

Current and Emerging Issues in Medical Malpractice¹

By Kevin L. Ross²

I. Introduction

While there are a number of topics within the area of medical negligence that are ripe for discussion as current and emerging issues, this paper will focus on two in particular.

First, an update will be provided with respect to the duty of care owed by physicians to an unborn child, and the ability of that child, once born alive, to claim in negligence against that physician. This update will focus on the Court of Appeal's 2008 decisions in *Bovingdon v. Hergott* and *Paxton v. Ramji*, and the decision of the Court of Appeal in *Liebig v. Guelph General Hospital* released in June of 2010.

Second, this paper will discuss recent developments involving patient claims for psychiatric impairment caused by physician negligence. These developments centre around the Ontario Court of Appeal's recent application of the Supreme Court's 2008 decision in *Mustapha v. Culligan Canada Inc.* in the context of medical malpractice.

II. Update on a Physician's Duty of Care to the Unborn

Historically, the law in Ontario has recognized a number of circumstances in which a physician owes a duty of care not only to a mother, who is the patient, but also to a child *en ventre sa mere*. Provided it is later born alive, that child can bring a claim for negligence alleging that the physician caused the child some injury prior to its birth. While certain specified claims have been regarded as actionable, Ontario, like most other common law jurisdictions, has been unreceptive to claims for 'wrongful life'.

Wrongful life claims, generally, are brought by a child, usually disabled, against a physician, where it is alleged that 'but for' the negligent act or omission of the defendant

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while the child was *in utero*, the child would never have been born.³ Put simply, "...the child argues that, had the risk or certainty of disability been known, its parents would either have avoided its conception or would have had it aborted"⁴

Courts have been unwilling to recognize wrongful life claims for two primary reasons. First, it has been considered contrary to public policy to impose on a physician a duty of care to an unborn child to see that the child is not born. Second, it has been deduced that wrongful life claims place the court in the impossible position of having to determine how to measure compensating a plaintiff for the harm of being born.⁵ Put another way, "it is impossible in concrete terms for judges to assess damages in wrongful life claims since this entails comparing the value of a disabled life to the value of having no life at all."⁶

Over the years, Canadian courts have sought to limit the ability of infant plaintiffs to claim for 'wrongful life', while still permitting situations in which the law ought to recognize claims by infant plaintiffs for injuries suffered from the negligence of health care professionals while *in utero*. For this reason, the analytical approach followed in *Bovingdon v. Hergott*⁷, and the scope of the decision reached in *Paxton v. Ramji*⁸, both 2008 decision of the Ontario Court of Appeal, have come as a rather large surprise to those practicing in the area of medical negligence.

These two Court of Appeal decisions have refuelled the controversy surrounding the issue of whether a 'wrongful life' claim is possible in Ontario. In addition, these cases have placed in doubt whether, and in what circumstances, a physician owes any duty of care to an unborn child at all. Adding to the uncertainty is the decision of the Court of Appeal in *Liebig v. University of Guelph*, released in June of 2010, which appears to

³ See Thor Hansell, "Duty of Care in Wrongful Life Cases: Does such a duty exist in Canada?" (2009) *CBA Critical Issues in Health Law: A National Summit* at p.1.

⁴ Margaret Fordham, "A life less ordinary—The rejection of actions for wrongful life" (2007) 15 T.L.J. 123.

⁵ See the English Court of Appeal decision in *McKay v. Essex Area Health Authority*, [1982] 1 Q.B. 1166 (Eng. C.A.). See also *Lacroix (Litigation guardian of) v. Dominique* (2001), 202 D.L.R. (4th) 121 (Man. C.A) leave to appeal denied [2001] S.C.C.A. No. 477 [*Lacroix*].

⁶ Yola S. Ventresca & Peter W Kryworuk, "Revisiting Wrongful Life Claims in Canada - Can There Be a Cause of Action: *Bovingdon v. Hergott*" (2008) 34 *Advoc. Q.* 216 at 217 See also Darryl A. Cruz, "*Paxton v. Ramji*: Principled Legal Consistency" (2009) *CBA Critical Issues in Health Law: A National Summit*.

⁷ [2008] 88 O.R. (3d) 641 (C.A.) [*Bovingdon* (C.A.)].

⁸ [2008] 92 O.R. (3d) 401 (C.A.) [*Paxton* (C.A.)].

reach the opposite conclusion to that of both *Bovingdon* and *Paxton*.⁹ This paper will attempt reconcile these cases, and will attempt to shed some light on the current state of the law in this area of medical negligence.

BOVINGDON V. HERGOTT

In *Bovingdon*¹⁰, an action was brought against a physician by twin girls (and their family members), who were born severely disabled. The action was based on the physician's alleged failure to provide the mother with the information necessary to make an informed decision about whether to begin taking the fertility drug, Clomid. It was alleged that the physician failed to inform the would-be mother of the full extent of the risks of taking the drug, of the potential of having twins, of the potential for premature birth, and of the possible injury to the twins arising as a result.

At trial, the jury found that the doctor was negligent for failing to provide adequate information about the drug to the mother. In addition, the trial judge found as a matter of law that the physician owed a duty of care to the twins. Following the analysis used by the Manitoba Court of Appeal in *Lacroix*, Pardu J. concluded that the claim was not an action for 'wrongful life' because this was not a case where the doctor's negligence only caused the twins to be born; in this case, the doctor's negligence caused both the birth of the twins and their damages.¹¹

Speaking for the Court of Appeal, Feldman J.A. criticized the approach of the trial judge and of the Manitoba Court of Appeal in *Lacroix*. She opined that the two-category approach used in *Lacroix* did not provide a "coherent theory" that could guide courts in this area of the law. Given this instability, she preferred a traditional tort analysis that considered whether the doctor prescribing a legal fertility drug owed a duty of care to future children.¹²

⁹ 2010 ONCA 450 at para. 6 [*Liebig* (C.A.)]

¹⁰ *Bovingdon v. Hergott*, [2006] O.J. No. 4672 (QL) (S.C.J.) at paras. 9-10.

¹¹ *Ibid.* at para 4. Following *Lacroix*, *supra* note 5, the trial judge noted that cases involving a claim by a child born with abnormalities generally fall within one of two categories: (i) cases in which the abnormalities have been caused by the wrongful act or omission of another; and (ii) cases in which, but for the wrongful act or omission, the child would not have been born at all. While cases falling to the former category have generally been held to be actionable, cases within the latter have been regarded as 'wrongful life' claims.

¹² *Bovingdon* (C.A.), *supra* note 7 at paras. 55-61.

Feldman J.A. concluded that in this instance the physician did not owe a duty of care to the twin girls and, therefore, allowed the appeal. It was held that the doctor owed a duty of care only to the mother, and that the scope of this duty was only to ensure that she possessed sufficient knowledge to make an informed decision about whether to take Clomid.¹³ Further, the existence of a co-extensive duty on the physician towards both mother and future child was rejected. In the view of Feldman J.A., this could lead to conflicting duties which, it was felt, could reduce the autonomy of the mother to make decisions on her own behalf.¹⁴

PAXTON V. RAMJI

In *Paxton*¹⁵, Ms. Paxton sought treatment from Dr. Ramji, her family doctor, for acne. Believing that she would not become pregnant, the doctor prescribed Accutane, a teratogenic¹⁶ drug. Importantly, Ms. Paxton's husband had a vasectomy some 4 ½ years earlier. Unfortunately, after taking the drug it appears that the vasectomy failed and Ms. Paxton became pregnant, subsequently giving birth to a disabled child. Both the parents and the child claimed against the doctor for negligently prescribing the drug to a woman of child-bearing potential.

At trial, the judge found that the doctor owed a duty of care to the infant plaintiff before conception not to prescribe Accutane to her mother without taking all reasonable steps to ensure that the mother would not become pregnant while taking the drug. However, the trial judge also found that the respondent doctor met the standard of care by relying on the father's vasectomy as an effective form of birth control.¹⁷ The trial judge dismissed the child's action against the doctor. Both the plaintiff and the defendant appealed.

The Court of Appeal dismissed the plaintiff's appeal and the decision of the trial judge dismissing the action was upheld. While the Court of Appeal agreed with the result at

¹³ *Ibid.* at para. 70. The Court of Appeal felt that the choice to take the drug rested ultimately with the mother, who does not owe a duty to her future child at any time.

¹⁴ *Ibid.* at para. 71.

¹⁵ [2006] O.J. No. 1179 [*Paxton* (S.C.J.)].

¹⁶ A teratogen is an agent that causes or increases the risk of abnormal fetal development. See among other articles on the subject M.A. Honein, L.J. Paulozzi & J.D. Erickson, "Continued occurrence of Accutane®-exposed pregnancies" (2001) 64:3 *Teratology* 142.

¹⁷ *Paxton* (S.C.J.), *supra* note 15 at para. 29.

trial, they did so on the grounds that the doctor owed no duty of care to the unborn plaintiff. Feldman J.A., writing for the court, took issue with the duty analysis of the trial judge that engaged in questions over whether this case was a ‘wrongful life’ action. Expanding on her analysis in *Bovingdon*, Feldman J.A. pronounced that to ask whether the case is one of wrongful life is to ask the “wrong question”.¹⁸ Instead, she regarded the duty of care issue as best dealt with through the traditional negligence law framework.

At the outset of her analysis, Feldman J.A. sought to determine whether this particular case fit within an established or recognized duty of care.¹⁹ After reviewing some of the authorities, Feldman J.A. concluded it was “...fair to say that there is no settled jurisprudence in Canada on the question whether a doctor can be in a proximate relationship with a future child who was *not yet conceived or born* at the time of the doctor’s impugned conduct.”²⁰ Similarly, she held that there is also no “...existing category of recognized relationship that can be extended by simple analogy to impose, or refuse to impose, a duty of care on a doctor to a future child of the doctor’s female patient.”²¹ Feldman J.A. concluded that the proposed duty in this case was a novel one.²²

Accordingly, Feldman J.A. proceeded with the two-stage *Anns* test to determine whether the proposed duty of care should be recognized in law. While the court agreed that it was reasonably foreseeable that prescribing the drug could harm a potential child, the court reached the conclusion that there was insufficient proximity in the relationship to recognize a duty.²³

¹⁸ Paxton (C.A.), *supra* note 8 at para. 29.

¹⁹ Citing the Supreme Court’s decisions in *Childs v. Desormeaux*, [2006] S.C.J. No. 18 and *Cooper v. Hobart*, [2001] 3 S.C.R. 537, Feldman J.A. wrote “Where the relationship between the plaintiff and defendant is of a type that has already been judicially recognized as giving rise to a duty of care, or is analogous to a recognized category, a court may usually infer that sufficient proximity is present and that if the risk of injury was foreseeable, a *prima facie* duty of care will arise” Paxton (C.A.) *ibid.* at para. 30.

²⁰ Paxton (C.A.) *ibid.* at para. 53.

²¹ *Ibid.* at para. 54. Citing unique policy considerations, Feldman J.A. rejects the analogy of the proximity between mother and fetus—*Dobson v. Dobson*, [1999] 2 S.C.R. 753. Feldman J.A. also rejects the analogy of the duty imposed on a third party motorist towards an unborn child—*Duval v. Seguin* (1973), 1 O.R. (2d) 482 (C.A.). Lastly, Feldman J.A. rejects the analogy between a physician and the duty owed to unrelated third parties for harm arising out of the doctor’s treatment of a patient—*Ahmed v. Stefaniu* (2006), 275 D.L.R. (4th) 101 (Ont. C.A.).

²² Paxton (C.A.) *ibid.* at para. 59.

²³ *Ibid.* at paras. 64-76.

Considering proximity, Feldman J.A. sought to determine whether the physician and the unborn child were in a sufficiently ‘close and direct relationship’ as to justify the imposition of a duty. Citing the Supreme Court of Canada’s decision in *Syl Apps Secure Treatment Centre v. B.D.*²⁴, which considered the potential of conflicting duties as a policy reason against finding a proximate relationship, Feldman J.A. concluded that a duty owed to the child could conflict with the duty owed to the mother.²⁵ It was reasoned:

If a doctor owes a duty of care to a future child of a female patient, the doctor could be put in an impossible conflict of interest between the interests of the future child and the best interests of the patient in deciding whether to prescribe a teratogenic drug or to give the patient the opportunity to choose to take the drug.

These conflicting duties could well have an undesirable chilling effect on doctors...Thus, imposing a duty of care on a doctor to a patient’s future child in addition to the existing duty to the female patient creates a conflict of duties that could prompt doctors to offer treatment to some female patients in a way that might deprive them of their autonomy and freedom of informed choice in their medical care.²⁶

The Court of Appeal further reasoned that no proximity exists between doctor and fetus because the relationship is not sufficiently ‘close and direct’. Feldman J.A. opines that “[a]lthough a doctor’s actions can, in some cases, directly harm a future child, the doctor’s relationship with a future child is necessarily indirect” and is “mediated” through the patient.²⁷ Interestingly, this stage of the analysis ends with the following:

The conflicting duties that would be owed by a doctor to a female patient and to her future child (whether conceived or not yet conceived) in prescribing medication to the female patient, together with the indirect relationship between a doctor and a future child, reflect two aspects of the same reality. Because the woman and her fetus are one, both physically and legally, it is the woman whom the doctor advises and who makes the treatment decisions affecting herself and her future child. The doctor’s direct relationship and duty are to the female patient. That relationship and that duty of care prevent a relationship of the requisite proximity between the doctor and future child because the interests of the mother and her future child may possibly conflict.²⁸

Having concluded there was no *prima facie* duty of care, Feldman J.A. also concluded at the second stage of the *Anns* test that there are residual policy considerations that militate

²⁴ [2007] 3 S.C.R. 83, 2007 SCC 38 [*Syl Apps*].

²⁵ *Paxton (C.A.)*, *supra* note 8 at para. 64.

²⁶ *Ibid.* at paras. 66-68.

²⁷ *Ibid.* at para. 71.

²⁸ *Ibid.* at para. 76.

against the imposition of a duty. Cited were the potential interference with a woman's right to have an abortion, and the potential interference with the societal obligation "...to preserve a woman's bodily integrity, privacy and autonomy rights".²⁹

Whether considering policy or proximity, one can observe that the same factor is at the heart of the Court of Appeal's reasoning with respect to the duty of care. This is the concern that a physician will be placed in an irreconcilable conflict between the duty he or she owes patient mother, and the duty owed to the unborn child.

RESULTING UNCERTAINTY

Following the *Bovingdon* and *Paxton* decisions, a line of judicial authority held to establish a duty upon a physician to take care with respect to unborn children was thrown into doubt.³⁰ In *Paxton*, while the court could have confined its decision denying a duty to children in the 'wrongful life' context, or to children yet to be conceived, the language of the decision appears to go much further. On its face, the decision applies to all tort claims by a child against his or her mother's physician for events prior to that child's birth. Such a sweeping decision appears to conflict not only with other provincial appellate decisions³¹, it also seems at odds with previous decisions of the Ontario Court of Appeal concerning a physician's duty of care to an unborn child.³²

LIEBIG V. GUELPH GENERAL HOSPITAL

The infant plaintiff, Kevin Liebig, was born on March 12, 2001 at the Guelph General Hospital. During delivery, he suffered complications at birth that resulted in a diagnosis of cerebral palsy. The infant plaintiff, along with family members, sued the defendants including the physicians, the hospital and nursing staff who provided maternal-fetal care to Kevin and his mother. The plaintiffs alleged, among other things, a breach of the duty

²⁹ *Ibid.* at para. 79.

³⁰ See *Montreal Tramways Co. v. Léveillé*, [1933] S.C.R. 456 at 8; *Tsur-Shofer v. Grynsman*, [2004] O.J. No. 2361; and *Milne v. St. Joseph's Health Centre*, [2009] O.J. No. 4004. For a more complete listing and review of these cases see the judgment of Tausendfreund J. in *Liebig v. Guelph General Hospital*, [2009] O.J. No. 4292 [*Liebig* (S.C.J.)].

³¹ See *Lacroix*, *supra* note 5. See *Cherry v. Borsman* (1990), 75 D.L.R. (4th) 668 (B.C.C.A.).

³² For instance, *Commisso v. North York Branson Hospital*, [2003] O.J. No. 20 (C.A.) where the Court of Appeal upheld the finding of a trial judge that there was proximity between a physician and a child *in utero*. See also *Crawford v. Penney*, [2004] O.J. No. 3669 (C.A.).

of care by the defendants in caring for Kevin during his mother's labour and delivery. After the defendants denied owing the infant plaintiff a duty of care, the plaintiffs brought a motion pursuant to Rule 21 for a declaration before trial that the defendants owed such a duty in relation to the delivery.

At the hearing, the position of the defendants was that both the *Bovingdon* and *Paxton* decisions of the Court of Appeal applied to the maternal-fetal care scenario, and that no duty of care was owed. The plaintiffs, on the other hand, argued that those decisions did not apply because the focus of the care provided in both *Bovingdon* and *Paxton*, unlike in this particular case, was for the sole benefit of the mother.³³

Justice Tausendfreund granted the motion declaring that the defendants owed a duty of care to the infant plaintiff in relation to his delivery. The motions judge analyzed the decisions of the Court of Appeal in *Bovingdon* and *Paxton* in considering whether a duty of care was owed in "the maternal-fetal care scenario of this case".³⁴ The conclusion was reached that the duty of care articulated by the Court of Appeal in those cases was restricted to pre-conception cases. Tausendfreund J. made this distinction based, in part, on the fact that the list of cases the Court of Appeal referred to in *Paxton* does not include any claims arising out of alleged negligence in the exercise of "maternal-fetal care"³⁵, although this term is not defined.

The motions judge went on to cite various cases across Canada recognizing the existence of a duty of care owed by physicians in the "maternal-fetal" context.³⁶ Based on the "legion of reported decisions" recognizing the duty of care owed to a fetus by physicians, he found that the Court of Appeal "could surely not have meant the maternal-fetal care scenario when referring to the proposed duty" as "a novel one".³⁷ In the result, the motions judge found that the court's reasoning in both *Bovingdon* and *Paxton* did not

³³ For instance, the plaintiffs argued that this case was distinguishable because 1) The health of the fetus in those cases was not the object of the care provided; 2) The focus of maternal-fetal care is the well-being of mother and fetus; and 3) In the maternal-fetal care setting there is neither a potential or an actual conflict of interest.

³⁴ *Liebig* (S.C.J.), *supra* note 30 at para. 16.

³⁵ *Ibid.* at para. 18.

³⁶ *Ibid.* at paras. 19-33. Justice Tausendfreund refers to over a dozen such cases including *Montreal Tramways Co. v. Léveillé*, *Crawford v. Penney*, *supra* note 32, *Commisso v. North York Branson Hospital*, *supra* note 32, *Tsur-Shofer v. Grynspar*, *supra* note 30, and *Milne v. St. Joseph's Health Centre*, *supra* note 30.

apply to situations like the infant plaintiff's, and that the defendants did indeed owe a duty of care. At the end of his judgment, Justice Tausendfreund noted:

In summary, I find that the court in both *Bovingdon* and in *Paxton* did not include in its consideration the maternal-fetal care cases such as the one before me. The duty to both mother and fetus in the maternal-fetal care scenario has been long established in Canadian jurisprudence.³⁸

The appeal of the defendants was initially heard by a 3-judge panel on March 1, 2010. After the initial arguments, however, the Chief Justice ordered that the appeal be re-argued before a 5-judge panel. On June 17, 2010, the Court of Appeal released its judgment dismissing the appeal and upholding the declaration made by the motions judge that the defendants owed a duty of care to the unborn plaintiff.

A unanimous Court of Appeal concluded that the appeal could be decided based on a “very long and well-established line of cases, duly cited by the motion judge, holding that an infant, once born alive, may sue for damages sustained as a result of the negligence of health care providers during labour and delivery”³⁹ The Court specifically noted that “[a]s the facts alleged in the present case clearly fall within an established category where a duty of care exists, it is not necessary to engage in a *Cooper-Anns* analysis” to establish a novel duty of care.⁴⁰

The Court addressed the defendant's argument that the recent decisions in *Bovingdon* and *Paxton* had introduced a fundamental change to the law requiring a departure from an established line of authority. It was noted that “[c]ases in the vein of *Bovingdon* and *Paxton*... involve claims made by infants yet to be conceived at the time the alleged negligence occurred...”⁴¹ While conceding that “[a]t various points in the *Paxton* judgment, the court cast the issue in terms of a duty of care to a child "not yet conceived

³⁷ *Liebig* (S.C.J.) *ibid.* at para. 33.

³⁸ *Ibid.* at para. 35.

³⁹ *Liebig* (C.A.), *supra* note 9 at para. 6. Feldman cites previous decisions of the Ontario Court of Appeal in *Crawford v. Penney* (2003), 14 C.C.L.T. (3d) 60 (ON S.C.) at para. 210, *aff'd* (2004), 26 C.C.L.T. (3d) 246 (C.A.); *Commission v. North York Branson Hospital* (2003), 48 O.R. (3d) 484 (C.A.) at para. 23.

⁴⁰ *Liebig* (C.A.) *ibid.* at para. 8.

⁴¹ *Ibid.* at para. 11.

or born" or "*conceived* or not yet conceived", The Court's ruling points out that the defendants have "adopt[ed] a strictly literal reading of those passages".⁴²

In rejecting the defendant's interpretation of *Paxton* and *Bovingdon*, The Court writes:

We do not read those passages as governing the issue raised on this appeal. In accordance with the tradition of the common law and the doctrine of precedent, *Paxton* and *Bovingdon* must be read in the light of their precise facts, the issues they addressed, and in a proper legal context... In our view, the authority of the labour and delivery cases remains intact and is unaffected by *Bovingdon* and *Paxton*.⁴³

Interestingly, the conclusion of the judgment of the Court of Appeal provides:

We recognize that, in the future, the reasoning in *Bovingdon* and *Paxton* may be brought to bear in other cases involving post-conception negligence. Indeed, in written and oral argument, counsel ventured opinions on a wide range of issues and possible scenarios extending well beyond the narrow compass of the facts of this case.⁴⁴

CAN THESE CASES BE RECONCILED?

What can be initially observed is that, based on the *Liebig* decision, the Court of Appeal's decision in *Paxton* is not as sweeping as some had originally argued. Rather than representing a fundamental change in the law, *Paxton* now appears to apply within certain boundaries which will require further delineation. At the very least, it can be said that when asked if a doctor owes a duty of care to an unborn child, the answer will continue to be "it depends".

The Court of Appeal in *Paxton* seems to state that no duty is owed by a physician to his or her patient's future child in any context. Indeed, the wording of the decision in *Paxton* does not seem to confine its scope to either the 'wrongful life' context or to situations in which the child is un-conceived.⁴⁵ The reasoning articulated in *Paxton* is that policy considerations serve to negate a relationship of proximity necessary for a novel duty of care to be established.

⁴² *Ibid.* at para. 12.

⁴³ *Ibid.* at para. 13.

⁴⁴ *Ibid.* at para. 14.

⁴⁵ Darryl A Cruz, "Paxton v. Ramji: Principled Legal Consistency" (2009) *CBA Critical Issues in Health Law: A National Summit* at 1.

In *Liebig*, while an opposite conclusion is reached with respect to the duty of care owed by a physician to an unborn child, the case does not overrule the reasoning employed in *Paxton*. Instead, *Liebig* is decided by recognizing an established duty of care in the labour and delivery context. In essence, it appears that labour and delivery cases are carved out as a category immune from undergoing the duty of care analysis utilized by the Court of Appeal in *Paxton*.

Interestingly, however, the reasoning used in *Paxton* can arguably be applied to negate a duty in many labour and delivery cases. One is at pains to envision a context prior to the moment of birth in which there is no potential for conflict between care for the mother and care for the child. Further, at what point prior to birth will a physician have a more direct relationship with the future child than he or she does with his or her current patient? Even in the labour and delivery context, the policy concerns outlined in *Paxton* serving to negate a proximate relationship are present in some degree.

If the immunity implied by *Liebig* does exist, it can additionally be asked whether all labour and delivery cases are alike? Does every single labour and delivery scenario fit within this established duty, or merely situations in which there appears to be no conflict between mother and child? Since no two labour and delivery cases are the same, does placing all such cases into an established duty of care impose uniformity where none actually exists?

While the decision of the Court of Appeal in *Liebig* seems to limit the applicability of *Paxton* to cases in which the doctor has prescribed drugs to the mother of a child who has yet to be conceived, the decision also explicitly recognizes the possibility that in future post-conception cases the reasoning in *Paxton* and *Bovingdon* could apply. For this reason, it has now been left to future cases to determine which situations are governed by an existing duty of care, and which will be subject to the reasoning used in *Bovingdon* and the duty analysis in *Paxton*. The key question for those practicing medical negligence law becomes just how far the reasoning in *Paxton* can be extended to other maternal-fetal health contexts?

While established duties of care seem to be immune from undergoing a *Anns-Cooper* duty of care analysis, many other situations are likely not settled law. It may be the case for these situations that there is a continuum of different maternal-fetal contexts. At one end are situations in which the physician is almost exclusively concerned with the mother's health and treatment. On the other end would be situations in which although the mother is the patient, the particular treatment given is focused around the health of the child rather than that of the mother.

As one moves along the continuum towards the latter types of cases, it would be open to argue that the doctor and the future child are in a more direct and un-conflicting relationship sufficient to overcome the policy considerations that negated the duty used in *Paxton*. Establishing proximity in such cases may depend on the ability to show that the care being provided concerns the fetus in a direct-enough way, and that for this reason there is no potential or actual conflict between caring for both mother and child.

This raises the question, however, should the duty of care analysis be determined on a case by case basis? Some authors feel that this would lead to inconsistent results as to when a duty was owed. In addition, little guidance would be provided to physicians who must make decisions on the ground when faced with split second medical issues.⁴⁶

And what of wrongful life claims? The Court of Appeal has indicated that to inquire into whether an action is for wrongful life is to "ask the wrong question". Now, all claims not fitting into an established duty will have to satisfy a court that a sufficiently proximate relationship exists between plaintiff and defendant, and that policy considerations do not militate against imposing a duty of care. This analysis makes it extremely unlikely that a 'wrongful life' claim could succeed, especially if the claim is made with respect to events occurring before the future child was conceived. That being said, analyzing claims under the duty of care framework does leave open the possibility that, on the right facts, a proximate relationship could be established. Granted, this may have to fit into a narrow period of time post-conception but during a period in which the pregnancy can still be terminated.

⁴⁶ *Ibid.* at p. 16.

III. Remoteness in Medical Negligence Cases: Psychiatric Injury Claims Post-*Mustapha*

By now, the Supreme Court of Canada's ruling in *Mustapha v. Culligan Canada*⁴⁷, a modern update on the snail in the bottle of ginger beer, is well-known to most personal injury lawyers. The plaintiff suffered nervous shock, including medically diagnosed psychiatric impairments, after seeing a dead fly in a bottle of water. The Supreme Court ultimately determined that although the plaintiff had suffered diagnosed psychiatric injuries, his damages were too remote to be recoverable because the defendant could not reasonably have foreseen the psychiatric injury suffered by their customer upon finding the fly.

Generally, the Supreme Court's analysis in *Mustapha* of proximate cause, or remoteness, in the context of psychiatric impairment lays down the following guidelines:

- ◆ There is to be no distinction between physical and psychological harm within the negligence analysis;
- ◆ While there is no distinction between the types of harm, not all damages are recoverable. For psychiatric impairment, damage must be 'serious and prolonged' with minor and transient upsets not constituting personal injuries that are compensable in tort;
- ◆ To be compensable at law, a plaintiff's injury must be reasonably foreseeable to the defendant;
- ◆ The degree of probability that would satisfy the reasonable foreseeability requirement is one that constitutes a 'real risk'... or 'one which would occur to the mind of a reasonable man in the position of the defendant ... and which he would not brush aside as far-fetched;
- ◆ The standard is an objective one—The law expects people to be of ordinary fortitude and, therefore, unusual or excessive reactions to events are not reasonably foreseeable; and
- ◆ Once a plaintiff establishes the foreseeability that a mental injury would occur in a person of ordinary fortitude, the defendant must take the plaintiff as it finds her for purposes of damage.

The principles enunciated in *Mustapha* have had cause to be considered since the release of that decision in May of 2008. Of particular interest to the field of medical negligence is the April 7, 2010 decision of Ontario Court of Appeal in *Frazer v. Haukioja*.⁴⁸ In particular, this decision raises the question as to what place the *Mustapha* remoteness analysis has in the medical negligence context.

⁴⁷ [2008] S.C.J. No. 27 [*Mustapha*].

⁴⁸ [2010] O.J. No. 1334 (C.A.) [*Frazer* (C.A.)].

FRAZER V. HAUKIOJA

In *Frazer*, the Court of Appeal upheld a trial judge's award in excess of \$2.6 million in damages and costs when a motorcyclist, who sustained an undisplaced ankle fracture in an accident, suffered psychiatric injuries related to the failure of his doctor to properly and fully advise him of the potential consequences related to his injuries.

The accident in question took place in November of 2001. After being thrown off his motorcycle, the plaintiff, Frazer, was taken to hospital where he was treated by the defendant, Dr. Haukioja, for multiple injuries. The defendant doctor initially diagnosed a left ankle fracture and soft tissue injury to his right ankle. Subsequently, a radiologist noticed a talar fracture of the plaintiff's right foot which was not brought to Frazer's attention by Dr. Haukioja for over a month. Even then, the doctor described the fracture as "tiny", "barely visible" and not requiring any further treatment. However, Frazer obtained information from two other doctors later that month. He was told that the fracture was more serious and was warned about potential future complications such as arthritis and the need for ankle fusion. Following the receipt of this information, Frazer became hyper alert and hyper aware regarding why Dr. Haukioja had not advised him about these issues and permitted him to continue to walk on the foot risking further and serious injury.

Frazer and his spouse brought an action against Dr. Haukioja for the delay in communicating the existence of a right talar fracture. The plaintiffs alleged that the delay resulted in the development of an orthopaedic disability. In addition, it was alleged that as a result of the delay, Frazer developed psychiatric impairments including anxiety disorder and panic disorder. The plaintiffs claimed damages for causing the psychiatric harm, for pain and suffering, for breach of fiduciary duty, and punitive damages alleging that the defendant doctor attempted to intentional cover up Frazer's injury.

At trial, Justice Moore concluded that the delayed diagnosis did not cause a permanent orthopaedic injury. Further, the trial judge found no evidence of cover up, intentional

wrong doing or malevolence, negating the claim for punitive damages.⁴⁹ The trial judge did, however, award damages for pain and suffering as a result of weight bearing during the period of delay in the amount of \$2,500.00. Moreover, it was decided that Dr. Haukioja's miscommunication was negligent, which gave rise to the psychiatric disorder of the plaintiff. The court awarded Frazer \$1,753,844.68 for general damages, past and future income loss, and for future care costs. Frazer's spouse was awarded \$50,000 for loss of care, guidance and companionship as a *Family Law Act* claimant.

The reasons of the trial judge focus on the issues of causation and remoteness. With respect to causation, the trial judge concluded that 'but for' the miscommunication, Frazer's current psychiatric disorder would not have arisen.⁵⁰ In addition, the trial judge made the alternative finding that the delay of Dr. Haukioja also materially contributed to the plaintiff's psychiatric impairment.⁵¹

With respect to remoteness, Justice Moore rejected the argument of the defence, based on the Supreme Court's decision in *Mustapha*, that the damages were too remote to be recoverable. Specifically, the defence argued that this injury was beyond anything that a person of ordinary fortitude would suffer, and that unusual or extreme reactions to events caused by negligence are imaginable but not reasonably foreseeable. Instead, The trial judge concluded that *Mustapha* could be distinguished, and that the psychological affects on the plaintiff were foreseeable, even if the precise extent of his disability was not.⁵²

The defendant appealed on a number of grounds including that the judge erred in the analysis of causation of the psychiatric injury, and that the damages for the psychiatric injury were too remote to be recoverable. LaForme J.A., writing for the Court of Appeal, dismissed the defendant's appeal and upheld the damage award at trial.

In its decision, the Court of Appeal noted that the test in *Mustapha* for the tort of negligence was the proper starting point for the analysis. The Court observed that liability required the following: (1) that the defendant owed the plaintiff a duty of care; (2) that

⁴⁹ [2008] O.J. No. 3277 (S.C.J.) at para. 234.

⁵⁰ *Ibid.* at para. 217.

⁵¹ *Ibid.* at paras. 217-222.

the defendant's behaviour breached that duty of care; (3) that the plaintiff suffered damage; and (4) that the damage was caused, in fact and law, by the defendant's breach.⁵³

On the issue of causation (cause in fact), the Court of Appeal held that the trial judge erred in applying the "material contribution" test after reasoning through the "but for" test. Nevertheless, it was held that this error has no impact on his final decision as the trial judge correctly applied the "but for" standard. As the trial judge found that the psychiatric damage was caused by Dr. Haukioja's non-disclosure, it was affirmed by the Court of Appeal that cause in fact was made out.⁵⁴

Considering the issue of remoteness, the Court of Appeal affirmed the finding of the trial judge that the injuries suffered by the plaintiff were reasonably foreseeable. The Court noted specifically that psychiatric injuries are now recognized as a class or type of injury that is compensable at law. To be compensable, however, the court noted that a plaintiff must show that a person of reasonable fortitude would have suffered a mental injury.⁵⁵

Although the appellant relied heavily on the *Mustapha* case in order to persuade the court that the injuries sustained by the respondent were not reasonably foreseeable, the Court of Appeal agreed with the trial judge that the instant case could be distinguished.

First, LaForme J.A. concluded that, unlike *Mustapha*, there was no evidence in this case that the respondent was anything but a person of ordinary mental fortitude. He noted:

In *Mustapha*, there were clear factual findings that the plaintiff's reaction was abnormal and a product of his particular hypersensitivity. All of the medical evidence characterized Mr. Mustapha's reaction as unusual, strange and highly individualized...

⁵² *Ibid.* at para. 227.

⁵³ *Frazer (C.A.)*, *supra* note 45 at para. 33.

⁵⁴ *Ibid.* at para. 45. In finding that the 'but for' test had been satisfied, the Court of Appeal declined to interfere with any findings of fact at trial with respect to causation. Specifically, the findings that 1) but for the non-disclosure, Frazer would have known the true severity of his injury; 2) but for the non-disclosure, Frazer would not have formed the belief that Dr. Haukioja was deliberately causing him harm; and 3) but for the non-disclosure, Frazer would not have experienced extra pain from weight bearing and thus formed the belief that he contributed to his own disability by walking on the ankle.

⁵⁵ *Ibid.* at para. 52.

There is no evidence that Mr. Frazer's injuries were the result of a similar hypersensitivity. To the contrary, in our case, all the evidence suggests that Grant Frazer had no particular sensitivities, emotional or otherwise.⁵⁶

Second, the Court of Appeal observed that, unlike the commercial relationship that existed between plaintiff and defendant in *Mustapha*, the nature of the breach in this case, when viewed in light of the relationship between Frazer and Dr. Haukioja, rendered psychiatric injury foreseeable. Specifically, LaForme J.A. reasoned:

Dr. Haukioja was in a position of trust and authority relative to Mr. Frazer. The nature of this relationship is, in my view, such that it should have fallen within Dr. Haukioja's contemplation that a breach of that trust as blatant as the one that occurred in this case could have severe ramifications for his patient's mental health.⁵⁷

Having affirmed the finding of the trial judge that it was foreseeable that the non-disclosure could give rise to the type of psychiatric injury that Frazer actually suffered, the Court dismissed the Appeal.

ANALYSIS OF FRAZER V. HAUKIOJA

The *Frazer* decision of the Ontario Court of Appeal raises several key questions for how the remoteness inquiry will be conducted in the context of medical negligence cases.

Firstly, the Court of Appeal was willing to distinguish the case in *Mustapha* on the grounds that this plaintiff was not shown to be a person with any pre-existing abnormal sensitivities, whereas the contrary was shown of Mr. Mustapha at his trial. Yet, can it not be argued that both Mr. Mustapha and Mr. Frazer had unusually sensitive reactions to the conduct of the defendant, whatever their personality before the incident? If the law expects a plaintiff to be of normal mental fortitude, how does the prior disposition of the plaintiff, if unknown to others, in any way affect the foreseeability of the abnormal reaction in the mind of the reasonable defendant? Does *Mustapha* not explicitly reject the notion that cultural factors, or subjective hypersensitivity, should be considered when assessing foreseeability?

The trouble with the reasoning used to distinguish this case from *Mustapha* is that, in reality, it can be said that both plaintiffs suffered hyper-sensitive, though medically

⁵⁶ *Ibid.* at paras. 55-56.

recognized, reaction to the conduct of the defendant. Even if only the general category of harm, rather than the specific mental disorder, needs to be foreseeable, what is the threshold for recoverable psychiatric injuries? If there was no evidence of malice by the defendant towards the plaintiff, is it reasonable to expect that the defendant foresee the plaintiff developing feelings of persecution? How and when did the plaintiff form such beliefs? From what sources of information were these beliefs derived? Do these feelings of persecution amount to a known psychiatric disorder, or is it merely emotional upset?

While the Court of Appeal indicates that *Mustapha* is the starting point of the remoteness analysis, this case is then distinguished based on very specific factual considerations. The Court concludes that because of the relationship between patient and doctor, mental injury to the plaintiff should have been foreseeable to the defendant. In fact, it is noted expressly by the court that "...it should have fallen within the defendant's contemplation that a breach of that trust as blatant as the one that occurred could have severe ramifications for his patient's mental health."

Although at first blush this case may serve to make the remoteness analysis in medical negligence cases more favourable to plaintiffs, the fact-specific findings in this case, including that this was a 'blatant' breach of standard of care by the defendant doctor, makes the case distinguishable. Indeed, it seems that the court in this case was particularly focussed on the conduct of the defendant. The delay in reporting to the plaintiff and the appearance that the doctor had altered his clinical notes likely influenced the trial judge's view as to whether the applicable standard of care was met. For these reasons, we must await further decisions of the court to determine whether this case represents a 'one-off' that is unlikely to be applied in other medical negligence cases.

IV. Conclusion

The foregoing paper has provided two areas in which there have been some fascinating recent developments. These developments have tangible implications for those practicing in the field of medical negligence. Generally, the cases that have been discussed create more uncertainty than certainty. While this uncertainty leaves room for creative argument

⁵⁷ *Ibid.* at para. 56.

for both plaintiff's and defence counsel, broadly speaking, the *Liebig* and *Frazer* decisions of the Court of Appeal open the door further to those representing plaintiffs in medical negligence actions. Both areas, however, are far from settled. In the context of duty of care to the unborn in particular, the existence of conflicting appellate authorities on the subject may necessitate the Supreme Court of Canada reviewing these issues.

Bibliography

Jurisprudence

- Bovingdon v. Hergott*, [2006] 83 O.R. (3d) 465 (S.C.J.).
Bovingdon v. Hergott, [2008] 88 O.R. (3d) 641 (C.A.).
Cherry v. Borsman (1990), 75 D.L.R. (4th) 668 (C.A.).
Commisso v. North York Branson Hospital, [2003] O.J. No. 20 (C.A.).
Crawford v. Penney, [2004] O.J. No. 3669 (C.A.).
Dobson v. Dobson, [1999] 2 S.C.R. 753.
Duval v. Seguin (1973), 1 O.R. (2d) 482 (C.A.).
Ediger v. Johnston, [2009] B.C.J. No. 564.
Frazer v. Haukioja, [2008] O.J. No. 3277 (S.C.J.).
Frazer v. Haukioja, [2010] O.J. No. 1334 (C.A.).
Lacroix (Litigation guardian of) v. Dominique (2001), 202 D.L.R. (4th) 121 (Man. C.A.).
Liebig v. Guelph General Hospital, [2009] O.J. No. 4292 2009, CanLII 56297 (ON S.C.).
Liebig v. Guelph General Hospital, 2010 ONCA 450.
McKay v. Essex Area Health Authority, [1982] 1 Q.B. 1166 (Eng. C.A.).
Milne v. St. Joseph's Health Centre, [2009] O.J. No. 4004 (Ont. Sup. Ct.).
Mustapha v. Culligan Canada Inc., [2008] S.C.J. No. 27.
Paxton v. Ramji, [2006] O.J. No. 1179, 2006 CanLII 9312 (ON S.C.).
Paxton v. Ramji, [2008] 92 O.R. (3d) 401 (C.A.).

Secondary Sources

Cruz, Darryl A. "Paxton v. Ramji: Principled Legal Consistency" (2009) Critical Issues in Health Law: A National Summit *Canadian Bar Association*.

Fordham, Margaret. "A life less ordinary — The rejection of actions for wrongful life" (2007) 15 T.L.J. 123.

Halpern, Richard C. "Birth Trauma and the Duty of Care" presented at the OTLA 2010 Spring Conference on May 27 & 28, 2010 in Toronto. Retrieved 3 August 2010 Online: <<http://www.thomsonrogers.com/birth-trauma-and-duty-care>>.

Hansell, Thor. "Duty of Care in Wrongful Life Cases: Does such a duty exist in Canada?" (2009) Critical Issues in Health Law: A National Summit *Canadian Bar Association*.

Honein, M.A., L.J. Paulozzi & J.D. Erickson, "Continued occurrence of Accutane®-exposed pregnancies" (2001) 64:3 Tetratology 142.

Ventresca, Yola S. & Peter W Kryworuk, "Revisiting Wrongful Life Claims in Canada - Can There Be a Cause of Action: *Bovingdon v. Hergott*" (2008) 34 *Advoc. Q.* 216.

"Year in Review: Developments in Canadian Law in 2008" (2009) 67(2) *U.T. Fac. L. Rev.* 359.