Obstetrical Malpractice

Introduction

By the time an obstetrical legal case reaches trial, many, many years have gone by since the delivery. Illustrative of this point is the fact that most of the recent obstetrical cases which have been decided by our courts in the last year or so, involve deliveries which occurred in the early 1990s. For that reason, from a medical professional's point of view, recent judicial decisions may not necessarily be relevant to what happens today in the delivery of obstetrical care. Judicial developments may lag behind medical developments. Nevertheless, there are a number of legal issues which are commonly problematic in obstetrical cases, no matter when the delivery took place.

In this brief paper, I propose to review recent obstetrical decisions which have touched upon issues of charting, informed consent and the time within which a caesarean section should be done. I will limit my comments to recent cases since much material has already been written on these topics.

Chapter One - Time for Caesarean Section

Many of the obstetrical cases which end up in litigation involve deliveries which were performed by way of emergency caesarean section. These cases rarely involve allegations that the caesarean section, once started, took too long to perform. Rather, plaintiffs more commonly allege there was a delay in deciding upon a caesarean section, and/or insufficient preparation for the possibility a caesarean section might be required.

The issue of the time within which to perform a caesarean section in the presence of a dire emergency was at issue in *Commisso et al. v. North York Branson Hospital* (2000), 48 O.R. (3d) 484, a case which was recently considered and upheld by the Ontario Court of Appeal, [2003] O.J. No. 20 (Ont. C.A.). In that case, after a failed trial of mid-forceps, the attending obstetrician opted to proceed to an emergency caesarean section because of fetal distress. The time between the failed forceps attempt and the delivery of the baby was 17 minutes. The elapsed time between the time of identifying the dire emergency (fetal distress) and delivery was 13 to 14 minutes. The plaintiffs argued that the baby could have been delivered more quickly had the mid-forceps attempt been done in a room with a double set up. They also argued that the standard of care should call for delivery of a baby within 10 minutes since scientific evidence suggests that permanent damage is caused to the baby from ten minutes or more of asphyxia.

In *Commisso*, the plaintiffs' argument in favour of a double set up did not find favour with the courts.

On the issue of the timeliness of the caesarean section, the trial judge found that the appropriate standard of care was:

> "Where a fetus is at risk . . . the doctor must move as expeditiously as possible to deliver the baby, having due regard for the safety of both patients - baby and mother."

The Court of Appeal agreed with this description of the standard of care and found that in the circumstances of this case, the obstetrician could not have delivered the baby any quicker. Moreover, almost all the steps he had taken prior to delivery were not directly criticized by the plaintiffs. In reality, therefore, the plaintiffs were advocating in favour of a standard of care i.e., delivery in less than 10 minutes, which was not humanly possible to meet.

The decision in *Commisso* must be contrasted with the most recent decision of Madam Justice Lang in *Grass v. Women's College Hospital et al.,* [2003] O.J. No. 5313. The

Grass decision suggests, quite surprisingly, that 8 minutes from the time a decision is made to the time of delivery, is too long.

In *Grass*, there was initially an attempt at vacuum extraction at 1:28 a.m. Simpsons forceps were then applied, after which it was realized that the baby's position was occupit posterior. Tucker forceps were applied at 1:32 a.m. with rotation to an anterior position but during the next contraction, the baby rotated to a transverse position. Fetal bradycardia was evident at 1:35 a.m. Thereafter a trial of Kiellands forceps was unsuccessful and at 1:40 a.m., a caesarean section was called. The patient was transferred to the delivery room and the baby delivered at 1:48 a.m.

What is striking about the chronology in *Grass* is that only 8 minutes elapsed from the decision to perform a c-section to the delivery of the baby. None of the experts criticized this time delay and in fact, the trial judge commented that the time for delivery was “amazingly brief”. Despite this fact, the plaintiffs argued that the attempts at forceps should have been done in a room with a double set up, presumably so the baby could be delivered more quickly. But with an elapsed time of 8 minutes from the decision to proceed with a c-section to delivery, how much more quickly could this baby have been delivered?

In *Grass*, the trial judge was critical of the physician's decision to make a last attempt with forceps (Kiellands) in the labour room, as opposed to in the delivery room where a c-section could be done, if required. In this case, the Kiellands forceps were unsuccessfully applied in the labour room after which a caesarean section was called, the patient transferred to the delivery room, and the baby delivered, all within 8 minutes.

Given these facts and particularly that the c-section could not have been carried out any more quickly, it is difficult to understand the finding of liability made in *Grass*. The trial judge does not seem directly critical of the decision of a trial of Kiellands forceps per se, but rather, critical of not transferring the patient to the delivery room first. Had the transfer been done first, the baby could have been delivered 4 to 6 minutes earlier according to the trial judge. This implies that the trial judge was of the view that Kiellands forceps should not have been attempted but this is not so clear. We can perhaps speculate that the trial judge was swayed by the causation evidence. By considering the outcome and working backwards, the causation evidence suggested that hypoxia began at about 1:35 a.m., just prior to the application of Kiellands forceps. More importantly, however, the trial judge was also very critical of the obstetrician's post-delivery charting which seemingly adversely affected the physician's credibility.

The *Grass* and *Commisso* decisions appear impossible to reconcile on the issue of timeliness of the c-section. Perhaps the Court of Appeal will get an opportunity to consider the *Grass* decision.

Chapter Two - Informed Consent

It has long been the law that a physician has a duty to obtain informed consent from the patient before going ahead with any procedure. The scope of what information is to be disclosed depends on what is considered to be a "material risk" in the circumstances. In a leading decision of *Reibl v. Hughes*, [1980] 2 S.C.R. 880 at 884-5, Chief Justice Laskin, as he then was, stated:

> "It is now undoubted that the relationship between surgeon and patient gives rise to a duty of the surgeon to make disclosure to the patient of what I would call all material risks attending the surgery which is recommended. The scope of the duty of disclosure was considered in *Hopp v. Lepp,* [1980] 2 S.C.R. 192 at p. 210, where it was generalized as follows:
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> > "In summary, the decided cases appear to indicate that, in obtaining the consent of a patient for the performance upon him of a surgical operation, a surgeon, generally, should answer any specific questions posed by the patient as to the risks involved and should, without being questioned, disclose to him the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation. However, having said that, it should be added that the scope of the duty of disclosure and whether or not it has been breached are matters which must be decided in relation to the circumstances of each particular case."
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> The Court in *Hopp v. Lepp*, supra, also pointed out that even if a certain risk is a mere possibility which ordinarily need not be disclosed, yet if its occurrence carries serious consequences, as for example, paralysis or even death, it should be regarded as a material risk requiring disclosure."

The scope of the duty to disclose therefore depends not only on how likely a risk is to materialize, but also on whether a risk is likely to result in serious consequences, even if the chances of the risk materializing are slim.

In *Brito v. Woolley*, [2003] B.C.J. No. 1539, a recent decision of the British Columbia Court of Appeal, the issue was whether or not informed consent had been obtained to an attempt at vaginal delivery of twins. Cord prolapse occurred during the delivery of the second twin and the plaintiffs argued that cord prolapse was not a risk which had been disclosed by the obstetrician

prior to proceeding with a vaginal delivery. The plaintiffs argued that had they known of the risk of cord prolapse, which is significantly higher in the second of twins, they would not have consented to a vaginal delivery but rather, elected to have a caesarean section. The evidence at trial suggested that the risk of cord prolapse with the delivery of the second twin is in the area of 1% to 3%. The court nevertheless found that it was a material risk within the scope of the duty to disclose, not because of its likeliness of occurrence but rather, because it carried very serious consequences should it occur.

The Court in *Brito* found that the physician had breached the standard of care by failing to disclose the risk of cord prolapse. While the physician had breached the obligation to disclose material risks, the court also found that it was not causative of the outcome because in any event, the mother would have consented to an attempt at vaginal delivery.

In *Anderson-Redick v. Graham et al.* (2000), 258 A.R. 42, the issue was informed consent to the application of forceps. Once the mother reached full dilation during delivery, her labour arrested. There was contradictory evidence about what discussions had taken place between the attending obstetrician and the mother at the time the labour arrested. The mother claimed she was simply given no choice and told that forceps would be applied. The physician's composure apparently intimidated the patient and she, for that reason, did not ask further questions. There was no record of the discussion in the chart and the physician did not have a clear recollection of the discussion.

On this issue, the trial judge accepted the plaintiff's expert's testimony on the duty to disclose information in those circumstances. At the time the arrest occurs, there are two options namely, caesarean section or continuation with the labour which should be discussed with the patient. If forceps are being considered as an option, the patient should be advised of the following, according to the trial judge:

> "The patient should be advised that forceps are a potentially traumatic procedure that has very specific criteria. A prolonged, difficult, slow labour with arrest, more often than not, makes vacuum and forceps more difficult, which will cause problems to the baby and potentially to the mother. With a mid-forceps delivery, there can be trauma to both mother and baby. The higher the head, the more difficult and dangerous the procedure . . . "

While the trial judge in *Anderson-Redick* found that the obstetrician had failed to disclose a sufficient level of information in terms of the options once the labour arrested, the trial judge nevertheless found that there was no causation. In other words, the patient would have proceeded as she did, even had she been explained the various options and risks.

Chapter Three - Charting

Charting is an issue which plagues most, if not all, medical malpractice cases. Obstetrical cases are no different. In a perfect world, all events occurring during the course of a labour and delivery would be charted. In reality, however, it is impossible for health professionals to chart contemporaneously with the events particularly in emergency circumstances. Rarely has there been a chart which passes the scrutiny which time and the benefit of hindsight allow. Moreover, although it shouldn't, knowing the outcome was bad affects the reader's point of view.

When key events are not charted, it makes those events more difficult to prove should the matter eventually end up in litigation. In the *Grass* decision, Madam Justice Lang made some general comments about the issue of charting:

> "Charting is within the control of hospitals and professionals; its importance is recognized and emphasized repeatedly in different guidelines. There is no requirement to record every detail, nor would a level of perfection be expected. In many circumstances, it simply is not possible to chart particulars contemporaneously, particularly when the medical team is involved in urgent patient care. . . . Nonetheless, as a general principle, basic information should be recorded as contemporaneously as possible and, where it is impractical for the physician to chart, the particulars should be given by the physician to the birthing nurse so the nurse can so chart."

There were numerous problems with charting identified by Madam Justice Lang in the *Grass* decision although they purportedly did not affect the outcome per se. This is so because

Madam Justice Lang found that the obstetrician's decisions were not informed by anything that was in the chart. However, the lack of charting by the physician clearly undermined her credibility at trial. There was an additional problem in that three notes dictated by the physician subsequent to the delivery apparently were inconsistent and/or had errors.

One of the most common problems is the lack of charting of material events. If there is no record in the chart, then the court will turn to the parties' recollections to fill in the blanks. If the recollections differ, then other matters may be considered such as consistency with other notes in the chart. If no one has any recollection, the court may also accept the physician's evidence on what his or her normal practice is in similar situations.

One matter which has recently preoccupied judges in obstetrical matters is the failure to chart the station of the baby's head before the application of forceps or vacuum.

In *Trajdos v. Bala*, [2003] O.J. No. 4953, the issue was whether the attending obstetrician had breached the standard of care by applying a vacuum extractor to facilitate delivery of a baby. This issue, in turn, depended on the station of the presenting part prior to the application of the vacuum. Unfortunately, there was no record in the chart of the station and no one had any direct recollection. The physician's delivery record subsequently dictated stated that the head was “a bit high” prior to the application of the vacuum. The physician gave evidence at examinations for discovery and at trial that the head being a “bit high” meant that it was either at station 0, +1 or +2. The physician also gave evidence that his normal practice would have been to apply the vacuum extractor only if the head was engaged. The trial judge accepted this evidence and found that the head was indeed engaged at the time the vacuum extractor was applied.

The case of *Knight v. Sloan*, [2003] O.J. No. 3453 involved a somewhat similar situation. In a VBAC situation, the obstetrician attempted a mid-forceps delivery purportedly because he was concerned about possible scar dehiscence. Whether the application of forceps met the

standard of care depended in part on whether there were any concerns about dehiscence at the time of the application of forceps. There were no notes in the chart about any concerns and the physician's consultation note was not helpful. No one had a clear recollection but the physician argued that he would have applied forceps only if there was a concern over dehiscence of the scar. That evidence was not accepted by Mr. Justice Granger who was not persuaded by the physician's evidence. There was no corroborating note in the chart to suggest that there was any concern about possible dehiscence prior to the application of forceps.

In both *Trajdos* and *Knight*, the defendant physician gave evidence about his normal practice in order to explain gaps in the notes. In *Trajdos*, the physician's evidence was accepted but in *Knight*, it was not. The different outcomes are likely attributable to the credibility of the particular physician.

Another problem commonly encountered with charting issues relates to the charting of discussions relating to informed consent. Oftentimes, the fact that there was a discussion held with the patient about treatment options is not charted. In those circumstances, courts will accept the physician's evidence about his or her standard procedure, assuming the physician has no independent recollection. More often than not, the patient will deny there being a discussion and how much of that evidence is accepted will depend on the credibility of the parties.

Occasionally, a note in the chart will assist in not only determining the state of certain events but as well, will corroborate a professional's decision making process. In *Grass*, for instance, Madam Justice Lang implied that documenting the reasoning behind a judgement call may make a difference. Madam Justice Lang stated the following:

> "Had Dr. Weisberg made a documented, reasoned judgement call, based on all the facts, to proceed to a Kiellands application, then that may have been a call balancing risks and benefits and would have been within the standard of care."

Conclusion

Recent court decisions have again confirmed the importance given to charting. Lack of charting, particularly on key issues, poses difficult problems for health care professionals who, years later, have to fill in those gaps.

The law with respect to informed consent continues to develop. Recent decisions have, for instance, imposed on physicians the duty to disclose the risk of cord prolapse in vaginal delivery of twins and to disclose the possible risks associated with the application of forceps.

The time within which a caesarean section should be done is an issue which continues to plague courts as exemplified by the recent decisions in *Commisso* and *Grass*. It seems difficult to reconcile these two decisions and the most that can be said is that courts will deal with those situations on a case by case basis.