

BIRTH TRAUMA AND THE DUTY OF CARE

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INTRODUCTION

Until the Ontario Court of Appeal decision in *Paxton v. Ramji*¹ all parties to a negligence claim arising out of birth trauma would have assumed that physicians and nurses owe a duty of care to a fetus subsequently born alive. They would have proceeded to address whether the standard of care had been breached, whether causation was satisfied and then assessed the damages. Where negligent conduct was established, damages would be awarded which would have included the child's personal claims for care, loss of income and non-pecuniary general damages, among other claims.

In *Paxton*, Ms. Paxton sought treatment from Dr. Ramji, her family doctor, for acne. Believing that Ms. Paxton would not become pregnant, the doctor prescribed Accutane, a teratogenic² drug. Importantly, Ms. Paxton's husband had a vasectomy some 4 ½ years earlier. Despite this, Dr. Ramji did have a pregnancy test performed on Ms. Paxton before prescribing the drug. The test was negative. Unfortunately, after taking the drug it appears that the vasectomy failed and Ms. Paxton become pregnant, subsequently giving birth to a disabled child. The case was dismissed at trial, the trial judge having found that the doctor had met the applicable standard of care. The plaintiffs appealed.

Unfortunately for the law of negligence in birth trauma cases, and the law of negligence more generally, the Court of Appeal decided to dispose of the appeal

¹ *Paxton v. Ramji*, [2008] O.J. No. 3964 (C.A.).

² A teratogen is an agent that causes or increases the risk of abnormal fetal development.

after a more fundamental analysis of whether there was any duty of care owed by the physician to the fetus which could be breached. The Court of Appeal was not content to rely on the trial judge's finding, having posited a duty of care, that the standard of care had been met.

THE DUTY OF CARE

Little attention has been paid to the notion of duty of care in medical malpractice cases, based on the plethora of cases that provide precedent for the existence of a duty of care and the paucity of cases in which it has appeared necessary to consider duty. The matter of standard of care can not be addressed, however, unless there first exists a duty of care.

The notion of duty traces back to the principles enunciated in *Donoghue v. Stevenson* and the concept of "neighbour". Legal duties extended to neighbours, considered those who were so directly affected by the actions of a wrongdoer that the affected party should have been in the mind of the wrongdoer when the impugned act was committed.

The duty of care analysis is the one prescribed by the House of Lords in *Anns v. Merton London Borough Council*³ and adopted and modified by the Supreme Court of Canada in *Kamloops v. Nielson*⁴, decided in 1984, and *Cooper v. Hobart*⁵, decided in 2001. This will be referred to as the "Anns test". *Anns* is a 1978 case. There is a substantial body of negligence law decided before *Anns* was adopted in Canada where a duty of care was found owing, largely on the neighbourhood principles enunciated in *Donoghue v. Stevenson*⁶ that clearly did not involve the specific application of the Anns test. There is good reason to

³ *Anns v. Merton London Borough Council*, [1978] A.C. 728 (H.L.).

⁴ *Kamloops v. Nielson*, [1984] 2 S.C.R. 2.

⁵ *Cooper v. Hobart*, [2001] 3 S.C.R. 562.

⁶ *Donoghue (or McAlister) v. Stevenson*, [1932] A.C. 562 (H.L.).

believe that the application of the Anns test is to be reserved for establishing new duties of care not previously recognized by our courts.⁷

As will be discussed below, the Anns test involves the consideration of foreseeability, proximity and public policy. This paper need not delve into a review of foreseeability. The matter of proximity involves consideration of “relationships” and whether the relationship between the wrongdoer and the injured party is one such that the wrongdoer would or ought to have in contemplation the interests of the injured party in performing the act that gives rise to the claim. Where proximity is established and there exists a *prima facie* duty of care, that duty can be negated by broader policy considerations. Importantly, the burden is on the plaintiff to prove a *prima facie* duty of care based on proximity; the defendant has the burden of negating that duty with countervailing policy considerations.⁸

THE DUTY OF CARE FOR MATERNAL FETAL MEDICINE

Paxton was a case that concerned the physician’s obligation, if any, to a fetus not yet conceived where none of the parties had a potential fetus in contemplation. It also addressed the difficult issues surrounding the notion of “wrongful life”⁹, although the trial judge concluded that the case was not a wrongful life claim as the child would have been born even if the drug not been used, but without disability. In the duty of care analysis done by the Court of Appeal in Paxton, the comments by the court were not confined to only those circumstances involving not yet conceived babies. The troublesome comments by the Court are as follows:

1. At paragraph 25:

⁷ See Linden and Feldthusen, *Canadian Tort Law*, 8th edition, (Markham: Lexis Nexus Canada Inc., 2006) at page 302.

⁸ See Childs v. Desormeaux, [2006] S.C.J. No. 18.

“The issue whether a child born with birth defects should be entitled to successfully assert a negligence claim against a doctor or other health-care provider for harm suffered before birth has tested the mettle of many courts...”

By referring to “harm suffered before birth” the court has failed to distinguish between cases involving fetuses conceived and not conceived. The court makes no distinction between labour and delivery scenarios and other situations. The court also fails to address a very long line of cases which preceded Paxton where a duty was posited, as will be discussed below. Further, a review of the long line of labour and delivery cases clearly demonstrates that those cases did not “test the mettle” of the court, given the fact that a duty of care was posited in each and every labour and delivery case.

2. At paragraph 38:

“The question of a doctor’s legal proximity with a future child (whether conceived or not yet conceived) at the time of the doctor’s impugned conduct has been considered by Canadian courts in a number of contexts.”

The nature of the relationship between physician and fetus is different depending on when and why the physician becomes involved. The Paxton situation, where the fetus is not conceived, is quite different from the labour and delivery setting, where the physician’s care is largely concerned with fetal well-being. In the continuum of care between those two extremes, the matter of proximity may well take on different meaning. While proximity considerations may well differ significantly for future children

⁹ Wrongful life cases are concerned with the birth of children who, but for the negligence, would never have been born.

conceived and those not yet conceived, the court fails to make this distinction in Paxton. Further, one of the contexts of the relationship between physician and future child not reviewed by the court in Paxton was in the labour and delivery setting.

3. At paragraph 40:

“...Canadian courts have taken different approaches to the question whether there can be a proximate relationship between a doctor and a future child.”

While that may be true in some contexts, it is most certainly not the case in the context of the labour and delivery scenario. Every decision in Canada involving liability of a doctor to a fetus subsequently born alive has presumed a duty of care. That is, proximity was posited. There has been only one approach in labour and delivery cases: sufficient proximity exists to establish a duty of care.

4. At paragraph 52 (and perhaps the most troublesome quote from the case):

*“...I believe it is fair to say that there is no settled jurisprudence in Canada on the question whether a doctor can be in a proximate relationship with a future child who was not yet conceived **or born** at the time of the doctor’s impugned conduct.”*

Until Paxton, in the labour and delivery scenario it seemed well settled indeed that there was a proximate relationship between the obstetrician and the baby about to be born. It is unclear why the court felt compelled to include the words “or born” in the above passage, although it is undoubtedly related to the analysis of conflict of duty, to be discussed below. Insofar as labour and

delivery is concerned, the jurisprudence did not become “unsettled” until the Court of Appeal decision in Paxton.

5. At paragraph 76:

“The conflicting duties that would be owed by a doctor to a female patient and to her future child (whether conceived or not yet conceived) in prescribing medication to the female patient, together with the indirect relationship between a doctor and a future child, reflects two aspects of the same reality.”

The matter of conflicting duties will be discussed below. As to the “indirect relationship between a doctor and a future child”, it is difficult to see how that notion reflects aspects of the same reality as the matter of conflict. It is unclear what is meant by indirect, except to say that some treatment of the mother must indirectly affect the fetus. There are, however, many situations in antenatal care where the fetus is “directly” affected by the conduct of the physician. The notion of “indirect” is more obvious in the situation where the fetus is not yet conceived. It cannot get more indirect. It is less clear where the fetus is conceived.

With respect to the proximity analysis under the Anns test, one is looking at relationships which are sufficiently “close and direct” as to justify imposing liability. In using the phrase “close and direct” it appears that it may have a different meaning than that implied by Feldman JA. The Supreme Court of Canada addressed this as follows:

This factor is not concerned with how intimate the plaintiff and defendant were or with their physical proximity, so much as with whether the *actions* of the alleged wrongdoer have a close or direct effect on the victim, such that the wrongdoer ought to have the victim in mind as a person potentially

harmed. A sufficiently close and direct connection between the actions of the wrongdoer and the victim may exist where there is a personal relationship between the alleged wrongdoer and victim. However, it may also exist where there is no personal relationship between the victim and wrongdoer.¹⁰

Consider the following quote from *Donoghue v. Stephenson*:

A duty to take care arises when the person or property of one was in such proximity to the person or property of another that, if due care was not taken, damage might be done by the one to the other. I think that this sufficiently states the truth if proximity be not confined to mere physical proximity, but be used, as I think was intended, to extend to such close and direct relations that the act complained of directly affects a person whom the person alleged to be bound to take care would know would be directly affected by his careless act.¹¹

There is a long line of cases, including cases in the Court of Appeal¹², which have assumed a duty of care in the labour and delivery setting. As stated earlier, there is not a single case in Canada that has suggested an absence of such duty. Nor has any court ever felt compelled to conduct a first-principles duty analysis in that setting.

Despite the recognition by the Court of Appeal in *Paxton* that the duty of care can be confused with the standard of care, it is suggested that the court in fact confounded these two important but distinct concepts. It is important to recognize that the absence of a duty of care protects the wrongdoer unconditionally from negligent acts. No duty of care means immunity from liability. There is no accountability, no deterrence and no justice as between wrongdoer and injured party if no duty arises. Without a duty, courts are deprived of the flexibility to impose obligations in important relationships that

¹⁰ See *v. Hamilton-Wentworth Regional Police Services Board*, [2007] S.C.J. No. 41.

¹¹ See *Donoghue v. Stevenson*, [1932] A.C. 562, at page 581.

justify a remedy. On the other hand, the standard of care analysis permits complete flexibility and allows accountability when it ought to reasonably be imposed. Indeed, the Court of Appeal in Paxton could have brought about the same disposition it did through a standard of care analysis (as employed by the trial judge) rather than a duty of care analysis.

In *Liebig v. Guelph General Hospital*¹³ an action was brought in relation to harm suffered during labour and delivery. Counsel for the plaintiff, Barbara Legate, delivered a Request to Admit asking the defendants to admit that a duty of care was owed in connection with the delivery of the child. The defendants denied the duty of care and a motion under rule 21 to determine an issue followed. Mr. Justice Tausenfreund, in a judgment dated October 14, 2009, found that a duty of care was owed by the nurses and doctors to a fetus born alive. The defendants appealed to the Court of Appeal. A review of the motion judge's decision is found below.

The *Liebig* appeal was heard by a 3-judge panel on March 2, 2010. Subsequently the Chief Justice ordered that the appeal be re-heard by a 5-judge panel of the Court of Appeal, clearly recognizing the important of this case for obstetrical malpractice actions and the law of negligence more generally. At a minimum, the Court of Appeal in *Liebig* will be asked to distinguish the case from *Paxton* and affirm the duty of care in the labour and delivery setting found in the long line of cases preceding *Paxton*. It is also open to the court to find that the comments in *Paxton* involving conceived future children were obiter dicta. Finally, there may be some willingness to consider overruling *Paxton*'s duty of care analysis.

¹² See *Commisso v. North York Branson Hospital*, [2003] O.J. No. 20 (C.A.); and, *Crawford v. Penney*, [2004] O.J. No. 3669 (C.A.).

¹³ *Liebig v. Guelph General Hospital*, Superior Court of Justice File No. 38906, Court of Appeal File No. C51224.

THE PAXTON DECISION

The trial judge in Paxton found that Dr. Ramji had a duty to the “unconceived” child not to prescribe a teratogenic drug unless he was satisfied, based on a reasonable standard of care, that Ms. Paxton would not become pregnant. Having done so, the trial judge went on to find that the physician met the standard of care. This approach to liability certainly highlights the flexibility of a standard of care analysis even in the context of an unconceived child. The Court of Appeal was not content with this approach, for reasons detailed below.

The trial judge also considered whether Paxton was a “wrongful life” case.¹⁴ Had Dr. Ramji ensured that Ms. Paxton used guaranteed contraception while on Accutane, the child would not have been born, giving the case the appearance of a wrongful life case. On the other hand, if the standard prohibited the doctor from prescribing Accutane to women of child-bearing potential then the child would have been born, but without disability caused by the drug. On the trial judge’s reasoning, the child would have been born either way, and therefore the case was not a claim for wrongful life.

The Court of Appeal in Paxton decided to ignore the possible characterization of the case as a claim for wrongful life and opted to look at the issue of duty of care from first principles. In fact, the court went further and held that to ask whether the case is one of wrongful life is to ask the wrong question.¹⁵ The first question to ask is whether the wrongdoer owed a duty of care at all to the plaintiff. It is only after a duty of care is established on legal principles that the court can then go on to determine whether the standard of care has been met.

¹⁴ A wrongful life case involves claim by the child born with a disability where the child alleges that the birth would not have occurred but for the defendants’ negligence. That is, the child would not have been born at all. In contrast, “wrongful birth” cases are claims brought by the parents (not the child) alleging that the child would not have been conceived or born but for the physician’s negligence.

¹⁵ See Paxton paragraph 29.

There are dozens of cases in the setting of labour and delivery, both before and after the Anns test was adopted in Canada, that clearly found sufficient proximity between health care professional and fetus to allow claims by the born alive child for harm caused in utero. The Supreme Court of Canada has held that where a relationship of proximity has been previously recognized or where a relationship may be analogous to a category of previously recognized relationships, the proximity requirement of the Anns test is met.¹⁶

This approach of recognizing categories that determine proximity underscores the importance of precedent. Otherwise the adoption of the Anns test would require exposing the entire history of negligence law to a re-assessment under the Anns test. It would mean that parties would be subjected to the uncertainty that such a scenario creates and would substantially undermine the law of negligence. Recently the Supreme Court of Canada stated:

In many cases, the relationship between the plaintiff and the defendant is of a type which has already been judicially recognized as giving rise to a duty of care. In such cases, precedent determines the question of duty of care and it is unnecessary to undertake a full fledged duty of care analysis.¹⁷

The Supreme Court of Canada has addressed this issue of precedent or category of duty many times. In *Hill v. Hamilton-Wentworth*¹⁸ the court stated at paragraph 25:

Proximity may be seen as providing an umbrella covering types of relationships where a duty of care has been found by the courts. The vast majority of negligence cases proceed on the basis of a type of relationship previously recognized as giving rise to a duty of care...The categories of relationships characterized by sufficient proximity to attract legal liability are not closed, however. From time to time, claims are made that relationships hitherto unconsidered by courts support a duty of care giving rise to legal liability....The result is a concept of liability for negligence

¹⁶ See *Cooper v. Hobart*, paragraphs 25, 31 and 36.

¹⁷ See *Mustapha v. Culligan*, [2008] S.C.J. No. 27.

¹⁸ *Hill v. Hamilton-Wentworth Regional Police Services Board*, [2007] S.C.J. No. 41.

which provides a large measure of certainty, through settled categories of liability – attracting relationships, while permitting expansion to meet new circumstances and evolving conceptions of justice.

This passage implies that the duty of care analysis is to be done when the particular case gives rise to a relationship not previously addressed by the courts. In other words, the Anns test is to be used to expand the law of negligence.¹⁹ There is no room for the application of the Anns test in the context of relationships covered by the “umbrella” of cases where proximity has been found previously. Tort law is intended to develop gradually or in small increments so that negligence law can provide a reasonable degree of certainty.²⁰

In *Healy v. Lakeridge Health Corp.*, Justice Perell put it this way:

The contemporary analysis of whether a duty of care exists begins by asking whether the plaintiff and the defendant are in a relationship that the law categorically recognizes as involving a duty of care or whether the relationship constitutes a new category of claim. If the claim falls within an established category, then precedent will have established that there is a duty of care associated with the relationship between the parties.²¹

Clearly, labour and delivery cases have given rise to the judicially recognized duty described by the Supreme Court of Canada and other courts. In fact, there has never been a labour and delivery case that found no duty of care owing by the health care professional for antenatal negligence followed by a born alive child. Linden and Feldthusen in their text on tort law state:

It was not the goal of the Supreme Court to overrule all of its carefully developed body of negligence law nor even to re-evaluate all the existing categories...

¹⁹ See also *Childs v. Desormeaux*, [2006] S.C.J. No. 18, at paragraph 15.

²⁰ See Hill paragraph 27.

²¹ *Healy v. Lakeridge Health Corp.*, [2010] O.J. No. 417.

In the rare case, and it should *only* be the rare case, when a full duty analysis is needed, the new *Anns* test as described in *Cooper* must now be employed.²²

Applying the *Anns* test to the existing body of negligence law would be to effectively use the test to “dismantle” the law of negligence, the effect of which would be the re-litigation of previously recognized duties. This has been characterized as allowing previously recognized duties to be “cancelled”. In *Cooper v. Hobart*²³ the Supreme Court of Canada cited the importance of *Anns* as a test for determining proximity and the importance of policy considerations “in new situations”. When a case comes within an already recognized category, or even an analogous category, a *prima facie* duty may be posited.²⁴

The *Anns* test begins with a consideration of foreseeability. Clearly the potential of a teratogenic drug to cause injury to a child not yet conceived is foreseeable. As foreseeability was obvious in *Paxton*, no further discussion on this aspect of the *Anns* test is needed. Consideration of the other two important matters in the *Anns* test, proximity and policy considerations, is far less clear.

With regard to proximity, the court is asked to consider whether the doctor and the future child are in such a “close and direct relationship” that imposing a duty of care, with all the obligations that duty gives rise to, is justifiable. In *Paxton*, the issue of proximity troubled the Court of Appeal due to the potential for conflict between the duty the doctor owed the mother and any duty that might be owed to the fetus. It was the potential for such conflict that led the court to find that there was no relationship of proximity. At paragraph 66 the court stated:

If a doctor owes a duty of care to a future child of a female patient, the doctor could be put in an impossible conflict of interest between the

²² See Linden and Feldthusen, *Canadian Tort Law*, 8th edition, at page 302.

²³ *Cooper v. Hobart*, [2001] 3 S.C.R. 537, paragraph 25.

²⁴ *Cooper v. Hobart* paragraph 36.

interests of the future child and the best interests of the patient in deciding whether to prescribe a teratogenic drug or to give the patient the opportunity to choose to take the drug...

These conflicting duties could well have an undesirable chilling effect on doctors...Thus, imposing a duty of care on a doctor to a patient's future child in addition to the existing duty to the female patient creates a conflict of duties that could prompt doctors to offer treatment to some female patients in a way that might deprive them of their autonomy and freedom of informed choice in their medical care.

With regard to maternal autonomy, the court pointed out that women are entitled to make decisions concerning their own bodies without regard to the well-being of their future child and, in doing so, cannot be held liable to the born alive child for any harm done.²⁵ The difficulty with the analysis of maternal autonomy is that the court assumes that the doctor must be cloaked with the same immunity from liability as the woman in order to protect maternal autonomy. This is simply not the case, as will be explained below. The court also found that the relationship between the physician and the future child was "indirect", militating against the existence of a proximate relationship.²⁶ Again, there are important policy considerations, to be explained below, which in fact militate for proximity rather than against.

Despite having found that proximity was not made out in Paxton, and thus no duty of care existed, the court still considered the policy consideration stage of the Anns test, also finding that policy reasons provided immunity to the doctor for any negligence. Policy considerations arise when there is sufficient proximity to impose a duty of care but where policy considerations apply to negate that duty. It is important to recognize that a duty either exists or it does not. If there is no duty of care, no amount of negligence, no matter how egregious, and no amount of harm, no matter how catastrophic, will give rise to a claim. Policy considerations will negate duties in some situations, but not in others. Thus,

²⁵ See Paxton paragraph 73.

²⁶ See Paxton paragraph 71.

where it is sought to limit or qualify a duty, it must be done in the context of a standard of care analysis, not through duty of care.

It is important to keep in mind the impact of the duty of care analysis contrasted with the standard of care analysis. The absence of a duty of care denies a remedy in tort and is “quite literally, to deny justice.”²⁷

In the context of the Paxton decision, some difficult issues arise. They include the following:

- 1) In view of the labour and delivery cases where proximity has been posited, did the Court of Appeal err in asking whether a duty of care was owed by Dr. Ramji and doing the Anns analysis? In other words, did the factual scenario in Paxton fall within the category of duty established in labour and delivery cases, by analogy?
- 2) Was the law unsettled as to whether a doctor can be in a proximate relationship with a future child not yet conceived or born at the time of the negligence?
- 3) When looking at proximate relationships between doctors and future children, is there a distinction between negligence occurring before and after conception?
- 4) If it was appropriate to apply the Anns test to the facts in Paxton, what impact does the finding that there was no duty of care in that case have on other obstetrical malpractice cases, and labour and delivery cases in particular?
- 5) Is a finding of “no duty” in Paxton compatible, on a principled basis, with a finding of a duty in labour and delivery cases?
- 6) Should Paxton be limited to the facts and the comments about duty to conceived future children be considered obiter dicta?

²⁷ See Hill paragraph 35.

- 7) Does the analysis evolve from one of duty of care to standard of care as one moves along the continuum of medical care provided to women of child-bearing potential?

BOVINGDON v. HERGOTT

Another important case to consider in any duty of care discussion is the Ontario Court of Appeal decision in *Bovingdon v. Hergott*.²⁸ In that case the plaintiff was having difficulty getting pregnant and the defendant physician prescribed fertility medication to her. She subsequently became pregnant and delivered twins suffering from disability related to prematurity. The plaintiff complained that the doctor failed to warn her of the risks of multiple gestations and prematurity thereby depriving her of the ability to make an informed decision. The mother and the children brought a claim against the doctor.

The plaintiffs' case in *Bovingdon* was that the woman would not have taken the fertility medication had she known of the risks and, therefore, the children would never have been born. It may be sufficient to distinguish this case from the labour and delivery cases by simply pointing to the fact that the children were not yet conceived at the time of the alleged negligence. On the other hand, it is clearly foreseeable that the conduct of the physician may affect the future but as yet unconceived children of the woman taking fertility treatment. There would be no reason to prescribe the treatment but for that purpose. The court held:

Because the doctor's duty with this type of drug is only to provide information sufficient to allow the mother to make an informed choice, it cannot be said that the children have a right to a drug-free birth. Nor can the doctor owe a duty to the children that is co-extensive with his duty to the mother. To frame the duty in that way is to overlook the fact, as discussed above, that the choice is the mother's; she is entitled to choose to take the drug and risk conceiving twins without considering their interests. If she does, the children have no complaint against her or the doctor.

²⁸ *Bovingdon v. Hergott*, [2008] O.N.C.A. 2, leave to appeal refused [2008] S.C.C.A. No. 92.

I conclude that in this case, the appellant had no duty of care to the future children not to cause them harm in prescribing Clomid to the mother. The doctor owed a duty of care only to the mother, which duty consisted of ensuring that she possessed knowledge sufficient to make an informed decision...

The first paragraph quoted above is not particularly troublesome. The second is unfortunate. The starting point for the analysis in these two paragraphs is a mother's immunity from liability for any harm caused to her child in utero. A mother can not and ought not to be held liable for such harm. The repercussions of holding her liable fully support providing her with that well-recognized immunity.²⁹ The issue, however, is whether there is any compelling reason to cloak a physician with the mother's immunity from liability to the fetus. It is suggested that the answer is clearly "no". Arguably different considerations apply depending on where in the continuum of care the facts of the case bring the inquiry. For example, there may be important distinctions between pre-conception fertility treatment, at one end of the spectrum, and second stage labour at 40 weeks gestation at the other end of the spectrum. It may well be that at some point between these two poles, the duty of care analysis shifts to a standard of care analysis. On the other hand, the duty of care analysis is insufficiently flexible to address all the possible fact situations, while the standard of care analysis is robust and effective in delivering a fair and equitable result in any scenario.

Having said that, the Court of Appeal in *Bovingdon* has said that a doctor cannot owe a duty of care to the children that is "co-extensive" with a duty to the mother. Quite apart from the fact that *Bovingdon* looks very much like a "wrongful life" case, and could have been dismissed on that basis, the approach taken by the Court of Appeal is one that again confuses duty of care with standard of care. There are no compelling reasons to deny the potential for co-extensive duties.

²⁹ See *Dobson v. Dobson*, [1999] 2 S.C.R. 763.

The problem that concerned the court in *Bovingdon*, the potential for conflict between the two duties, is easily resolved in the standard of care analysis.

Recognizing maternal autonomy, the doctor's obligation must be merely to ensure that the mother, who, by necessity, must make decisions for herself and her unborn child, is fully informed. Should the mother make a decision that has an adverse effect on her unborn child and that decision is made after the doctor met his obligation to fully inform the mother of her options, the doctor will not be liable for adverse consequences, not because he is cloaked with the mother's immunity, but rather because he has discharged his duty. Using *Bovingdon* as an example, clearly the standard of care should require a physician to let his patient know that fertility drugs increase the risk of multiple gestations; that multiple gestations can result in prematurity; and, that prematurity carries increased risk of morbidity and mortality. If the mother opts to take the medication after receiving all the information the standard of care requires, there is no liability for a bad outcome. To hold otherwise would be to deprive all women with fertility issues of potentially helpful treatment. The defendant physician in *Bovingdon* failed to meet the standard of care by providing the mother with sufficient information to make an informed decision. Whether there should be liability imposed in the *Bovingdon* situation is really an inquiry that harkens back to the wrongful life analysis.

The court is undoubtedly correct in saying that children do not have a right to a drug-free birth. That would clearly violate the mother's right to make choices. But the fact that the children are not entitled to a drug-free birth does not mean there is no duty of care. The mother can expose the unborn children to risks of increased morbidity and mortality without risk of liability. The doctor can be complicit in this, without attracting liability, provided the standard of care has been met.

Feldman J.A. does state that there is no duty of care owed to “unborn children”, and unfortunately fails to make a distinction between unborn children conceived or not. It is the failure to make that distinction in both Bovingdon and Paxton that has led to some unfortunate controversy which arises from this loose language. It is suggested that the fundamental approach used by the court in both cases is flawed. While it may have been appropriate to approach the duty of care analysis in Paxton and Bovingdon from first principles, using the Anns test, it is suggested that the existence of a duty in both these cases does not turn on the matter of conflicting duties between that owed to mom and that owed to child. In the fertility situation, any policy reasons for rejecting a duty do not arise out of the conflicting duty concern but may well arise out of the interest in promoting fertility treatment as a matter of sound public policy. Again, that seems unnecessary in view of the fact that fully informing the mother is sufficient to meet the standard of care in relation to the fetus.

In Bovingdon, Feldman J.A. made the following statement:

If future children have a right to a drug-free birth, as the respondents suggest, then doctors might decide to deny women the choice of taking Clomid on the basis that providing such choice might be a breach of the doctor’s duty to the unborn children. In my view, the policy of ensuring that women’s choice of treatment be preserved supports the conclusion that the doctor owed no legal duty to the unborn children in this case.³⁰

It is unfortunate that the respondent’s argument was based on the assertion of the right of the fetus to a drug-free birth. That is clearly not the case and is incompatible with the duty analysis suggested in this paper. Doctors are not apt to deny fertility treatment in circumstances where the mother’s informed choice results in a finding that the doctor has met the standard of care that his duty of care to the unborn child demands. For reasons expressed elsewhere in this paper, policy considerations offer compelling arguments for the recognition of a

³⁰ See Bovingdon paragraph 71.

duty of care owed by a doctor to a conceived child, if not an not yet conceived child.

THE MOTIONS JUDGE IN LIEBIG

The motion in Liebig before Justice Tausenfrend³¹ addressed Paxton and Bovingdon directly in the context of the labour and delivery setting. The defendants denied a duty of care was owed to the child in connection with his delivery. The plaintiffs sought a declaration on a rule 21.01 motion that a duty of care was owed.

The position of the defendants in Liebig was simply that the two Court of Appeal decisions apply to the maternal-fetal care scenario, and that no duty of care is owed. The plaintiffs argued:

- The focus of the care provided in both Bovingdon and Paxton was for the sole benefit of the mother;
- The health of the fetus in those cases was not the object of the care provided;
- The focus of maternal-fetal care is the well-being of mother and fetus; and
- In the maternal-fetal care setting there is neither a potential or an actual conflict of interest.

The motions judge pointed out that, in reference to the claims that have “tested the mettle” of many courts, the Court of Appeal in Paxton did not include in the list of cases, those concerned with maternal-fetal medicine. On the other hand, the motions judge did note the long line of birth trauma cases where a duty of care has been recognized. Reference was made to Crawford v. Penney and

³¹ Liebig v. Guelph General Hospital, [2009] O.J. No. 4292 (Ont. Sup. Ct.)

Commisso v. North York Branson Hospital, both decisions of the Ontario Court of Appeal.

In view of the long line of maternal-fetal care cases where a duty of care has been recognized, Tausendfreund said:

“...the Court of Appeal could surely not have meant the maternal-fetal care scenario when referring to ‘the proposed duty’ as ‘a novel one’...

In summary, I find that the court in both Bovingdon and in Paxton did not include in its consideration the maternal-fetal care cases such as the one before me. The duty to both mother and fetus in the maternal-fetal care scenario has been long established in Canadian jurisprudence.³²

The motions judge made a declaration that the defendants owed a duty of care in relation to the delivery of the plaintiff Kevin Liebig. The defendants have appealed. The appeal was initially heard by a 3-judge panel on March 1, 2010, with OTLA having been granted intervenor status. After arguing the appeal, the Chief Justice ordered that the appeal be re-argued before a 5-judge panel. The appeal will be heard on May 20, 2010.

BIRTH TRAUMA CASES AFTER PAXTON

A number of decisions have been rendered in labour and delivery cases subsequent to the decision in Paxton. Some cases have made direct reference to Paxton and others have not. It is suggested that those cases that have not cited Paxton have omitted to do so not because the defendants were unaware of the case, but rather because even defendants are having difficulty seeing how the case can apply to the labour and delivery setting.

The 2009 case of Milne v. St. Joseph’s Health Centre³³ was a pre-labour case involving a mother presenting to the emergency department with severe

³² See paragraphs 33 and 35.

abdominal pain. Intermittent observation and the failure to recognize an impending disaster caused by a hidden placental abruption resulted in the birth by c-section of a seriously disabled baby. Prior to trial the case against the physician settled and the trial concerned only the several liability of the nurse and the hospital. The trial judge assessed liability against the physician and the nurse. As in the long line of birth trauma cases that preceded Paxton, the court in Milne accepted that the nurse and the physician owed a duty of care to the fetus. In terms of the potential for conflict, it was recognized that in the setting of a placental abruption there is potential for sudden decompensation on the part of the mother or the fetus. Both need to be monitored carefully. Clearly there were two patients being cared for and there was no indication that the defendant hospital or the court was troubled by any potential for conflict.

In *Ediger v. Johnston*³⁴ the British Columbia Supreme Court was invited to consider whether a duty of care was owed by physician to fetus in labour and delivery. The plaintiffs' claims concerned the negligent application of mid-forceps and the failure to have a "double set-up" in the event a c-section became necessary. The trial judge in *Ediger* makes reference to the British Columbia Court of Appeal decision in *Cherry v. Borsman*³⁵, a case where that court found a duty of care owed to a child born disabled following a negligent attempt at an abortion. The court also addressed the Ontario Court of Appeal decisions in *Bovingdon* and *Paxton*. Based on these decisions, the defendant doctor argued that it was no longer clear law that a duty of care is owed to a fetus.

The issue of conflicting duties was addressed in *Ediger*. The question of conflict, according to the trial judge, is answered "by the simple reality that mothers make decisions...for their unborn children".³⁶ This is indeed a complete answer to the conflict issue. To the extent the interests of the mother may conflict with the

³³ *Milne v. St. Joseph's Health Centre*, [2009] O.J. No. 4004 (Ont. Sup. Ct.).

³⁴ *Ediger v. Johnston*, [2009] B.C.J. No. 564 (B.C.S.C.)

³⁵ *Cherry v. Borsman* (1990), 75 D.L.R. (4th) 668.

³⁶ See *Ediger*, paragraph 186.

interests of the fetus, the physician has discharged her duty when she has met the standard of care by giving the mother all the information needed to make an informed decision. After that, it is entirely for the mother to resolve the conflict. A doctor will not be liable for the choices made by the mother, no matter what harm caused to the fetus, provided the doctor has met the standard of care.

In Ediger the court was urged by the plaintiff to interpret Paxton as being confined to the duty of care owed to an “unconceived” fetus. The court concluded that the language used by Feldman JA appears to have contemplated conceived and not yet conceived fetuses. Having done so, the court then attempts to make a distinction between the cases by looking to the “issues and conclusions as illuminated by the factual context of the case from which they arose”.³⁷ In doing so, the court concluded that to the extent the reasons might be seen as extending to a conceived fetus, those comments are *obiter dicta*. Support for this conclusion is found by the court in Ediger by virtue of the failure of the Court of Appeal in Paxton to discuss earlier decisions, like Crawford v. Penney, which recognized a duty of care. If Paxton is read to apply to cases involving conceived children then it stands in conflict, according to Ediger, with numerous decisions that have recognized the duty.³⁸

CONFLICT

The matter of conflict is considered only after a *prima facie* duty of care is found under the proximity analysis. However, the conflict step of the Anns test is not invoked in cases where the duty of care asserted already falls in a recognized category. In those circumstances the courts will be satisfied that there are no overriding policy considerations that would negative the duty of care.³⁹ Once the duty has been shown to be novel and proximity is made out, the second stage

³⁷ See Ediger paragraph 197.

³⁸ See paragraph 200.

³⁹ See Cooper v. Hobart paragraph 39.

conflict analysis of Anns comes into play. It is not all conflict that will operate to extinguish a duty of care. As stated in Hill:

...conflict or potential conflict does not in itself negate a *prima facie* duty of care; the conflict must be between the novel duty proposed and an “overarching public duty”, and it must pose a real potential for negative policy consequences.⁴⁰

In considering where a conflict might arise that is sufficient to negate a duty of care, the Supreme Court of Canada has suggested addressing the following questions:

1. Does the law already provide a remedy?
2. Would recognition of the duty of care create the spectre of unlimited liability to an unlimited class?
3. Are there other reasons of broad policy that suggest that the duty of care should not be recognized?⁴¹

Central to the decisions in Paxton and Bovingdon is the matter of conflict between the interests of the mother and those of the fetus. Maternal autonomy is recognized by the mother’s immunity from liability for harm caused to her fetus in utero. The fundamental flaw in the reasoning of Feldman JA in both Bovingdon and Paxton arises out of the conclusion that to preserve the mother’s immunity it is necessary to grant the physician the same immunity. This does not follow.

Maternal autonomy can be preserved while imposing liability for physicians for negligence resulting in harm to a fetus later born alive. It is clear that a child may sue in tort for injury caused before birth.⁴² The duty of care does not crystallize until the fetus is born alive. Recognizing that mothers necessarily make

⁴⁰ See Hill paragraph 40. See Cooper v. Hobart, paragraph 37. See also cases like Syl Apps Secure Treatment Centre v. B.D., [2007] 3 S.C.R. 83, where a conflict was found.

⁴¹ See Cooper v. Hobart, paragraph 37.

⁴² See Montreal Tramways, [1933] S.C.R. 456; Duval v. Seguin, [1972] 2 O.R. 686 (H.C.); Winnipeg Child and Family Services v. D.F.G., [1997] 3 S.C.R. 925.

decisions for their fetus, which is entirely consistent with maternal autonomy, doctors are entitled to rely on the mother's decision. Whether that decision favours maternal health over fetal well-being is not the issue. The fact that the mother must make decisions for both herself and her baby must be recognized in formulating the standard of care. In so doing, the matter of conflict, real or imagined, is completely addressed.

The perception of a potential conflict is more imagined than real. Unlike the mother's own physician, the obstetrician is specifically consulted in relation to fetal well-being. Ultimately, the matter of conflict is more appropriately addressed in considering the ultimate standard of care.

Acknowledging a mother's unfettered responsibility for making decisions affecting fetal health ensures that physician liability will be found only in appropriate circumstances. Indeed, the failure to recognize a duty of care owed by a physician to a fetus may well create conflict between the physician and the mother. Pregnant women engage the services of obstetricians primarily to ensure the birth of a healthy child. Many of the tests and procedures women are subjected to during pregnancy have the objective of fetal well-being in mind. Ultrasounds, amniocentesis, non-stress tests, biophysical profiles, scalp sampling, and other tests are focused on fetal well-being. Mothers consent to all kinds of invasive procedures, including forceps delivery, vacuum delivery and c-sections, all with a view to fetal health. If she felt the obstetrician's obligation to provide the highest level of care to her fetus might be compromised in any way, she would seek out another physician willing to assume a duty of care to her unborn child.

Provided maternal autonomy can be maintained under the duty analysis, there is no real potential for negative policy consequences, as described in Hill above, and therefore no justification for relieving a physician of liability to the fetus. As the mother's treatment choices "trump" the interests of her fetus, thereby entirely

preserving maternal autonomy, there is no reason to cloak the health care practitioner with immunity from liability. As stated in Hill:

...even if a potential conflict could be posited, that would not automatically negate the *prima facie* duty of care. The principle established in *Cooper* and its progeny is more limited. A *prima facie* duty of care will be negated only when the conflict, considered together with other relevant policy considerations, gives rise to a real potential for negative policy consequences.⁴³

Proximity is said to involve the examination of the relationship at issue. The factors to be considered include expectations, representations, reliance and other interests.⁴⁴ It is suggested that these notions also fit within the policy considerations analysis. For maternal-fetal care, the expectations are abundantly clear. It seems highly likely that the treating physician is going to have the same high expectations for competent care of the unborn baby as does the mother. The physician undoubtedly represents to the mother, indirectly if not directly, that she possesses those skills needed to ensure fetal well-being and the birth of healthy child. Clearly, mother relies on her physician for quality care in accordance with the highest standards of practice. It can be said that the interests of the mother and the health care providers are far more likely to coincide than conflict.

POLICY CONSIDERATIONS

Once proximity is found, the court must then consider residual policy considerations as the final branch of the Anns test. These policy considerations are concerned broadly with the impact of recognizing a duty of care on the legal system and society, rather than the relationship between the litigants.⁴⁵

⁴³ See Hill paragraph 43.

⁴⁴ See Hill v. Hamilton-Wentworth [2007] S.C.J. 41 at paragraph 24.

⁴⁵ See Cooper paragraph 37 and Hill paragraph 31.

Looking at maternal-fetal care in this broader context it is not difficult to see that decreasing fetal morbidity and mortality is very much in the interests of the legal system and society. It is difficult to imagine a setting where imposing a duty is more important. Expectant parents expect the highest standard of care for their unborn child. Most of the developments in maternal-fetal medicine are focused on fetal well-being. One of the functions of tort law is to protect from the deliberate and careless acts which lead to harm. It is the reasonable expectation of expectant mothers that physicians and nurses in maternal-fetal care will conduct themselves in a competent, non-negligent manner.⁴⁶

Imposing a duty to take reasonable care on those providing maternal-fetal care will help reduce fetal morbidity and mortality. Any negative repercussions from imposing such a duty are dubious at best and substantially out-weighed by society's interests in healthy newborns.

As stated by the Supreme Court of Canada in *Montreal Tramways Co. v. Leveille*⁴⁷:

If a child after birth has no right of action for pre-natal injuries, we have a wrong inflicted for which there is no remedy,...If a right of action be denied to the child it will be compelled, without any fault on its part, to go through life carrying the seal of another's fault and bearing a very heavy burden of infirmity and inconvenience without any compensation therefore. To my mind it is but natural justice that a child, if born alive and viable, should be allowed to maintain an action in the courts for injuries wrongfully committed upon its person while in the womb of its mother.

In the context of the remote and often imagined potential for conflict between a physician's duty to a mother and that to a child, the case for the imposition of a duty is compelling. All policies considerations are completely and adequately addressed in the standard of care analysis. One merely needs to define the conduct required to meet a particular duty of care.

⁴⁶ See Hill paragraph 39.

⁴⁷ *Montreal Tramways v Leveille*, [1933] S.C.R. 456.

Under the duty of care analysis, one is not able to limit the “scope” of the duty. The standard of care analysis allows the flexibility to limit the scope of a duty. Ultimately, both the duty of care analysis and the standard of care analysis can be used to reduce a wrongdoer’s exposure to liability, but the distinction between the two is important. The danger of using the duty of care analysis to limit scope is illustrated in Paxton, in the off-chance that was what the Court of Appeal intended. It is disruptive for negligence law and creates uncertainty for litigants. It also undermines the important function of tort law in the context of maternal-fetal care, a most undesirable effect from the perspective of the individual litigants and society more broadly.

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