to have been wrong; a potential decision not to take action may require the involvement of the patient just as a potential decision to take action may require it. Were Professor Murphy to be wrong in what she said it would have no effect on our decision but in fairness to her we would wish to make clear that we do not consider that in the passage under consideration (MS688 to 689) she did say what was attributed to her.

[71] The context of the passage of evidence referred to by Mr Milligan was Professor Murphy's conclusion that the registrar must have interpreted the trace as normal, or at least no more than suspicious and confirmed to the midwife that it was satisfactory to continue with the previously determined plan which was to continue with labour subject to watchful waiting. The answer which gave rise to Mr Milligan's criticism was:

> "You would generally get informed consent for intervening. If you are planning to continue to observe, you simply say hello, who you are, you've looked at the CTG, she's making good progress, and that you will be called back if there are any concerns. That is the correct approach."

Mr Milligan followed this up with: "So, you don't think you need to obtain consent to continue with labour?", to which Professor Murphy answered:

> "It's inherent …in the woman's trust that she is on the labour ward being cared for by staff who are helping her to achieve a vaginal delivery. If the obstetrician needed to intervene, then of course she would need to explain her reason for doing so, discuss what the options were and, if possible, the risks and benefits of the approach she was going to take."

We would regard Professor Murphy's answers as being entirely coherent and, to the extent they might be seen as a reflection of what was decided in *Montgomery*, correct as a matter of law. Where it is possible, the patient must be involved in the decisions which require to be made in a course of treatment in order that she can assess the balance between risk and benefit, and she must be given the advice necessary to allow her to give informed consent. In the case which the professor was being asked about such a discussion was to be taken to have occurred at the time of determining the original management plan, that being for spontaneous vaginal delivery with watchful waiting in the second stage up to the point of delivery subject to the possibility of intervention "if there are any concerns" requiring the registrar to be called on by the midwife. At about 2230 there were concerns on the part of the midwife in that she was uncertain about the interpretation of the trace. She called on the registrar who attended and assessed the CTG, in Professor Murphy's view, as normal, or at least no more suspicious. Rightly in Professor Murphy's opinion, the registrar did not find there to have been a material change in the clinical picture. There was therefore no need to consider adopting an alternative course of treatment to the previously agreed plan to which the pursuer had been party. We would see Professor Murphy's reference to "intervening" as meaning departing or considering departing from the plan to proceed to spontaneous delivery. That would require discussion because it implies new information (the emergence of risk) and a new risk/benefit balance. However, if there was no question of departing from the previously agreed plan (because there was no clinical reason to consider so doing) there was no decision to be made and no need to discuss matters with the patient; her consent to what she had previously agreed was, as Professor Murphy put it, "inherent".