Indexed as:

Ing (Litigation Guardian of) v. Guest

Between
Adam Ing, an infant under the age of eighteen years by his Litigation Guardian Shing Ing and the said Shing Ing, Plaintiffs, and
Barrie A. Guest, Eric A. Deigan, Douglas A. Murdoch, Sai-Kui Lee, York County Hospital and Heather Rossi, Defendants

[1993] O.J. No. 1818

Court File No. 33181/88

Ontario Court of Justice - General Division

Coo J.

August 9, 1993.

(12 pp.)

Medicine -- Physicians and surgeons -- Malpractice -- Negligence -- Duty and standard of care -- Obstetricians -- Injuries to infant during birth.

Action for damages. The infant plaintiff suffered substantial brain damage as a result of the pinching of the umbilical cord, caused by mid-forceps delivery efforts performed by the defendant obstetrician. The mother of the infant, who was having her first baby, had no complications until the final moments preceding the birth. There was a continuing drop in the heart rate of the fetus to about 60, which drop was communicated to the obstetrician who immediately commenced the forceps delivery. The first two attempts gave warning signs of discontinuance to the obstetrician which he ignored. There was no set-up ready so that an emergency C Section could be performed in the event of predictably possible trouble.

HELD: Action allowed. Legal responsibility for the plaintiffs' damages rested entirely with the obstetrician. The general practitioner could not be held liable for failing to discuss decisions for which the expert was responsible and which he was paid to make.

Richard J. **Sommers,** Q.C. and Robert Roth, for the Plaintiffs.
W. Niels Ortved and Lisa Clarkson, for the Defendants.

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1 **COO J.**:-- This is a medical malpractice action, maintained to trial only against a general practitioner and an obstetrician, arising out of medical treatment and attention given by both in connection with the birth of a child at York County Hospital on January 4, 1988. All claims and crossclaims against the hospital were, on consent, abandoned by both plaintiffs and continuing defendants, and it was specifically and flatly stated that the position of those defendants was that the hospital was in no way negligent in connection with what happened here.

2 The child has very substantial disabilities which have existed since birth, and it is alleged that both doctors were professionally negligent in the way in which problems in the birth process were handled, and that their negligence produced the damages.

3 At the opening I struck out the jury notice on application by the defence, and while one must always have at least some lingering reservations about prematurity, as it turned out that decision was manifestly correct in light of the way in which the evidence unfolded.

4 The agreed-upon damages have been approved of by another judge of the court. This is the first time I have encountered this bipartite approach to a case involving the interests of a minor plaintiff. I say this not in criticism, but in comment. I have not been advised of the amounts involved in my determination of liability.

5 A great number of documents in the way of medical reports and records have on consent been filed, together with textual and other references adopted by witnesses as expressing their views or the given medical wisdom on the subjects canvassed. Some were not so supported, and some supported only to one qualified degree or another. Those not adopted, or described as representing the given wisdom of the time on the subject, are not evidence of the legitimacy or otherwise of the positions espoused.

6 To deal with easier matters first, I have no doubt on the evidence that the infant suffered his substantial brain damage and consequent past and future losses as a result of the pinching of the umbilical cord, caused by mid-forceps delivery efforts performed by the obstetrician. Almost all the medical witnesses who were asked about it indicated that this was the most likely probability. There is nothing on the basis of which I would be prepared to conclude that there was anything in any malformation of the cord, maternal difficulty or intrinsic fetal flaw which made any contribution to the loss of blood flow, and thus oxygen, consequent on the cord pinching. This conclusion is consistent with the evidence and with common sense, and is certainly in line with the inherent probabilities of the situation.

7 I have to deal with the liability issue. There is no dispute as to the standard to be applied to the activities of the doctors in this case. It is in the application of that well-understood standard that the problems arise.

8 The mother involved was an oriental person, small in stature and weight, having her first child, who had gained a good deal of weight during the pregnancy and whose pregnancy had really been substantially uneventful up until the final moments preceding the birth. Her husband, also oriental, who attended at the trial every day, and who was present with his wife throughout her confinement in the delivery area of the hospital, is a very much larger person in every way. The length of the first and second stages of the birth process were not out of line, and certainly not well out of the ordinarily acceptable. The SF measurement was significant but not something remarkable. There was recorded some unremarkable moulding of the fetal skull. There were, then, no dramatic and major signs of forewarning of possible or probable cephalopelvic disproportion. But there were a number of small flags, as at least one witness put it; including the points touched upon in the foregoing comment, slowness of dilatation with no speedup as it progressed and the early moulding to pay attention to and to file away for later possible consideration. Dr. Steinberg dealt with these aspects in more detail than other doctors who touched upon the issues, and made it transparently clear that it was not that shoe size, as an example, was something which should have carried the day in the decision-making process, but that there were a large number of factors to be taken into account, none of them conclusive, yet all of them contributing, each in its own small way, to the proper assessment of the situation, and the weighing of risks and prospects when more major developments took place. One does not advance the consideration of the totality of evidence by attempting either to over-value or to trivialize these factors.

9 The arguments on each side, as skilfully developed during almost two days of argument, are compendiously set forth in written submissions filed with the court.

10 I have come to certain general conclusions on the evidence, which may succinctly be stated. I am not faced with the dilemma of resolving the real impact on the law in Canada of the principle, if such it really be, of Maynard v. West Midlands Regional Health Authority, [1985] 1 All ER 635. I do make the point that in its application one must, I think, remember that the court cannot and should not abandon to formula its responsibility to decide what evidence to accept and what not. I do not believe that the Maynard case intended to suggest otherwise. The point sought to be addressed in Maynard is that assuming two conflicting bodies of reliable, credible and respectable expert testimony, dealing with a medical problem of treatment or diagnosis, the judge should not simply deem himself or herself driven in that almost impossible situation to decide which to accept as applicable to measure the defendant doctor's conduct, but should recognize that a doctor should not be condemned in such circumstances to the possible obloquy of an adverse finding about conduct in following one of at least two different acceptable standards of medical propriety. That represents an entirely practical and sensible approach.

11 I do not deal with that situation here for the simple reason that bringing to the measurement of

the expert testimony those general principles of credibility, practical logic and common sense to be brought to the assessment of all testimony, I found the defence witnesses, including the parties, in varying degrees either unreliable, overreaching, or reflective of an unrealistic and unhelpful advocacy stance which renders most of their expressed views unacceptable. I found them in the giving of some of their evidence obviously uncomfortable, and in some areas bluntly unbelievable. As one example only, their dismissal of accumulating warning signs, each as being trivial, and therefore all apparently to be labelled together as unimportant routine manifestations in what even they very grudgingly conceded in differing words to be a procedure with risk, I found disturbing, and so contrary to rationality as not to involve judicial expression of inappropriate opinionating about differing legitimate convictions in an area of special expertise.

12 On the other hand, I found the plaintiffs' witnesses, despite those criticisms outlined in great detail and with great skill by defence counsel, and despite cross-examination to the outer edge of legitimacy, to be reliable, sensible and logical in the way in which they went about their analytical and descriptive tasks. I was very much impressed not just with their obviously very high level of expertise and experience, but with what struck me as their meticulously careful attempt to be fair and reasonable in what they had to say.

13 In a post-trial reading of the daily transcript, those images are not as obvious from the written word as I thought would likely be the case. All I can say about that is that the actual capacity to listen and measure was an advantage which certainly was importantly present in this case.

14 I must also confess that the approach of the plaintiffs' witnesses to the situation struck me as containing the essence of common sense, to a very real degree lacking in the defence position on the issues involved.

15 It was unreasonable, and reflected lack of proper care, for a highly-trained expert obstetrician to place the fetus in a position of prospective fatal or tragic risk, without backup capacity ready to perform a C Section; and then in a hospital, under the care of a general practitioner and the obstetrician, with an anaesthetist knowledgeable in obstetrical matters and a very experienced nurse well-versed in elective and emergency C Sections and with O.R. experience present; with operating instruments, oxygen, at least some fetal resuscitation equipment, anesthetics and disinfectant soap close at hand; O.R. and other nursing staff on call, with the former seemingly present before the mother was moved into the adjacent room where the C Section was in fact performed; the mother already under terminal epidural anesthetic, to act in a way and to take time which made either death or serious brain damage predictable if not inevitable. To suggest that that was without fault, I find absolutely unacceptable, to use as unemotional a term as seems apt. The word used by Dr. Steinberg was "outrageous", and that may not be far wide of the mark. I trust that it was lack of experience in pressure situations which led to what happened.

16 It must be remembered that so long as no special skill and expertise is required, a midwife, father, fireman or taxi driver can act in the birth of a baby. The reason people are trained, at great

expenditure of time and public and private commitment, to be true experts in a specialized field, is so that when there is real trouble they can do something meaningful about it. That should have, but did not, happen here.

17 No one for the defence said that the quick emergency operation posed unacceptable risks, or was impractical or incapable of being done. It was readily apparent that the plaintiffs' expert witnesses could not understand why it was not done, and neither can I. It did not involve high-tech sophisticated procedures or techniques, nor exceptional skills or training. The room adjoining that in which the mid-forceps was attempted had all the requisite instruments packaged in sterile containers. No one suggested that they could somehow not be unwrapped within seconds or a very few minutes, and put to use. The defence evidence talked around this point, although of course I am invited to infer from what was said that the action envisaged by the plaintiffs' experts was not practically possible. On the evidence I have, I can come to no such conclusion, and indeed am convinced to the contrary.

18 Despite some points made in argument for the defence, it was clear to the obstetrician, and I am sure also to the G.P., that when there was a continuing drop in the heart rate of the fetus to about 60, not just coincident with forceps pressure, with no rebound and an ominous absence of variability in the graph line, there likely, or with very real possibility, had developed as serious a problem as a fetus can ever face; that is the prospect of death or permanent brain damage. It was treated as though it were just another routine problem in the daily business of the general practice of medicine. The situation called for blunt, major and immediate action, with the clock ticking towards the time when action might well be without point. There should have been immediate efforts to elevate the fetal head, and perhaps some effort to stop uterine activity, although that is questionable given the methods available at the time. Much more importantly that should have been followed at once by the C Section, unaccompanied by the usual and in fact perhaps unavailable full panoply of surgical facilities.

19 The nurse screamed, ran out the door looking for help, made a call to the switchboard to have a pediatrician summoned, and had someone else call for the O.R. nurses. The anaesthetist said, almost unbelievably, that in effect he really cannot remember much of what happened save for his notes. I hope and presume that is not because such an appalling thing was common in his experience of the time.

20 The G.P. said that things went along as fast as possible, as though he were describing preparation for an optional surgical task. He testified that in effect he remembered little by way of detail about what happened. His memory of this dramatic and unusual event strikes me as at the very least puzzling and unsettling. (He had earlier conceded that there were signs which might point, but obviously did not point him, in the way of possible CPD, and he was almost casual in regard to the generation of inaccurate maternal weight gain information, even accepting his version of the start weight used.)

21 The obstetrician, the person in complete charge, in effect did nothing to reflect that he had to do something effective at once; possibly a reflection of lack of sufficient experience to deal with something outside the routine or experimental in the classroom, or the supervised arena of the early days of practice of medicine in a specialized field. In my opinion it just was not good enough, and most assuredly did not measure up to the standard required, and to the steps which should have been taken particularly as described by Drs. Bernstein, Farine and Fruitman, all of whom in a variety of ways of expression made that same point. At one stage in his evidence the obstetrician indicated that, in the face of the heart monitor's dire message, the reason he decided to do a C Section was that he finally became convinced that he was starting to face a disproportion which in fact I find should have been manifest much earlier. I realize that one cannot fairly take one small comment out of context, but that was a reflection of the entirety of his attitude and testimony.

22 Nothing in this emergency response was anything to be expected only of a top level hospital, as opposed to the hospital at which all this occurred. As Dr. Bernstein said epigrammatically, the measure of the standard of care in this particular situation was not a function of geography. I was unimpressed by the small blizzard of documentation and paucity of substance in the obstetrician's comments about his ability to do the emergency C Section at the time and in the way described by the plaintiffs' witnesses, who were not really taxed on this point in cross-examination. I am totally unconvinced that he could not and should not have gone on with the task. Even knowing the issue, and clearly aware of the point, his evidence focused on the optimal as though it were the essential. Placing instruments on a tray in accordance with a diagram, doing an instrument count and all the rest, on evidence which accept without question, was preferable but inexcusable in the situation which bad presented itself. (Ms. Cornell, the clinical coordinator for all relevant aspects of the hospital's operations, at the time and for many years, a person of obvious good, solid judgment, certainly could not understand what the problem was in gaining quick access to instruments, and felt the ready tray to be an unnecessary duplication; and that point of view seems at least modestly to be reinforced by the fact that the hospital has not continued in this action at the instigation of the doctors.) He had quickly to call for, lead and see to the essential, and did not.

23 I am further of the opinion that the background information available to the obstetrician through the G.P. should have alerted him to the fact that there was a modestly increased risk, put no higher than that, accompanying the deep right occiput transverse arrest mid-forceps delivery which was ultimately attempted. The way in which that effort unfolded in its stages should have alerted the obstetrician to the fact that there were increasing and accumulating warning signs to watch out for, and that he should have been even more alert to the risks being run. It is clear that both doctors proceeded on the assumption that there was to be a mid-forceps attempt, as evidenced by what I am entirely satisfied was the original decision made by the family doctor to do it himself, until he was called to account on the point in a deferential way by the nurse in attendance, the movement of the mother to a delivery room of the hospital, the administration of the terminal epidural anesthesia for the mid-forceps before the obstetrician had even arrived, and what seems to have been either the almost complete absence of history review about the mother, and precisely how things had gone to that point, by the obstetrician, or alternatively a failure to appreciate the signals that were there to be

seen and appreciated. The determination already made by the G.P may have played some part in how the obstetrician came to exercise what was undoubtedly his responsibility - that is to decide what was to be done. (At this point it may be appropriate to add that while there may be differing views on the use of prostin, and legitimacy of concern about it given the points raised in the evidence, I am certainly not prepared to conclude that its use in this case by the G.P. was negligent, or that its use made any real contribution to what occurred, save for it being part of the background against which all else had to be measured.)

24 I am satisfied that from the beginning the forceps delivery being attempted was, as described by all the plaintiff's witnesses, a procedure of great inherent risk. It ought to have been obvious that the real risk of cephalopelvic disproportion was present, given all the above outlined background factors and what I conclude to have been, certainly after ARM and administration of prostin, uterine activity at an acceptable level, not to be confused with some developing maternal discouragement and ineffectiveness. In general terms it had to be wrung from Dr. Natale in cross-examination that the type of forceps delivery here involved was indeed "the hardest sort of operation", to adopt defence counsel's categorization of the general description of Dr. Manning. The scramble amongst defence witnesses to avoid any such concession was unseemly, and manifestly not based on truly held medical views.

25 I am not prepared to conclude with certainty that the medical standards of the time directed that the procedure in the particular circumstances of this case should never have gone forward at all, or even that it should have started only with a setup in place to handle an immediate C Section; although I certainly would not join in Dr. Natale's expression of that step as constituting "heresy", but rather as a good idea whose time had, and perhaps has, not yet come.

26 I am certain that, on the evidence, it probably should not have continued after the first effort with the Kjellands forceps, with its accompanying twisting back of the fetal head, certainly not after the second application of these forceps, with its slipping of the head within the forceps, and absolutely not after the first 30-40 seconds of moderate traction Haig-Ferguson manoeuvres, with total lack of fetal descent. In any event and most assuredly it should not have continued after the first or possibly second of these stages, without what has been referred to as the "double setup" in place, when the accumulation of background and foreground warnings was manifest, and there was still time readily available. No one ordinarily expects trouble in daily life, and always assumes that it will not eventuate. But that approach was fraught with enormous danger to others in the case of the activities as they unfolded in the delivery room on the day in question.

27 Had there been, as there should have been, a setup ready so that an emergency C Section could be performed in the event of predictably possible trouble, the child would now probably be living an untroubled routine life, one which will never now be a possibility for him.

28 Had there been none, but had the obstetrician reacted to the desperate situation with which he was suddenly faced, in a timely and emergency way, it is at least likely that all would still have been

well, and that training, skill and developed judgment would have paid off. But sadly it did not happen. Even in hospitals, places where trouble is coped with as part of routine business, there seems to be no necessary assurance of the required professional response.

29 I am satisfied that there ought to have been no attempt to pursue, at least beyond the first stages, the midforceps delivery; that the process should have stopped before it reached the stage at which there was major trouble; that a C Section capacity should have been readied before it was; and that all of this aside, there should have been performed emergency surgery to deliver the baby well short of the time when it did in fact occur and short of the ten minute limit spoken of by the witnesses as being prospectively crucial. On this last point there is really no persuasive evidence at all that there would have been major risks involved in this undertaking; certainly not for the mother, and, certainly on balance, not relatively speaking for the child. (There was probably no legal risk involved either. The father, an obviously intelligent and sophisticated person, was there to help and to communicate with his wife, and to provide any required instructions to the medical team which surrounded the mother.)

30 I do not propose to become embroiled in the tortuosity of medical language surrounding the issues here for considerations and what is a "trial of forceps" and what is a "failed forceps" or a "failed trial of forceps". The point is that what was undertaken was a mid-forceps procedure which all concede for this mother and baby had risks; that they were modestly greater given those background matters to which have already made reference; that the level of risk which clearly ought to have been appreciated increased with each stage in the enterprise, and that nothing was done at any stage until it was too late to have an organized backup road open against the possibility that the warning signs should develop into real trouble, and that when they did, the required emergency response was lacking. Even the obstetrician made the point that, especially in obstetrics, emergencies do occur.

31 I can find no legal liability resting upon the G.P. He called in the obstetrician, upon whom thereafter rested the full responsibility for what happened. He was available for consultation. He made no decisions which determined the course followed or the ultimate outcome. He did not participate in any active way in what occurred, and there is no reason to conclude that he could fully appreciate what was transpiring as the forceps procedure progressed. It is impossible to know what he communicated to the obstetrician, and what precise attention was paid. He cannot be found liable for failure to generate inopportune debate on the delivery room floor about decisions for which the expert was responsible and paid to make. He gave evidence that he joined in supporting those decisions, which I have found to be wrong; but they were not his to make, and thus not his to take legal responsibility for. While this issue was really not touched upon in the submissions made, I cannot see that legal responsibility should rest with him. In all the circumstances it would seem reasonable to dismiss the action against him without costs.

32 I conclude that legal responsibility for the plaintiffs' damages does rest with the obstetrician, for reasons which I have provided.

33 Judgment Should 90 accordingly, with costs to the plaintiffs. If there are any issues which require determination, whether in consequence of Rule 49 or otherwise, I may be spoken to on a date which may be arranged through Janice Dickie in the office of the Trial Coordinator. I presume that the issue of interest has been dealt with.

COO J.