

The Evolution of Litigation in Obstetrics and Gynaecology: From Medical Paternalism to Patient-Centred Accountability

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Abstract

Litigation in obstetrics and gynaecology has changed substantially over the past century, reflecting parallel developments in clinical practice, legal doctrine, bioethics and societal expectations. Historically, the doctor-patient relationship was predominantly paternalistic. Physicians exercised wide discretion over treatment and disclosure, while courts generally deferred to professional judgement. In the United Kingdom, this approach was crystallised in *Bolam v Friern Hospital Management Committee* (1957), under which clinical conduct was generally defensible when supported by a responsible body of professional opinion.

The subsequent rise of bioethics, human rights and patient autonomy progressively challenged professional dominance. The law began to distinguish questions of clinical expertise from decisions that properly belonged to patients. This transition culminated in the United Kingdom Supreme Court judgment in *Montgomery v Lanarkshire Health Board* (2015), an obstetric case that repositioned informed consent around material risk, reasonable alternatives and the individual patient's perspective.

These developments have particular significance in obstetrics and gynaecology, where decisions are frequently time-critical, outcomes may be catastrophic and questions of bodily integrity, reproduction and personal values are intrinsic to care. Contemporary litigation therefore extends beyond allegations of technical negligence. Claims increasingly involve failures of communication, consent, escalation, multidisciplinary working, organisational governance, respectful maternity care and equity.

This special article traces the transition from medical paternalism to patient-centred accountability and examines its implications for contemporary practice. It argues that effective medico-legal risk reduction depends less on defensive medicine than on technically competent care, individualised communication, shared decision-making, reliable clinical systems and transparent learning when harm occurs.

Keywords: *Obstetrics; Gynaecology; Litigation; Medical Negligence; Informed Consent; Patient Autonomy; Patient Safety; Human Rights*

Abbreviations

AI: Artificial Intelligence; CTG: Cardiotocography; FIGO: International Federation of Gynecology and Obstetrics; GMC: General Medical Council; MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK; NICE: National Institute for Health and Care Excellence; RCOG: Royal College of Obstetricians and Gynaecologists; WHO: World Health Organization

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Introduction

Obstetrics and gynaecology occupies an unusual position in medico-legal practice. It encompasses events that are physiologically complex, emotionally significant and, at times, rapidly unpredictable. Decisions made during pregnancy, labour, fertility treatment, reproductive healthcare and gynaecological surgery may have consequences extending far beyond the immediate clinical episode. Obstetrics in particular is associated with substantial malpractice exposure and, when serious neurological injury occurs at birth, exceptionally high long-term care costs [1,2].

The history of litigation in the specialty cannot be understood simply as a history of increasing claims. It is also a history of changing authority. For much of modern medicine, doctors were regarded as the principal arbiters of both what treatment should be given and what patients needed to know. Professional judgement occupied the centre of negligence analysis, and patients had comparatively limited influence over decisions made on their behalf [8-12].

During the second half of the twentieth century, this settlement became increasingly difficult to sustain. Greater recognition of individual rights, the development of modern bioethics and changing attitudes towards professional authority altered expectations of the clinical relationship [8-10]. At the same time, evidence-based medicine, clinical governance and technological advances transformed obstetric and gynaecological practice [6,7].

The legal response was equally important. *Bolam v Friern Hospital Management Committee* established the paradigm of professional deference in English medical negligence law [14]. *Bolitho v City and Hackney Health Authority* subsequently confirmed that professional opinion was not immune from judicial scrutiny [16]. Most significantly for obstetrics, *Montgomery v Lanarkshire Health Board* shifted the law of risk disclosure away from medical custom and towards the patient's entitlement to make an informed choice [17].

Modern investigations of maternity failures also demonstrate that serious harm rarely results from a single isolated act. Failures of communication, escalation, teamwork, staffing, leadership and organisational learning commonly interact with clinical error [6,34-37]. Litigation has consequently become one component of a wider framework of accountability encompassing professional regulation, clinical governance, patient safety and human rights.

This article examines that transition from paternalistic medicine to patient-centred accountability. Rather than treating litigation solely as a threat to clinical practice, it considers what the evolution of medico-legal standards reveals about the changing obligations of obstetricians, gynaecologists and healthcare organisations.

Medical paternalism and the origins of professional authority

Paternalism was embedded in medicine long before the emergence of modern negligence law. The traditional physician assumed responsibility for determining what was in the patient's best interests, and beneficence was often given greater weight than autonomous choice [8-12]. Information could be withheld if disclosure was thought likely to cause distress or interfere with treatment.

The model had particular resonance in reproductive healthcare. The medicalisation and institutionalisation of childbirth transferred increasing authority from women, families and community birth attendants to hospitals and medically trained practitioners. Advances in anaesthesia, antisepsis, surgery and transfusion contributed to safer maternity care, but institutionalisation also reinforced professional hierarchies.

These hierarchies existed within societies in which women often possessed restricted political, economic and legal power. Decisions about childbirth, fertility and reproductive surgery were therefore shaped not only by clinical knowledge but also by prevailing assumptions about gender, family and social roles. Explicit discussion of alternatives and individual preferences occupied a much smaller place in clinical practice than would now be considered acceptable.

Early recognition of bodily self-determination nevertheless began to challenge this position. In *Schloendorff v Society of New York Hospital* (1914), the New York Court of Appeals articulated an enduring principle of bodily autonomy [13]. Although modern informed-consent doctrine developed gradually and differently across jurisdictions, the case became an important landmark in the legal history of consent.

The aftermath of the Second World War further altered the ethical landscape. The Nuremberg Code placed voluntary consent at the centre of ethical research involving human participants, while the Declaration of Helsinki strengthened international principles of respect for persons [21,22]. These instruments were designed principally for research, but they contributed to a broader reconsideration of consent and professional power in clinical medicine.

Paternalism has not disappeared entirely. Obstetrics continues to expose tensions between professional obligations to prevent harm and a competent woman's right to make decisions that clinicians may regard as unwise. The contemporary difference is that professional concern does not, by itself, extinguish autonomy.

The Bolam era: Professional standards and judicial deference

The most influential expression of professional deference in English negligence law arose in *Bolam v Friern Hospital Management Committee* in 1957 [14]. The judgment became central to medical negligence litigation and reinforced the role of expert professional opinion in defining acceptable clinical practice.

There were sound reasons for judicial caution. Clinical medicine is characterised by uncertainty. More than one reasonable management strategy may exist, and an adverse outcome does not establish negligence. This is particularly important in obstetrics, where clinicians may be required to make urgent decisions about fetal compromise, haemorrhage, hypertensive emergencies, operative delivery or maternal deterioration on incomplete information.

The difficulty arose when professional custom became almost synonymous with the legal standard. If the profession determined not only how a procedure should be performed but also how much information a patient should receive, patients' interests risked being assessed through the clinician's perspective alone.

Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital reflected the continuing influence of professional standards on disclosure [15]. A significant qualification later emerged in *Bolitho v City and Hackney Health Authority*, where the House of Lords made clear that courts were not obliged to accept expert opinion merely because a body of professionals supported it; such opinion had to withstand logical analysis [16].

The development of evidence-based medicine reinforced this transition [7]. Systematic evaluation of interventions, national guidelines, audit and clinical governance provided additional sources against which practice could be assessed. Guidelines do not themselves determine negligence, nor can they substitute mechanically for clinical judgement, but they make the reasoning behind departures from accepted practice increasingly important.

For obstetrics and gynaecology, the legacy of *Bolam* therefore requires nuance. It remains highly relevant to questions requiring clinical expertise, but it no longer provides a universal answer to every medico-legal question. Most notably, it does not determine the extent of a clinician's obligation to disclose material risks for the purpose of obtaining informed consent.

The rise of autonomy and informed choice

The transformation of consent law formed part of a wider social change. Bioethics, civil-rights movements, consumerism and growing scepticism towards institutional authority encouraged a more participatory conception of healthcare [8-10].

Beauchamp and Childress's framework placed respect for autonomy alongside beneficence, non-maleficence and justice [10]. Although the principles can conflict in individual cases, autonomy challenged the assumption that beneficent professional intentions were sufficient justification for decisions affecting another person's body.

Few specialties illustrate the importance of this development as clearly as obstetrics and gynaecology. Decisions about contraception, sterilisation, pregnancy, mode of birth, prenatal testing, fertility treatment and reproductive surgery may depend as much on an individual's values and life circumstances as on probabilities of clinical benefit.

American jurisprudence provided an early patient-centred approach in *Canterbury v Spence* (1972), which rejected the proposition that the medical profession should have exclusive control over what risks patients were entitled to know [20]. The decision helped articulate a disclosure standard concerned with information material to the patient's decision.

The significance of communication also expanded. Consent was increasingly understood not as a signature on a form but as a process through which information, professional advice and patient values are brought together. Research into malpractice suggests that the decision to pursue legal action may be influenced by patients' experiences of communication and their perception of whether clinicians were open, respectful and responsive after an adverse event [3-5].

Patient autonomy does not require clinicians to become neutral providers of information or to offer interventions that are clinically inappropriate. It requires them to explain reasonable options, communicate uncertainty and provide professional recommendations without assuming ownership of decisions that properly belong to a competent patient.

Montgomery and the reorientation of consent

Montgomery v Lanarkshire Health Board [2015] UKSC 11 arose directly from obstetric practice and became one of the most important modern judgments on informed consent [17].

Mrs Montgomery, who had diabetes and was of small stature, faced an increased risk of shoulder dystocia with vaginal birth. Her consultant did not discuss that risk in detail because she considered the likelihood of serious fetal injury to be small and believed that, if informed of the risk, Mrs Montgomery would probably request a caesarean section. Shoulder dystocia subsequently occurred during vaginal delivery, and her child sustained severe injury.

The Supreme Court rejected the proposition that the extent of risk disclosure should be determined principally by professional practice. Doctors are required to take reasonable care to ensure that patients are aware of material risks associated with recommended treatment and of reasonable alternatives or variants [17].

Materiality contains both objective and individual elements. A risk may be material because a reasonable person in the patient's position would attach significance to it or because the clinician knows, or reasonably should know, that the particular patient would regard it as significant. A numerical probability cannot, by itself, establish whether a risk matters.

The later Supreme Court decision in *McCulloch v Forth Valley Health Board* clarified that the identification of which alternative treatments are clinically reasonable continues to involve professional judgement, while disclosure of material risks and reasonable alternatives remains governed by the patient-centred approach established in *Montgomery* [19]. This distinction is important because it preserves the clinician's responsibility to define clinically reasonable options without returning to paternalistic control over what a patient should be told.

The implications for obstetrics and gynaecology are extensive. Planned vaginal birth after previous caesarean section, elective repeat caesarean birth, induction of labour, management of breech presentation and assisted vaginal birth all require consideration of clinical evidence alongside individual preferences. Similar reasoning applies throughout gynaecology when patients consider alternatives such as hysterectomy, myomectomy, medical management or interventional radiological treatment.

Professional guidance now reflects this approach. The General Medical Council emphasises shared decision-making and the exchange of information relevant to the individual patient [23]. NICE recommends embedding shared decision-making into routine care [24], while the Royal College of Obstetricians and Gynaecologists provides consent guidance designed to support women's decision-making [25].

Documentation remains important, but its purpose should not be misunderstood. A detailed record may provide evidence of what was discussed; it cannot convert an inadequate conversation into valid consent. Templates and checklists can improve consistency, but they become counterproductive if used as substitutes for genuine dialogue.

The practical lesson from Montgomery is therefore not that clinicians should disclose more information indiscriminately. They should communicate more relevant information, discover what matters to the individual patient and document how the eventual decision was reached.

Why obstetrics remains medico-legally vulnerable

Obstetrics combines relatively uncommon catastrophic outcomes with potentially enormous lifetime consequences. When intrapartum events result in severe neurological injury, compensation may need to provide decades of specialist care, therapy, equipment, accommodation and loss-of-earnings support. This explains why maternity claims may account for a disproportionate share of indemnity expenditure relative to the number of claims or clinical encounters [1,2,33].

Fetal surveillance and intrapartum decision-making

Cardiotocography remains a recurrent feature of obstetric litigation. Interpretation is imperfect, interobserver variability exists, and a tracing must be considered in the context of the entire clinical picture [27]. Litigation commonly examines not merely whether an abnormality was present but whether it was recognised, communicated, escalated and acted upon appropriately.

Retrospective certainty presents a particular hazard. Once a poor neonatal outcome is known, an earlier trace may appear more obviously concerning than it did prospectively. Fair assessment therefore requires attention to the information available to clinicians at the time rather than judging decisions solely through knowledge of the outcome.

Delay and escalation

Allegations of delayed delivery frequently involve more than the decision of an individual obstetrician. They may encompass delayed recognition of deterioration, difficulty obtaining senior review, communication between midwives and doctors, anaesthetic availability, theatre capacity and competing emergencies.

The same principle applies to maternal deterioration. Severe haemorrhage, sepsis, thromboembolism and hypertensive disorders demand reliable recognition and escalation systems. The most recent MBRRACE-UK maternal report continues to identify lessons concerning recognition, multidisciplinary care, escalation and inequity [34].

The medico-legal question therefore increasingly extends from 'Who made the error?' to 'What combination of clinical and organisational conditions allowed the harm to occur?'

Gynaecological litigation: Surgery, diagnosis and reproductive medicine

Although birth injury attracts considerable attention because of its financial consequences, gynaecological practice has its own distinctive areas of exposure.

Surgical claims may involve injury to the bladder, ureter, bowel, blood vessels or nerves; haemorrhage; infection; conversion to open surgery; or delayed recognition of postoperative complications. An operative complication is not automatically evidence of negligence. Litigation may instead turn on whether the procedure was appropriately indicated, whether the surgeon possessed suitable competence, whether reasonable precautions were taken, whether the complication was recognised promptly and whether the possibility had been adequately discussed before surgery.

The growth of laparoscopic and robotic surgery adds a further dimension. New technologies may improve recovery and expand therapeutic possibilities but create questions about credentialling, learning curves, supervision and institutional responsibility for introducing new techniques safely.

Diagnostic delay is another important source of claims. Missed or delayed recognition of ectopic pregnancy, ovarian torsion, gynaecological malignancy and other conditions can result from failures at several points in the pathway: assessment, investigation, interpretation, referral, follow-up or communication of results. Contemporary diagnostic-safety thinking therefore treats diagnosis as a process distributed across individuals and systems rather than as a single cognitive event [28].

Reproductive medicine creates still more complex questions. Assisted reproductive technologies engage consent, embryo and gamete handling, genetic information, confidentiality and parenthood, often against a rapidly changing technological and regulatory background [29,30]. As reproductive technologies develop, the boundary between traditional clinical negligence and disputes involving autonomy, identity and reproductive rights is likely to become increasingly important.

Communication, candour and the decision to litigate

Technical quality and communication cannot sensibly be separated. Patients experience healthcare through both.

Following an adverse event, patients and families commonly want to understand what happened, why it happened, what the consequences will be and what will be done to prevent recurrence. Poor communication during this period may magnify the original harm. Conflicting explanations, unexplained delays, defensive behaviour or perceived avoidance can undermine trust even when the underlying complication was not negligent.

The association between communication and malpractice has long been recognised [3,4]. This should not be reduced to the simplistic proposition that being courteous prevents litigation. Patients are entitled to pursue legitimate claims irrespective of the quality of the clinician-patient relationship. Rather, good communication is itself a component of high-quality care and may prevent uncertainty and misunderstanding from becoming additional sources of grievance.

Open disclosure following adverse events is therefore important. Acknowledgement of harm, an appropriate apology, explanation of known facts and commitment to investigation should form part of a mature patient-safety culture [5,31]. Where facts remain uncertain, candour requires clinicians to say so rather than speculate.

From individual error to organisational accountability

One of the most important developments in patient safety has been recognition that adverse events frequently emerge from interactions between human error and system weakness [6]. This perspective has particular relevance to maternity services, where

obstetricians, midwives, anaesthetists, neonatologists, theatre staff, laboratory services and blood banks must coordinate care, often under considerable time pressure.

Major maternity investigations in the United Kingdom have repeatedly identified recurring organisational problems. The Morecambe Bay Investigation described serious failures of clinical practice, collaboration and governance [35]. The Ockenden review of maternity services at Shrewsbury and Telford identified deficiencies involving escalation, multidisciplinary working, governance and learning from adverse outcomes [36]. The East Kent investigation similarly emphasised organisational culture, teamwork and failures to listen to families [37].

These findings matter to litigation because they challenge the assumption that preventable harm can always be attributed to a single negligent practitioner. If staffing is inadequate, escalation pathways unreliable, concerns repeatedly ignored or lessons from previous incidents not implemented, responsibility may properly extend to the organisation.

Clinical governance must therefore address the conditions in which clinicians work. Training individuals while leaving dysfunctional systems unchanged offers limited protection to patients.

Human rights, respectful maternity care and equity

The evolution from paternalism to autonomy has increasingly intersected with human-rights principles. Reproductive healthcare engages bodily integrity, privacy, equality, dignity and family life. These interests are particularly visible in maternity care, where the urgency of clinical situations can create tension between perceived fetal interests and the pregnant woman's choices.

The World Health Organization has stated that disrespectful and abusive treatment during childbirth can threaten rights to life, health, bodily integrity and freedom from discrimination [38]. Evidence from multiple countries has documented mistreatment during facility-based childbirth and has shown that it can arise both from interpersonal conduct and from health-system conditions [39,40].

Respectful maternity care is not simply a matter of hospitality or patient satisfaction. Unconsented procedures, coercion, discriminatory treatment, breaches of privacy and disregard for a competent patient's decisions may engage ethical and legal principles distinct from whether an intervention was technically performed correctly.

Patient-centred accountability also requires attention to unequal outcomes. Maternal morbidity and mortality are not distributed evenly across populations. Contemporary maternity surveillance continues to identify important differences in maternal outcomes between groups [34]. Not every disparity constitutes negligence or unlawful discrimination, but persistent differences in recognition of deterioration, access to services or quality of communication raise legitimate questions for healthcare organisations.

Traditional tort litigation may be poorly suited to addressing structural inequality because it focuses on an identifiable claimant, defendant, duty, breach, causation and damage. Regulation, public-health policy, quality improvement and human-rights approaches therefore remain necessary complements to litigation.

Defensive medicine: An unintended consequence?

Fear of litigation can alter clinical behaviour. Obstetrics is particularly susceptible because clinicians know that an apparently routine labour can deteriorate rapidly and that an adverse neonatal outcome may lead to scrutiny many years later.

Defensive practice can take several forms. Some may involve additional investigation or earlier intervention; other forms may include avoidance of particularly high-risk cases or excessive documentation designed primarily for anticipated litigation. Empirical work has examined associations between malpractice pressure and obstetric practice, including caesarean delivery [41].

The central problem is that reducing medico-legal exposure is not always synonymous with improving care. An unnecessary caesarean section carries its own immediate and future risks. Excessive investigation may produce incidental findings and additional intervention. Documentation written principally for legal defence may become less clinically useful.

The appropriate response to litigation risk is therefore not indiscriminate intervention. Safer practice rests on sound clinical judgement, evidence-based pathways, timely escalation, effective teamwork and high-quality shared decision-making.

Technology, digital records and emerging liability

Digital medicine is altering both clinical practice and the evidential landscape of litigation. Electronic health records provide time-stamped documentation, medication histories, investigation results and communication trails. They may clarify events, but they can also expose inconsistencies, copied text, retrospective amendments and failures to act on electronically available information.

Artificial intelligence introduces more fundamental questions. Predictive algorithms may support fetal surveillance, recognition of maternal deterioration, imaging, pathology, documentation and risk stratification. Such systems may improve safety, but their use complicates conventional concepts of responsibility.

The World Health Organization has emphasised the need for transparency, safety, accountability, equity and appropriate governance in health-related artificial intelligence [42,43]. Legal scholarship and clinical literature likewise identify unresolved questions concerning the responsibilities of clinicians, healthcare institutions and technology developers when AI-supported decisions contribute to harm [44,45].

If a clinician follows an algorithmic recommendation that proves harmful, questions may arise about the reasonableness of reliance on the system. If the clinician rejects a recommendation, the rationale may subsequently be scrutinised. Algorithmic performance across different populations creates a further concern: a system trained on inadequately representative data may reproduce or amplify existing inequalities.

Technology should therefore be viewed as a component of the clinical system rather than as a means of eliminating human responsibility. Validation, monitoring, transparency and clear governance will become increasingly important as AI moves into routine reproductive healthcare.

Litigation as a source of learning

Litigation is commonly experienced by clinicians as adversarial and distressing. Prolonged proceedings can affect professional confidence and wellbeing, and defensive responses are understandable. Yet a healthcare system that regards every claim solely as a threat loses an important opportunity to learn.

Claims data can reveal recurring patterns in delayed escalation, fetal surveillance, operative complications, consent and communication. When combined with incident reports, mortality reviews, patient complaints and clinical audit, litigation can contribute to a richer understanding of preventable harm [32,33].

The difficulty is ensuring that learning reaches clinical practice. Repeated identification of the same failures without effective implementation represents an organisational failure in itself. A mature safety system should therefore integrate legal claims with clinical governance. The objective is not merely to identify lessons for the clinician involved but to determine whether similar vulnerabilities exist elsewhere in the service.

Alternative approaches to compensation and resolution

Traditional tort litigation serves important functions. It can compensate injured patients, establish standards and provide accountability. It also has recognised limitations. Proceedings may be prolonged, expensive and emotionally demanding, while proving negligence and causation can be difficult even when severe avoidable harm has occurred.

These limitations have prompted interest in mediation, early-resolution programmes and no-fault compensation systems [46-48]. No single model is suitable for every healthcare system. Removing the requirement to establish fault may facilitate access to compensation, but schemes must still determine eligibility, causation and the level of support to be provided.

Alternative dispute resolution may be particularly valuable where the underlying conflict involves communication, explanation or disagreement about what occurred. It cannot replace formal adjudication where authoritative determination is required, but it can offer a less adversarial route in appropriate cases.

The broader policy objective should be to combine fair compensation with timely resolution, transparency, affordability and effective learning.

Practical implications for obstetric and gynaecological practice

The evolution of litigation suggests several practical principles for contemporary practice.

First, clinical competence remains fundamental. Patient-centred care does not displace evidence-based medicine; it changes how professional expertise is used.

Second, consent should be treated as a continuing conversation rather than a completed form. Clinicians should identify the patient's priorities, explain material risks in understandable terms and discuss reasonable alternatives [17,23-26].

Third, records should document clinical reasoning rather than merely outcomes. In urgent care especially, a contemporaneous explanation of why a decision was made can be more informative than formulaic documentation.

Fourth, escalation systems must be explicit and functional. Staff should know when and how to obtain senior assistance, and organisational culture must permit concerns to be raised without inappropriate hierarchy [34-37].

Fifth, adverse events require candour. Patients and families should receive timely, compassionate and accurate information, followed by explanation as further facts become available [5,31].

Finally, institutions should examine claims collectively. Recurrent themes across incidents, complaints and litigation may reveal system weaknesses that individual case review fails to identify [32,33].

These measures should not be understood primarily as legal protection. They are components of good clinical care. Their medico-legal value arises precisely because they improve the quality and reliability of care.

Future directions

The next phase of medico-legal development in obstetrics and gynaecology is likely to be characterised by increasing scrutiny of the quality of decision-making rather than simply the existence of documented consent.

Shared decision-making will become more sophisticated as patients gain access to personalised risk calculators, decision aids and electronic health information [24,49]. This may improve understanding but will also require clinicians to communicate the limitations of predictions and the uncertainty inherent in population-derived estimates.

Artificial intelligence will test existing concepts of professional responsibility, particularly where algorithmic recommendations become embedded in routine care [42-45]. Regulation will need to clarify standards for validation, oversight and accountability.

Human-rights principles are also likely to remain influential, especially in relation to reproductive autonomy, respectful maternity care, discrimination and access to services [38-40]. These developments may further blur traditional boundaries between clinical negligence, regulatory accountability and rights-based claims.

Healthcare organisations will face increasing scrutiny of workforce capacity, safety culture and their ability to learn from adverse events. The legal history of medicine has moved progressively from unquestioned professional authority towards external accountability; the next stage may focus increasingly on the accountability of healthcare systems themselves.

Conclusion

The history of litigation in obstetrics and gynaecology is fundamentally a history of changing relationships between expertise, authority and individual rights.

Medical paternalism placed the physician at the centre of decision-making. Bolam gave legal expression to substantial professional deference, particularly in matters requiring clinical expertise. Bolitho demonstrated that expert opinion must nevertheless withstand rational scrutiny, while the broader development of bioethics and patient-rights jurisprudence challenged the assumption that doctors should determine what information patients needed to know.

Montgomery, appropriately arising from an obstetric dispute, marked a decisive shift. The clinician's responsibility is no longer simply to recommend what professional opinion considers appropriate, but to create the conditions in which the patient can make an informed decision about matters affecting her own body and life. McCulloch subsequently clarified the continuing role of professional judgement in defining which treatment alternatives are clinically reasonable.

Contemporary litigation has expanded beyond technical negligence. Communication, consent, teamwork, escalation, organisational governance, dignity, equality and respectful maternity care all contribute to modern conceptions of accountability.

Obstetrics and gynaecology will remain medico-legally challenging because uncertainty cannot be eliminated and some adverse outcomes will occur despite exemplary care. The appropriate objective is therefore not the elimination of litigation through defensive medicine. It is the creation of healthcare systems in which sound clinical judgement is combined with reliable processes, transparent communication and genuine respect for patient autonomy.

Seen in this way, litigation is neither merely an occupational hazard nor an adequate patient-safety system in itself. It is one mechanism within a broader framework of accountability. Its most constructive contribution occurs when the lessons generated by individual cases are converted into safer care for future patients.

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All authors contributed to the conception and development of this special article, critically reviewed the manuscript for important intellectual content, approved the final version for submission, and agree to be accountable for the integrity of the work. The corresponding author acts as guarantor.

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Declaration of Originality and Exclusive Submission

The authors declare that this manuscript is original, has not been published previously, and is not under consideration for publication elsewhere.

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