Case Name:

Tsur-Shofer v. Grynspan

Between
Daphna Tsur-Shofer and Daphna Tsur-Shofer as Litigation Guardian on behalf of Naomi Shofer, plaintiffs, and Dr. Shlomo Grynspan, Dr. J.S. Lee and North York General Hospital - Branson Division, H. Kadanka, J. Mustard, E. Jin, C. Vallat, A. McLean, S. Itwaru, S. Wells and R. Salituro, defendants

[2004] O.J. No. 2361

[2004] O.T.C. 486

131 A.C.W.S. (3d) 545

Court File No. 00-CV-194204CM

Ontario Superior Court of Justice

B. Wright J.

Heard: February 9-12, 16-20, 23-24, 26-27, March 1-5 and 8-12, 2004.
Judgment: June 4, 2004.

(102 paras.)

Counsel:

Richard J. **Sommers** and Hilik Y. Elmaliah, for the plaintiffs.

Harry Underwood and W. Grant Worden, for Dr. Grynspan and Dr. Lee.

William D.T. Carter and Katharine L. Byrick, for North York General Hospital - Branson Division, C. Vallat, A. McLean and S. Itwaru.

1 **B. WRIGHT J.**:-- In the early morning of September 18, 1994, two women, at full-term pregnancies, were admitted to Branson Hospital. Both babies were delivered by caesarean section. Unfortunately, the plaintiff's daughter, Naomi, was brain damaged at birth. Ms. C.S. was admitted at 1:40 a.m. with vaginal bleeding. The plaintiff was admitted at 2:35 a.m. with a breech presentation.

2 Dr. Lee, the on-call obstetrician, came to the hospital and saw Ms. C.S. at 4:10 a.m. and the plaintiff at 4:25 a.m. Prior to seeing the plaintiff, Dr. Lee decided to deliver Ms. C.S.'s baby by caesarean section and then perform the plaintiff's caesarean section.

3 The plaintiffs allege that the treatment and care provided to them by Doctors Grynspan and Lee, and nurses Vallat, McLean and Itwaru, fell below the standard of care and their negligence caused Naomi's damages.

4 At the commencement of trial, on consent, this action was dismissed, without costs, against the defendants H. Kadanka, J. Mustard, E. Jin, S. Wells and R. Salituro.

5 At the end of the trial I requested counsel to provide me with written submissions, which I have received.

6 The parties have agreed on the amount of the damages.

7 Appendix "A" is a pertinent time line of the events surrounding the treatment and care of the plaintiffs and Ms. C.S.

Liability of Dr. Grynspan

8 Dr. Grynspan is the obstetrician who oversaw Ms. Shofer's pregnancy. Throughout the trial counsel for the plaintiffs maintained the claim against Dr. Grynspan even though counsel for Dr. Grynspan and Dr. Lee advised plaintiffs' counsel that any failures of Dr. Grynspan did not impact in any way on any of Dr. Lee's decisions in the care of the plaintiffs.

9 Plaintiffs' counsel noted that the Antenatal Records forwarded to the hospital by Dr. Grynspan were devoid of relevant and important information. In particular, there was no information about two obstetrical ultrasounds, which indicated the fetus in a breech position. Counsel for the plaintiffs suggested that if the Antenatal Records had contained complete information, Dr. Lee's decisions concerning the care of Ms. Shofer would have been different. Dr. Lee testified that the knowledge of the two ultrasounds indicating a breech presentation would not have changed his decisions with respect to the care of Ms. Shofer.

10 I note that under the heading "Requested Findings of Negligence" in the plaintiffs' written

argument no mention is made of any negligence of Dr. Grynspan. Whatever may have been the inadequacy of the Antenatal Records, that inadequacy did not contribute to the cause of Naomi's injuries. The action against Dr. Grynspan is dismissed with costs.

Liability of Nurses Vallat, McLean and Itwaru

11 The plaintiffs allege that the nurses were negligent because they failed to use continuous electronic fetal heart rate monitoring and failed to monitor the fetal heart rate of Naomi between 3:28 a.m. and 4:19 a.m., and between 5:02 a.m. and 5:26 a.m. I find that the lack of fetal heart rate monitoring during these times did not contribute to the cause of Naomi's injuries.

12 The plaintiffs allege that Nurse Itwaru was negligent because she failed to notify Dr. Lee immediately of Naomi's significant fetal heart rate abnormalities, which became evident commencing at 4:27 a.m.

13 Dr. Lee arrived in the hospital at 4:00 a.m. He visited Ms. C.S. at 4:10 a.m. Because of her continued vaginal bleeding he assessed her situation as an emergency and decided to do an immediate caesarean section. Prior to Dr. Lee's arrival the nurses had assessed Ms. C.S.'s situation as an emergency.

14 Dr. Oppenheimer, the expert called on behalf of Dr. Lee, testified that at 4:10 a.m. Dr. Lee made the appropriate decision to do an immediate caesarean section on Ms. C.S. He stated, "There was an indeterminate time to get this baby delivered in order to prevent further problems."

15 While the nurses were making preparations for Ms. C.S. to have a caesarean section Dr. Lee visited Ms. Shofer around 4:25 a.m. He did not examine her. Ms. Shofer testified:

> Dr. Lee came in. He explained that he had to do another caesarean section and then he would do mine. He was with me two minutes. He was in a rush.

16 Dr. Lee was in a rush because Ms. C.S. required an immediate caesarean section.

17 After Dr. Lee left Ms. Shofer my notes record Itwaru's evidence:

> 4:25 Catheterizing for 1-1 1/2 minutes. Swab down. Locate entrance to urethra. Inject water into balloon.
>
> 4:28 She was complaining of contractions. I did vaginal exam. 5 cm. pp.-2
>
> Put volume up on monitor. I expected changes because she was in supine position.

4:29 Deceleration of FHR. Baby compensating and picking up oxygen. Not fully recovered from catheter procedure.

4:30 A dip in FHR. Not really a deceleration

IV Bolus - increase flow of IV and then record on strip

Patient on right side. FHR 170 down to 90

SROM (spontaneous rupture of membrane) thick meconium.

She said she was wet. I removed sheets and under pad. Thick fresh meconium.

Variable decelerations reoccurring. Period of recovery and then go back down

4:35 FHR down to 60. Patient turned on side. IV Bolus

4:45 FHR decelerating to 60 but not recovering. Increased flow of oxygen. Turned to right side. I ran down to C. section room and told Dr. Lee

I never had a situation where the FHR did not recover after a nurse intervention. I was concerned with the FHR. It was a crisis situation. Dr. Lee needed to intervene asap. I had no idea what stage he was at with Ms. C.S.

18 The plaintiffs submit, "Nurse Itwaru did not advise Dr. Lee of the emergency until 4:46 a.m. or 4:47 a.m., some 19 to 20 minutes after the emergency arose." It is the plaintiffs' position that the emergency with Ms. Shofer arose at 4:27 a.m. and Nurse Itwaru fell below the standard of care because she did not immediately advise Dr. Lee of the problem.

19 In the timing of events down to minutes there may be some discrepancies in the actual times. However, I take issue with the plaintiffs' position that the emergency arose at 4:27 a.m. It was not until 4:35 a.m. that the FHR was down to 60 at which time the nurse turned Ms. Shofer on her side and increased the IV. It was not until 4:45 a.m. that the FHR was not recovering at which time Ms. Shofer was turned on her right side and oxygen was increased.

20 In the context that Nurse Itwaru knew that Dr. Lee was involved in an emergency situation with Ms. C.S. and, her previous experience that the FHR had recovered after nurse intervention, it was reasonable in my view for Itwaru to do the nurse interventions to determine if the FHR would recover. It was when she discovered that the FHR was not recovering that she immediately, at 4:45 a.m., advised Dr. Lee of the problem.

21 Nurse Itwaru is an experienced Labour and Delivery room nurse. In the circumstances noted above she made a judgment call as to when she needed to advise Dr. Lee. In my view her actions did not fall below the standard of care.

22 Since Dr. Lee had commenced surgery on Ms. C.S. at 4:40 a.m., even if Nurse Itwaru had advised Dr. Lee five minutes earlier it would have been too late for him to do anything to assist Ms. Shofer.

23 The plaintiffs postulate that if Dr. Lee had been advised by Nurse Itwaru of Ms. Shofer's situation one minute before he commenced Ms. C.S.'s surgery he would have aborted that surgery and gone to assess Ms. Shofer immediately. The plaintiffs submit that Dr. Lee would have reviewed the FHR strip and:

> ... in light of what the tracing, in fact, demonstrates beginning at 4:45, he would have diagnosed acute fetal distress, reprioritized the patients and intervened by emergency caesarean section.

24 The plaintiffs rely on Dr. Lee's evidence as to what he would have done as follows:

> If I have seen that tracing right then, my diagnosis at that point would be acute fetal distress and I would intervene and then will take her to the section room and deliver the baby as soon as I can.
>
> ...
>
> Well, at that time I would immediately report to doctor Mustard of my change of heart that we are dealing with an acute emergency and I need to deliver Mrs. Shofer at the earliest time, and assuming by that time she has the patient will be awakened up already and at that time the patient probably will be moved to the recovery room for close monitoring for Mrs. C.S., and then we move Mrs. Shofer right into the section room and did a section with a table already counted, nurses sitting there, Dr. Jin sitting there. The only change is the patient. We move the patient out, move Mrs. Shofer in.

25 It is interesting to note that the plaintiffs rely on Dr. Lee's evidence, the very person they

allege was negligent in their care. I suggest the main reason to put forward this hypothetical situation is to attempt to have the court find another party, in addition to Dr. Lee, liable for Naomi's injuries.

26 The plaintiffs' postulation is purely speculative and a poor speculation. What happens to the aborted emergency with Ms. C.S. and Dr. Oppenheimer's opinion that an immediate caesarean section was appropriate for Ms. C.S. "... to get this baby delivered in order to prevent further problems."? If the plaintiffs' hypothetical situation had materialized it is probable that the plaintiffs in this action would be Ms. C.S. and her child and not Ms. Shofer and Naomi.

27 The plaintiffs fail to factor into their submissions the fact that Ms. Shofer was admitted to the hospital at 2:35 a.m. and, Dr. Lee did not come to see her until 4:25 a.m., and failed to take the time to examine her. If Dr. Lee had taken the time to examine Ms. Shofer at 4:25 a.m., it is more than likely that he would have been in the process of examining her at the time that the emergency arose.

28 The plaintiffs' expert, Dr. Harman, opined that Dr. Lee's failure to examine Ms. Shofer at 4:25 a.m. fell below the standard of care. Dr. Harman testified:

> It is likely that he would have found a degree of cervical effacement, that is, thinning of the cervix that was quite progressed from the initial documentation, that he would have found a degree of cervical dilation immediate between 5 centimetres and fully dilated and that he would have found the membranes bulging very tensely through the cervix at that time.
>
> The station of the presenting part would have told him that delivery was imminent rather than going to take a number of hours, which one might have expected in a primagravida, that is, a woman in her first labour. Generally speaking, one might expect between one and one-and-a-half centimetre progression in cervical dilation for each hour of labour. In her case, progression was from two or three centimetres of dilation when she arrived to fully dilated and pushing within two-and-a-half hours. In fact, according to the nurse's notes, she began pushing strongly by 4:45. The urge to push in a primagravida is often associated with near total cervical dilation, that is, in the range of 8 to 9 centimetres. This is called by some the transition period when the urge to push first becomes noticeable. Indeed, she may have been fully dilated already by that time, but it is a good indication that the cervix is nearing full dilation.
>
> ...
>
> The point of an early physical examination and determination of the type of

> breech will have a significant impact on the physician's concern about the possibility of umbilical cord prolapse. Had Dr. Lee examined the patient vaginally at 04:25, finding that the membranes were bulging and that she was likely about to rupture her membranes, he would have been able to palpate through the membranes searching for the umbilical cord lying below the baby. Before the membranes have ruptured, before the cord has fallen out, there is what's termed umbilical cord presentation. That is the umbilical cord is presenting itself and if the membranes rupture it will be delivered first before the baby.

With respect to Dr. Lee's assertion that delivery in Ms. Shofer was hours away, Dr. Harman explained:

> The problem with breech deliveries and again failing the physical examination of his patient, he couldn't know whether ruptured membranes were likely, sooner or later, and whether the cord was presenting. This was not something that the nurse specified in her physical examination so it wasn't possible for him to know what would happen should the membranes rupture. So I have a problem with planning on being away from this patient who is now in accelerating labour for a given time period when he couldn't do anything about the urgencies which may happen.
>
> ...
>
> In this case, the anticipation that she was going to take all night labouring away and that the caesarean section could be done some other time in the morning perhaps as thought by Nurse Itwaru, or some other time that was better for everybody, doesn't work for many exceptional patients, and the problem or the reason for having obstetrics in the first place is that not everybody follows an ideal paradigm and the obstetrician's value to the individual patient is to anticipate and if not fully anticipating at least to deal with those irregularities that occur and not to say well she's average, therefore this is going to happen, but to say she brings with her a risk focus and these things might happen.
>
> ...
>
> I believe one of the principles of allowing a patient with breech presentation to continue in progressive labour is that she is protected from adverse events by the presentation of anaesthesiology, operating room facilities and personnel and

> obstetric personnel capable of dealing with her emergencies. I think if the physician plans on being unavailable for I guess whatever reason in a labouring breech patient, he should personally examine the patient and explain to the patient that he had to be away to do something else, and at the end of that I think they would both agree that this was potentially a dangerous proposition. Things happened by coincidence that make that necessary on occasion.
>
> In this particular case, that needed not to happen because of the collision of these two patients. It could have been avoided almost entirely. I believe it is Dr. Lee's responsibility to Mrs. Shofer at 04:25 to be able to assure the safety of her baby at that point in her labour. (Emphasis added)

29 Had Dr. Lee examined Ms. Shofer at 4:25 a.m. he would have discovered that Ms. Shofer's baby needed to be delivered as soon as possible. However, at that point he would have been on the horns of a dilemma. He would have been faced with two emergency caesarean sections and he would have been in a quandary as to which one deserved priority. Whichever one he chose to perform first it is likely that he would have placed the other mother and child at risk of injury.

30 The plaintiffs called nursing expert Kathryn Doren. She obtained her Bachelor of Science in nursing at McMaster in 1981 and her Masters in Science at University of Toronto in 1994. She has considerable experience in labour and delivery room procedures and has taught these procedures to nurses at community hospitals. Having reviewed the evidence relating to the actions of the nurses it was her opinion that the nurses did everything they could under the circumstances. I have come to the same conclusion. I find that the nurses did not fall below the standard of care. I find that the nurses admirably performed their duties which were hampered by Dr. Lee who I will find shirked his duties and placed the nurses in an untenable position. Dr. Lee's failures were unfair to the nurses in their attempt to fulfil their professional duties.

31 The action against C. Vallat, A. McLean, S. Itwaru and North York General Hospital - Branson Division is dismissed with costs.

Liability of Dr. Lee

32 At 2:00 a.m., Dr. Lee was called at home and was advised that Ms. C.S. had been admitted to Labour & Delivery. He was told by Nurse McLean that Ms. C.S. had ruptured her membranes at 11:00 p.m. the previous day and that she presented to the hospital, at term, with a history of heavy vaginal bleeding. On admission, Nurse McLean observed that the pad was soaked with blood and that Ms. C.S. "was bleeding quite briskly." The bleeding was painless at that time. Dr. Lee was also informed that an electronic fetal heart rate monitor was applied and showed poor fetal heart rate variability.

33 Dr. Lee elected to manage Ms. C.S. from home. He ordered routine blood work, urinalysis, IV

infusion and pain medication. Dr. Lee also instructed Nurse McLean to carry out a vaginal examination, prepare Ms. C.S. for a possible caesarean section and commence Syntocinon induction of labour.

34 Without coming to the hospital to find out any information about Ms. C.S.'s previous history and to examine her, Dr. Lee gave the nurses certain orders. At the time he gave those orders he was not aware of the cause of the bleeding. This was not a normal pregnancy but one which was accompanied by uncertain risks.

35 Dr. Lee did not come to the hospital to see Ms. C.S. until 4:10 a.m. at which time he was faced with an emergency situation and decided that Ms. C.S. required an immediate caesarean section.

36 At 2:50 a.m. Dr. Lee is called again at home by Nurse McLean and was told that another patient, Ms. Shofer, had been admitted to the hospital with breech presentation in labour.

37 Nurse Vallat had examined Ms. Shofer and recorded the following on her chart:

> Came in walking. C/o contractions q.4 min. Now in distressed. Cx 2-3 cm. 80% effaced. p.part soft? Breech-head in upper left abdomen. Put on monitor. Audible deceleration ?60.

38 Nurse McLean testified that she would have told Dr. Lee what nurse Vallat had recorded on the chart. Over the telephone Dr. Lee made certain orders including an X-ray to confirm the breech.

39 The defendant submits that it was irrelevant that Dr. Lee did not attend on the patients earlier because his management plan would not have changed. I cannot accept that submission. Dr. Lee could not develop a proper management plan until he had examined the patients and diagnosed their problems.

40 It is also submitted that Dr. Lee's judgment as to when he should come in to see a patient depended upon the information he received from the attending nurses. Nurses cannot diagnose medical problems. They can only indicate to a doctor their views on a patient's condition. In my view, far too much emphasis, in this case, was placed on nurses' responsibility to advise doctors about a patient's condition. There appeared to be an inference that a doctor is not required to attend at a hospital to see a patient until told to do so by a nurse. That situation cannot be a proper standard of care of a doctor.

41 Nurse Vallat has many years experience as a Labour and Delivery nurse. Although Nurse Vallat was certain that: (1) the presenting part was soft; (2) the fetal heart was heard in the upper abdomen; (3) the head was in the upper abdomen; and (4) she was able to follow the baby's spine around down to the bottom, she wrote, "? Breech" in her progress note. She explained, however, that as a nurse "you do not diagnose ... that's the doctor's domain."

42 I find that had Dr. Lee come to the hospital at around 3:00 a.m. and examined Ms. Shofer he would have confirmed Nurse Vallat's opinion of a breech presentation. There would have been no need to order an X-ray and to wait for the results.

43 I find that an X-ray or ultrasound to confirm a breech presentation is only required when there is some doubt as to whether there is a breech presentation. In this instance there would have been no doubt.

44 I also find that at Branson Hospital it was the practice and policy of all obstetricians, including Dr. Lee, to perform caesarean sections for breech presentations and not to allow a trial of labour because doctors were aware of the risks of cord prolapse or cord compression with the resultant danger of injury to the fetus.

45 I find that had Dr. Lee attended at the hospital around 3:00 a.m. he would have performed a caesarean section on Ms. Shofer resulting in a perfectly healthy Naomi. Dr. Lee would also have had plenty of time to perform the caesarean section on Ms. C.S. which was started at 4:40 a.m. resulting in a perfectly healthy baby.

46 At 2:50 a.m. Dr. Lee was aware that two high-risk patients with abnormal pregnancies had been admitted to the hospital. He was the on-call obstetrician but he failed to attend at the hospital to see either patient until 4:10 a.m. and 4:25 a.m. when he had never met either patient, knew nothing about their history and could not make a diagnosis or a plan of treatment until he examined them.

47 Dr. Lee failed to attend his two high-risk patients promptly when called. By 3:30 a.m., the medical care needs of both patients collided. Shortly after 3:30 .m., Nurse Itwaru saw Ms. C.S. and observed her bleeding. She told Nurse McLean that she thought the bleeding was "too much" and that Dr. Lee ought to be notified.

48 At 3:40 a.m., the X-ray technician advised Nurse McLean that the X-ray demonstrated that "the head was up." At that point, Nurse McLean realized that Ms. C.S.'s "condition was not improving, that she had continued to bleed and she was very likely going to need a caesarean section." The fetal heart rate became non-reassuring with poor variability and Ms. C.S.'s blood pressure dropped from 120/90 to 110/70.

49 Nurse McLean became concerned because she knew she had "two high-risk patients who required caesarean sections ... and she wanted Dr. Lee in the hospital ...". She was scared about Ms. C.S.'s bleeding because she knew that they could lose both the mother and the baby very fast and baby would not "last very long."

50 Dr. Lee was, therefore, called at home. This time, Nurse McLean spoke with him about both Ms. Shofer and Ms. C.S. and asked him to come in. She related to him the results of the X-ray examination and informed him of Ms. C.S.'s "continued bleeding". Dr. Lee advised Nurse McLean

that Ms. Shofer was to have a caesarean section and that he would "be in to assess [Ms. C.S.] and probably do a caesarean section."

51 Nurse Itwaru testified that Ms. C.S. was now an emergency, so much so that she was unable to apply the fetal heart rate monitor on the patient under her care, Ms. Shofer. In fact, as far as the nurses were concerned, Ms. C.S. was "an emergency long before Dr. Lee came into the hospital."

52 At 3:40 a.m. Dr. Lee knew that he was faced with performing two caesarean sections. Because he had not seen either patient he did not know which one would be the more urgent situation. With the information he had he should have known that it was quite possible that both patients would require urgent surgery. He was only one surgeon. At that point in time he had the opportunity to call in a second surgical team but failed to do so.

53 The defendants' expert, Dr. Oppenheimer, testified that in his experience it was a fairly regular occurrence to have two patients both requiring caesarean sections.

54 It was his view that in such a situation he would call in a team and triage the patients depending on which patient was the more urgent. He would operate on the more urgent one followed by the other one.

55 However, in this case, there were two patients who required emergency surgery. It is extremely difficult to triage patients when there is only one doctor to perform two surgeries.

56 Dr. Oppenheimer viewed the circumstances of this case as an unforeseeable, unfortunate result. In my view, Dr. Oppenheimer took a rather cavalier attitude to the fact situation in this case.

57 The nurses testified that in their long years of practice they had never had to face a situation where two caesarean sections were required to be performed and where only one surgeon was available.

58 I do not accept Dr. Oppenheimer's opinion that Dr. Lee met the standard of care in his care of Ms. Shofer and Naomi. In cross-examination of Dr. Oppenheimer the following exchange took place:

> Q. After a thorough review of all of the documents you conclude that Dr. Lee acted entirely appropriately?
> A. Yes
> Q. You would hold up his conduct as a shining example to your students?
> A. Not necessarily, I felt he met the standard of care.

The Law

Duty of Care

59 Dr. Lee was the on-call obstetrician for Branson Hospital on September 18, 1994. He had a duty of care to any patient who required obstetrical care.

60 The issue in this case is not whether Dr. Lee breached his duty of care to Ms. C.S. although his care of Ms. C.S. impacted his ability to provide adequate care to Ms. Shofer.

61 On the facts of this case I find that Dr. Lee breached his duty of care to Ms. Shofer and Naomi.

Standard of Care

62 In Crits v. Sylvester et al. (1956), 1 D.L.R. (2d) 502 (Ont.C.A.), Mr. Justice Schroeder set forth the classic statement at p. 508:

> Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing, and if he holds himself out to be a specialist, a higher degree of skill is required of him than one who does not profess to be so qualified.
>
> I do not believe that the standard of care has been more clearly or succinctly stated than by Lord Hewart C.J. in R. v. Bateman (1925), 41 T.L.R. 557 at 559. 'If a person holds himself out as possessing special skill and knowledge by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment. If he accepts the responsibility and undertakes the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment .... The law requires a fair and reasonable standard of care and competence.'

63 Doctors Braithwaite and Harman were both of the opinion that Dr. Lee fell below the standard of care when he failed to attend at the hospital to evaluate Ms. Shofer when he was advised of her admittance and condition at 2:50 a.m.

64 Dr. Braithwaite said:

> In my opinion, when Mrs. Shofer presented to the hospital, she presented as a breech with fetal heart rate abnormalities, that in itself would have mandated the attendance of the on call physician. The fact that there was very little in the way of information available to the health care team made it all the more important that somebody attended and did an appropriate evaluation of the status and the

> risk of the pregnancy at that point in time.
>
> He needed to come in and he needed to talk to the patient to review her history, to do an examination and determine himself whether ... indeed she was a breech and act accordingly. I should also say that we have to always keep in mind that in this particular evening Dr. Lee did not have just Mrs. Shofer to deal with. When Mrs. Shofer attended, Dr. Lee in fact had another high risk patient in the delivery suite, a Mrs. C.S. and so in fact he had two significantly elevated risk patients in the delivery suite so to my mind he was mandated to be physically present.
>
> When the nurse called Dr. Lee early that morning, he was informed that she felt that the presentation was a breech presentation and that fetal heart rate decelerations had been encountered. That in itself mandates the obstetrician to attend both to assess what is happening with the fetal heart rate and also whether in fact a breech is presenting. But in addition, Dr. Lee and the health care professionals did not have any ancillary information. So they would not know whether there was a problem with the size of this fetus, whether in fact it was small for its date which is something that might - that would in fact influence how they were going to manage a case, the urgency of the case.
>
> Dr. Lee was informed of a high-risk pregnancy and labour, fetal heart rate deceleration, a likely breech, he should have come in immediately to assess the situation personally.

The fact that Dr. Lee only delivered breech presentation by caesarean section was also a significant factor in Dr. Braithwaite's opinion:

> ... Dr. Lee was informed of a likely breech by an experienced nurse. He was also informed of a non-reassuring fetal heart rate tracing. He knew that he did not deliver breeches vaginally and so he should have come in personally, confirmed the breech through his own exam, check the fetal heart rate, done what he felt was an appropriate in the way of resuscitative measures at that point and proceeded to caesarean section. There would be no point in allowing Mrs. Shofer to continue to labour if he was to do a caesarean section. By doing so, he just exposed Mrs. Shofer to the risks of a labouring breech, [which were], cord compression, prolapse of the cord when the membranes ruptured, fetal distress. He could have come in, confirmed the breech, and done a caesarean section under a regional - a spinal or an epidural anaesthetic and not have to subject her to an emergency caesarean section with inherent risks involved in a general

anaesthetic.

65 A similar opinion was expressed by Dr. Harman:

> I believe that her arrival at the hospital and the diagnosis by the nurse who received her as being a primagravida, that means in her first pregnancy, with a breech presentation mandated the attendance of the physician as soon as possible. That's the first point at which I believe Dr. Lee did not achieve the standard of care prevalent at that time. Had Dr. Lee been present in the hospital beginning approximately at 3 a.m., his observations about Ms. Shofer would have shown him A, that she was evidently a breech presentation, there would have been no need to proceed with the x-ray. The second thing, which would have been obvious soon after that, was the very rapid rate at which she was progressing. Dr. Lee performing the pelvic examinations himself would have been aware of the very rapid changes in the cervix. I believe that it is incumbent on the attending physician supervising a labour with the intention of vaginal breech delivery to be available in the hospital at all times. If the decision is made to deliver the patient by caesarean section as soon as the diagnosis of breech presentation is the plan, as I believe it was with Dr. Lee's pattern of practice, then the proper thing to do is to make sure about the breech presentation as soon as possible. Having organized that, proceed directly to caesarean section once all of those aspects of anaesthesiology, proper preparation of the patient in terms of laboratory evaluation and other preparations, proper consent and the availabilities of personnel. When all of those are in place, the caesarean section should be carried out without further delay.
>
> It is not an emergency situation but it is a situation waiting for something bad to happen. So this goes back to my response to your earlier question about how does an attending physician respond to the threat of an emergency, and that is by disposing it in an efficient and safe way so that it doesn't come back to overlap with the care of another patient.

66 At 2:50 a.m., Dr. Lee is aware that two full-term pregnant women have been admitted to Branson Hospital with abnormal pregnancies with high risk of additional problems. He has no firsthand knowledge of their condition, nor does he know anything about their medical histories.

67 In Wilson v. Swanson (1956), 5 D.L.R. (2d) 113 (S.C.C.), Rand J. cites with approval at p. 120 the statement at p. 84 of Rann v. Twitchel (1909), 82 Vt.79:

> He is not to be judged by the result, nor is he to be held liable for an error in judgment. His negligence is to be determined by reference to the pertinent facts existing at the time of the examination and treatment, of which he knew, or in the

> exercise of due care, should have known. It may consist in a failure to apply the proper remedy upon a correct determination of existing physical conditions, or it may precede that and result from a failure to properly inform himself of these conditions.

68 In Chattu v. Pankratz, [1990] B.C.J. No. 704 (B.C.S.C.), the court stated at p. 8:

> Judgment implies the weighing, assessing or evaluating of such information as may be available. Here the defendant exercised his judgment on incomplete information, because he failed to carry out a full and careful examination ... I conclude that the defendant was in breach of the duty he owed to the plaintiff to make a full and careful examination, and that if he had made a full and careful examination he would almost certainly have diagnosed vascular impairment, or arterial insufficiency ... as a probable cause of the plaintiff's symptoms.

69 Because Dr. Lee failed to attend at the hospital shortly after 2:30 a.m. he deprived himself of the opportunity to familiarize himself of the conditions of the two patients in order to devise the appropriate plan of treatment for each, which likely would have resulted in all being well. The inevitable negative result happened because he failed to attend at the hospital in a timely fashion.

70 In Edmison v. Boyd, [1985] A.J. No. 898 (Q.B.), aff'd, [1987] A.J. No. 216 (C.A.), leave to appeal to S.C.C. refused (1987), 51 Alta.L.R. (2d) xii (note) (S.C.C.), the defendant obstetrician was caring for a patient who he knew would be a high-risk pregnancy. This defendant was found to be negligent for not attending the patient at the hospital in time to prevent injury to the minor plaintiff. The evidence was described by Hope J. at para.27:

> As to what transpired prior to the plaintiff going to the hospital that day I accept the plaintiff's evidence to the effect that approximately 11:00 a.m. she telephoned the defendant's office and spoke to his nurse; his nurse indicated that the baby was probably dropping and advised her to lie down with her feet up, which she did with the result that her pain increased whereupon she telephoned a friend and spoke to her for about twenty minutes during which they clocked the pains at about ten minutes apart. She then telephoned the defendant's office again between 1:30 and 1:50 p.m. and again spoke to his nurse, identified herself and advised that her pains were worse. The nurse inquired as to whether there was any showing - and whereupon the plaintiff remarked that if she was in labour, is she supposed to be? The nurse then told her not to wait but to go to the University of Alberta Emergency ward and the doctor would meet her there. This, the plaintiff took to mean the defendant would meet her there. I find that the defendant was telephoned at 3:45 p.m. by the case room nurse at the hospital to the effect that the plaintiff had arrived, that she was three centimetres dilated; the fetal heart was normal but she was rather agitated and speaking of a

> Caesarean delivery. This was the first information that the defendant obtained following the telephone calls to his office nurse. The defendant did not contact the hospital prior to the 3:45 p.m. telephone call from that hospital. Thus, he did not instruct the hospital to advise him immediately she came in, nor did he speak to the resident in charge of the case room about the arrival of the plaintiff notwithstanding his concern about the baby's health on August 5th. In fact, he did not know when she actually arrived at the hospital. The next thing that happened is that the resident, Dr. Black, telephoned the defendant at 4:10 p.m. and advised him of his findings. The defendant gave certain instructions including the administering of morphine which was carried out at 4:15 p.m. (16.15 hours). The defendant could not recall whether or not the defendant had been prepped at the time she gave birth to the child. At 16.17 (4:17 p.m.) the chief nurse at the hospital was unable to hear the baby's heartbeat.

71 In finding the defendant negligent, Hope J. stated at paras.30-32:

> Under these circumstances the defendant could have and should have gone to the hospital at 3:45 p.m. on being advised of her being there and at the latest following Dr. Black's call at 4:10 p.m. in order to personally assess and attend to the plaintiff, particularly because she was a high risk patient as discussed above and because he was suspicious of the health of the baby. Had he been there he would have learned of the loss of the fetal heartbeat at 4:17 and could have delivered the baby by forceps immediately upon loss of the heartbeat.
>
> For the foregoing reasons I am of the opinion that there was a want of competent care and skill on behalf of the defendant to such an extent as to lead to the bad result. Further I am of the opinion that ordinary common sense should dictate that under the several circumstances I have mentioned immediate action, investigation and attendance was necessary. His failures that I have outlined show a want of due care, skill and diligence amounting to negligence in this case.

72 In an American case, Thomas v. Corso, 288 A. (2d) 379 (Md.App.) the court, affirming the judgment of the Circuit Court, quoted from "In Louisell and Williams, Medical Malpractice", sec. 8.05, pp. 206-07, as follows:

> The duty to attend the patient after a physician-patient relationship has been established is a clearly defined specific duty within the general duty of care. A physician cannot properly withdraw from a case under diagnosis or treatment without giving reasonable notice. How much attention a particular case may require in order to satisfy the standard of reasonable care, often is a matter for expert evidence. It requires no expert evidence, however, to show that failure

> altogether to attend a patient, when common sense indicates that without attention the consequences may be serious, is not reasonable care. (Emphasis added) ...

73 I suggest that the average person on the street when given the facts in this case would have no difficulty giving an opinion that Dr. Lee fell below the standard of care by failing to attend at the hospital shortly after 2:50 a.m. to provide appropriate care for the two patients. It is just plain common sense! If Dr. Lee met the standard of care by not coming to the hospital until 4:00 a.m. the public, especially women, would protest the legal definition of standard of care.

74 On behalf of Dr. Lee it is submitted that Dr. Lee exercised his judgment as to when to come to the hospital to see the two patients. It is argued that in such an exercise of judgment an error in judgment may be made but, that does not mean that Dr. Lee fell below the standard of care.

75 In Wilson v. Swanson, supra, Rand J. said:

> An error in judgment has long been distinguished from an act of unskilfulness or carelessness or due to lack of knowledge .... the honest and intelligent exercise of judgment has long been recognized as satisfying the professional obligation.

76 In my view, Dr. Lee failed to exercise "honest and intelligent" judgment. Dr. Lee gambled and lost. No, he did not lose, Naomi lost the opportunity to live a normal life because Dr. Lee failed to come to the hospital until it was too late to provide proper care. When doctors gamble with human life instead of using common sense they fall below the standard of care.

77 With respect to Dr. Lee's knowledge of the condition of the two patients at 3:40 a.m., Dr. Harman said the following:

> At this point Dr. Lee is faced with the inevitable collision of two patients with the potential for very serious complications. He should do whatever necessary to anticipate that both of those patients may have a dramatic worsening of their high-risk conditions. Either Mrs. C.S. may start to hemorrhage uncontrollably or her fetus experience fetal distress, or secondly, Ms. Shofer could develop one of the two primary complications of breech delivery, that is cord prolapse or impaction of the presenting part into the pelvis with cord compression. These are things sitting, waiting to happen and at 3:40 he knows now there are two patients on the list for potential disasters. Neither of these is certain to happen but both of them required him to be physically present. You should be able to assume that by the fact that both of these patients are present with these complications that a caesarean section will be required very soon.
>
> It is my belief that he had enough information to conclude that both patients

> would require caesarean section very soon. It was not possible for him to know at home over the telephone which patient required prioritization, which patient might deteriorate most rapidly. He was compelled to go to the hospital and I believe he was compelled also by his definition of the need for caesarean section of both of these patients to call one team and to consider calling at least a second anesthesiologist if not the whole second obstetric team.
>
> Realizing that mobilizing two whole teams of people without his examination would be an extraordinary generation of manpower, I think the practical and realistic thing for him to do would be to call in one team as he was proceeding immediately to the hospital to decide between these two patients.
>
> ...
>
> Most of those considerations would have depended on his examination of the patient. They would include an initial decision about how likely it was that the patient would require delivery more or less at the same time. He would have to judge the acuity of each situation. Having physically examined both of those patients, he would then be in a position to make the judgment about who should be delivered first by what route.
>
> I believe that had he attended the patient shortly after the telephone call at around 3:40, it would have been very difficult for him to decide between the two patients and this would have provoked him to call a second anesthesiologist to prepare whichever was the second patient for very very prompt transition from the delivery of one patient to the delivery of the second.
>
> I believe that Dr. Lee, had he done this, would have decided to perform a caesarean section on both patients based on his personal physical examination and discussion with those patients and that that decision would have been clear. If it wasn't already clear by the information over the telephone, it would have been clear within a few minutes of his arrival at hospital.

78 In School Division of Assiniboine South No. 3 v. Hoffer, [1971] 4 W.W.R. 746 (Man.C.A.) the court said at p. 752:

> It is enough to fix liability if one could foresee in a general way the sort of thing that happened. The extent of the damage and its manner of incidence need not be

> foreseeable if physical damage of the kind which in fact ensues is foreseeable.

79 It is my view that with the knowledge that Dr. Lee had at 2:50 a.m. of two high risk patients, he should have foreseen in a general way the probable consequences of not attending immediately at the hospital to assess both patients and to take appropriate action.

80 In Michaluk v. Rolling River School Division (2001), 5 C.C.L.T. (3d) 1, at 9, the Manitoba Court of Appeal stated:

> Another factor to be considered in determining whether the injury incurred is within the class or character of the reasonably foreseeable injury is whether reasonable steps could have been taken to protect against the injury, which actually occurred.

81 Dr. Lee lived within five minutes of the hospital. There was no reason to preclude him from attending at the hospital shortly after 2:50 a.m. when he knew two high-risk patients were in the hospital and he was the on-call obstetrician.

82 There is also no reason why Dr. Lee did not call in a second surgical team at 3:40 a.m. when he knew he was faced with having to perform two caesarean sections and did not know which one would take priority or whether both required to be performed immediately.

83 The above two actions, which if they had been taken by Dr. Lee were, "... reasonable steps which could have been taken to protect against the injury, which actually occurred."

84 If Dr. Lee had attended at the hospital shortly after 2:50 a.m. he would have been able to perform both caesarean sections without incident. If Dr. Lee had called in a second surgical team at 3:40 a.m. it is likely that Ms. Shofer's caesarean section would have commenced at least by 4:40 a.m., the actual time when Ms. C.S.'s caesarean section commenced. If that had happened it is probable that Naomi's injuries would have been avoided.

85 It is my view, in the words quoted above from Crits and Sylvester, that Dr. Lee failed to "exercise a reasonable degree of care" and, failed "to use diligence, care, knowledge, skill and caution in administering the treatment" of Ms. Shofer and Naomi.

86 On all of the evidence, I have no hesitation in finding that Dr. Lee's care and treatment of Ms. Shofer and Naomi fell well below the standard of care which the law outlines and which the public expects of an obstetrician. I find that Dr. Lee's failures constitute negligence.

Causation

87 There was a general consensus amongst the experts called by both the plaintiffs and the defendants with respect to the cause of Naomi's brain injury. They all agreed that Naomi suffered an acute profound hypoxic-ischemic injury to her brain shortly before her birth.

88 The only disagreement surrounds the timing of the brain injury. No one knows for sure at what time the brain injury to Naomi occurred.

89 The plaintiffs' experts attempt to show that had Naomi been delivered five to ten minutes earlier she would not have suffered any injury. That was Dr. Macnab's theory: Naomi would not have suffered any injury if delivered prior to 5:16 a.m.

90 The weight of the evidence does not support the plaintiffs' theory. In my view, it was necessary for the plaintiffs to propound this theory in order to dovetail it with their other theory that had Nurse Itwaru told Dr. Lee earlier of Ms. Shofer's problems he would have been able to deliver Naomi prior to any injury. I have already rejected that theory. There is no evidence to support the proposition that Dr. Lee could have delivered Naomi any sooner than her actual delivery time.

91 The weight of the evidence supports the theory that the injury to Naomi likely occurred between 4:45 a.m. and 5:00 a.m.

92 Although the plaintiffs' expert, Dr. Hill, believed that the insult to Naomi happened, "... over a relatively brief period of time prior to delivery," he agreed that there was:

> ... severe bradycardia beginning at approximately 4:35 with further documentation of severe bradycardia at 4:45, 4:50 and 5:00.

93 Dr. Levin, the defendants' expert, was of the view that Naomi would have suffered an insult lasting a relatively short time. He postulated that the period of acute total hypoxia-ischemia lasted 10-15 minutes. He stated:

> ... there was a period of variable decelerations between 4:30-4:45. At 4:45 the foetal heart rate fell to 60 beats - one minute after the onset of the insult - the heart rate remained at this rate until approximately 5:00 i.e. duration of insult of 15 minutes ... I postulate that the foetal heart rate and foetal circulation recovered in the period 5:00-5:26 when the infant was delivered. If the acute ischemic insult had continued beyond 5:00 Naomi would have been more severely damaged. I conclude that neurological injury would not have been prevented if Naomi had been delivered at any time after 5:00 given that the brain damage most likely occurred between 4:55-5:00.

94 Another defendants' expert, Dr. Marrin, said:

> The brain damage that occurred in this case can result from less than 15 minutes of severe asphyxia. We know that there was a 15 minute period of sustained bradycardia from 4:45-5:00. In my opinion, it is likely that this period of intense asphyxia caused Naomi's brain injury.

95 Even the plaintiffs admit that at 4:45 a.m. Dr. Lee would have diagnosed acute fetal distress. They say:

> However, in light of what the tracing, in fact, demonstrates beginning at 04:45, he would have diagnosed acute fetal distress, reprioritized the patients and intervened by emergency caesarean section.

96 I find that it is more probable than not that Naomi's injury occurred between 4:45 a.m. and 5:00 a.m. on September 18, 1994.

97 I find that the cause of the injury to Naomi was the failure of Dr. Lee to come to the hospital within a reasonable time after he knew of Ms. Shofer's admittance at 2:35 a.m. At that time Dr. Lee knew that two patients had been admitted with abnormal pregnancies. However, Dr. Lee did not see Ms. Shofer until 4:25 a.m. at which time he was in a rush to perform an emergency caesarean section on Ms. C.S. and told Ms. Shofer that her surgery would have to wait.

98 Because of Dr. Lee's failures to come to the hospital earlier and/or to arrange for a second surgical team, Dr. Lee was helpless to avoid Naomi's inevitable injury.

99 The "but for" test works perfectly on the facts of this case. But for the negligence of Dr. Lee, Naomi would not have suffered any injury.

Result

100 Judgment to go in favour of the plaintiffs against Dr. Lee in the amount of the agreed upon damages with costs.

101 The claims against Dr. Grynspan and nurses Vallat, McLean, and Itwaru are dismissed with costs.

102 If the parties are unable to agree on the amount of the costs they may provide me with written submissions.

B. WRIGHT J.

* * * * *

APPENDIX "A"

SHOFER v. NORTH YORK BRANSON HOSPITAL et al.

Pertinent Time-Lines

1:40 a.m.

Ms. C.S. admitted - heavy flow vaginal bleeding.

2:00 a.m. Dr. Lee called and report given about Ms. C.S. and he gives nurses certain orders.

2:20 a.m. Dr. Lee ordered patient to be prepared for possible caesarean section (c/s).

2:35 a.m. Ms. Shofer admitted. Nurse diagnoses breech condition.

2:50 a.m. Dr. Lee called. He orders X-ray to confirm breech presentation.

3:40 a.m. X-ray called to say head was up. Dr. Lee called and patient to have c/s.

Dr. Lee informed of Ms. C.S.'s continued bleeding. "Is going to be in to assess patient and probably do a caesarean section. Patient informed of possible caesarean section."

4:00 a.m. Dr. Lee comes to the hospital.

4:10 a.m. Dr. Lee talked to Ms. C.S. and explained c/s.

4:25 a.m. Ms. Shofer - seen by Dr. Lee and advised that her c/s would be done after Ms. C.S.'s c/s.

4:28 a.m. Ms. Shofer - catheterized - 5cm, p.p. -2.

4:30 a.m. Ms. Shofer - FHR 120-126; SROM; thick meconium present, variable decels reoc-curring; Foley Catheter inserted.

4:30 a.m. Ms. C.S. - entered the OR

4:31 a.m. Ms. Shofer - IV Bolus. Patient on right side.

4:32 a.m. Ms. Shofer - SROM thick meconium.

4:35 a.m.
Ms. Shofer - FHR down to 60 - Patient on side and IV bolus given.

4:40 a.m. Ms. C.S.'s surgery commenced.

4:44 a.m. Ms. C.S.'s baby delivered.

4:45 a.m.
Ms. Shofer - FHR down to 60; not recovering. Dr. Lee advised in OR; suturing c/s patient Ms. C.S.

Ms. Shofer moved to right side, pushing vigorously. Meconium +++ PV.

4:45 a.m. Ms. C.S.'s placenta delivered.

4:48 a.m. Ms. Shofer pushing vigorously.

4:50 a.m.
Ms. Shofer - FHR down to 60 not recovering. Dr. Lee informed again. Patient turned to left side.

5:00 a.m. Ms. Shofer - FHR 60, showing signs of recovering but dropping again. VE Cx fully dilated. Thick meconium present. Breech presenting.

5:00 a.m.)
5:02 a.m.) Ms. Shofer to OR.
5:15 a.m.)

5:05 a.m. Ms. C.S.'s surgery completed.

5:20 a.m. Ms. Shofer - anaesthesia started.

5:23 a.m. Ms. Shofer - surgery commenced.

5:26 a.m. Ms. Shofer - baby delivered.

cp/ci/e/nc/qw/qlscl/qlkjg