5. Reproductive Harm, Social Justice and Tort Law: Rethinking 'Wrongful Birth' and 'Wrongful Life' Claims

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Introduction

In this chapter we consider how developments in reproductive medicine and technology – from sterilisation techniques to pre-conception and pre-natal testing, advice and prescribing, to medically assisted conception techniques such as IVF – have brought new issues to bear on traditional tort law principles, by taking a closer look at what we call 'reproductive torts'. In doing so, we consider the following themes separately, but also the relationship between them. First, the idea of reproductive harm – what is it, who does it affect, and who should pay for it when it occurs? Secondly, social justice and reproduction, particularly in relation to structural inequalities relating to gender, race, class and disability. Thirdly, tort law's response, considering specifically its purpose and development and the extent to which it can address reproductive harm and issues of social justice.

These issues are interesting, and should concern us because, in the first place, feminist legal analysis has long shown that tort law has struggled with acknowledging and compensating gendered harms.[1] And reproduction is a highly gendered activity. Reproductive harm is also not a straightforward personal injury, at least in the context of how tort law has developed. Reproductive negligence *may* result in physical harm, but it may not or, even if it does, the more significant issue is often the reproductive repercussion and the impact that has on a person's life – their desire to have a child, not to have a child, to have a particular child or to avoid having a particular child.[2] All are issues of life self-direction or personal autonomy.

As well as autonomy, these issues further relate to social justice concerns. For example, if people are not compensated for negligence which results in the birth of a child that they did not intend to have, statistically speaking it will be women who shoulder the costs and burden of raising that child; thus creating and maintaining gender injustice. Injustice relating to disability, race and class

[1] See e.g., Joanne Conaghan, 'Gendered Harms and the Law of Tort: Remedying (Sexual) Harassment' (1996) 16 (3) *Oxford Journal of Legal Studies* 407 and 'Law, harm and redress: a feminist perspective' (2002) 22 (3) *Legal Studies* 319.
[2] For the framing of reproductive negligence in this three-pronged way, see Dov Fox, 'Reproductive Negligence' (2017) 117 *Columbia Law Review* 149.

are also important, as we shall see. The main question to consider is how good tort law is (or is not) at dealing with wider injustices in society and, specifically, the tort of negligence, which relies on individual people – in our case, patients – to bring individual claims against those at fault (that is, healthcare professionals) for causing the harm that they have suffered. This chapter interrogates whether this focus on individual professional liability, combined with the retrospective nature of tort law and its emphasis on individualised compensation (corrective justice), dooms tort law as an ineffective means of ameliorating societal injustice. Or, might we be more hopeful on that front, and point also to tort law's role in distributive justice in this context?

'Reproductive Torts' and Professional Liability <2>

What do we mean by 'reproductive torts'? This is an important question, as we clearly do not mean all reproductive mishaps. People have always sought to control their reproductive lives; whether as individuals or in conjunction with others, from sexual partners, to friends and experts who may offer 'advice'.[3] However, when 'mistakes' happen – a missed contraceptive pill, a carelessly put on condom, or a miscalculation over an ovulation cycle – 'injured' parties – such as the woman who ends up pregnant, or those who end up as parents when they did not want to be – do not generally have recourse in tort law, and there are good reasons for this. The corrective and/or distributive impulses of tort law are not necessarily well served by imposing liability in these circumstances; and a great deal of harm to social relations may also occur. Moreover, most people simply would not have the necessary resources to pay for their negligence.

Instead, this chapter considers what happens when professionals are involved in procedures that affect our fertility or reproductive capacity or autonomy. Typically, these will be healthcare professionals, but sometimes related technical professionals such as embryologists in a fertility clinic, or a technician responsible for medical testing or keeping storage freezers working. Developments in reproductive medicine, such as contraceptive and sterilisation techniques, pre-

[3] To make clear, we are not concerned with *intentional* injury here – including non-consensual sex/rape but also things like 'stealthing', or tampering with a person's contraceptive device, whether that's a pill, a condom, or something else. We are also not talking about reproductive injury from things like environmental toxins, for which states and corporations often escape liability and arguably should be held accountable (see further Khiara Bridges, 'Beyond Torts: Reproductive Wrongs and the State' (2021) 121 *Columbia Law Review* 1017. For an account of environmental pollution affecting claimants, though not specifically about reproductive harm, see Iain Frame's chapter in this volume.

natal testing and prescribing, and medically assisted conception, have brought new issues to bear on tort law in terms of professional liability. As we know, all healthcare professionals owe their patients a duty of care not to be negligent in the provision of treatment – but how far does this extend?

Like all other branches of medicine, reproductive medicine is not without risk. Properly informed patients are aware of this and should have opportunities to make decisions based on an evaluation of such risks in relation to their own personal circumstances.[4] That aspect of autonomy is, however, not our focus here. Instead, when we consider reproductive negligence in this chapter, we mean negligently performed treatment. For example, an incorrectly performed sterilisation; a doctor failing to order the proper tests when a pregnant woman presents with symptoms of rubella or seeks genetic testing for a certain condition; or when results are read incorrectly; or the wrong sperm or embryo is used in fertility treatment. Patients *do not* consent to these negligent errors and in cases where the legal rules of breach and causation are also satisfied, a patient *should* be able to claim damages against a negligent practitioner (with the employer being vicariously liable). But as we will see, claiming for damages is not always straightforward in the reproductive context.

If reproductive harms are not well recognised by tort law, we then face several questions – first, whether they should be, in terms of the tort of negligence incrementally developing?[5] Secondly, if so, what damages should be recoverable and whether the answer to this should be any different in the context of publicly funded NHS treatment, as compared to treatment in the private healthcare sector – which raises different considerations of risk-spreading due to the profit-making dimension of treatment provision. Thirdly, if not, how else should we hold negligent professionals accountable, improve clinical standards and respond to the harms and social injustice experienced by patients and their families in the aftermath of negligently provided treatment? A significant issue underpinning all these questions is that our current tort system relies on individual fault, but claimants will be compensated through professional insurance; the premiums for which are paid for either via policy holders (or policies held by their employer), or

[4] *Montgomery v Lanarkshire Health Board* (Scotland) [2015] UKSC 11. For an interesting critical analysis of the impact of this case on the principle of consent in healthcare law see T.T. Arvind and Aisling McMahon, 'Responsiveness and the role of rights in medical law: Lessons from *Montgomery*' (2020) 28(3) *Medical Law Review* 445.
[5] As we were reminded in *Robinson v Chief Constable of West Yorkshire Police* [2018] UKSC 4, the proper role of the 'Caparo test' is to assist with this incremental development (*Caparo Industries plc v Dickman* [1990] 2 AC 605, 617-618).

in the case of a public health service like the NHS, ultimately through general taxation.[6] Does this do anything to improve standards, or help clinicians to perform to the best of their ability? Does it properly distribute risk and societal resources? What does this redistribution say about the society we live in or aspire to live in, and how does it relate to social justice aims? It is these questions that this chapter addresses in the specific context of reproductive harm.

In thinking about these questions, it is helpful to bear in mind this quote from the Law Commission report on injuries to unborn children which prefaced the Congenital Disabilities Act 1976:

> Law is an artefact and, if social justice requires that there should be a remedy given for a wrong, then logic should not stand in the way. A measure of damages could be artificially constructed.[7]

We like what this quote says about law: that it is an artefact – that is, a thing made by humans. We all know this, but when it comes to the common law, rules of precedent, or traditions of legal theory and philosophy, the law sometimes takes on its own persona as a pre-given entity or dogma that we cannot alter, interpret, or re-interpret. What we really wanted to emphasise with this quote is the way it brings attention to social justice, wrongs, and the need for a remedy – and that if the current logic of the law does not provide a remedy when social justice has been wronged, damages could – and we might argue *should* – be 'artificially' constructed – or just constructed! In the context of negligence (factually) causing congenital disabilities, damages have been facilitated through legislative means to overcome certain doctrinal impediments.[8] This also provides us with food for thought when it comes to reproductive negligence and what we should focus on: should our focus be on reworking the logic of tort law to better encompass reproductive harm and social justice related issues? Or would a different legal measure, such as legislation, be preferable? Obviously, this reflects the enduring debate on whether judges, parliament or the executive should develop rules in response to changing norms and new issues. The idea of what legal change is needed will be returned to at the end of this chapter. For now, we will spend some time illustrating exactly what we see are then current problems with the existing law.

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[6] For a wider critique on the role of fault in clinical negligence see Ian Kennedy, 'Clinical Negligence Reform is an Ethical and Financial Necessity' *Prospect*, 9 August 2021.
[7] Law Commission, *Report on Injuries to Unborn Children*, (1974) No. 60, Cmnd 5709, para 89.
[8] Congenital Disabilities Act 1976.

The tort of clinical negligence – reproductive challenges <2>

As indicated earlier, tort law, and clinical negligence specifically, has been heavily criticised in terms of its ability to protect patients and improve professional standards (its deterrent function), as well as the difficulties patients face in bringing and establishing claims (its corrective function).[9] We know, for example, that the medical profession itself set the 'standard' for breach, with the courts showing a firm reluctance to interfere with the 'reasonable doctor' test (the *Bolam* test);[10] although things may be shifting on this front, especially in relation to patient decision-making, with a move towards recognising the value of properly informed consent.[11] Further difficulties arise from the complexity of proving both legal and factual causation, as there may be several different factors leading to a patient's injury, illness or death.[12]

However, while issues of breach and/or causation usually form the backdrop for critical discussions pertaining to clinical negligence, in the context of reproductive torts, they have not been the main challenges: indeed, breach and causation are often clearly established in terms of legal principle. Instead, what we see are issues around the conceptualisation of legal 'harm' as well as policy considerations being used to prevent claims succeeding. So, rather than the breach and causation requirements, it is the application of the 'fair, just and reasonable' factor from *Caparo* which stands in the way of the tort of negligence developing incrementally and responsively to those who experience reproductive harm. Another issue relating to duty of care comes into play when we consider harms that do not directly affect the patient, where duty is straightforward, but affects their child. Does a doctor's duty of care extend to children born following negligent treatment? Additionally, there are questions about the *scope* of a doctor's duty: does it relate only to a condition tested for or does it relate to all conditions that a child is born with?

In considering these doctrinal questions, it is important to keep in mind what we want the law to *do*, because that will influence how we think it should develop. Is it about determining our own lives, our autonomy? The idea of reproductive self-determination, planning or decision-making?

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[9] For a helpful critical consideration of the ethical imperatives for compensating for clinical negligence through tort law, see Shaun Pattinson, *Medical Law and Ethics* (2020, 6th ed) (Sweet & Maxwell).
[10] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583.
[11] *Chester v Afshar* [2004] UKHL 41; *Montgomery*, n 4 above.
[12] *Wilsher v Essex Area Health Authority* [1988] AC 1074 – notwithstanding inroads made into medical causation by courts applying the concept of 'material contribution to harm' in some cases: *Bailey v Ministry of Defence* [2008] EWCA Civ 883; *Williams v The Bermuda Hospitals Board* [2016] UKPC 4.

One of the reasons why medical and technological developments relating to reproduction are interesting is that they often make 'choices' very explicit, as well as sometimes introducing new choices and options: Do I want to have a child now? Do I want to stop having children? Do I want *this* child? Children and families are increasingly seen as being 'planned' rather than just 'happening'. Of course, this is an oversimplification that fails to capture the reality that rationality is not always the main motivation underpinning reproductive decision-making and that people can have their reproductive hopes and 'choices' hugely restricted.[13] Moreover, reproductive medicine is far from certain, particularly in terms of explaining failed reproduction, which we often have very little control over. However, the ability – or need – to make reproductive decisions, and to be explicit about choices that might otherwise have gone unsaid or simply not have been possible before the development of various reproductive technologies from reliable medical contraception to IVF, has arguably reshaped notions of reproductive autonomy and decision-making. 'Family planning' is actively encouraged by governments and policy makers, and citizens who do so are regarded as 'responsible'. However, is responding to the desire to control our reproductive lives, or reproductive autonomy, all that tort law should seek to achieve? Or, if we consider the wider aims of reproductive justice, which are that people not only have control over their bodies, but also access to the resources that they need, to include resources to parent and care for their children,[14] should it have wider social justice aims? How can tort law, focused as it is on individuals who suffer 'injury', at the hands of those at fault, play a role in the wider distribution of societal resources?[15]

Naming the reproductive torts <2>

[13] See further Carol Sanger, 'The Lopsided Harms of Reproductive Negligence' (2017) 118 *Columbia Law Review* 29. This article is discussed in detail in the conclusion of this chapter.

[14] Loretta Ross and Rickie Sollinger, *Reproductive Justice: An Introduction* (2017, University of California Press).

[15] For our purposes, a comparison with ideas that come from critical disability studies is useful. Disability activists and critical disability scholars are critical of depictions of disability in law – as something tragic, to be pitied, as making a person less than whole. This is reflected in the 'wrongful birth' and 'wrongful life' cases involving disability, which we discuss later. A different approach might be to use the social model of disability – which looks at barriers faced in society – to frame the narrative in the legal case, rather than purely the medical model which sees disabled persons as in need of 'fixing' and therefore, in our sense, in need of compensation. In terms of tort law, there is certainly room for improvement in how disabled persons and their lives are narrated and, importantly, responded to. The need to do so clearly relates to social justice ambitions for society, both for the individuals involved in litigation, but also wider discourses and material realities.

To help us answer some of these questions, we now turn to 'wrongful birth' and 'wrongful life' claims in negligence.[16] Before doing so, we should acknowledge that there are terminological difficulties attached to such claims. As Harvey Teff states:

> These labels are unfortunate not least in their bizarre, even macabre, overtones. One is not instinctively attracted to the cause of someone who appears to be impugning life itself…. [T]he terms are neither immediately intelligible nor readily distinguishable from each other…they conceal a host of different legal and social implications, depending both on the circumstances leading up to the birth and on its consequences.[17]

He concludes that the terms are 'potentially a source of considerable confusion'.[18] We agree, but believe that what is important here is that the terms are highly emotive in conveying not only that a wrong has been done to the claimant, but also that 'pregnancy', 'birth', 'conception' or even 'life' itself can quite simply be 'wrong', in and of themselves. Some of the difficulties these labels cause are illustrated as we work through the following sections. That said, it is difficult to know what to replace the terms with: what we discuss are 'personal injuries', but not as tort law has hitherto understood personal injury. Should we use something more generic like 'reproductive torts,' as this chapter suggests? Or does this fail to encompass significant differences between potential causes of action? Conversely, with more specific labels like 'pregnancy' or 'prenatal' torts, do we become overly pre-occupied with differences relating to whether the defendant's negligence caused the child's injuries, conception, or birth? Another idea is 'wrongful suffering' which, rather than making assertions about the value of a birth or a life itself, shifts the focus to the experience of the claimant, and what they have suffered. But how would that square with trying to frame disability or care in a more positive way? There are no clear answers, which is why, for now, we continue to use the standard terms adopted in the literature.

Wrongful birth <3>

[16] There is another growing subset of related cases, not covered in this chapter, which some commentators call 'loss of genetic affinity' claims. These are cases where, for example, the wrong gamete or embryo is used in a woman's fertility treatment, depriving her or her partner of the genetic connection to their child. See e.g., Vera Lucia Raposo, 'Wrongful genetic connection: neither blood of my blood, nor flesh of my flesh' (2020) 23 *Medicine, Healthcare and Philosophy* 309; and Bond and Gardner, Chapter 10, this volume.

[17] Harvey Teff, 'The Action for "Wrongful Life" in England and the United States' (1985) 34 *International & Comparative Law Quarterly* 423, 425.

[18] ibid.

We use 'wrongful birth' as an umbrella term to include two distinct types of claim from adults following reproductive negligence: 'wrongful pregnancy' and 'wrongful conception'. In them, parents seek compensation for an unplanned birth and child, where clinical negligence has led to the child being born. 'Wrongful pregnancy' claims arise where the parent(s) sought medical treatment in order *not* to conceive at all, such as a sterilisation procedure, which is then performed negligently. In these cases, parents have a child that they actively sought treatment to avoid having. 'Wrongful conception' claims occur when the parent(s) may well have been trying to conceive, but medical negligence means that their reproductive plans have been frustrated. For example, negligent pre-natal testing or advice might mean that a woman is not properly informed of a particular risk of her child developing a certain condition or illness which, had she known about, she may have chosen to end the pregnancy. Alternatively, there may be a mistake in the gametes or embryos used in someone's fertility treatment – for example with patient(s) who have used pre-implantation genetic diagnosis (PGD) to screen embryos for a particular genetic trait that they have a family history of and wish to avoid.[19] Instead of implanting an embryo that does not have the tested for genetic trait, an embryo with the genetic trait could be mistakenly implanted and a child with the associated condition, which the parent(s) sought to avoid may be born.

These claims have proved controversial, because, despite satisfying the usual principles of liability, and despite compensation once being available in English law, over the past two decades the courts have refused to award full compensation in relation to the child's upbringing, reflecting a deliberate change in (judicial) policy. Additionally, some exceptions have been created, which are interesting as they only come into play when a child is born with a disability, or when a parent has a disability.

Wrongful pregnancy <4>

In 2000, the House of Lords delivered an important ruling: *McFarlane v Tayside Health Board*.[20] In this decision, their Lordships – all male at this time, and all reasonably affluent – reversed nearly two prior decades of case law whereby parents had been able to recover not only the costs

[19] The UK has a comprehensive regulatory framework for embryo screening, with the authorised use of PGD limited to scenarios where there is a 'significant risk' of 'serious' illness, physical or mental disability or other medical condition – see Human Fertilisation and Embryology Act 1990 (as amended), Schedule 2, section 1ZA.
[20] [2000] 2 AC 59.

associated with the pain and distress of an unwanted pregnancy and birth following a negligent sterilisation procedure, but also for the cost of the child's upbringing.[21] Prior to *McFarlane*, upbringing (or maintenance) costs were recoverable because they satisfied the usual principles of negligence: that is, they are reasonably foreseeable damage caused by a breach of a duty of care. In other words, it is reasonably foreseeable that if a clinician performs a sterilisation procedure negligently, a child, all of whom come with upbringing costs, may be born.[22] On what basis then, did their Lordships refuse to compensate the McFarlanes – who sought sterilisation of Mrs McFarlane precisely because they felt they could not cope financially (and likely emotionally and physically) with a further child – reversing twenty odd years of case law?[23]

You might expect that for something so significant to tort law – the reversing of well-established legal principle – we would be able to point to coherent and principled reasoning. Many scholars have tried, all concluding that we cannot.[24] Instead, *McFarlane* is an example of a case where the judges disagree on separate points, but somehow reach the same conclusion (that upbringing costs should not be recoverable), all for very different reasons.[25] These include the idea that such a cost is 'pure economic loss', only compensable in tort in very specific circumstances,[26] that the benefits of having a child outweigh the harms, that paying upbringing costs would leave parents overcompensated, and that recovery would go against the opinion of the 'reasonable man'[27] that a (healthy) child is a 'blessing'.[28] Undoubtedly, much of this reasoning rests on assumptions, highly generalised and selective experiences of parenting and is based on particular world-views – all dressed up as a policy-based exception to established legal principle. Distributive justice concerns were also raised, on the reasoning that it would be unfair for society – through the

[21] See in particular, *Scuriaga v Powell* [1979] 123 SJ 406, approved in *Emeh v Kensington and Chelsea and Westminster Area Health Authority* [1984] 3 All ER 1044.
[22] This is explained clearly by the (as she then was) Rt Hon Lady Justice Hale DBE in 'The Value of Life and the Cost of Living - Damages for Wrongful Birth' (2001) 7(5) *British Actuarial Journal* 747. She also critiques the highly gendered impact of this decision and others that followed: i.e., the particular impact on women as they go through pregnancy and birth, and then are statistically most likely to be a child's primary carer.
[23] Note that the decision was not universally welcomed. Kirby J in the Australian case *Cattanach v Melchior* [2003] HCA 38 (where the majority of the High Court permitted the recovery of maintenance damages) considered that *McFarlane* went well beyond the merely unconventional and was 'arbitrary and unjust'.
[24] See for example Laura Hoyano, 'Misconceptions about Wrongful Conception' (2002) 65 *Modern Law Review* 883; Anne Morris, 'Another fine mess... the Aftermath of *McFarlane* and the decision in *Rees v Darlington Memorial Hospital NHS Trust*' (2004) 20 *Professional Negligence* 2; Cressida Auckland and Imogen Goold, 'Offsetting Damages in Wrongful Conception and Birth Cases: A Way through the Post-McFarlane Mire' (2022) 138 *Law Quarterly Review* 407.
[25] See further Rosamund Scott, 'Reconsidering "Wrongful Life" in England After Thirty Years: Legislative Mistakes and Unjustifiable Anomalies' (2013) 72(1) *Cambridge Law Journal* 115.
[26] Arising and developed from *Hedley Byrne & Co Ltd v Heller & Partners Ltd* [1964] AC 465.
[27] See Haim Abraham, Chapter 4 this volume, for a queer critique of the reasonable man, or person.
[28] See Nicolette Priaulx, 'Joy to the World! A (Healthy) Child Is Born! Reconceptualizing Harm in Wrongful Conception' (2016) 13(1) *Social & Legal Studies* 5.

NHS – to pay for the raising of the parents' child; the converse of which, of course, is that the costs of raising a child should be privatised and absorbed by the family, rather than society at large. This is a view of distributive justice that is blind to, in particular, the gender and class dimensions of further privatising the costs of the care of children born following negligence.[29] It is regrettable that none of their Lordships acknowledged either the gendered dimension of their decision, nor the greater impact it would have on less affluent families in society, such as the McFarlanes.

McFarlane has been an influential case, with later judges regarding it as important precedent not only for wrongful birth, but also wrongful life claims, as well as, for example, in a contract law dispute, where a fertility clinic used a man's previously stored sperm to inseminate his ex-partner without his consent.[30] It has also been influential in other common law jurisdictions. But it has also been heavily criticised, in relation to the previously mentioned gender and class dimensions, and also for its undermining of the legal coherency of negligence.[31] Given these criticisms, it is perhaps not surprising that in order to lessen the impact of the decision, subsequent case law quickly established two exceptions to the exception (to established legal principle) in *McFarlane*.

First, in *Parkinson v St James and Seacroft University Hospital NHS Trust*,[32] the Court of Appeal decided that parents are entitled to recover for *additional* costs associated with the upbringing of a disabled child, when the child's birth follows negligent sterilisation treatment. Brenda Hale was on the Court of Appeal bench in this case, and her discomfort with the *McFarlane* decision is very clear in the case report. Second, in *Rees v Darlington Memorial Hospital NHS Trust*,[33] the House of Lords declined to overrule the decision that damages could not be awarded for the upbringing costs of a healthy child – likely because *McFarlane* was a majority decision from only three years earlier. Instead (by a slim majority) they decided that a case brought by Karina Rees, a disabled mother of a healthy child, could be distinguished from *McFarlane*. While full damages were still denied for the birth of a healthy child, a judicially invented 'conventional sum' of £15,000 was awarded to Ms Rees, as a way of acknowledging that she, who was blind and had sought

[29] See Nicolette Priaulx, 'Damages for the "unwanted" child: time for a rethink?' (2005) 73(4) *Medico-Legal Journal* 152.
[30] *ARB v IVF Hammersmith and anor* [2018] EWCA Civ 2803, discussed later.
[31] See e.g., Hoyano and Morris, n 24.
[32] [2001] EWCA Civ 530.
[33] [2003] UKHL 52.

sterilisation as she did not want a child that she felt she could not cope with, had suffered a wrongful interference with her reproductive autonomy.

This idea of a 'conventional award' goes against many of the principles of tort law. It might be argued that perhaps it goes some way to recognising that a wrong was done, and maybe it was a useful way of recognising a 'reproductive injury' that is to do with something more intangible like autonomy, rather than physical or psychiatric injury in the traditional sense. However, in the context of full damages (the upbringing costs that would otherwise have been recoverable 'but for' the policy exception created by the House of Lords in *McFarlane*), £15,000 seems rather meagre. This is particularly true in the light of modern healthcare ethics, which place a very high value on patient autonomy.[34] The question, therefore, is whether a higher sum would have made the situation better, or if only full damages would suffice?

It is also useful to reflect on whether the two 'disability exceptions' here can be justified. Arguably, the Court of Appeal in *Parkinson* went as far as it could under the restrictive precedent created by the *McFarlane* ruling, with the judgment perhaps acknowledging the reality that it often costs more to care for a disabled child given the ableist society we live in and shrinking welfare and other public supports.[35] But what about the House of Lords in *Rees*? Should they have been braver in overruling *McFarlane*, rather than creating a further disability-based exception? Would this have better responded to the demands of justice, rather than prioritising legal rules like precedent?[36]

When we look more closely at *Rees*, we start to see more clearly what the judges were actually uncomfortable with, which was perhaps less the thought of overruling a recent House of Lords bench, and more about the thought of the NHS compensating parents, some of whom may be relatively affluent, for the costs of raising healthy children. In other words, we come back to the supposedly common-sense logic of a healthy child being a 'blessing' that cannot constitute damage (while a disabled child can): despite the context of the claimant actively seeking medical treatment precisely to avoid having a child. Generally, the NHS pays a not insignificant amount to patients in compensation, with payments in the obstetric sector being particularly high. Yet

[34] For a discussion of this and whether this dominance is or can be translated into law, see Sheila McLean, *Autonomy, Consent and the Law* (2009, Taylor & Francis).
[35] A critical disability studies approach would take this critique further, and argue that rather than make individualised compensation payments, we should aim to change the wider support in society for disabled lives.
[36] As *McFarlane* itself ironically had not done.

paid they are, and as Nicolette Priaulx has argued, it is not clear why the NHS budget should determine the direction of tort law in this context, when in other areas it does not.[37] Or, if distinctions are to be made based on a child being healthy rather than disabled, why it should be the courts and not Parliament who decide this. Indeed, if the courts were genuinely affronted by the thought of the NHS paying out full maintenance costs to affluent parents, why was it not seen as more appropriate to put a threshold on the recoverable costs, as opposed to prohibiting them entirely and only allowing for the 'extra' costs of a child's disability? We come back to the issue of disability later.

In terms of case law, what happened next? For many years, students would learn about the *McFarlane* decision, then the exceptions drawn from *Parkinson* and *Rees*, and that would be it. But since then, there have been some very interesting cases, in different contexts: namely fertility treatment and pre-natal testing cases. These fall under the heading of 'wrongful conception', as opposed to wrongful pregnancy.

Wrongful conception <4>

In the context of fertility treatment, *ARB v IVF Hammersmith*[38] is a useful case to consider. *ARB* involved a couple who started fertility treatment together, leading to the birth of one child, before storing their remaining embryos for future use. The couple then separated, but the woman, unbeknownst to her former male partner – who had since married a different partner – went back to the clinic later to restart the fertility treatment, forging his signature on the relevant consent forms. She later sent him a text saying "And by the way I'm pregnant. Baby due [in the summer]".[39]

A daughter was born and the man (ARB) sued the clinic for breach of contract and claimed upbringing costs as part of the 'damage'. In the High Court judgment, Mr Justice Jay relied on *McFarlane* and *Rees* as providing a general policy exemption – transferrable to contract law – to providing damages for reasonably foreseeable harm in the context of a healthy child's upbringing costs.[40] An appeal by ARB on this point was subsequently dismissed by the Court of Appeal. Is

[37] Priaulx, n 29.
[38] *ARB v IVF Hammersmith and anor* [2018] EWCA Civ 2803.
[39] See *ARB v IVF Hammersmith Ltd and anor* [2017] EWHC 2438 (QB), para [47].
[40] So, the policy exemption from tort moved across to contract, in the context where someone was paying for services. This move was expressly acknowledged by Jay J, ibid., at [294] and [305]-[318].

this the correct outcome? Does the answer to this depend on how we conceptualise the harm experienced by ARB – was it simply a breach of his reproductive autonomy, or something more? Does the answer to that depend on whether the law regards him to be the legal father of the child, who must provide for her financially?[41] Or is that not the point? In other words, is the fact that ARB had his autonomy and reproductive control wrongly interfered with enough that he should have a remedy? If so, what should the remedy be?

This kind of questioning inevitably leads to more questions. Do differently situated claimants make us feel differently about what the 'just' outcome of a case might be? For example, we know from the case report that the McFarlanes already had four children and were – as many people are – concerned about the financial and emotional impact of having a further child. It is perhaps easy to sympathise with them and their circumstances and feel that they should be compensated. In contrast, we gain a picture of ARB being in significantly better-off financial circumstances, not least with the mention of private school fees for the children. Do differences in familial and financial circumstances influence whether we think a healthy child's upbringing costs should be fully recoverable; or whether there should be a standard amount, or whether the amount should differ relative to the affluence of the family – but perhaps not in the way tort has traditionally compensated, so that the wealthy get more, but that in cases of more need, the compensation is larger and vice versa? What about who the defendant is? In *ARB* it was a for-profit fertility clinic, not the NHS. This brings us back to the arguments about risk spreading and social utility, and whether that needs to be differently weighed in the context of private as opposed to publicly funded healthcare? Finally, what about the accountability of the clinic: it does seem that something quite wrong has happened here, so what should the remedy be, especially when the defendant has made a profit out of the negligent activity? Should they be held accountable directly to the 'victim' – a version of corrective justice; or should accountability here be more general, perhaps through professional regulation, and say the clinic receiving a fine from the sector regulator for poor practice? Would this be better for distributive justice, or would it miss the point?

A further, more recent case to consider is *Khan v Meadows*, heard by the Supreme Court in 2021.[42] Ms Meadows was not trying to avoid having a child – she wanted a child, but when she became

[41] For a critical discussion of this issue in a cognate case, see Sally Sheldon, '*Evans v Amicus Healthcare*, *Hadley v Midland Fertility Services*: Revealing Cracks in the 'Twin Pillars'?' (2012) 16(4) *Child and Family Law Quarterly* 437.
[42] [2021] UKSC 21.

pregnant she discovered a family history of haemophilia and sought pre-natal testing in order to find out if she was a carrier of the relevant gene, with a view to terminating her pregnancy if she was. Ms Meadows was negligently told by Dr Khan that she was not a carrier of the relevant gene, so she proceeded with her pregnancy. Her son was born with haemophilia, and also autism. The issue was the extent of damages she could claim for, under the 'disability exception'. Was it just the additional upbringing costs associated with her son's haemophilia, or the full costs of his care given his additional needs associated with autism? This question about the scope of Dr Khan's duty was important as the damages for the latter were set at £9m, whereas the costs associated with the haemophilia only were set at £1.2m. Ms Meadows' claim succeeded in the High Court, but in the Court of Appeal damages were reduced to £1.4m, with the Supreme Court agreeing.

What was the more 'socially just' award out of this binary choice? It seems that for the Court of Appeal and the Supreme Court the issue was the 'risk' (or responsibility) the doctor had assumed, compared to the risks assumed by Ms Meadows:

> As to the apportionment of risk, the doctor would be liable for the risk of a mother giving birth to a child with haemophilia because there had been no foetal testing and consequent upon it no termination of the pregnancy. The mother would take the risks of all other potential difficulties of the pregnancy and birth both as to herself and to her child.[43]

On this view, Dr Khan had assumed the risk of not testing for the haemophilia gene, while Ms Meadows assumed all other risks in connection with going ahead with a pregnancy. In addition, it would be unfair to hold a doctor liable for something they had no role in testing for because the extent of the damages would be disproportionate to their responsibility. However, it might be argued that this prioritises one version of legal logic over the reality of people's lives. The other version is that adopted in the initial High Court judgment by Mrs Justice Yip, which was to accept that without (but for) the doctor's negligence, Ms Meadows would have terminated her pregnancy and her son would not have been born. In other words, she would not be caring for a son with both haemophilia and autism.[44] Another legal concept that the judges could have used is the 'egg-shell skull' rule, which is that you take your victim as you find them. But perhaps that

[43] Davies LJ, *Khan v MNX* [2018] EWCA Civ 2609, Para 26ii.
[44] This is like the reasoning in *Chester v Afshar* [2004] UKHL 41, in the context of negligent treatment advice, where the 'damage' was the deprivation of a 'choice', and as a consequence, the defendant was liable for the full damages, even though their 'fault' may not have been proportionate.

is tricky – the 'victim' in a wrongful conception claim is the parent, not the child – although of course they are bringing a claim for the child's benefit as well as their own, as they try to secure compensation to help with the child's upbringing. Another useful way to reason or analyse the 'damage', is to argue that tort law needs to go beyond recognising only 'parts' of us, and to contemplate the full human experience.[45] Ms Meadows' experience is that she is caring for a son with two very severe conditions. Only by taking account of both of those in the award of damages do we acknowledge her and her son's full humanity and experience.

Yet, this kind of thinking raises more questions. The first is about the framing of *Khan v Meadows*, and the case being brought by the mother rather than her son (or the mother and the son). Is it fair that he cannot bring a claim in his own right, if his mother can in the same circumstances? And, what about the general language of damage, loss, harm and injury? Is the traditional language of tort law useful when we talk about conditions that people are born with? This brings us full circle, back to the question of terminology and what to call these claims, and leads nicely to the question of 'wrongful life' claims.

Wrongful life <3>

Wrongful life claims are claims not from the patients who were directly treated (the mother and/or father), but from the child(ren) born following negligent treatment. The damages would therefore be for life, as opposed to for the child's upbringing, which applies only to the child's minority. This makes them a potentially more powerful claim. In wrongful life claims, children typically seek compensation because they have been born with very severe disabilities. It is important to note that the doctor's negligence is not the direct cause of the disability, illness or condition in a wrongful life claim.[46] Instead, the issue is that the mother was not (properly) advised of the possibility of the child being born with the illness or disability – because of negligent pre-natal testing, advice, or failure to do so[47] – and thus she was deprived of making an informed decision about continuing with the pregnancy, or to opt into treatment that may potentially have helped lessen the effects of the condition. Alternatively, there could be pre-

[45] See e.g., Nicolette Priaulx, 'Reproducing the properties of harms that matter: the normative life of the damage concept in negligence' (2017) 1 *Journal of Medical Law and Ethics* 1.
[46] This type of claim would fall under the Congenital Disabilities Act 1976.
[47] In the UK, non-invasive pre-natal testing is offered as routine, while more invasive testing like amniocentesis is offered if a certain risk threshold is established.

conception negligence, as in *Toombes v Mitchell*,[48] which we consider later. In this case, the claimant's mother was negligently advised that taking folic acid was not necessary, with her daughter subsequently being born with spina bifida, which folic acid helps prevent.

Whether pre-natal or pre-conception negligence, the nub of the wrongful life claim is that but for the defendant's negligence, the child would not have been born (and the damage suffered would have been avoided). Framing the claim in this way, we can see how the name 'wrongful life' has emerged. Interestingly, historically (that is, before the widespread use of the technologies that we have discussed here), in the US, wrongful life claims were also submitted by 'illegitimate' children, not against medical practitioners, but against their putative fathers.[49] No such case was successful, but they highlight a very interesting issue of societal injustice – the (supposed) stigma and shame of illegitimacy – as well as legal distinctions between 'legitimate' and 'illegitimate' children. For us, another important aspect of wrongful life claims is that that they can remove some stigma from a parent who prefers not to make a wrongful birth claim, worried that this somehow makes a statement that they did not want and do not love their child.[50]

Some more recent wrongful life claims have involved racial issues, rather than a child's disability or illness. For example, a couple (usually white), expects (or contracts with) a fertility clinic to provide them with sperm from a white donor, but sperm from a black or other racially different donor is accidentally used. The children then suffer racial abuse, and a questioning of their family origins that they would not otherwise have suffered had they inherited their parents' white privilege. Should these children be able to claim from the careless fertility clinician, who, after all, made a profit from their wrongdoing? This is a difficult question that we will later return to. For now, we wonder if it would be better to frame these cases differently. Not as about 'wrongful life' – for it seems challenging to say that a child's life is wrongful because of the colour of their skin, given that it is not their skin that is the problem, but societal racism – but instead as 'the child is born and suffers because of the defendant's negligence', shifting the focus away from a 'wrongful life' to the negligent actions of the defendant and their role in the child's suffering. But this requires yet further terminological gymnastics.

[48] [2021] EWHC 3234.
[49] For example, *Zepeda v. Zepeda*, 190 N.E.2d 849 (III. App. Ct. 1963).
[50] This point is illustrated in *Toombes v Mitchell*, where the claimant's mother did not want to bring a wrongful birth claim precisely for this reason.

The framing of 'wrongful life' cases as some kind of value judgement between life and non-existence is one reason they have been considered controversial. But there are other reasons. Carol Sanger captures another here:

> [T]ort reforms that might otherwise extend notions of liability for reproductive negligence may be seen as dangerous or unacceptable because of their explicit recognition that not all children are wanted and that people will take steps to prevent their births.[51]

This relates to the idea that the development of reproductive technology and medicine has made reproductive decisions more explicit – whether to have children, when, how many, and so forth. Part of these calculations is to consider, as Sanger suggests, that not all children are wanted (or a 'blessing'), and that people will take steps to prevent their birth. Though she is referring to termination of pregnancy (for whatever reason), we can also extend this critique to pre-conception testing of IVF embryos, for example. Nevertheless, this possibility of pregnancy termination has been very influential in the development of wrongful life claims. This of course says something about the value that we give – or rather do not – to the reproductive autonomy of women in society. There is still a huge amount of controversy over abortion and its permissibility.[52] Sanger goes on to analyse how the framing of reproductive autonomy as being about 'choice' has somewhat backfired on the feminist movement, in the sense that it paved the way for abortion to be framed in consumerist terms by its opponents. Or as a type of lifestyle choice for women, rather than a *right* or a *need*. Similar arguments are made in relation to technologies that allow for embryo selection or pre-natal testing: or so-called 'designer babies'.

Pitched against this consumerist framing of reproductive choice, is the sanctity of life discourse, so the idea that all life is precious, and that humanity should not decide who lives or dies, or rather, who does or does not come into existence. As well as these conservative impulses and critiques of wrongful life claims, some progressives have also been critical, mainly invoking reasons of disability and racial injustice, and questioning what the claims potentially say about disabled life, or racialised existence. Lydia X. Z. Brown, a critical disabilities scholar and activist, criticises the individualistic nature of wrongful life claims, arguing that they are a highly problematic legal tool designed to achieve compensation for one individual, rather than focusing

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[51] Sanger, n 13, p 46.

[52] As illustrated in the US with the recent Supreme Court decision in *Dobbs v. Jackson Women's Health Organization*, No. 19-1392, 597 U.S. (2022), which in overturning *Roe v. Wade*, 410 U.S. 113 (1973) and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), declared that the US Constitution did not provide a right to abortion.

on bigger societal issues and structures which would remove the need for the claim in the first place.[53] Similarly, Wendy Hensel analyses the impact of such claims on disabled persons and their experiences, and makes the argument that they should not be allowed because of the pejorative messages that they send about disability.[54]

So far, you will have noticed, we have only cited US literature on wrongful life. There is a reason for that, which is that different US states have different rules on whether or not wrongful life claims are permissible. Most states do not allow them, but some do, and they are permitted in some circumstances in others. This inevitably means there is a bit more to write about! In the UK context, the scholar who has written the most in-depth analysis of wrongful life claims is Rosamund Scott.[55] However, her substantive work was published a decade ago, reflecting the fact that wrongful life cases have been regarded as inadmissible since the English Court of Appeal decision in *McKay v Essex Health Authority*.[56]

Mary McKay was born with very severe disabilities, caused by the fact that her mother, Jacinta McKay, had contracted rubella during the early stages of pregnancy. Jacinta suspected she had rubella and visited a doctor about her symptoms. Negligence on the doctor's part meant the condition went undiagnosed and Jacinta was unable to make a properly informed decision about continuing with the pregnancy considering the risks. The judges gave several reasons for concluding that wrongful life claims should not be admissible. In these reasons, we see the spectre of the sanctity of life principle, when a severely disabled child is refused compensation that would help significantly to improve her quality of life, on the basis that her claim offends the sanctity of life. Another version of the framing reflects a determination that the costs for meeting Mary's care should come from her mother, family and general taxation (social security), rather than through the professional insurance of a negligent doctor.[57]

We can draw our own conclusions about how the judges believed resources should be attributed in society, and who should bear the responsibility of risk and the burdens of care but, unsurprisingly, none of their reasoning was so overtly political. Instead, they suggested, first, that

[53] Lydia X. Z. Brown, 'Legal Ableism, Interrupted: Developing Tort Law & Policy Alternatives to Wrongful Birth & Wrongful Life Claims' (2018) 38(2) *Disability Studies Quarterly*.
[54] Wendy F. Hensel, 'The Disabling Impact of Wrongful Birth and Wrongful Life Actions' (2005) 40 *Harvard Civil Rights – Civil Liabilities Law Review* 141.
[55] Scott, n 25.
[56] [1984] 1 QB 1166 (CA).
[57] Although note that tortious damages are much higher than social security/disability benefits.

it would be contrary to public policy for a doctor to owe a child a duty of care to ensure that s/he did not exist, as this would undermine the sanctity of human life. Secondly, they thought that it might result in doctors being under a duty to persuade pregnant women to have a termination. Thirdly, they said that the law did not recognise being born as 'damage': life, however painful or disabled, is better than non-existence. Finally, they suggested damages could not be quantified, it being impossible to quantify the relative value of existence versus non-existence.

All aspects of this reasoning can be challenged. It is an equally valuable policy argument that 'a doctor has a duty to do their job properly so that their patient can make informed choices about whether or not to continue with a pregnancy', which will ensure patients' trust. The idea that doctors would have a duty to persuade women to terminate pregnancies seems highly misplaced, as any such duty would be restricted merely to advising her of this option. This is how the principles of informed consent already operate, and it is very clear under the law that pregnant women must consent to a pregnancy termination. Again, it would merely be imposing a duty on doctors to do their job properly. The third reason is a value judgment and one that arguably none of us – especially those with relative good health and a daily existence free from severe pain or life-limiting illness – are qualified to make. Further, judges and policy makers make quantifications about life and disabilities all the time.[58] Was this then just a convenient excuse?

How convinced should we be by this reasoning? What does it say about who should bear the responsibility for reproductive (professional) negligence? Should society be left to pick up the tag? Individual families? Parents? Or would it be more appropriate for professional insurance to pay, or at least contribute? If we do instinctively think that wider society should bear the brunt of the costs, then given structural inequalities relating to health and disability, amongst other factors, a further question is whether tort 'helps' by raising awareness, testing private law and finding its faults and parameters, or 'hinders' wider civil society action by 'individualising' the damage, both in terms of the person who suffers and the element of 'fault'? In other words, is tort a distraction to wider societal change, or can it complement those efforts?

In 2013, Rosamund Scott asked whether the time had come to revise *McKay*, given developments in how courts had more recently developed the sanctity of life principle (in neo-natal and other

[58] See e.g., *Judicial College Guidelines for the Assessment of General Damages in Personal Injury Cases* (16th edn, Oxford University Press, 2021).

end of life decisions) as well as possibilities for wrongful life claims in the context of assisted reproduction under the Congenital Disabilities Act 1976, implemented before many current assisted conception techniques were developed.[59] Additionally, she built an argument for allowing wrongful life claims when the child's suffering reaches a certain threshold. However, there has been absolutely no change in the law in this area since *McKay*, and the reasoning in *McKay* has been followed in many other jurisdictions, with the effect of 'fossilising' the common law. There are some alternative models of legal reasoning, but not many. And where there have been successful cases, such as in France in the *Perruche* case,[60] legislative action has swiftly followed to bar future claims.[61] One example of a successful wrongful life claim is the Californian Supreme Court case of *Curlender v Bio-Science Laboratories*,[62] where a child recovered damages after negligent prenatal testing failed to detect that she had Tay-Sachs disease. In this case, the judges observed that the 'reality of the 'wrongful life' concept is that such a plaintiff both exists and suffers due to the negligence of others'. So, a different way is possible. This leads us neatly to consider what might be called a recent 'revival' in wrongful life claims in the UK.

Reviving Wrongful Life claims, tort and social justice <2>

Toombes v Mitchell[63], mentioned earlier, starkly brings us back to the controversial role of pregnancy termination in wrongful life claims. Unlike *McKay*, which was about prenatal testing and advice, Caroline Toombes was given negligent advice about taking folic acid when she visited her GP to discuss family planning. Dr Mitchell advised it was not recommended and was up to her, when in fact it is medically recommended to take folic acid in advance of conception and at the start of pregnancy. Acting on this negligent advice, Caroline Toombes conceived and gave birth to Evie Toombes. Evie was born with a severe congenital defect caused by spinal tethering, causing her severe pain and significant debilitating conditions including double incontinence. Caroline Toombes did not want to bring a wrongful birth claim, for the reasons discussed earlier. Instead, Evie herself brought a wrongful life claim against the doctor.

[59] Scott, n 25.
[60] Nov. 17, 2000, JCP 2000, II, 10438.
[61] It is interesting that this legislative action did not make compensation impossible, but instead brought about an administrative agency to administer compensation when gross negligence causing disabilities could be shown. See further Julia Field Costich, 'The *Perruche* case and the issue of compensation for the consequences of medical error,' (2006) 78 *Health Policy* 8.
[62] [1980] Civ 58192.
[63] Above, n 48.

In the *Toombes* judgment, emphasis was placed on the fact that there had been pre-*conception* rather than pre-*natal* negligence – in other words, no question of pregnancy termination arose. This being true, the focus that the High Court judge continued to place on the undesirability of doctors being under a duty to present pregnancy termination as an option to their patients was surprising and can be interpreted as ongoing judicial discomfort with traditional wrongful life claims. However, it was the pre-*conception* distinction that allowed Evie Toombes' claim to succeed, on the basis that her case was framed not as between existence or no existence, but rather that as her mother would have delayed conception and taken folic acid for a few months, a different child would have been conceived at a different date, and one who was unlikely to have the spinal cord tethering. We do not know yet how much Evie's compensation award will be, but given the severity of her conditions, an award in the millions is likely, as was reported in the press.[64]

It is interesting how the media portrayed this case, and how they highlighted that Evie is a keen horse rider and show jumper and indeed competes professionally in both able bodied and para-Olympic competitions. She also campaigns for invisible disabilities,[65] describing herself on her Foundation website as an ambassador and educator, with the motto: 'find a way, not an excuse' – which sits uneasily with wider disability justice activism, as it seems to individualise the challenges that disabled persons face in society and potentially sends the message that 'you just have to try harder'. Given how she has had to manage her condition, the equipment and support that is required, and how the professional show-jumping world is not readily accessible to her without the need for significant specialised support and equipment – which seemingly she herself must fund and secure[66] – we are not sure this motto encapsulates the wider concerns of social justice. As with *Khan* and *ARB* which we have already discussed, it is valuable to reflect on this case, noting one's emotional reaction to it, and considering whether the outcome sits well in terms of social justice. *Toombes* is an effective contrast to a case like *McKay*, where Mary's condition was so debilitating that she simply would not have been able to present herself in the way Evie Toombes has been able to. That, of course, is fine – not all persons who are ill or disabled have the same life, and it is important that law and case reports acknowledge that. But

[64] For example, Laurence Dollimore 'Spina bifida showjumper WINS landmark legal case over her 'wrongful conception': Evie Toombes, 20, who sued her mother's GP claiming she should never have been born could win MILLIONS in damages' *Mail Online* 1 December 2021.
[65] Via the Evie Toombes Foundation (see https://foundation.evietoombespararider.com/).
[66] We can see this in the explanation for what the fundraising associated with Evie's Foundation will go towards – namely a specialised medical facility and horse box.

equally, if Evie Toombes is entitled to damages, hers being the first successful wrongful life claim since *McKay* in the 1980s – what does that say about children in a similar situation to Mary McKay – should they not also be compensated?

Another wrongful life claim presented itself earlier in *A and B (by C, their mother and next friend) v A (Health and Social Services Trust)*,[67] heard in the Northern Irish High Court, then Court of Appeal. It is interesting for very different reasons from *Toombes*. A and B (the children, who were twins), were not born with severe disabilities. Instead, they were born with a different skin colour from their parents and each other when a fertility clinic negligently used sperm from the wrong donor in their mother's fertility treatment. The harm that the children were claiming for related not to physical injury, but rather to racist abuse and harassment that they had been subject to, as well as their relationship with their parents being questioned (that is, the assumption that their mother had had an extra-marital affair). *A and B* is difficult and controversial for several reasons.[68] It is very difficult, wrong and completely undesirable to say that being born a certain skin colour is a 'harm'. A person's skin colour is not the harm, racism is, and we all know it exists, and that people suffer deeply from it, just as people suffer from ableism, sexism and various other intersections of inequality and injustice. But should people be able to claim damages through the tort system for racism that occurs in part because of the negligent action of a doctor?

A and B's claims were unsuccessful. In coming to this conclusion, the Northern Irish judges took an unhelpfully colour-blind approach to analysing the family's suffering. What would have been better would have been to acknowledge the damage done by the fertility clinic's negligence, and to put this in the context of wider societal and public responsibilities to ameliorate the impact of racism. In other words, to highlight the accountability of the negligent clinic, but also the wider role of the state.[69] Obviously, this is a difficult line to tread, as the legal claim rests on problematic assumptions around the genetic family, the privilege of whiteness, as well as inheritability. There is also an important social justice question here, as to the extent to which systemic and structural issues in society like racism, sexism, ableism and so forth, are well

[67] [2011] NICA 28.
[68] See Sally Sheldon, 'Is it a harm to be born with different skin colour to your parents?' *BioNews* 616, 18 July 2011.
[69] As argued comprehensively by Julie McCandless in her re-written feminist judgment on the case in Máiréad Enright, Julie McCandless and Aoife O'Donoghue (eds), *Northern/Irish Feminist Judgments: Judges' Troubles and the Gendered Politics of Identity* (Bloomsbury, 2017), chapter 30. Also see Marian Duggan's response to the re-written judgment in the same volume and chapter.

addressed by tort law, relying as it does on individual fault, harm, and recovery.[70] Can tort law be developed to take account of these collective issues, or, if you are really concerned about them, are you better off campaigning and taking action in other ways?

That said, the doctor/clinic *had* been negligent, and it feels right that they should be held accountable for negligent practices. Further, the family *did* suffer in terms of their reproductive plans being disrupted – their reproductive autonomy – and *then* because of this, having the legitimacy of their family questioned repeatedly, as well as experiencing racist abuse and harassment. Is it possible to (theoretically) allow the claim to acknowledge these issues, while at the same time, not also contributing to racialised social injustice?

Conclusions: What can tort law do? <2>

The time has probably come for tort law to rid itself of the problematic labels attached to 'wrongful birth' and 'wrongful life' claims. But how? And what should we replace them with? Dov Fox suggests that, because current torts cannot and do not respond well to the nature of reproductive harm, we should replace these heads of loss with a new, broader tort of 'reproductive negligence'.[71] But what should this look like? He frames reproductive negligence as being about loss of control or choice. Understandably, this is an effort to pin the proposed tort to autonomy interests and rights.

This proposal has prompted some important critiques. Carol Sanger, for example, questions how the tort would be devised, and the extent to which it considers the wider political context in which a tort of reproductive negligence would operate.[72] In doing so, she urges three main points of caution in relation to Fox's proposal. First, she urges caution with framing any tort of reproductive negligence as being about control and choice, for two reasons. The first is political, in terms of the rhetorical connotations of couching reproductive planning in the language of choice, given that this has allowed opponents of the abortion rights movement to attribute abortion with connotations of consumerism and self-satisfaction (as discussed earlier). The downside of a choice framework, therefore, is making something like having children (or not)

[70] See Patricia Williams' critical race theory critique of a similar wrongful life case in the US: 'The Value of Whiteness', *The Nation* 12 November 2014. See also Suzanne Lenon and Danielle Peers, '"Wrongful" Inheritance: Race, Disability and Sexuality in *Cramblett v Midwest Sperm Bank*' 25(2) *Feminist Legal Studies* 141.
[71] Fox, n 2.
[72] Sanger, n 13.

seem selfish or self-serving. Secondly, Sanger asks whether choice accurately reflects what has been lost in these cases, which she alternatively frames as 'a loss of a hoped-for outcome' or disappointment. In other words, while we may all adapt the language of 'reproductive control' and 'family planning', real-life trajectories are marked by much more ambivalence and chance than we are often prepared to concede. And while faith in technology and invention may make us think we are in control,[73] we should not forget that in this context we are not concerned with failed technology, but lack of careful medical practice, which often comes down to *chance*. Sanger also questions whether parents would want to frame any action as being about loss of control, given that loss of control over a certain 'planned for child' can often become acceptance (of the child you do have).

The second of Sanger's three main criticisms relates to the gendered nature of the harms, which Fox discusses only in gender-neutral terms. Here, Sanger wonders whether the differences potentially experienced by women and men in understanding the nature of the harm involved are too crucial to leave undeveloped: so for example, the emotional harm of fertility-related stress and how this is experienced differently by women and men,[74] notwithstanding the different physical interventions that take place in treatment. She argues that we should acknowledge this gender dimension throughout the process of trying to ascertain the cause of action: even if it comes to be implemented in a gender-neutral way. So, for example, she says we must ask what is at stake when motherhood is denied – and try to understand this by looking at why women seek it in the first place: whether to meet social, emotional, spousal expectations; keep a relationship together; move it forward; experience pregnancy; pass on a family name, genes, closeness, love; the idea of what having a baby is thought to mean and so forth. We should also ask the same for fatherhood; and see how the answers may be different.

Finally, Sanger's third concern, which appeared in part in her concern about framing a reproductive negligence tort as being about 'choice', is about how reproductive torts, especially wrongful life claims, ultimately come to be about abortion politics – we saw this clearly in *Toombes*. As she argues, the issue of abortion looms large: 'abortion suddenly seems to be about everything, and everything can quickly come to be about abortion'.[75] In other words, abortion

[73] Though see Emily Jackson, Chapter 7, this volume.
[74] We must also extend this reasoning to trans and other gender non-conforming persons and their particular reproductive experiences and expectations.
[75] Sanger, n 13.

can be seen as a cipher for a much wider political conversation around basic reproductive rights and access to decent reproductive and sexual healthcare.[76] The Northern Ireland *A and B* wrongful life case is a good example, with the original judges tying themselves in knots about duties being owed to foetuses (while being completely inattentive to the wider restrictions on abortion in the jurisdiction in place at the time of the case), as indeed is case law from English courts, with judges worried that to allow wrongful life claims would to somehow mean imposing duties on doctors to recommend terminations – a complete straw-man given that a woman must clearly consent to a termination under the law. Either way, Sanger encourages us to think about the wider political context in which doctrine develops, within which she regards a basic proposal for a tort of reproductive negligence as simply not up to the job: even as she is sympathetic to the aims of Fox's proposal.

Khiara Bridges is also sympathetic to Fox's aims, particularly as they relate to the harms imposed by negligent *private* actors – clinicians, fertility practitioners and so forth.[77] But in her reproductive justice critique of his proposed new tort, she introduces the harms that result when public actors impose, deprive, and confound procreation and asks how *state*-inflicted harms in this domain compare to private actor–inflicted harms. Importantly, she urges us to reconsider the harms caused by private actors' reproductive negligence in light of inequality along race and class lines. This brings us back to one of the broader themes of this chapter, which is whether tort law can help with wider social justice issues, rather than merely provide individualised corrective compensation. Bridges' point about analysing harms in light of societal inequality is a generative method for thinking about this possibility. Perhaps, when it comes to inequality, we should not confine our thinking to certain 'niche' areas of law, but all areas in a type of 'all hands on deck' approach to social justice.[78] We know, for example, that anti-discrimination and public sector equality duties have thus far failed to fully grasp or respond to the intersectional reality of people's lives.[79] Could tort law do any better, if we started to explicitly develop principles with social justice as a priority – in a way that collectivises, rather than privatises responsibility for health and care, and recognises and values not only the suffering, but also the experiences,

[76] See, for example, the feminists@law Rapid Response collection to the decision in *Dodds v. Jackson* (above note 59) (2002, volume 11(2), which addresses the impact of the decision on issues beyond abortion.
[77] Bridges, n 3.
[78] As argued for by Martha Chamallas, 'Social Justice Tort Theory' (2021) 14 *Journal of Tort Law* 309.
[79] On the former, see Kimberlé Crenshaw, 'Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics' (1989) 1 *University of Chicago Legal Forum* 139. On the Public Sector Equality Duty in the Equality Act 2004, see Simonetta Manfredi, Lucy Vickers and Kate Clayton-Hathway, 'The Public Sector Equality Duty: Enforcing Equality Rights Through Second-Generation Regulation' (2017) 47(3) *Industrial Law Journal* 365.

transitions and adjustments that people who are injured, and those who love and care for them make – without under-stating the need for societal resources, and indeed, society and the state's obligation to foster equality and resilience through the institutions, like law, that it propagates?