PRENATAL HARM AND THE DUTY OF CARE

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In this article, the author explores the jurisprudence surrounding a contentious area of tort law: wrongful life claims. These claims focus on the situation in which the physician's negligence lies in the failure to provide the child's parents with the opportunity to prevent the birth of the child. Historically, courts have been unreceptive to wrongful life claims, and current Canadian jurisprudence on this issue lacks clarity owing to inconsistent treatment of these cases by the courts. The author exposes errors in reasoning in two cases decided by the Ontario Court of Appeal, noting that these cases add to the incoherence of the legal landscape. She concludes with an appeal for Supreme Court authority or legislation to clarify the law.

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I. INTRODUCTION

Reproductive technologies can no longer be described as new — prenatal diagnostic testing has been available since the late 1960s,[1] and Louise Brown, the first person born through in vitro fertilization, is 37 years old.[2] As the technologies have become increasingly sophisticated, our expectations about the level of control we can exert over our reproductive capacity have changed. Most women and couples seek to control the number and timing of their children, and, to some degree at least, their health and developmental attributes. When a physician's negligence frustrates these aims, parents may seek compensation. Children who are born with disabilities resulting from medical negligence may also seek compensation. Parental claims are those for wrongful conception (or wrongful pregnancy) and wrongful birth, while a "wrongful life" claim is one made by a child, alleging that "but for" the physician's negligence he or she would not have been born.[3] These claims typically arise in

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1 See e.g. Henry L Nadler, "Antenatal Detection of Hereditary Disorders" (1968) 42:6 Pediatrics 912; Joseph Dancis, "The Antepartum Diagnosis of Genetic Diseases" (1968) 72:2 J Pediatrics 301.

2 PC Steptoe & RG Edwards, "Birth After the Reimplantation of a Human Embryo" (1978) 2:8085 Lancet 366.

3 Ellen I Picard & Gerald B Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4th ed (Toronto: Thomson Carswell, 2007) at 260–67.

cases of negligence resulting in unwanted pregnancy after failure of a sterilization procedure, loss of an opportunity to terminate an otherwise wanted pregnancy because of a failure to provide accurate medical information or advice, or harm to the fetus as a result of a medical procedure during pregnancy.[4]

While wrongful conception and wrongful birth cases have been accepted as legitimate,[5] the wrongful life claim is a different story. These cases are generally viewed as assertions by the child that he or she would have been better off having not been born at all.[6] Courts and lawmakers alike have raised numerous public policy-based objections to permitting wrongful life claims, including the possibility that they will lead physicians to encourage abortion so as to avoid liability,[7] and the concern about the challenge faced by judges who must assess damages, which requires comparing the value of life with a disability against non-existence.[8] Some courts have insisted that as a matter of public policy, life is always preferred to non-existence.[9]

Wrongful conception, birth, and life claims — the "birth torts" — are medical malpractice claims and could certainly be analyzed as any other negligence claim. But the courts have adopted specific labels and approaches to these claims, perhaps suggesting a high level of judicial unease with this species of claim.[10] In addition to being treated as a distinct category within negligence law, the birth tort cases have been handled inconsistently within and between jurisdictions, and the result is an area of law that is confused and confusing.[11]

The Canadian approach to negligence claims brought by children against their mothers' physicians, since the 2001 decision of the Manitoba Court of Appeal in *Lacroix v. Dominique*,[12] has been to distinguish cases on the basis of the following characteristics: did the negligence cause the child's disabilities? Or did the negligence result in the birth of the child (who, without the negligent act or omission, would not have been born at all)? Cases where harm resulted from the negligence of a third party (physician or otherwise) have been handled as routine negligence claims that crystallize upon the birth of the child. Cases of the

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4 This list of potential factual scenarios is based on that set out by Justice Low in *Krangle (Guardian ad Litem of) v Brisco* (1997), 154 DLR (4th) 707 (BCSC) at para 60, aff'd 2002 SCC 9, [2002] 1 SCR 205. He also includes unwanted birth following an unsuccessful abortion procedure.

5 Although the wrongful conception claim has been recognized, courts have been loath to award damages for child-rearing costs on the theory that the birth of a healthy child is not cause for compensation. See e.g. *Pozdzik v Wilson et al*, 2002 ABQB 351, 311 AR 258; *McFarlane v Tayside Health Board* (1999), [2000] 2 AC 59 (HL (Eng)); *Christensen v Thornby*, 255 NW 620 (Minn 1934).

6 See Erin L Nelson, *Law, Policy and Reproductive Autonomy* (Oxford: Hart, 2013) at 207; JK Mason, *The Troubled Pregnancy: Legal Wrongs and Rights in Reproduction* (Cambridge: Cambridge University Press, 2007) at 237–40. See also Wendy F Hensel, "The Disabling Impact of Wrongful Birth and Wrongful Life Actions" (2005) 40:1 Harv CR-CLL Rev 141, for a discussion of wrongful birth and wrongful life claims from the disability rights perspective.

7 *McKay v Essex Area Health Authority*, [1982] QB 1166 [*McKay*].

8 See e.g. *ibid*; *Jones (Guardian ad Litem of) v Rostvig* (1999), 44 CCLT (2d) 313.

9 See e.g. *McKay*, *ibid* at 1180, 1188; *Harriton (by her tutor) v Stephens; Waller (by his tutor) v James & Anor; Waller (by his tutor) v Hoolahan*, [2004] NSWCA 93, 59 NSWLR 694 at para 24; *Procanik v Cillo*, 478 A (2d) 755 (NJ 1984) at 772, Schreiber J, dissenting in part.

10 Sanda Rodgers, "A Mother's Loss Is the Price of Parenthood: The Failure of Tort Law to Recognize Birth as Compensable Reproductive Injury" in Sanda Rodgers, Rakhi Ruparelia & Louise Bélanger-Hardy, eds, *Critical Torts* (Markham: LexisNexis Canada, 2009) 161 at 162.

11 Rodgers, *ibid* at 163; Nelson, *supra* note 6 at 205–29.

12 *Lacroix (Litigation Guardian of) v Dominque*, 2001 MBCA 122, 202 DLR (4th) 121 [*Lacroix*], leave to appeal to SCC refused, 28796 (14 February 2002).

latter type have been classed as wrongful life claims and have been repeatedly rejected by Canadian courts.[13]

This approach has led to the emergence of two somewhat parallel lines of authority in the prenatal injury context — the cases in which a third party (physician or otherwise) acts negligently and causes the harm that the child complains of,[14] and those in which the harm alleged is the physician's failure to prevent the birth of the child (where the physician will not be liable). Unfortunately, as will become evident as this discussion proceeds, the facts in these cases do not always lend themselves to clear classification.

The lack of clarity in Canadian law around wrongful life claims became plainly apparent in the wake of two fairly recent decisions of the Ontario Court of Appeal. Both cases involved alleged preconception negligence by a physician. It appears that both were defended, in part at least, on the basis that the child plaintiff's claim amounted to one for wrongful life — no doubt in the hope of taking advantage of the Canadian courts' refusal to recognize these claims. Arguably, however, neither of these cases is a typical wrongful life case. The hallmark of a wrongful life claim is that the physician's negligence is in the failure to provide the child's parents the opportunity to prevent the child's birth. Without the provider's negligence, the child would not have been born. As will be discussed in detail below, the Ontario Court of Appeal cases in question do not fit neatly within this category. One of the cases involved the question of informed consent by a woman to treatment with a fertility drug,[15] and the other concerned prescription of Accutane[16] (a drug used in treating acne) to a woman who unexpectedly became pregnant during the course of treatment.[17]

After outlining the reasoning of the Ontario Court of Appeal in these cases, I explain why, in my view, they are wrongly decided from the standpoint of the duty of care analysis. I describe the Court's attempt in a later case to explain and limit its reasoning in *Paxton* and *Bovingdon* to claims involving preconception negligence, and proceed to contend that even with that limitation, the Court's reasoning is unconvincing. I conclude by highlighting the need for Supreme Court authority or legislation clarifying the law around prenatal and preconception negligence.

II. PRENATAL HARM AND THE DUTY OF CARE AT THE ONTARIO COURT OF APPEAL

In 2008, two cases involving facts that could be understood to raise wrongful life claims were heard by the Ontario Court of Appeal. In *Bovingdon*, the defendant physician

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13 Nelson, *supra* note 6 at 213.

14 See *Bonbrest v Kotz*, 65 F Supp 138 (DC Dist Ct 1946); *X and Y (By Her Tutor X) v Pal*, [1991] NSWCA 302, 23 NSWLR 26 [*Pal*]; *de Martell v Merton and Sutton Health Authority*, [1992] EWCA Civ 2, [1993] QB 204; *Burton v Islington Health Authority*, [1992] EWCA Civ 2, [1993] QB 204. See also *Congenital Disabilities (Civil Liability) Act 1976* (UK), c 28 [*Congenital Disabilities Act*]; *Montreal Tramways Co v Léveillé*, [1933] SCR 456; *Duval v Seguin*, [1972] 2 OR 686 (H Ct J); *Watt v Rama*, [1972] VR 353 (VSC).

15 *Bovingdon (Litigation Guardian of) v Hergott*, 2008 ONCA 2, 88 OR (3d) 641 [*Bovingdon*], leave to appeal to SCC refused, 32510 (29 May 2008).

16 Accutane is a trade name of isotretinoin. I will refer to Accutane throughout to mean isotretinoin.

17 *Paxton v Ramji*, 2008 ONCA 697, 92 OR (3d) 401 [*Paxton* CA], leave to appeal to SCC refused, 32929 (23 April 2009).

prescribed Clomid[18] (a fertility drug) to Carolyn Bovingdon in order to induce ovulation and help Bovingdon conceive.[19] While taking Clomid, Carolyn Bovingdon conceived twins. After the twins were born prematurely and with severe disabilities, they brought a negligence claim against the defendant physician. The claim asserted that the twins' premature birth and resulting disabilities were caused by Dr. Hergott's negligent failure to inform their mother of the risks of taking Clomid, including twinning and premature birth resulting in disabilities. Bovingdon also brought an informed consent claim on her own behalf.[20]

In *Paxton*, the plaintiff (Jaime Paxton) was conceived while her mother was taking Accutane, a teratogenic drug with the potential to cause serious fetal malformation.[21] So severe are the risks of ingesting Accutane during pregnancy that the drug is strictly contraindicated in pregnancy and in women of child-bearing potential unless they agree to take exceptional precautions to prevent pregnancy.[22] Dr. Ramji prescribed Accutane to Jaime's mother (Dawn Paxton) prior to Jaime's conception, believing that there was no risk of Dawn becoming pregnant, as her husband (and only sexual partner) had undergone a vasectomy four and a half years earlier.[23] As the failure rate of vasectomies is less than 1 percent, particularly after the first few months post-procedure, Dr. Ramji concluded that the vasectomy could be considered a reliable form of birth control.[24] Remarkably, however, the vasectomy failed and Jaime was conceived while Dawn was taking Accutane.[25] Jaime was born with several "severe disabilities as a result of her exposure to Accutane while *in utero*, including a right facial palsy, seizures, generalized hypotonia, megalencephaly of the left occipital lobe of the brain, prominent dysmorphic features, hearing loss, anotia (absent right ear), and microtia (malformed left ear)."[26]

Bovingdon was a jury trial; the jury found that Dr. Hergott negligently failed to provide Carolyn Bovingdon with information about the risks of Clomid. The trial judge subsequently held that the physician owed a duty of care to the twins as well as to their mother, meaning that the twins were also entitled to damages. The trial judge held that the twins' claim was not a wrongful life claim, because Dr. Hergott's negligence caused both the birth of the twins and the harm.[27]

In *Paxton*, the trial judge (Justice Eberhard) held that Dr. Ramji owed a duty of care to Jaime Paxton, which she framed as a "duty of care to the unconceived potential child of his patient Dawn Paxton."[28] Justice Eberhard also considered — and rejected — the possibility

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18 Clomid is a trade name of clomiphene, an ovulatory stimulant. It induces ovulation (the production of eggs) in the ovaries of women who are not ovulating but wish to conceive. MedlinePlus, "Clomiphene" (1 September 2010), National Institutes of Health, US National Library of Medicine, online: <www.nlm.nih.gov/medlineplus/druginfo/meds/a682704.html>.

19 *Bovingdon*, *supra* note 15.

20 *Ibid*. The mother's informed consent claim was successful.

21 *Paxton v Ramji*, 2006 CanLII 9312 (Ont Sup Ct J) [*Paxton* SC]; *Paxton* CA, *supra* note 17. This line of cases will be referred to collectively as *Paxton*.

22 *Paxton* CA, *ibid* at paras 5–6, 11.

23 *Paxton* SC, *supra* note 21 at para 24.

24 *Ibid* at para 91.

25 *Paxton* CA, *supra* note 17 at para 9.

26 *Ibid* at para 11 [emphasis in original].

27 *Bovingdon*, *supra* note 15 at paras 3–4. For the trial judge's reasons, see *Bovingdon (Litigation Guardian of) v Hergott* (2006), 83 OR (3d) 465.

28 *Paxton* SC, *supra* note 21 at para 215.

that Jaime's claim was in reality one for wrongful life.[29] In her view Jaime's claim was properly characterized as one alleging a breach of the "duty to the unconceived child of a woman of child bearing potential seeking Accutane not to prescribe it unless he was satisfied, in accordance with the standard of care required of a reasonable and competent doctor in similar circumstances, that she would not become pregnant while taking the drug."[30] On this view, had Dr. Ramji lived up to his duty not to prescribe Accutane to a woman of child-bearing potential, Jaime's mother would not have been taking Accutane when Jaime was conceived, and Jaime would not have suffered harm.[31]

In considering whether Dr. Ramji owed a duty to Jaime, Justice Eberhard noted that a physician would clearly owe a duty to the already conceived child of a woman to whom he or she prescribed Accutane. As she explained:

> Let us imagine a woman of child bearing potential asking a doctor for [an] Accutane prescription and the doctor, out of incompetence or immorality, fails to inquire about or address birth control and blithely gives the drug. The risk and injury will be no more or less profound if the prescription is given pre or post conception. A pregnancy is foreseeable and proximate in either circumstance by reason of the patient being a woman of child bearing potential.[32]

In the end, Dr. Ramji was not liable to Jaime because he met the standard of care required of a reasonable physician in like circumstances.[33] In other words, it was reasonable for Dr. Ramji to rely on the father's vasectomy to prevent Dawn Paxton from conceiving a child while she was taking Accutane.

Both cases were appealed[34] and, in both appeals, the Ontario Court of Appeal took the view that since *Lacroix*,[35] Canadian courts have been taking the wrong approach to these types of cases. As Justice Feldman correctly noted, some of the cases involve facts that lend themselves to characterization either as a wrongful life case where the negligence was in the failure to prevent the child's birth, or as a claim that the physician's negligence caused the harm. As she explained:

> In [*Bovingdon*], this court rejected as unhelpful the two-category approach adopted by the Manitoba Court of Appeal in *Lacroix*. For example, because it was the epilepsy drug in *Lacroix* that caused the injury to the fetus, the cause of action could well have been viewed not as one for wrongful life, but as one where the act of the doctor in prescribing the drug caused the damage.
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> The same is true in the present case. On the one hand, the appellant's action could be viewed as a claim for wrongful life in the sense that, accepting the trial judge's finding that Accutane was an indicated treatment

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29 A wrongful life claim would involve a claim by Jaime that, had Dr. Ramji counseled Dawn Paxton to use two forms of birth control while she was taking Accutane, Jaime might not have been conceived (*Paxton* CA, *supra* note 17 at paras 19–21).

30 *Paxton* SC, *supra* note 21 at para 208.

31 *Ibid* at para 209.

32 *Ibid* at para 206.

33 *Ibid* at para 212–15.

34 Although the Ontario Court of Appeal approaches both cases from a similar perspective, I focus on the decisions in *Paxton* because they offer more fully articulated sets of reasons to analyze at the trial and appellate levels.

35 *Supra* note 12.

> for Dawn Paxton's acne, the duty on the doctor must have been to ensure that Jaime Paxton would never be conceived, making her claim one for wrongful life. On the other hand, in the trial judge's view, the appellant's action was not a claim for wrongful life because the doctor's duty was to refuse to prescribe Accutane to Dawn Paxton as a woman of childbearing potential. Had the doctor discharged this duty, Jaime Paxton would have been born healthy.
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> The different ways of viewing the claims in *Lacroix* and in the present case illustrate that the categories posited in *Lacroix* are malleable and do not provide a rigorous analytical framework for deciding the issue whether the proposed duty of care should be recognized.[36]

In the Court's view, instead of attempting to categorize the claims as wrongful life (or not), the courts should undertake a full-blown, first principles duty of care analysis based on the test outlined in *Anns v. Merton London Borough Council*[37] and clarified by the Supreme Court of Canada in *Cooper v. Hobart*.[38] The duty of care analysis requires the court to consider questions of foreseeability of harm, proximity of plaintiff and defendant (including policy considerations relevant to the relationship between the parties), and residual policy considerations that might justify refusing to impose a duty of care.[39]

After applying the duty of care test to the facts of both cases, the Court of Appeal concluded that a physician does not owe a duty to a future child, whether conceived or not yet conceived at the time of the negligent act, because of a lack of proximity between the physician and fetus or future child.[40] The primary reason for the conclusion on proximity is the possibility that the physician will owe conflicting duties to woman and future child. The Court expressed concern that physicians might refrain from offering pregnant women health care options that could potentially cause harm to the fetus, because of the fear that in offering the option, they would breach their duty to the fetus. A second, related reason for the finding of insufficient proximity is the indirect nature of the relationship between the parties.[41] Each of these concerns will be considered in Part III, below.

In its reasons in both *Paxton* and *Bovingdon*, the Court of Appeal referred to the potential victim of the physician's negligence as a "future child" and in *Paxton*, added that there is no duty to a future child who is "conceived or not yet conceived" at the time of the negligent act.[42] Shortly after the Court released its reasons in *Paxton*, physicians defending labour and delivery claims began taking the position that they owed no duty of care to a future child, even in the labour and delivery context. In one such case, *Liebig v. Guelph General Hospital*,[43] the plaintiff served a "Request to Admit" on the defendant, asking the defendant physician to admit that a duty of care was owed to the infant plaintiff. The defendant

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36 *Paxton* CA, *supra* note 17 at paras 49–51.
37 (1977), [1978] AC 728 (HL (Eng)) [*Anns*].
38 2001 SCC 79, [2001] 3 SCR 537 [*Cooper*]. See also *Edwards v Law Society of Upper Canada*, 2001 SCC 80, [2001] 3 SCR 562; *Childs v Desormeaux*, 2006 SCC 18, [2006] 1 SCR 643; *Syl Apps Secure Treatment Centre v BD*, 2007 SCC 38, [2007] 3 SCR 83; *Holland v Saskatchewan*, 2008 SCC 42, [2008] 2 SCR 551.
39 *Cooper*, *ibid*.
40 *Paxton* CA, *supra* note 17.
41 *Ibid*.
42 *Ibid* at para 76; *Bovingdon*, *supra* note 15 at para 61.
43 2010 ONCA 450, 321 DLR (4th) 378 [*Liebig*].

physician refused to do so, asserting that on the basis of the reasons in *Paxton*, he owed no duty of care to the plaintiff, who was not yet born at the time of the alleged negligence.

Prior to the decisions in *Bovingdon* and *Paxton*, it had long been thought to be the case that a physician does indeed owe a duty of care to a fetus that is in the process of being born;[44] accordingly, the motions judge in *Liebig* held in favour of the infant plaintiff. The defendant physician appealed to the Ontario Court of Appeal. The appeal was first held before a panel of three justices of the Court, but arguments were later re-heard by five members of the Court. Ultimately, the Court concluded that the reasoning in *Paxton* and *Bovingdon* did not overturn the labour and delivery jurisprudence, in which all parties (including the courts) had long assumed that a physician owes a duty of care to the fetus in the birth process.[45] Instead, the two earlier decisions should be understood to apply to their specific facts, where the fetus had not yet been conceived at the time of the alleged negligence by the physician.[46] The Court thereby limited the "no duty of care"[47] ruling to claims by children who are not yet conceived at the time of the physician's negligent act.[48]

In keeping with the "tradition of the common law"[49] the Court declined to go any further than to state that the labour and delivery cases remain good law after *Paxton* and *Bovingdon*. The Court's reasons leave many questions unanswered. The most obvious is whether the physician owes a duty of care to the fetus only in the labour and delivery process, or whether the duty arises earlier in pregnancy. And if not, why not? Is there something unique about the birth process that justifies imposing a duty only at that point in time? If not limited to the birth process, then how far back does the duty extend? Any point in time after conception? Or, again, is there something that occurs part way through a pregnancy that justifies imposing a duty of care at that point, but not before? Finally, if the answer is any point in time after conception, then when, precisely, does conception take place?

III. MISSTEPS AND MISSED STEPS: WHY *PAXTON* AND *BOVINGDON* ARE WRONGLY DECIDED

I have argued elsewhere that the decisions in *Paxton* and *Bovingdon* raise issues of autonomy in reproductive decision-making and are troubling from that perspective.[50] Here, my critique focuses on the duty of care analysis. The Court of Appeal gave two primary reasons for declining to find that a physician owes a duty of care to a "not yet born or conceived child." First, that the imposition of a duty is precluded by the potential for a conflict between the duty owed by the physician to the female patient and that owed to the fetus or future child. Second, the relationship between physician and fetus or future child is insufficiently "close and direct" to justify imposing a duty of care. Each of these reasons will be considered in turn.

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44 See e.g. *Ediger (Guardian ad litem of) v Johnston*, 2009 BCSC 386, 65 CCLT (3d) 1 [*Ediger*]; *Crawford (Litigation Guardian of) v Penney* (2003), 14 CCLT (3d) 60 (Ont Sup Ct J), aff'd (2004), 26 CCLT (3d) 246 (CA); *Commisso v North York Branson Hospital* (2000), 48 OR (3d) 484 (Sup Ct J), aff'd 168 OAC 100.

45 *Liebig*, *supra* note 43 at paras 6–8.

46 *Ibid* at paras 10–13.

47 *Ibid* at para 11.

48 *Ibid*.

49 *Ibid* at para 13.

50 Nelson, *supra* note 6 at 217–20.

Before turning to these issues, it is worth pausing for a moment to emphasize the unexpected nature of the Court's reasoning in these cases. Given the current law around prenatal harm, it is easy to see why the Court thought that a different approach might be warranted. But it is not so easy to understand why the Court thought that the solution required recourse to the *Anns* analysis. The test outlined in *Anns* is reserved for cases in which the courts are faced with a novel claim, or a case of first impression, where the duty alleged cannot be analogized to a recognized duty of care.[51] Yet these cases seem to be clearly analogous to cases in which a duty has been recognized — such as the labour and delivery cases, which assume that a physician owes a duty of care to an unborn child,[52] and the line of cases holding that third parties owe a duty of care to a child *en ventre sa mère*.[53] As I hope to show, this was the first in a series of errors in reasoning made by the Ontario Court of Appeal.

A. CONFLICTING DUTIES

The Court's concern about conflicting duties is framed in relation to women's reproductive autonomy. The worry centres on the possibility that physicians might decline to offer treatment options to women based on the chilling effect of the possibility that a lawsuit could be brought by the future child.[54] In other words, physicians will elect to limit women's options in order to avoid potential liability to a potential child.[55]

It is beyond dispute that circumstances arise in medical practice where a physician caring for a pregnant (or potentially pregnant) woman will feel conflicted in his or her ability to look after the best interests of both the woman and her future child. The woman's life or health may depend on a treatment that threatens the health or viability of the fetus. If a pregnant woman is diagnosed with cancer, her interest in obtaining prompt treatment may conflict with the best interest of the fetus in avoiding exposure to potentially harmful medications. Sometimes health problems arise that threaten both lives and create a situation where only one can be saved. But while the Court of Appeal is not wrong about the potential for conflict that can arise in the course of caring for pregnant (or potentially pregnant) women, it missed a critical step in its reasoning, in failing to distinguish between conflicting interests and conflicting duties.

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51 *Cooper*, *supra* note 38 at paras 36–39; Lewis N Klar, *Tort Law*, 5th ed (Toronto, Ont: Carswell, 2012) at 179; Allen M Linden & Bruce Feldthusen, *Canadian Tort Law*, 9th ed (Markham: LexisNexis Canada, 2011) at 304–305. As Linden and Feldthusen explain, the analysis is intended for use in rare cases, not as a means of revisiting existing or already recognized duties of care.

52 See *supra* note 44.

53 See *supra* note 14.

54 See *Paxton* CA, *supra* note 17 at paras 65–76.

55 *Ibid* at para 68. As Justice Feldman explains:

> These conflicting duties could well have an undesirable chilling effect on doctors. A doctor might decide to refuse to prescribe Accutane to a female patient, even where it is indicated and the patient agrees to fully comply with the PPP, in order to avoid the risk of a lawsuit brought by a child who is conceived despite compliance with the PPP or because the mother fails to comply with the PPP.

1. CONFLICTING INTERESTS AND CONFLICTING DUTIES

To understand whether the Court of Appeal's argument about conflicting duties has any traction, it is essential to understand the nature of the duty (or duties) in question. A physician owes a duty to his or her patient to exercise reasonable care and skill "in all that is done to and for the patient."[56] The duty requires reasonableness, not perfection, on the part of the physician.[57] It demands that the physician have the well-being of the patient in mind when considering how to proceed, and that the physician exercise the care and skill that would be exercised by a reasonable physician in similar circumstances. It does not require the physician to guarantee an optimal outcome for the patient; as with all defendants, the expectation is that the physician act reasonably with regard to the interests of those to whom he or she owes a duty of care.[58] If a duty of care is owed to a future child, the duty will be framed in the same terms as that owed to the female patient: as an obligation to exercise reasonable care and skill in all that is done to and for the patient.

Where a pregnant woman needs a type of treatment that could harm the fetus, it may indeed be impossible for the physician to reconcile the interests of the woman and the fetus, or to ensure that the health of both are completely protected. But the inability to reconcile these competing interests is a result of biological reality, not of the existence (or lack thereof) of tort law duties — whether or not a duty is owed, there will be cases in which the competing interests cannot be reconciled. It seems that the Ontario Court of Appeal's analysis, implying the existence of an irresolvable conflict between the duty owed to the female patient and to the future child, is compelling only if the conflict cannot be managed. In turn, this prospect arises only if the duties resting on physicians are absolute. As noted above, they are not.

Andrew Robertson defends the analysis of the Court of Appeal in *Paxton*: he asserts that the duty to a future (he appears to mean not yet conceived) child could indeed give rise to an irreconcilable conflict between the duty to the female patient and the duty to the future child. Robertson describes a scenario involving a female patient who has made "a fully informed decision to take the risk of possible harm to a future foetus in order to obtain the benefits of the medication in question, but the doctor has reason to doubt that the patient will diligently use contraception."[59] As he explains, the conflicting duties cannot be reconciled because "the doctor could not reasonably be expected to be mindful of both sets of interests, given the potential for conflict and the difficulty of reconciling them."[60]

Robertson's example is based on the facts in *Paxton* where the "medication in question"[61] is Accutane. His concern (and that of the Court of Appeal) seems at odds with what happens in real life medical practice where physicians are caring for pregnant (or potentially pregnant) women. Some medications are known to be harmful to the fetus, some are

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56 Picard & Robertson, *supra* note 3 at 213.

57 See e.g. *Wilson v Swanson*, [1956] SCR 804; *Carlsen v Southerland*, 2006 BCCA 214, 53 BCLR (4th) 35.

58 See e.g. *Blyth v Birmingham Waterworks Co* (1856), 11 Ex Ch 781.

59 Andrew Robertson, "Policy-Based Reasoning in Duty of Care Cases" (2013) 33:1 LS 119 at 127–28. For the record, conflicting duties are not the focal point of Robertson's analysis.

60 *Ibid* at 128.

61 *Ibid*.

suspected to pose a risk of harm, and some are considered to be safe during pregnancy.[62] Most medications have not been tested for their potential effects on a developing fetus. Prescribing medication to a pregnant woman (or one who is trying to conceive) always involves a balancing act wherein the physician must consider the health of his or her female patient and the risk to the fetus or future child.[63]

Accutane is a unique case, for a number of reasons. First, it is indicated for the treatment of certain kinds of acne. Although acne can cause considerable suffering, it is not a life-threatening condition, and Accutane is therefore rarely (if ever) required to preserve or promote health.[64] Moreover, the drug is known to be a potent teratogen.[65] As a result, its use is strictly contraindicated in pregnancy, as well as in women who are unwilling to comply with the exacting pregnancy avoidance protocol in place for women of child-bearing potential.[66] In most cases, the protocol requires the use of two distinct and effective forms of birth control during the treatment period.[67] It is abundantly clear to physicians who prescribe Accutane that they must not prescribe the drug to pregnant women, nor to women who will not agree to take extraordinary steps to prevent pregnancy.[68] Consequently, and contrary to Robertson's assertion, a reasonable doctor does in fact have the interests of a potential future child firmly in mind when deciding whether or not to prescribe Accutane.[69]

A drug like Accutane seems to cast the potential for conflict in sharp relief, in that it can only be potentially harmful to the future child. There is little, if any, potential benefit to the future child as a result the child's mother taking Accutane while she is pregnant, and a significant potential for harm. But most health care interventions do not pose such a stark threat, and most do offer the promise of a health benefit to the patient. Most of the time, health care interventions that benefit a pregnant woman (or one who may become pregnant) will also benefit the fetus or future child by safeguarding its mother's health. Therefore, in most cases, the interests of woman and future child will be aligned (where treatment is aimed at improving the woman's health), or the situation will be such that the risk to the future child is not sufficient to outweigh the potential benefit to the woman. Even if the Ontario Court of Appeal is right to be anxious about the potential for conflicting duties and the physician's response to the conflict, it seems unlikely that this concern arises frequently. Moreover, if the medication or treatment is needed by the woman to preserve her health, the physician cannot withhold the option without risking liability to her.

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62 Margaret P Adam, Janine E Polifka & JM Friedman, "Evolving Knowledge of the Teratogenicity of Medications in Human Pregnancy" (2011) 157:3 American J Medical Genetics Part C: Seminars in Medical Genetics 175; JE Polifka & JM Friedman, "Clinical Teratology: Identifying Teratogenic Risks in Humans" (1999) 56:6 Clinical Genetics 409; Susan E Andrade et al, "Prescription Drug Use in Pregnancy" (2004) 191:2 American J Obstetrics & Gynecology 398.

63 Adam, Polifka & Friedman, *ibid*; Polifka & Friedman, *ibid*.

64 Accutane can potentially improve mental health (acne, particularly severe acne, has been associated with depression and anxiety: SC Kellett & DJ Gawkrodger, "The Psychological and Emotional Impact of Acne and the Effect of Treatment with Isotretinoin" (1999) 140:2 British J Dermatology 273). However, Accutane has itself been associated with psychopathology: Vassilis P Kontaxakis et al, "Isotretinoin and Psychopathology: A Review" (2009) 8:2 Annals General Psychiatry 2.

65 *Paxton* CA, *supra* note 17 at paras 2, 6–7, 60.

66 *Ibid*.

67 *Ibid* at para 6.

68 *Ibid* at paras 6, 11.

69 Likewise, physicians who prescribe Clomid must necessarily have the possibility of conception — and therefore a potential future child — in mind.

Ironically, given the Court of Appeal's reasoning in *Liebig*, more significant conflicts of interest do arise during pregnancy. Pregnant women and their physicians are often faced with health issues that require discussion of the risks and benefits (both to the woman and to the fetus) of a treatment, and a decision as to how to balance the competing interests.[70] Not only is this balancing possible, it is frequently called for in medical practice. It is also integral to physicians' professional and ethical obligations, regardless of whether those obligations are recognized in law.[71]

The most profound potential conflicts between the interests of the woman and the fetus likely develop during late pregnancy, specifically, during labour and delivery, where circumstances can dictate that saving the life of either the woman or the fetus requires that the interests of the other be ignored or discounted. It seems hard to imagine a conflict more irreconcilable than that, yet the courts have not suggested that the potential for conflict rules out a duty being owed to both woman and fetus. Instead, this is the one scenario in which, according to the Ontario Court of Appeal, a duty is definitely owed to both.[72]

In any case, as explained by Justice Holmes of the British Columbia Supreme Court, to the extent that a conflict of interests exists, "it is answered by the simple reality that mothers make decisions — both as to medical care and in other areas — for their unborn children. As to the conflict of interests (mother's versus unborn child's) implicated in that decision, it is for the mother, and not the physician, to resolve."[73]

Provided that the physician appropriately informs the woman about the benefits and risks of a proposed treatment to her and to the fetus or future child, and presents her with all of her options and their potential prognoses, the physician will have discharged his or her duty to both.

2. PHYSICIANS AND THE DUTY OF CARE TO THIRD PARTIES

Based on the foregoing explanation, it strikes me that the approach taken by the Ontario Court of Appeal to the conflicting duties issue was not fully considered. If the real objection to the dual-duty approach is the potential for conflict, that objection is difficult to square with the Court's later decision in *Liebig*, which holds that the duty can be owed in the one situation in which conflict is most likely. Perhaps there is something else driving the Court of Appeal's reasoning in *Paxton*, such as reluctance to impose liability on physicians where the actions of another individual play a key role in determining the outcome.

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70 See e.g. Picard & Robertson, *supra* note 3 at 334; Mason, *supra* note 6 at 79; The American College of Obstetricians and Gynecologists, "Committee Opinion No 321: Maternal Decision Making, Ethics and the Law" (2005) 106:5 Obstetrics & Gynecology 1127; Royal College of Obstetricians and Gynaecologists, *Ethics Committee Guideline No. 1: Law and Ethics in Relation to Court-Authorised Obstetric Intervention* (London, UK: Royal College of Obstetricians and Gynaecologists, September 2006). See also *Tameside & Glossop Acute Services Unit v CH (a patient)*, [1996] Fam 353; *Re MB (An Adult: Medical Treatment)* [1997] EWCA Civ 3093, [1997] 2 FLR 426; *St George's Healthcare NHS Trust v S* (1998), [1999] Fam 26 (CA).

71 *Ibid*.

72 *Liebig*, *supra* note 43.

73 *Ediger*, *supra* note 44 at para 186.

To add to the concern about a physician facing liability because of the actions of their patients, the patient in question in this context (the female patient or pregnant woman) is immune from liability to her later-born child for her choices and actions during pregnancy.[74] The Court may have been worried that because a mother cannot be liable to her child even if her actions during pregnancy cause harm, the natural tendency of courts might be to find a way to find fault with the physician in order to allow for some compensation to flow to the child.[75]

Just as in any situation where a physician gives advice, a pregnant (or potentially pregnant) patient may fail to follow the advice. As long as the physician properly and clearly explains his or her advice, and takes reasonable steps to ensure that the advice is understood, the standard of care is met.[76] Here, the difference is that there is (eventually) a third party to whom the doctor could be liable.

The concept that a physician might owe a duty of care to a third party is not foreign to medical malpractice law. There is authority to the effect that physicians may be found liable to a third party if the physician's negligence causes harm to that person.[77] An example: a patient undergoes a medical procedure involving sedation or anaesthetic. The physician does not properly advise (or follow through on advice to) the patient that they must not drive home after the procedure. The patient drives home and causes an accident that injures another driver. It is clear that the accident was caused by the patient's inability to react to traffic in a timely way, due to the effects of the sedative medication. Here, the physician will face potential liability to the injured third party; at a minimum, it is clear that the physician owes a duty of care to that individual.[78]

But what if the physician clearly explains to the patient that driving after the procedure would be dangerous, requires the patient to arrange for a driver to come into the clinic and identify him- or herself to clinic staff and confirm that he or she will drive the patient home, and the patient and driver both assure clinic staff that they appreciate the need for the patient to refrain from driving? After they exit the clinic, the driver hands the car keys to the patient, who proceeds to drive home. An accident occurs, causing harm to a third party. The effects of the sedative medication are responsible for the accident. The physician owes a duty. Will the physician be liable? Not on a coherent application of negligence law.

Take Andrew Robertson's scenario, where the physician is asked to prescribe Accutane, and properly informs the patient of the necessary contraceptive precautions. The patient nevertheless decides to run the risk of pregnancy. If the physician owes a duty of care to a future child, the questions will centre on whether the physician discharged the duty and, if not, whether the failure by the physician to discharge the duty caused the child's loss. If the standard of care was met (in other words, if the physician acted reasonably in caring for his

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74 *Dobson (Litigation Guardian of) v Dobson*, [1999] 2 SCR 753.

75 This is suggested in Justice Feldman's reasoning in *Paxton* CA, *supra* note 17 at paras 73–75, where she focuses on the indirect relationship between physician and fetus.

76 Picard & Robertson, *supra* note 3 at 349–52.

77 *Ibid* at 221–23. The authors note that there are cases in which there can be compelling policy reasons to refuse to impose a duty; the example they provide is the case of a physician examining a child for suspected abuse being found to owe no duty of care to the parent(s).

78 *Ibid* at 222–23, referring to *MacPhail v Desrosiers et al* (1998), 170 NSR (2d) 145 (CA).

or her patient), then that ends the inquiry and there is no liability. What must a physician do in order to act reasonably when prescribing Accutane to a woman of child-bearing age? In essence, he or she must follow the Pregnancy Prevention Program (PPP) put together by the manufacturer of Accutane, or some other, equally effective strategy aimed at ensuring that the female patient does not conceive during the treatment time frame.[79] The physician's approach will be compared to that of the reasonable physician with like qualifications practicing in like circumstances. If the physician's actions are reasonable when viewed through this lens, then he or she will be found to have met the standard of care and will avoid liability, even if the female patient does not follow the physician's advice.[80] As long as he or she has discharged the duty by meeting the standard of care, it is not the physician's responsibility to ensure that his or her patients act as they are advised to.[81]

B. INSUFFICIENT PROXIMITY

In addition to the concern based on conflicting duties, the Ontario Court of Appeal held that a physician cannot owe a duty of care to the actual or potential fetus because the parties are not in a sufficiently "close and direct" relationship.[82] The Court noted that while the physician's actions can have a direct effect on the fetus, the relationship itself is indirect. The physician cannot give advice directly to, nor seek consent from, a fetus. Instead, the relationship between physician and fetus is "mediated" through the pregnant patient.[83]

This is no different from the "relationship" a physician has with a third party who may be injured by the physician's negligence in failing to (for example) prevent his or her patient from driving when to do so is unsafe. In fact, the relationship between the physician and third party in this situation is even less "close and direct" than in the case of a pregnant patient's fetus. The physician and the injured party are strangers. But tort duties can be owed to strangers. The issue is not whether the doctor and injured party know each other personally, or could come into physical contact with each other. The question is whether someone in the position of the third party driver should be within the physician's contemplation (because they are within the class of foreseeable victims) when the physician is deciding how (or if) to advise his or her patient about driving.

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79 The Pregnancy Prevention Program is described and referred to in *Paxton* CA, *supra* note 17 at para 6, and by the trial judge in *Paxton* SC, *supra* note 21 at paras 114–19. The trial judge notes that a drug manufacturer cannot dictate the standard of care by which a physician prescribing the drug will be measured, thus it is possible that he could choose to follow another approach, provided that the approach meets the standard of care of the reasonable physician prescribing Accutane to a woman of child-bearing potential (*Paxton* SC, *ibid* at para 120).

80 See Picard & Robertson, *supra* note 3 at 212. Indeed, that was the conclusion of the trial judge in *Paxton* SC, *ibid* at para 154.

81 Picard & Robertson, *ibid* at 348–52.

82 *Paxton* CA, *supra* note 17 at para 71–75.

83 *Ibid* at para 71.

As the Supreme Court of Canada explained in *Hill v. Hamilton-Wentworth Regional Police Services Board*:

> The most basic factor upon which the proximity analysis fixes is whether there is a relationship between the alleged wrongdoer and the victim, usually described by the words "close and direct". *This factor is not concerned with how intimate the plaintiff and defendant were or with their physical proximity, so much as with whether the actions of the alleged wrongdoer have a close or direct effect on the victim, such that the wrongdoer ought to have had the victim in mind as a person potentially harmed.*[84]

It seems clear from the Supreme Court's reasoning about the meaning of "close and direct"[85] that the Ontario Court of Appeal's concerns are misplaced. Harm to the fetus or future child is clearly foreseeable when a physician is negligent in providing treatment or advice to a pregnant patient. And as illustrated by the Supreme Court's reasoning, the parties are also in a relationship of sufficient proximity to justify the imposition of a duty of care.

IV. PRECONCEPTION NEGLIGENCE: WHY THE ONTARIO COURT OF APPEAL IS WRONG, EVEN AFTER *LIEBIG*

The preceding discussion considered the Ontario Court of Appeal's reasoning around the duty of care owed by a physician to a future child. As explained above, the Court has narrowed the application of its reasoning in *Paxton* and *Bovingdon* to preconception negligent conduct. I will focus now specifically on the cogency of that limitation and explain why the Court of Appeal's conclusion is flawed.

Although "conception" is widely understood to signal the beginning of a pregnancy or the point at which life begins, it is a term without a precise definition. And while the lack of precision might not be critical in all instances, a clear and common meaning is essential if the term is to have important legal significance — such as marking a dividing line between when a physician can and cannot be found liable in negligence.

From a scientific standpoint, conception is a process (or, more accurately, a series of processes) as opposed to a fixed point in time.[86] First, the sperm cell must inseminate the oocyte (egg cell). The sperm attaches to the outer membrane of the oocyte and begins to penetrate its cell wall. Once the sperm cell has successfully penetrated the cell wall and enters the oocyte, fertilization is complete. During the second stage in the process, the fertilized oocyte becomes an embryo. After fertilization, the genetic material contributed by the oocyte and the sperm is reassembled into 23 pairs of chromosomes and the resulting zygote (one-celled embryo) is genetically unique, a new individual. In the hours and days that follow fertilization, the zygote will begin to divide into several cells, first becoming a morula (roughly three days after fertilization) and then a blastocyst (three-and-a-half to four

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84 2007 SCC 41, [2007] 3 SCR 129 at para 29 [emphasis added].

85 *Ibid*.

86 Allen J Wilcox, Donna Day Baird & Clarice R Weinberg, "Time of Implantation of the Conceptus and Loss of Pregnancy" (1999) 340:23 New England J Medicine 1796; Elizabeth Taylor & Victor Gomel, "The Uterus and Fertility" (2008) 89:1 Fertility & Sterility 1 at 1–2. Sally Sheldon explains the challenge in identifying implantation as a regulatory bright line: Sally Sheldon, "The Regulatory Cliff Edge between Contraception and Abortion: The Legal and Moral Significance of Implantation" (2015) 41:9 J Medical Ethics 762.

days after fertilization, shortly after the developing embryo enters the uterus). Approximately four to five days after fertilization, the blastocyst begins to implant into the lining of the maternal uterus. In turn, implantation occurs over approximately a week-long period, ending roughly 12 days after insemination began.[87]

The above is a cursory overview of the process of conception. Nonetheless, it is clear that conception is a process involving several stages, and that there are numerous points in time which could be selected to mark "conception" for purposes of legal rights and responsibilities. One need only look to the United States for a wide array of laws defining conception as being complete at different points along the continuum.[88] Accordingly, if conception is to be used as the foundation for a duty of care owed by a physician to a future child, uncertainty remains as to when the duty arises. But this raises a further key question: should we consider conception, an admittedly messy and ill-defined "event," to be an appropriate dividing line at all?[89]

Not only is the idea of conception itself approximate and indeterminate, the scope of "preconception negligence" is significant. To say that an event occurred prior to conception can mean many different things — anywhere from hours or days, to years before conception. The Court's instincts are sound; we must tread carefully in considering the implications of deciding that preconception negligent conduct can lead to liability to a future child. That said, the Court's conclusion (that no duty of care is owed to an unconceived child) is too far-reaching.

Take as a starting point the immediate preconception time frame. Given that a duty of care is owed to an unborn but already conceived child,[90] it seems difficult to justify a conclusion that no duty of care can be owed by a physician to a future child for negligent conduct in the days or weeks before conception. If a physician can be expected to have the interests of the embryo or fetus of his or her pregnant patient in mind, surely he or she can be expected to have the interests of the potential embryo or fetus in mind, particularly when the alleged negligence occurs very close in time to conception. Harm to a future child is no less foreseeable, and the relationship no less proximate,[91] where the child is conceived the week after an Accutane prescription is initiated than where the female patient is already pregnant when the drug is prescribed. Likewise, the timing of the negligent conduct relative to conception seems irrelevant in the case of a physician who is providing assisted reproductive technology services to a woman who hopes to conceive.

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87 For a detailed discussion of the timeline and the various stages of conception, see Keith L Moore, TVN Persaud & Mark G Torchia, *The Developing Human: Clinically Oriented Embryology*, 10th ed (Philadelphia: Elsevier, 2016), ch 2–3 (which describe the first and second weeks of human development).

88 Susan L Crockin & Celine Anselmina Lefebvre, "Sound Bites or Sound Law and Science? Distinguishing 'Fertilization' and 'Conception' in the Context of Preimplantation IVF Embryos, ESCR, and Personhood" (2012) 3:4 Ethics in Biology, Engineering & Medicine: An Intl J 247; Philip G Peters, Jr, "The Ambiguous Meaning of Human Conception" (2006) 40:1 UC Davis L Rev 199.

89 Sheldon, *supra* note 86.

90 See *supra* note 14.

91 Foreseeability is, of course, not the only consideration relevant to the imposition of a duty of care; the parties must also be in a relationship of sufficient proximity to ground a duty. I have argued that the Ontario Court of Appeal's reasoning on the lack of proximity between physician and fetus is unpersuasive. In my view, this is equally true where the negligence takes place before the child is conceived.

As the alleged negligence recedes in time relative to the time of conception, the more open-ended (and potentially troubling) the idea of preconception liability becomes. Concerns about indeterminacy will become more important in thinking about whether negligent conduct can lead to liability. But even where there is a significant lapse in time between the negligent conduct and the child's conception, there may be good reasons to impose liability, and drawing a bright line at "conception" (recognizing the indeterminacy of that idea) does not seem fair, nor in keeping with the nature of the common law as an institution. Where the allegedly negligent act takes place years or decades before a woman conceives a child, and the negligence is unrelated to her reproductive capacity, the argument in favour of recognizing a duty (and hence the possibility of liability) to the future child is relatively weak. By contrast, where we consider conduct that took place years prior to conception but that is related to a woman's reproductive health, or the health of a future child, we may be able to marshal arguments that push more convincingly in the direction of recognizing a duty of care to the future child.[92]

In addition to recognizing claims by children for harm suffered while they were in utero, other common law jurisdictions have accepted that preconception negligence can give rise to a valid claim. All US states accept that an actor can be liable to a later-born child for harm caused during pregnancy;[93] several also accept that liability can follow where the harm occurred prior to the child's conception.[94] Of the states in which the issue has been judicially considered, seven have allowed recovery and four have denied that such claims can lead to recovery.[95] Courts in the remaining states have suggested that a duty of care in relation to preconception harm may exist in some circumstances.[96]

Steinbock notes that where courts have refused to recognize claims for preconception harm, the primary concern seems to be that recognition of such claims will result in indeterminate liability, in relation to both time and amount. In the cases where recovery has been permitted, the reasoning has been similar to that adopted in the prenatal harm cases, where the timing of the harm-causing act is the only real difference. For the most part, the courts have been prepared to conclude that the timing of the negligence is not an insurmountable hurdle, as long as the harm is foreseeable and causation can be established.[97]

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92 See Matthew Browne, "Preconception Tort Law in an Era of Assisted Reproduction: Applying a Nexus Test for Duty" (2001) 69:6 Fordham L Rev 2555 for an argument along these lines.

93 Bonnie Steinbock, *Life Before Birth: The Moral and Legal Status of Embryos and Fetuses*, 2nd ed (New York: Oxford University Press, 2011) at 109–10.

94 See e.g. *Renslow v Mennonite Hospital*, 367 NE (2d) 1250 (Ill 1977) [*Renslow*]; *Bergstreser v Mitchell*, 577 F (2d) 22 (8th Cir 1978) [*Bergstreser*] (negligence in performing a Caesarean section in one pregnancy led to uterine rupture during the next pregnancy, resulting in the need for an emergency Caesarean and leading to brain damage in the second child); *Empire Casualty Co v St Paul Fire & Marine Insurance Co*, 764 P (2d) 1191 (Colo 1988) [*Empire Casualty*] (physician liability for preconception negligence involving Rh incompatibility of a future child).

95 For cases denying recovery, see *Albala v City of New York*, 429 NE (2d) 786 (NY 1981) (negligence in performing an abortion caused perforation of the uterus, leading to brain damage in the child of the woman's next pregnancy); *Hegyes v Unjian Enterprises, Inc*, 286 Cal Rptr 85 (Ct App 1991) (a driver who injured the mother in a motor vehicle collision was not liable for injuries caused to her later-conceived child). For an in-depth discussion of the American cases, see Julie A Greenberg, "Reconceptualizing Preconception Torts" (1997) 64:2 Tenn L Rev 315; Browne, *supra* note 92.

96 Steinbock, *supra* note 93 at 114–15.

97 *Ibid* at 111–13.

There is also authority in Australia for the proposition that preconception negligence can lead to recovery. In *Pal*,[98] a claim was brought by a woman (AA) whose physicians failed to diagnose her syphilis. During her first pregnancy, AA's obstetrician (Dr. Pal) failed to screen her for syphilis. AA also saw a specialist pediatrician (Dr. Grunseit) late in her first pregnancy as well as after the child's birth. AA's first child died approximately one month after his birth, and AA was told by Dr. Grunseit that the child's death was caused by toxoplasmosis and that she would not have a similar problem in any subsequent pregnancy. AA later conceived a second child, CA, and was cared for prior to and during this pregnancy by Dr. Harris. Dr. Harris did not submit AA to syphilis testing during her second pregnancy. CA was born with congenital syphilis and with dysmorphic features, epilepsy and developmental disabilities. AA and CA brought negligence claims against all three physicians, on the basis that their failure to submit AA to testing for syphilis was a breach of the standard of care and caused harm to her and to CA.[99]

The New South Wales Court of Appeal found that all three defendants owed a duty of care to AA and to CA, even though CA was not born at the time of the negligent conduct, and even though she had not yet been conceived at the time of Dr. Pal's negligence. In holding that a duty of care was owed by the defendant physicians, the Court reasoned that a defendant owes a duty of care not only to those who are readily identifiable victims at the time of the negligent conduct, but to all those within the class of persons put at risk of harm by the defendant's careless behaviour. In the Court's view, Dr. Pal as an obstetrician caring for AA owed a duty to AA, and would have been able to foresee that a failure on his part to exercise due care in respect of AA could lead to harm to "children later born to her."[100] Moreover, those children should be viewed as being "within the category of persons to whom the doctor was in a relevant relationship of proximity."[101]

English law on the recoverability of preconception harm is governed by statute. The *Congenital Disabilities Act*[102] grants a child born with disabilities a cause of action in the following circumstances:

> (2) An occurrence to which this section applies is one which —
>
> (a) affected either parent of the child in his or her ability to have a normal, healthy child; or
>
> (b) affected the mother during her pregnancy, or affected her or the child in the course of its birth, so that the child is born with disabilities which would not otherwise have been present.[103]

Section 1(2)(a) includes claims based on preconception activities that could "affect" the child's mother's ability to have a "normal, healthy child." Examples include permitting a female patient to become Rh-isoimmunised either by transfusion or by failing to take

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98 *Supra* note 14.
99 CA was only able to recover for the congenital syphilis infection as she was unable to prove causation with respect to the other harms (*ibid*).
100 *Ibid* at 42.
101 *Ibid* at 44.
102 *Supra* note 14.
103 *Ibid*, s 1(2).

prophylactic steps after birth, leading to Rh disease in a later-born child,[104] or causing damage to a woman's uterus in the course of performing a procedure such as an abortion or Caesarean section, leading to uterine rupture during a subsequent pregnancy, in turn causing potentially catastrophic harm to the fetus.[105]

The child's claim under the *Congenital Disabilities Act* is derivative, meaning that the tortfeasor must have owed a duty of care to one of the parents in order for the child to have a valid claim.[106] Parental injury is not required; it is enough that the parent was owed a duty by the negligent actor, and the duty was breached. The failure to recognize (or act upon) the need to take steps to prevent Rh-isoimmunisation, or the failure to take care not to perforate or otherwise damage a woman's uterus during a medical procedure seem to be clear instances of situations where the woman would have a potential claim against a physician.

Thus, there is a claim available for preconception negligence in England. In its report recommending the adoption of legislation to deal with liability in this area, the Law Commission declined to embark upon a detailed consideration of the common law treatment of such claims,[107] instead providing insight into its rationale for recommending legislation.

As the Commission explained, there are important distinctions between claims for prenatal injuries and other injuries. One such difference is "the fact that an event or occurrence (resulting from a negligent act or omission) can cause pre-natal injury even though it happens before the injured person's conception."[108] Using the example of a negligently manufactured pram, the Commission noted:

> If a manufacturer negligently manufactures and markets a pram it is no answer to the claim of the child under whom it collapses that he was not alive at the date of its manufacture. In the case of pre-natal injuries, however, the equivalent of the pram's "collapse" necessarily also occurs before the plaintiff is in existence and may occur even before the plaintiff is conceived. It is this latter possibility which has caused great concern amongst those whom we have consulted.[109]

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104 Rh disease arises when the mother and child are Rh-incompatible. The mother in this instance is Rh-negative and the child Rh-positive. The mother will produce antibodies that will attach Rh-positive fetal blood cells. The antibodies do not form until after the Rh-negative mother has been exposed to Rh-positive blood. This can happen if she is given a transfusion of Rh-positive blood or if she has previously been pregnant and the fetus was Rh-positive. The harm to the child is preventable (avoid transfusing incompatible blood types, or administer Rho immune globulin appropriately during and after pregnancy to prevent the development of antibodies). See Ossie Geifman-Holtzman et al, "Female Alloimmunization with Antibodies Known to Cause Hemolytic Disease" (1997) 89:2 Obstetrics & Gynecology 272. For cases allowing recovery, see *Renslow*, *supra* note 94; *Empire Casualty*, *supra* note 94.

105 See *Bergstreser*, *supra* note 94.

106 *Supra* note 14, s 1(3).

107 United Kingdom, Law Commission, *Report on Injuries to Unborn Children* (London: Her Majesty's Stationery Office, 1974) at para 7 [Law Commission Report, UK]. The Commission also noted that the Scottish Law Commission, in its report on the same issue concluded that, "the Scottish courts, by applying existing principles of law, would admit the right of a child who has been born alive to recover damages for ante-natal injuries which it has sustained by reason of the wrongful act of another … whether the defender's act occurred before or after conception" (*ibid* at para 10). See also United Kingdom, Scottish Law Commission, *Report of the Scottish Law Commission, Liability for Ante-natal Injury* (Edinburgh: Her Majesty's Stationery Office, 1965) at para 29.

108 Law Commission Report, UK, *ibid* at para 33.

109 *Ibid* at para 76.

The Commission provided a number of examples of negligent acts prior to a child's conception that can lead to harm or injury to the child. These include negligently caused pelvic injury to the child's mother, radiation exposure causing harm to either parent's reproductive organs leading to gene mutation, congenital syphilis caused by transfusion with infected blood prior to conception, and negligence in procuring sperm for assisted insemination.[110] Like some of those whom it consulted, the Commission was somewhat apprehensive about the potential expansion of liability should preconception claims be permitted. However, the Commission concluded that there should be a remedy available for a child born with disabilities caused by some "tortious injury inflicted upon its parent."[111] The Commission endorsed limits on the extent of liability in such cases: specifically, that liability should be limited by parental knowledge of the harm so that where parents are aware (or should be aware) of the risk to the future child prior to conceiving a child, and proceed to conceive in spite of their knowledge, the original negligent actor will not be liable to the child. The Commission also recommended that liability be limited to the first generation of children only (the immediate children of the individual to whom the duty was breached).[112]

In commenting specifically on the potential liability of the medical profession for preconception negligence, the Commission made a point that is instructive with respect to the concerns articulated by the Ontario Court of Appeal in *Paxton*:

> Another very real fear, which the medical profession has, is that they will be placed in difficulties if any conflict of interest arises, as it frequently does, between the interests of the mother and foetus. These fears also are, we think, misplaced. We do not think that any doctor who, exercising responsible care, resolved such a conflict in accordance with a received body of medical opinion would be liable either to the mother or to the child.[113]

The Ontario Court's concerns about conflicting duties and insufficient proximity in the context of preconception negligence are apparently not shared by some courts in the US or Australia, nor by law reform institutions in Scotland and England. In fact, the question about whether such claims can be brought has been taken to be settled law in these jurisdictions for some time. While this is by no means an exhaustive study of common law jurisdictions, it is fair to suggest that the Ontario Court of Appeal's reasoning is out of step with that in several jurisdictions with similar democratic and legal traditions.

As is clear from the foregoing, in my view the Ontario Court of Appeal made significant errors in its reasoning in *Paxton* and *Bovingdon*. When one of these errors was pointed out in *Liebig*, the solution the Court embraced was incomplete and inadequate. It also compounded one of the Court's original errors, which was the assumption — with little apparent thought or reflection — that preconception harm is not recoverable by a future child.

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110 *Ibid* at para 77.
111 *Ibid* at para 78.
112 *Ibid* at para 79.
113 *Ibid* at para 95.

V. CONCLUSION

Canadian lawmakers have work to do. The law on prenatal and preconception harm caused by physician negligence needs to be clarified, either by the courts or by legislators — a fact made painfully evident by the Ontario Court of Appeal's decisions in *Paxton* and *Bovingdon*. Though they involve some factual twists, neither case presents insuperable challenges.

Carolyn Bovingdon's claim was one alleging a lack of informed consent and was properly handled as such. The claim by the twins in *Bovingdon* is more complex — it could arguably be seen as a wrongful life claim, as the alleged negligence on Dr. Hergott's part was in helping to increase the odds that they would be conceived (which, in turn, led to their premature birth and disabilities). However, viewing the claim in this way suggests that once Dr. Hergott prescribed Clomid, he not only increased the odds of the twins' conception, but also made the harm inevitable. But twinning is not inevitable as a result of Clomid, and premature birth is not inevitable in twin pregnancies — so even if it was negligent for Dr. Hergott to prescribe Clomid, there was a chance that the twins would be born healthy in spite of his negligent conduct. A wrongful life claim is not one in which there is a chance that the child or children will be born healthy; the only way to avoid the harm in such a case is to prevent the birth. A better approach would have been to treat this claim as a routine negligence claim against Dr. Hergott. Even had the Court concluded that a duty of care was owed to the twins, their claim would likely have failed, as at least one other element of negligence — breach of the standard of care — would not have been made out.[114] In *Paxton*, again, even if Dr. Ramji owed Jaime Paxton a duty of care, as the trial judge concluded, there was no negligence and therefore no chance of success. Both of these cases turn on the standard of care, not the duty of care.

It is easy, but perhaps unwise to speculate about why the Court approached these cases as it did. The most likely explanation is simply this: Canadian law on the birth torts is inconsistent and unclear. The defendants in these cases took the opportunity to argue that the claims brought by the infant plaintiffs were wrongful life claims in the hope of taking advantage of the lack of clarity, and of the refusal of Canadian courts to recognize such claims. In turn, the Court fixated on the legal and policy issues relevant to wrongful life and the duty of care, and lost sight of the most obvious and straightforward resolution of these cases.

In declining to impose a duty upon physicians, the Court effectively insulated from liability those physicians who act negligently and cause harm to a future child (whether conceived at the time of the negligent conduct or not). Existing authority makes it clear that third parties can face liability where their negligence causes injury during pregnancy and where that injury manifests as harm to the later-born child. The Ontario Court of Appeal seems to suggest that physicians should be exempted from that line of authority because of

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[114] To prove a breach of the standard of care, the twins would have had to show that prescribing Clomid to increase the odds of conception is negligent (meaning that the reasonable physician would not have prescribed the drug). Given that Clomid is an accepted fertility treatment, it seems difficult to imagine that this assertion could succeed. That prescribing Clomid to a woman in Mrs. Bovingdon's circumstances would not be a breach of the standard of care is acknowledged in the Ontario Court of Appeal's reasons: *Bovingdon*, *supra* note 15 at para 59.

the risk that they will behave in a way that is contrary to their ethical and professional obligations to their pregnant patients in order to avoid the chance that they could eventually be sued by a child. It is worth emphasizing that simply imposing a duty on a physician to take care for the interests of a future child does not itself lead to liability. But declining to impose a duty rules out any potential for liability on the part of the physician, thereby over-determining the outcome.

Although the Ontario Court of Appeal's decisions create uncertainty about the scope of a physician's potential liability for negligently causing harm to a fetus in utero, I am more concerned about its wholesale rejection of the idea that preconception conduct can ground a negligence claim by a future child. The reasoning adopted by the New South Wales Court of Appeal in relation to preconception negligence is sound, as is that presented by the English Law Commission. The legislative approach proposed by the Law Commission and enshrined in the *Congenital Disabilities Act*, though it does not allow all claims for preconception harm, creates certainty and fairness for all involved. Adoption of an approach along these lines would be well-advised in Canada.

As to wrongful life claims, a full-blown argument on whether such claims should be recognized by Canadian courts is beyond the scope of this article. However, it bears mention that others have raised persuasive arguments that the failure to recognize such claims is unjustifiable.[115] In a recent article, Rosamund Scott argues that wrongful life cases should be allowed to proceed, albeit only in extremely limited circumstances.[116] In her view, such claims should be possible where the individual's life is so filled with suffering that the pleasures or benefits the child may derive from life are far outweighed by the negatives.[117] Where the child is suffering because of a congenital illness or disability — but not suffering to the extent that there is no good to be derived from his or her life — the parents should be able to bring a wrongful birth claim.[118]

To date, the Supreme Court of Canada has denied leave in almost all of the birth tort cases that have come its way. The Court has particularly shied away from cases that can be understood as involving wrongful life claims. Unless and until the Court grants leave in such a case and provides clear and cogent guidance as to the validity of claims such as those raised in *Paxton* and *Bovingdon*, lower courts will continue to struggle to resolve them and litigants will continue to engage in protracted and expensive litigation. If the Supreme Court of Canada is not willing to hear these claims, then provincial legislatures should demonstrate leadership and adopt legislation to clarify the law relating to the birth torts and preconception negligence claims.

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115 Anthony Jackson, "Wrongful Life and Wrongful Birth: The English Conception" (1996) 17:3 J Legal Med 349 (Jackson suggests not only that English courts should allow wrongful life claims, but that they should not recognize wrongful birth claims); Amos Shapira, "'Wrongful Life' Lawsuits for Faulty Genetic Counselling: Should the Impaired Newborn be Entitled to Sue?" (1998) 24:6 J Medical Ethics 369; Mark Strasser, "Wrongful Life, Wrongful Birth, Wrongful Death, and the Right to Refuse Treatment: Can Reasonable Jurisdictions Recognize All But One?" (1999) 64:1 Mo L Rev 29.

116 Rosamund Scott, "Reconsidering 'Wrongful Life' in England after Thirty Years: Legislative Mistakes and Unjustifiable Anomalies" (2013) 72:1 Cambridge LJ 115 at 137–39.

117 *Ibid* at 118, 130–33. Scott points to case law establishing that some conditions cause such severe suffering that courts have been prepared to consider whether life-sustaining treatment is in the child's best interests (*ibid* at 135–36).

118 *Ibid* at 118. As Scott notes, even a far less severe disability than would warrant a wrongful life claim could well have led the parents to terminate the pregnancy had they been made aware of the possibility.