

University of Alberta

Preconception Medical Duties: A Co-extensive Duty of Care Framework

by

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DEDICATION

This thesis is dedicated to my loving and supportive family: Mohammad, Mina, Miriam, Mona, and Sophie Sabzevari.

ABSTRACT

The question of whether a duty of care can be owed to a born alive child for preconception medical care was examined and answered negatively by the Ontario Court of Appeal in *Bovingdon (Litigation Guardian of) v. Hergott* (2008) and *Paxton v. Ramji* (2008). In this thesis, I review the relevant Canadian cases and conduct a thorough *Anns* test analysis of the proposed duty of care. I disagree with the conclusion in *Bovingdon* and *Paxton* and I suggest a framework for co-extensive duties of care that is suitable for both prenatal and preconception medical care.

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TABLE OF CONTENTS

<u>INTRODUCTION</u>	1
<u>Outline</u>	3
<u>Terminology</u>	5
<u>PART I – CANADIAN CASE LAW</u>	5
<u>Introduction</u>	5
<u>Cases before Bovington and Paxton</u>	7
<u>Webster v. Chapman</u>	7
<u>Trial Level</u>	7
<u>Appeal Level</u>	12
<u>Cherry v. Borsman</u>	14
<u>Trial Level</u>	14
<u>Appeal Level</u>	17
<u>Lacroix (Litigation Guardian of) v. Dominique</u>	20
<u>Trial Level</u>	20
<u>Appeal Level</u>	23
<u>Bovington (Litigation Guardian of) v. Hergott</u>	26
<u>Trial Level</u>	26
<u>Appeal Level</u>	28
<u>Paxton v. Ramji</u>	32
<u>Trial Level</u>	32
<u>Wrongful Life Reasoning</u>	40
<u>Appeal Level</u>	45
<u>Cases after Bovington and Paxton</u>	51
<u>PART II: DUTY OF CARE ANALYSIS (STAGE 1)</u>	54
<u>Introduction</u>	54
<u>Categorization</u>	56
<u>Proximity Analysis</u>	61
<u>Necessarily Incidental Argument</u>	62
<u>Conflict of Interest and Chilling Effect</u>	65
<u>Co-extensive Duties and Independent Duties</u>	70
<u>Co-extensive Duties and Consensual Treatments</u>	73

<i><u>Wills and Beneficiaries Analogy</u></i>	81
<i><u>Informed Consent</u></i>	85
Informed Consent and Conflict of Interest	89
<i><u>Independent Duties of Care</u></i>	97
<u>Conclusion</u>	102
<u>PART III: DUTY OF CARE ANALYSIS (STAGE 2)</u>	103
<i><u>Introduction</u></i>	103
<i><u>Policy Arguments Against</u></i>	107
<i><u>Effect on Insurance</u></i>	107
<i><u>Indeterminate Liability</u></i>	108
<i><u>Pronatalist Bias and Assumption of Pregnancy</u></i>	110
<i><u>Policy Arguments in Favour</u></i>	114
<i><u>Compensation</u></i>	114
Parent and Child Awards	117
“Normal” and “Disabled” Children	123
<i><u>Protection of future children</u></i>	126
<i><u>Conclusion: The Argument against Denying All Duties for the Sake of Extreme Cases</u></i>	128
<u>PART IV: AUXILIARY TOPICS</u>	131
<i><u>Introduction</u></i>	132
<i><u>Limits on Liability: Foreseeability in Duty of Care and Remoteness</u></i>	132
<i><u>Duty of Care</u></i>	133
<i><u>Remoteness</u></i>	136
<i><u>Contributory Negligence and the Apportionment of Liability</u></i>	137
<i><u>Wrongful Life</u></i>	142
<u>CONCLUSION</u>	144
<u>BIBLIOGRAPHY</u>	146

Introduction

It is well established in Canadian and common law jurisprudence that doctors owe a tort law duty of care to born alive children in relation to prenatal medical care.¹ In contrast, it remains a contested issue whether doctors owe a duty of care to born alive children in relation to preconception medical care.² In Canada, the question was considered directly by the Ontario Court of Appeal in *Bovingdon (Litigation Guardian of) v. Hergott* and *Paxton v. Ramji*, two cases involving preconception drug prescription.³ In *Bovingdon*, the doctor prescribed a fertility drug that led to harmful consequences for the twins that were subsequently conceived and born. In *Paxton*, the doctor prescribed an acne drug to treat a female patient's acne which, after a birth control failure, caused harm to the developing fetus during pregnancy. The lower courts in both cases accepted that a doctor owes a duty of care to a born alive child extending to before its conception, at least in the drug prescription context.⁴

¹ The term *prenatal* is used to refer to the period of time between conception and birth.

² The term *preconception* is used to refer to the period of time preceding conception. While the end point is conception, the starting point is more variable and is covered subsequently.

³ *Bovingdon (Litigation Guardian of) v. Hergott*, 2008 ONCA 2, 88 O.R. (3d) 641 [*Bovingdon*]; *Paxton v. Ramji*, 2008 ONCA 697, 59 C.C.L.T. (3d) 179 [*Paxton*]. It was considered briefly in Lacroix, *infra* note 57.

⁴ *Bovingdon (Litigation Guardian of) v. Hergott* (2006), 275 D.L.R. (4th) 168, 83 O.R. (3d) 465 (Ont. S.C.J.) [*Bovingdon Trial*]; *Paxton v. Ramji*, [2006] O.J. No. 1179, 2006 CarswellOnt 1844 (Ont. S.C.J.) [*Paxton Trial*].

At the appeal level, the Ontario Court of Appeal emphasized that these two cases involved a novel duty of care situation.⁵ The Court of Appeal went through the updated two stage *Anns* test from *Cooper v. Hobart*.⁶ At the first stage, the Court of Appeal accepted reasonable foreseeability of harm and considered whether there was a relationship of sufficient proximity between the plaintiff and defendant.⁷ The Court of Appeal confirmed a duty of care to parents for preconception medical care, but rejected the notion that a doctor could owe a duty of care to a born alive child for preconception medical care, on the basis of a lack of proximity as well as residual policy concerns.⁸

In this thesis, I consider in detail the Court of Appeal's tort law analysis and rulings in *Bovingdon* and *Paxton*. I critique the proximity and residual policy arguments presented in denying a duty of care relationship between medical practitioners and born alive children for preconception care. I question whether *Bovingdon* and *Paxton* should be persuasive to Canadian courts in other jurisdictions determining future cases involving alleged negligence during preconception medical care. I support a different legal path for future preconception drug prescription cases and preconception medical care cases in general.

⁵ *Bovingdon*, *supra* note 3 at paras. 61-62; *Paxton*, *supra* note 3 at paras. 53-54.

⁶ *Cooper v. Hobart*, 2001 SCC 79, [2001] 3 S.C.R. 537 [*Cooper*]. The *Cooper* analysis was done explicitly and in more detail in *Paxton* than *Bovingdon*, but similar policy concerns were considered and accepted in both cases.

⁷ *Paxton*, *supra* note 3 at para. 63.

⁸ *Ibid.* at paras. 64-79

I argue that preconception medical duties can and should be owed to born alive children, analogous to medical duties already owed during pregnancy. I propose and defend a co-extensive framework for medical duties owed to both parents and born alive children that is suitable for both the preconception and prenatal timeframes. Underlying the comparison is the question of whether the point of conception is as significant a legal marking point as it may appear to be at first glance. I conclude that conception is not an endpoint for tort law duties owed to a born alive child and that born alive children may be owed medical duties of care that parallel preconception medical duties already owed to their parents.

Outline

Part I of this thesis contains an in-depth review of the major Canadian cases that are relevant to determining potential preconception tort law duties. All the reviewed cases reached the Court of Appeal in the provinces of origin; the facts and reasoning involved are analyzed with the current perspective focussed on preconception duties. Several important issues considered during the review include the standard of care and causation rulings, as well as the handling of wrongful life arguments.⁹ Part I also includes a detailed review of the facts of *Bovingdon* and *Paxton* and the judicial reasoning present in both cases. Finally,

⁹ To see examples of wrongful life scenarios, see text accompanying notes 58-65, below. For a review of the tort of wrongful life, see Allen M. Linden & Bruce Feldthusen, *Halsbury's Laws of Canada – Duty of Care* at HNE 68 (QL).

Part I covers the Canadian cases and developments following *Bovingdon* and *Paxton*.

Part II of this thesis begins with the full *Anns* test analysis of a doctor's potential duty to a born alive child for preconception medical care. I argue that the policy concerns used by the Court of Appeal in *Bovingdon* and *Paxton*--necessarily indirect relationship, chilling effect, and conflict of interest--fail to distinguish preconception drug prescription from similar concerns that would be present and manageable in prenatal drug prescription or other medical care present in the prenatal timeframe.

Part II considers these policy concerns in detail, further developing a non-conflicting, co-extensive framework for preconception duties of care. Two hypothetical medical scenarios are considered and put to the test: preconception medical care for a patient preparing for an intended pregnancy and general medical care offered to a patient with reproductive capacity.

Part III continues the *Anns* test with a review of the policy concerns listed in *Bovingdon* and *Paxton*, as well as other relevant policy considerations. Part IV discusses the limits reasonable foreseeability places via duty of care and remoteness. Part IV also covers contributory negligence and apportionment of damages, concluding with a review of the close relationship between preconception duties and wrongful life scenarios.

Terminology

In regards to terminology used in this thesis, the term “preconception” is used to refer to the timeframe before conception, while “prenatal” is used to refer to the timeframe from conception to birth. The focus of *Bovingdon* and *Paxton* was on female patients and the gendered language used in this thesis reflects that consideration. While both male and female patients have the potential to be affected by preconception medical care, the practical application and primary impact of both preconception and prenatal medical care is currently female oriented and is the primary focus of this thesis.

The Court of Appeal in *Bovingdon* and *Paxton* at times referred to future children during its analysis.¹⁰ References to future children in this thesis are intentional and are used in situations where there is no need to distinguish between potential plaintiffs in preconception and prenatal medical care. Other relevant terminology used during this thesis is defined and explained through the course of the argument.

Part I – Canadian Case Law

Introduction

¹⁰ This use of “future children” and other terminology became the subject of legal attention immediately following the decisions. This is discussed during the review of the two cases in Part I.

In undertaking a consideration of a potential duty of care to born alive children for preconception medical care, the Court of Appeal in *Bovingdon* and *Paxton* considered some of the major Canadian case law in the area of preconception and prenatal medical care. *Webster*, *Cherry*, and *Lacroix* were all briefly considered by the Court of Appeal to determine that there was no consensus in the area of preconception medical care.¹¹ The facts and judicial reasoning in these three cases are reviewed in this section, along with *Bovingdon*, *Paxton*, and subsequent case law decisions.

It is important to thoroughly consider the earlier cases for several reasons. The decisions received close scrutiny when they were first released, but the primary focus of legal and scholarly attention was on the immediate effects relevant at the time. In particular, the focus was on what these cases meant for prenatal and preconception medical duties owed to parents. When the impact for born alive children was considered, the judicial reasoning on wrongful life took priority. It was not until *Bovingdon* and *Paxton* that the cases were re-examined for what they had to say about a potential duty of care to born alive children covering preconception medical care. The Court of Appeal's review of these cases was out of necessity brief; a deeper review is important and provides insight useful for the full *Anns* analysis in this thesis.

¹¹ *Cherry*, *infra* note 41; *Lacroix*, *infra* note 57; *Webster*, *infra* note 12. *Webster* was not mentioned in the Court of Appeal's decision in *Paxton* and was only briefly mentioned *Bovingdon*, but it is an important precedent and played an important role in *Paxton*'s trial court decision.

Also of interest and importance is the judicial reasoning used for determining the standard of care and causation in these cases. Many future preconception medical care lawsuits will involve informed consent disputes and one potential form of a preconception duty to born alive children is to properly inform their parents during preconception medical care. Therefore, it is important to clarify the proper handling of standard of care and causation for informed consent cases and to determine whether these decisions met that requirement. Similarly, wrongful life scenarios may appear in many future preconception cases, so it is worth reviewing how wrongful life was dealt with in these decisions.

Cases before *Bovingdon and Paxton*

Webster v. Chapman

Trial Level

Shirley Webster suffered from pelvic thrombosis after giving premature birth to one of her children. While in the hospital, she was prescribed the anticoagulant drug Coumadin for a four to six month therapy. After being released from the hospital, she was under the care of two doctors, Dr. Heywood and Dr. Chapman, in the relevant timeframe of this case. Dr. Heywood briefly managed the ongoing Coumadin therapy and advised Shirley to avoid becoming pregnant while taking the drug, as a pregnancy while on Coumadin could pose serious health complications for her. Dr. Heywood did not, however, advise

Shirley about the potential negative effects Coumadin may have on a developing fetus.

Shirley subsequently went under the care of Dr. Chapman. During her continuing Coumadin treatment, Shirley became pregnant. Dr. Chapman did not advise Shirley of the potential risks Coumadin posed to the development of the fetus. He made a decision based on the various factors involved, including the potential harm to Shirley from abruptly stopping the Coumadin treatment, to renew the Coumadin prescription. In making this decision, Dr. Chapman did not consult with a specialist. Shirley subsequently gave birth to a female child, Trisha, who had severe physical and mental disabilities. Trisha was expected to remain at a one year's old mental capability level and had a shortened life expectancy of 27 years.

Both mother and child sued Dr. Heywood and Dr. Chapman for negligence, alleging that Trisha's disabilities had been caused by exposure to Coumadin. The doctor who originally prescribed the Coumadin in the hospital was listed as a party to the action, but was dropped from suit before the trial.¹² At the Court of Queen's Bench of Manitoba, MacInnes J. did not distinguish between the preconception and prenatal timeframes covered by the two doctors. He held that there was "no issue in this lawsuit as to the question of

¹² *Webster v. Chapman*, [1998] 4 W.W.R. 335, 40 C.C.L.T. (2d) 212 at para. 2, [*Webster*]. This omission is unfortunate for review purposes as it was part of the preconception timeframe. It would have been useful to know about the factual situation at the hospital and to view the Court's analysis of the original preconception prescription.

duty of care” and the main focus would be on “whether Doctors Heywood and/or Chapman breached their respective duties of care, and if so, whether damages ... resulted from such breach.”¹³

In relation to Dr. Heywood, MacInnes J. noted that the lawsuits against Dr. Heywood were based on informed consent, specifically Dr. Heywood’s lack of disclosure of the potential risks to the fetus if Shirley became pregnant while taking Coumadin.¹⁴ In regards to the standard of care, he noted that Shirley had been informed of the serious risks becoming pregnant would create to her own health while on the Coumadin therapy. MacInnes J. concluded that information about the potential fetal risks was not part of the required disclosure and did not find a breach of the standard of care. In addition, he found a lack of causation, concluding that Shirley did not intend to become pregnant and would have continued to take the Coumadin, even if she had been advised of the risks to the fetus if she became pregnant.¹⁵

In summary, MacInnes J. rejected Shirley and Trisha’s claims against Dr. Heywood based on standard of care and causation issues, rather than lack of a duty of care. He concluded that a reasonable patient in Shirley’s circumstances would have continued the Coumadin therapy even with the full disclosure about

¹³ *Webster v. Chapman*, [1996] 9 W.W.R. 652, 30 C.C.L.T. (2d) 164, at para. 21 [*Webster Trial*].

¹⁴ *Webster Trial*, *supra* note 13 at paras. 23, 31.

¹⁵ *Ibid.* at paras. 35, 39.

fetal risks.¹⁶ It is a little disconcerting from a contemporary informed consent viewpoint that disclosure of the potential risk to a fetus was not found to be a relevant risk that a reasonable patient would want to know about.¹⁷

The conclusion that Shirley would not have acted differently, even if fully informed about the fetal risks, seems to have excluded the fetal risks from being part of the required informed consent disclosure. If so, this would be an improper blurring of standard of care and causation, two issues that should be determined separately. As an alternative, standard care could require a disclosure of fetal risk, while the case could still fail based on a lack of causation. This would protect plaintiffs in other situations which could meet the modified objective causation test and establish that they would have acted differently, if properly informed of the fetal risks.

A key point in the decision was the fact that Dr. Heywood did not prescribe or reissue the prescription of Coumadin and was “merely” administering the therapy.¹⁸ MacInnes J. distinguished the case facts from a patient thinking about or attempting to become pregnant and seeking advice in relation to Coumadin therapy or some other drug therapy, where such information would be material and require disclosure.¹⁹ Subsequent to *Webster*,

¹⁶ Note that the reasonable person would be taking birth control measures to prevent pregnancy. MacInnes J. accepted that Shirley was told to take birth control methods by Dr. Heywood while on Coumadin and that she had agreed to do so, which was the relevant fact for this conclusion.

¹⁷ *Webster Trial*, *supra* note 13 at para. 31.

¹⁸ *Ibid.* at para. 32.

¹⁹ *Ibid.* at para. 36.

such preconception guidance scenarios involving adult patients intending to become pregnant arose in both *Lacroix* and *Bovingdon*. The distinguishing of preconception medical care scenarios involving an intended pregnancy from general medical care is important; the two scenarios are analyzed separately in this thesis.

In relation to Dr. Chapman, MacInnes J. noted that there was no allegation made that Dr. Chapman failed to inform about the risks of Coumadin before pregnancy and that the plaintiffs did not attempt to raise a claim against Dr. Chapman based prior to Trisha's conception.²⁰ The alleged negligence was in regards to Dr. Chapman's failure after the pregnancy was discovered to consult a specialist when considering whether to continue the Coumadin treatment and his failure to inform Shirley of the risks involved to the existing fetus. MacInnes J. found that Dr. Chapman was negligent on both grounds, referring to the medical drug guide (Compendium) that specifically instructed physicians to inform pregnant women of potential risks to the fetus.²¹

In terms of the informed consent claim, MacInnes J. emphasized that while expert testimony is useful for helping to determine what should have been disclosed, the Court must make the decision using the standard of the reasonable patient in Shirley's circumstances. Similarly, while medical expertise is useful for determining the standard of care in regards to whether Dr. Chapman

²⁰ *Ibid.* at para. 46.

²¹ *Ibid.* at para. 79.

should have consulted a specialist, the Court can find that a doctor failed to meet the standard of care in the absence of such evidence.²² In the case at hand, Shirley's counsel did not provide any expert evidence to establish the standard of care, but MacInnes J. concluded that Dr. Chapman's lack of consultation and general handling of the Coumadin treatment during the pregnancy fell below the appropriate standard of care.²³

The main issue turned to causation. By the time the pregnancy was discovered, it was possible that the damage to fetal development had already been done and Dr. Chapman would not be held responsible for it, despite falling below the standard of care from that point onwards.²⁴ After considering the expert testimony on both sides, MacInnes J. concluded that Shirley and Trisha had not proved on the balance of probabilities that Trisha's injuries were caused by Dr. Chapman's negligence.²⁵

Appeal Level

The case was appealed to the Court of Appeal of Manitoba, where the decision on causation in relation to Dr. Chapman's negligence was overturned. It is, however, the judicial reasoning in relation to Dr. Heywood's alleged

²² *ter Neuzen v. Korn*, [1995] 3 S.C.R. 674 [*ter Neuzen*].

²³ *Webster Trial*, *supra* note 13 at paras. 72-74.

²⁴ Shirley discovered the pregnancy at 11 weeks. The main damage caused by Coumadin is caused in the earliest stages of pregnancy and MacInnes J. concluded that Dr. Chapman's negligence did not cause or aggravate Trisha's physical and mental disabilities.

²⁵ *Webster Trial*, *supra* note 13 at para. 120; This type of stumbling block is a common feature in medical cases, as causation is a difficult hurdle to leap for informed consent cases, see Picard & Robertson, *infra* note 45 at 191.

negligence that is most relevant to the current consideration of potential preconception duties. Twaddle J.A. accepted MacInnes J.'s decision in relation to rejecting the claim of negligence against Dr. Heywood for the preconception care timeframe. Twaddle J.A. made use of the fact that Dr. Heywood had warned Shirley against pregnancy due to the risks to her health and the fact that Shirley had confirmed that she would take contraceptive precautions.²⁶

Despite upholding the lower court's determination of the facts and conclusion in relation to the failed preconception claim against Dr. Heywood, Twaddle J.A. did not contest the potential existence of a duty of care both to the mother and to the born alive child for preconception care in some circumstances:

In the circumstances of this case, *both plaintiffs could succeed only if* they satisfied the Court that the mother would not have continued to take Coumadin had she been advised of the fetal risks. *The mother alone could possibly have succeeded if* she had satisfied the trial judge that disclosure of fetal risks would have resulted in her avoiding pregnancy or, at least, taking much greater precautions against pregnancy than she did. The judge would have had to be able to say that, if the advice had been given, a pregnancy was improbable. These conditions for success were considered by the trial judge who had heard the mother's evidence. He was not satisfied that they had been met.²⁷

²⁶ *Webster, supra* note 12 at para. 13. It is again curious that disclosing the dangers of Coumadin was not a material risk, as it takes the decision out of Shirley's hands. It may be that a particular plaintiff would react differently when they consider the risk to their potential child. Parents may decide to make sacrifices for or different risk assessments about their children or future children. It may be implicit that the reasonable patient standard curbed the potential for a different decision in this case and also that the Court of Appeal was being deferential to the findings of the lower court.

²⁷ *Webster, supra* note 12 at para. 15 [emphasis added].

The structure of reasoning above implies that the facts and evidence of a particular case can determine whether the born alive child's claim would be viable. Assuming that informing about the drug's fetal risks was found to be within the standard of care for informed consent, if Shirley established that she would have avoided the drug if properly informed, then both Shirley and Trisha may have had viable causes of action. On the other hand, with the same assumption, if Shirley established that she would have avoided pregnancy, this would be somehow fatal to Trisha's claim. It was not explicitly mentioned in the decision, but it can be inferred that this meant Trisha's claim would fall under wrongful life in the latter situation and be barred for that reason.²⁸

Cherry v. Borsman

Trial Level

The defendant, Dr. Borsman, performed an abortion for the adult plaintiff, Jody Cherry. Unknown to both Jody and Dr. Borsman, the abortion failed and Jody remained pregnant. Following the procedure, Jody's family doctor suggested that Jody may still be pregnant. Dr. Borsman disagreed and did not suggest a further pregnancy test or otherwise attempt to determine if the abortion had failed. After her period failed to return 8 weeks after the procedure, Jody again sought a pregnancy test, which Dr. Borsman ultimately provided. The resultant ultrasound scan showed that she was pregnant, but at

²⁸ *Webster's* factual situation was considered subsequently in the review of wrongful life categories in *Lacroix*, where Twaddle J.A. took the opportunity to expand upon the wrongful life issue. See *Lacroix*, *infra* note 57.

that point the abortion would not have been legal under the contemporary legal system.²⁹ Jody gave birth to Elizabeth, a child who had several physical and mental disabilities. Both mother and child sued Dr. Borsman for negligence, claiming that Elizabeth's disabilities were caused by the failed abortion.³⁰

At trial, Skipp J. of the British Columbia Supreme Court noted that the case involved "two plaintiffs with separate and distinct duties owed to each of them."³¹ Dr. Borsman had a duty to Jody Cherry to perform the abortion and post-abortion care with the appropriate standard of care.³² At the same time, it was "clearly foreseeable that a negligently performed abortion may affect a fetus" and Dr. Borsman was under a "duty to prevent this foreseeable harm."³³

Skipp J. considered the argument of a potential conflict of duties:

I find no conflict in the duties owed by the defendant doctor to the respective plaintiffs. Dr. Borsman owed a duty to the adult plaintiff to perform the abortion with due care and he owed a duty to the infant plaintiff not to injure her. The injuries inflicted upon the fetus resulted in rights which accrued to the child upon her live birth. Had the abortion been effective, her cause of action would not have arisen.³⁴

It would seem that a duty to a fetus during an abortion would be of very serious concern in terms of the potential impact on a female patient's autonomy

²⁹ *Cherry v. Borsman* (1990), 75 D.L.R. (4th) 668, 5 C.C.L.T. (2d) 243 at paras. 19-36 [*Cherry Trial*].

³⁰ The specific claim was that the failed abortion procedure caused an initial injury, harm during further fetal development, and finally a premature birth which included health complications.

³¹ *Cherry Trial*, *supra* note 29 at para. 53.

³² *Ibid.* at para. 55.

³³ *Ibid.* at para. 56.

³⁴ *Ibid.* at para. 60.

when seeking an abortion. Skipp J. argued there was no conflict because the fact that “the vast majority of abortions are successful and there are thus no infant plaintiffs to assert their rights.”³⁵ This unique characteristic of abortion care contrasts with other prenatal or preconception scenarios, where there is a far greater chance of born alive children surviving to assert their crystallized rights.

Was the duty owed to Elizabeth to perform an abortion diligently or is it to not perform an abortion at all? Skipp J.’s wording implies the latter duty. However, it cannot be expected that doctors would cease to perform abortions, which would seriously conflict with access to abortion in Canada. On the other hand, if the abortion and post-abortion care were performed up to the standard of care owed to Jody, then Elizabeth would not have been born.

Skipp J. distinguished the facts of the case from other wrongful life cases such as the English case of *McKay v Essex*, which involved a female plaintiff who was not properly informed of the chance of her fetus being harmed by a rubella infection during pregnancy.³⁶ The plaintiff lost the chance to consider having an abortion and her child was in fact harmed by the rubella infection. Skipp J. categorized these wrongful life cases as containing the “submission ... that the child would have been better off dead.”³⁷ Skipp J. noted that Elizabeth’s argument in the present circumstances was not structured like a lack of informed consent case. She was “not submitting that she would have been better off dead,

³⁵ *Ibid.* at para. 61.

³⁶ *McKay v Essex A.H.A.*, [1982] 2 W.L.R. 890 (C.A.).

³⁷ *Cherry Trial*, *supra* note 29 at para. 64.

but rather that she suffered injuries as a result of the defendant's negligence."³⁸ Therefore, Elizabeth's action was not one based in wrongful life and could succeed.³⁹

Skipp J's categorization of wrongful life cases is based on the informed consent structure, but wrongful life cases are not just limited to informed case scenarios. It is important to consider cause and effect when determining whether a case falls into wrongful life. Elizabeth may not have been asserting that she was "better off dead" but if the doctor had performed the duty properly, she would not have existed. The ultimate issue of comparing damages between life with an injury and non-existence would still be present in this scenario.

Elizabeth's counsel did not submit that she was "better off dead" and Skipp J. did not conclude this; however, a duty to perform a reasonably operated abortion nevertheless pushes the case toward the wrongful life trap. On the other hand, if the duty was accepted as a general duty not to cause any physical harm to the fetus, including a duty not to perform an abortion, then wrongful life would not be an issue.⁴⁰

Appeal Level

³⁸ *Ibid.* at para. 66.

³⁹ Causation was met for both plaintiffs, with Jody and Elizabeth both succeeding in their negligence claims.

⁴⁰ The issue of concern would then be, as mentioned earlier, an irreconcilable conflict of interest.

The decision was appealed to the British Columbia Court of Appeal, where it was upheld, aside from an adjustment of the calculation of damages.⁴¹

The Court considered the argument of a potential conflict of duties:

The defendant says such a dual duty of care to both the mother and fetus puts the surgeon in an impossible conflict of interest. He asks how can the surgeon have a duty to the mother to destroy the fetus and at the same time have a duty to protect the fetus. He goes on to say that duty of care to the mother negatives any duty of care to the fetus. As we understood counsel, his position is that because of the clear duty of care to the mother, and that duty of care being in sharp conflict with any alleged duty of care to the infant plaintiff, there cannot be any proximity as between the surgeon and the fetus, now the infant plaintiff. When we say proximity we mean as that word is used in the analysis of the concept of a duty of care in the law of negligence.

We cannot agree. We think the law would be wanting and badly flawed if it found itself in the position of having to deny any remedy to this infant plaintiff because of what at first glance may appear to be established principles of negligence. In our opinion the principles of negligence do not stand in the way of recovery for this plaintiff. We think that a surgeon, on performing an abortion in a case such as this, owes a duty of care to the mother to perform his task properly but at the same time owes a duty of care to the fetus not to harm it *if he should fail in meeting the duty of care he owes to the mother.*⁴²

The Court of Appeal upheld the trial judge's decision on negligence. One interpretation of the emphasized text is that it is a statement echoing the lower court's conclusion that a duty not to harm the fetus exists, but will rarely survive to crystallize at birth in abortion cases, because the abortion will prevent a born alive child. It is only a negligent abortion that allows a claim to survive to birth. However, what if the abortion is performed up to the standard of care, but harm

⁴¹ *Cherry v. Borsman* (1992), 94 D.L.R. (4th) 487, [1992] 6 W.W.R. 701 137 at paras. 167-170 [Cherry].

⁴² *Ibid.* at paras. 73-74 [emphasis added].

still occurs and the child is born alive? Is this duty not to harm the fetus still an actionable claim against the doctor?⁴³

Referring to the issue of wrongful life and the circumstances of the case, if Dr. Borsman met the duty and relevant standard of care owed to Jody, then Elizabeth would not have been born. It is only because of the failure of the abortion that Elizabeth was born and her right of action was allowed to take form. Like the lower decision, the Court of Appeal distinguished the case from wrongful life cases by noting that Elizabeth's claim was not argued as a reflection of her mother's lack of informed consent, but rather one based on a negligently performed abortion.⁴⁴ This distinction was criticized:

[T]he Court's insistence that it was not dealing with a wrongful life claim is rather difficult to accept. Even though the child's disabilities were the result of trauma caused by the doctor's negligence, the fact remains that if the doctor had not been negligent and had performed the abortion properly, the child would never have been born at all. For that reason, the child's action appears to have the classic hallmark of a wrongful life claim.⁴⁵

Cherry v. Borsman has been the subject of much analysis in the past twenty years. It is possible that a contemporary Court of Appeal deciding the case *de novo* would reach different conclusions both on wrongful life and duties to the fetus in relation to the sensitive issue of abortion, but it currently remains

⁴³ The possible standard of care owed by the doctor is further discussed in Part II, see text accompanying note 199, below.

⁴⁴ *Cherry*, *supra* note 41 at, para. 77.

⁴⁵ Ellen I. Picard & Gerald B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4th ed. (Toronto: Carswell, 2007) at 269.

an established precedent in British Columbia.⁴⁶ The case's classification in regards to wrongful life has been influential in subsequent cases, including *Lacroix*.

Lacroix (Litigation Guardian of) v. Dominique

Trial Level

The adult plaintiff, Janice Lacroix, suffered from temporal lobe epilepsy, which caused recurrent seizures. Janice was referred by her family doctor to a specialist, Dr. Dominique, who prescribed several anti-convulsant medications. Janice and her husband planned to have children and were referred again by their doctor to Dr. Dominique to discuss the possible impact of the anti-convulsant medications on her intended pregnancy. Janice continued taking the medications and gave birth to one healthy child, but her second child, Donna, was born with some development disabilities. Janice alleged that Dr. Dominique understated the potential risks to a developing fetus the anti-convulsant medications posed at the preconception consultation and that she would have delayed or avoided pregnancy if she had been properly informed. Janice and Donna both sued Dr. Dominique for negligence.

At trial, Jewers J. of the Court of Queen's Bench of Manitoba considered Dr. Dominique's duty to warn Janice and her husband about the potential risks to

⁴⁶ *Cherry* was briefly reaffirmed as the established precedent in *Ediger*, *infra* note 139 at para. 33.

a fetus when taking the prescribed medications.⁴⁷ Jewers J. accepted the testimony of the medical geneticist that the medical knowledge at the time was that there was a greater risk (2 to 3 times) of physical and mental disabilities caused by the medication and concluded that Dr. Dominique should have properly explained this risk to Janice to meet the appropriate standard of care.⁴⁸

In concluding that Dr. Dominique failed to clearly explain the risks, Jewers J. focused on the preconception guidance nature of the consultation:

The consultation ... was not just a regular meeting but was, in addition, for the specific purpose of discussing the effects of the medication on a fetus; indeed, according to Dr. Dominique, the meeting was not regular at all but was for the *sole* purpose of discussing a contemplated pregnancy; Mr. and Janice both very much wanted children and so the meeting was of considerable importance to them and they would tend to remember it and what was told to them.⁴⁹

Jewers J. next turned to causation and Janice's claim that she would not have accepted the risk of taking the medication if properly informed.⁵⁰ He accepted her claim and found that a reasonable person in Janice's personal circumstances would have postponed pregnancy for some time to attempt to become seizure free and to no longer require the anti-convulsant treatment.⁵¹ After considering the expert medical testimony, Jewers J. concluded that the plaintiffs had proved, on the balance of probabilities, that the anti-

⁴⁷ *Lacroix (Litigation Guardian of) v. Dominique*, [1999] 12 W.W.R. 38, 1999 CarswellMan 414 at para. 8 [*Lacroix Trial*].

⁴⁸ *Ibid.* at paras. 8, 25-31.

⁴⁹ *Ibid.* at para. 26.

⁵⁰ *Ibid.* at para. 32.

⁵¹ *Ibid.* at paras. 32-37.

convulsant medications taken during pregnancy caused Donna's developmental disabilities.⁵² All the elements of negligence were successfully established, though Janice's claim was barred by the expiry of the statute of limitations.⁵³

Jewers J. considered whether Donna's claim should be barred for being a wrongful life claim. He found that it did fall within the range of wrongful life and was not an actionable claim.⁵⁴ An attempt was made to distinguish the current situation from the valid claim in *Cherry*:

[T]hat case is distinguishable because it was the negligence of the doctor that directly led to the injuries to the fetus; whereas in the case at bar, there is no allegation that Donna's disabilities were caused by anything which the defendant negligently failed to do: the negligence alleged was in the giving of the advice and not in the administering of the medications which, after all, were essential to the health of the mother Janice. *Cherry (Guardian ad litem of) v. Borsman* could be determined on simple principles of negligence but this case cannot.

Jewers J.'s reasoning is in alignment with the judicial reasoning asserted in *Cherry*, which distinguished the doctor's negligently performed abortion from the informed consent cases where the mother lacked the chance to prevent

⁵² *Ibid.* at para. 80.

⁵³ *Lacroix Trial*, *supra* note 47 at paras. 97-101; *The Limitation of Actions Act* C.C.S.M. c. L150; *The Medical Act* R.S.M. 1987, C.M90, s. 61.

⁵⁴ *Lacroix Trial*, *ibid.* at paras. 88-89.

pregnancy.⁵⁵ The case at hand was a wrongful life scenario, as Jewers J. concluded that Janice would have avoided pregnancy if properly informed.

Appeal Level

The case went to the Court of Appeal of Manitoba, which dismissed the plaintiff's appeal of the limitation period defence. Twaddle J.A., who had previously authored the Court of Appeal's decision in *Webster*, took the opportunity to consider Donna's claim and the potential wrongful life issue in detail.⁵⁶ He accepted that wrongful life claims have not and should not be recognized in Canada.⁵⁷ Twaddle J.A. categorized infant plaintiff cases involving negligence:

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.⁵⁸

As examples of cases that fall within the first category, he included *Cherry* and *Webster*.⁵⁹ Cases falling into the second category would have their actions

⁵⁵ Note that whether informed consent cases fall under wrongful life depends on what would have been done by the adult plaintiff: avoiding pregnancy versus avoiding certain actions while still becoming pregnant.

⁵⁶ *Webster*, *supra* note 12. While wrongful life was considered behind the scenes in *Webster*, it took centre stage in *Lacroix*.

⁵⁷ *Lacroix (Litigation Guardian of) v. Dominique*, [2001] 9 W.W.R. 261, 2001 CarswellMan 334, at para. 37 [*Lacroix*].

⁵⁸ *Ibid.* at para. 24.

barred as wrongful life scenarios, and the current case fell into that category.⁶⁰ A problem with this categorization is that a single case could potentially be categorized under either category and sometimes both categories. In *Cherry*, as mentioned earlier, the negligent abortion may have caused the injuries to the born alive child, but a competently performed abortion would have likely prevented the birth of the child as well. Therefore, *Cherry* would simultaneously fall under both categories.⁶¹

It is interesting to note that even a slight variation of factual circumstances of *Lacroix* may have placed it into the first category, rather than the second. Twaddle J.A. noted that:

The plaintiffs' counsel is on firmer ground in making the submission that this case is closer to the first category of cases where the harm is caused by the doctor's negligent action. The cause of the harm was established as the medication which the doctor prescribed for the mother's use, not a hereditary characteristic or an infection. Can it be said that the doctor owed the future child a duty of care not to prescribe a medication for the mother which he knew carried the risk of injuring a fetus?⁶²

In the excerpt, the attempt to fit the factual circumstances into the first *Lacroix* category (cases in which the abnormalities have been caused by the wrongful act or omission of another) is paired with the suggested idea of a duty to avoid prescribing the drug. However, the informed consent framework can

⁵⁹ *Ibid.* at paras. 25-26.

⁶⁰ *Ibid.* at para. 41.

⁶¹ This flaw with the *Lacroix* categorization was noticed by Feldman J.A. in *Bovingdon*, *supra* note 3 at para. 57.

⁶² *Lacroix, ibid.* at para. 38.

also match the first category, if Janice had argued and successfully shown that a reasonable person in her circumstances would have avoided taking medication.

Twaddle J.A noted the difference between *Lacroix* and his decision in *Webster*:

[C]lose as this case may seem to *Webster v. Chapman*, supra, it features one fact not present in that other case. The mother in the present case testified that, if she had been advised of the danger, she would have avoided pregnancy, testimony which was accepted by the trial judge. It is thus quite clear that the mother would have elected to remain on the medication, notwithstanding the risk to a fetus should she unintentionally conceive.⁶³

In considering whether Dr. Dominique could have had a duty to a future child not to prescribe the anti-convulsant drug, Twaddle J.A.'s reasoning was based on the particular circumstances, where there were also risks of harm to the fetus from seizures during pregnancy that may be caused by epilepsy. It was not reasonable to avoid prescribing the drug in the circumstances:

The imposition of such a duty would immediately create an irreconcilable conflict between the duty owed by the doctor to the child and that owed to the mother. The medication was properly prescribed to treat the mother's epilepsy. *Without it, any fetus she might conceive would be at even greater risk from a seizure than from the medication.* Surely the doctor cannot withhold the medication from the mother, and put her at risk, for the sake of avoiding risk to a yet unconceived fetus which might be *at even greater risk if the mother's epilepsy went uncontrolled ...* [T]he medication for the mother which, though potentially harmful to the child, was required both for the mother's health and to avoid the risk to a fetus of the mother having a seizure.⁶⁴

⁶³ *Ibid.* at para. 40.

⁶⁴ *Ibid.* at paras. 39-40 [emphasis added].

In the particular circumstances of this case, the medication was not contraindicated and was in fact required by the requisite standard of care. However, if the circumstances were different and seizures were less likely, then perhaps it would change the conclusion on negligence. Therefore, under different factual circumstances, a duty to prescribe the appropriate drug for the circumstances could potentially have been owed to both mother and child without raising the “irreconcilable conflict” mentioned in *Lacroix*.⁶⁵

Bovingdon (Litigation Guardian of) v. Hergott

Trial Level

Carolyn Bovingdon and her husband were planning to have children. Due to her failure to ovulate after going off birth control pills and health problems she had experienced during her past pregnancies, Carolyn Bovingdon sought the preconception fertility advice of the defendant obstetrician, Dr. Hergott. Dr. Hergott diagnosed her with post-pill suppression and prescribed Clomid, an ovulation inducing drug. As a result of taking Clomid, Carolyn became pregnant, eventually giving premature birth to twins, Karley and Kaylin. The premature birth caused the twins to develop physical and mental disabilities. Carolyn Bovingdon started an action against Dr. Hergott, claiming that she had not been

⁶⁵ *Ibid.* at para. 39. It is the standard of care that is relevant to any conflict in regards to the consideration and potential balancing of the interests of female patient and future child. This concept is further explored in Part II.

properly informed of the increased risks of having twins when taking Clomid. A similar action was launched on behalf of the twins.

A jury concluded that Dr. Hergott was negligent in the disclosure of the material risks related to Clomid to Carolyn Bovingdon.⁶⁶ Defendant's counsel attempted to have the twins' claims barred on the basis of them falling under a wrongful life scenario. Pardu J. of the Ontario Superior Court of Justice considered which *Lacroix* category the case fell into. She noted that the defendant had "conceded that Clomid caused the twin pregnancy, which caused the premature birth, which caused the children's disability."⁶⁷ This causation concession proved to be a significant tactical mistake:

Given the concession by the Defendant that Clomid caused the children's injuries, in my view this case falls into the first category described in *Lacroix*, "cases in which the abnormalities have been caused by the wrongful act or omission of another."⁶⁸

The facts in *Bovingdon* are particularly interesting because the drug Clomid was responsible for both the conception and for the damage caused by premature birth. The facts arguably fall under both *Lacroix* categories; *Bovingdon*

⁶⁶ *Bovingdon Trial*, *supra* note 4 at para. 1.

⁶⁷ *Ibid.*

⁶⁸ *Ibid.* at para. 5.

is another example of how the *Lacroix* category approach is too conceptually simple to resolve complicated preconception and prenatal negligence cases.⁶⁹

After determining that the case did not fall under wrongful life, Pardu J. concluded that the defendant owed a duty of care to future children that was “co-extensive with his duty to the mother.”⁷⁰ She noted that the decision making process rested with the pregnant patient to make an autonomous decision once properly informed.⁷¹ Pardu J. distinguished the case from *Lacroix* by interpreting *Lacroix* narrowly and noting that a reasonable person in Carolyn Bovingdon’s position may well have refused to take Clomid, while the plaintiff in *Lacroix* would have reasonably taken the anti-convulsant medication, while avoiding pregnancy.⁷²

Appeal Level

The lower court decision was appealed to the Ontario Court of Appeal. Feldman J.A. considered several grounds of appeal, including whether the infant claims fell under wrongful life.⁷³ Feldman J.A. considered the *Lacroix*

⁶⁹ This point was made by Feldman J.A. at the appeal level in *Bovingdon*, *supra* note 3 at paras. 57-60.

⁷⁰ *Bovingdon Trial*, *supra* note 4 at para. 9.

⁷¹ *Ibid.* at para. 12.

⁷² *Ibid.*

⁷³ Feldman J.A. also considered whether parents of a child with disabilities could claim damages for expenses to be expected after the child reached the age of majority (18 years of age). See text accompanying note 291, below.

categorization process in detail.⁷⁴ She acknowledged the importance of following an appropriate tort law framework:

It is clearly very difficult to articulate a coherent theory of liability of a doctor to an unborn child that is based on a valid legal structure and satisfactorily addresses all the policy concerns that have troubled the courts and academics that have previously considered this issue.... I do not believe that the two-category approach in *Lacroix* provides a coherent theory that can assist courts in making the difficult decision of when a child should be able to recover damages from a doctor for being born with disabilities. The facts in *Lacroix* demonstrate the problem.⁷⁵

Feldman J.A. continued by noting that some situations fall under both categories, including potentially the facts of *Lacroix* itself.⁷⁶ In fact, *Lacroix* was closer to the first category (direct harm) because the anti-convulsant drug involved there had a direct and negative pharmacological effect on the fetus, whereas Clomid did not directly affect the twins in a similar manner.⁷⁷

In the end, the *Lacroix* categorization was beside the point, as it did not provide the proper framework for analyzing infant plaintiff tort law claims.⁷⁸ Instead, Feldman J.A. stressed the importance of going through the “normal analysis of tort liability: duty of care, standard of care, breach, and damage.”⁷⁹ In

⁷⁴ *Bovingdon*, *supra* note 3 at paras. 40-50.

⁷⁵ *Ibid.* at paras. 53-55.

⁷⁶ *Ibid.* at para. 57.

⁷⁷ *Ibid.* at para. 58. Specifically, the Clomid increased the chance of twinning, which increased the chance of a premature birth. Premature births can lead to medical complications, which is what happened in *Bovingdon*.

⁷⁸ *Ibid.* at para. 61.

⁷⁹ *Ibid.*

considering whether Dr. Hergott owed a duty to future children, she considered the reasoning of the lower court:

Because the doctor's duty with this type of drug is only to provide information sufficient to allow the mother to make an informed choice, it cannot be said that the children have a right to a drug-free birth. Nor can the doctor owe a duty to the children that is co-extensive with his duty to the mother. To frame the duty in that way is to overlook the fact, as discussed above, that the choice is the mother's; she is entitled to choose to take the drug and risk conceiving twins without considering their interests. If she does, the children have no complaint against her or the doctor.⁸⁰

For Carolyn Bovingdon, it was “entirely her choice whether to take the Clomid” and she did not owe any duty of care to her future children in that decision.⁸¹ Feldman J.A. appropriately denied the respondents’ assertion that the children had a “right to have a drug-free conception.”⁸² However, the reasoning for denying a co-extensive duty to the future children to properly inform their mother is less convincing, as it conflates the issue of duty of care with standard of care. The standard of care should be tempered by the fact that a mother makes health decisions for both herself and future children, but this itself should not negate the very existence of a duty of care to born alive children, whether covering medical care during pregnancy or before conception.

The Court of Appeal could have accepted that there was a co-extensive duty of care to Carolyn Bovingdon’s future children, with the standard of care

⁸⁰ *Ibid.* at para. 68.

⁸¹ *Ibid.* at para. 64.

⁸² *Ibid.* at paras. 62-63.

being to properly inform Carolyn Bovingdon of the risks involved with Clomid or any other fertility drug considered, nothing more onerous than what already existed as part of Dr. Hergott's duty to Carolyn Bovingdon.⁸³ As Pardu J. of the lower court noted, "it should not come as a surprise that a physician who negligently recommends fertility treatment is liable for children's injuries resulting from that negligence."⁸⁴ A co-extensive duty would also be consistent with prenatal duty of care scenarios, as a pregnant mother has the right to make health decisions for herself and her fetus all the way up to birth, but this fact alone does not deny a duty of care to the fetus in informed consent cases occurring during the prenatal timeframe.

Beyond the possible duty of care in relation to properly informing the mother, Feldman J.A. had to consider whether there was a duty of care to the future children to not cause them harm, analogous to the *Cherry* duty not to cause harm. Feldman J.A. concluded that Dr. Hergott "had no duty of care to the future children not to cause them harm in prescribing Clomid to the mother." Feldman J.A. conducted a policy analysis that would be thoroughly expanded upon in *Paxton*:

[A] policy analysis supports the conclusion that where the standard of care requires a doctor to give a woman the information to make an informed

⁸³ The standard of care for this duty would match that of the duty already owed to Carolyn; this highlights the importance of standard of care in any potential conflict between two duties. It is important to note that there is an assumption that any treatments being presented are reasonable under the circumstances. This factor and Professor Klar's relevant comments are considered in Part II.

⁸⁴ *Bovingdon Trial*, *supra* note 4 at para. 17.

decision about taking a drug or undergoing a procedure, the doctor cannot owe a co-extensive duty to a future child. Where the standard of care on the doctor is to ensure that the mother's decision is an informed one, a co-extensive duty of care to a future child would create a potential conflict of interest with the duty to the mother. If future children have a right to a drug-free birth, as the respondents suggest, then doctors might decide to deny women the choice of taking Clomid on the basis that providing such choice might be a breach of the doctor's duty to the unborn children. In my view, the policy of ensuring that women's choice of treatment be preserved supports the conclusion that the doctor owed no legal duty to the unborn children in this case.⁸⁵

While this policy reasoning will be examined in detail subsequently, it is important to note that a “right to a drug-free birth” is not a good characterization of a possible duty of care to the future children involved. It blurs a potential conclusion relevant to the standard of care (whether Clomid or any other drug should have been prescribed) with the appropriate duty of care. A characterization in greater alignment with the interests of both parent and child would be a duty to future children to prescribe the appropriate drug for the circumstances, which is equivalent to a duty to avoid prescribing a contraindicated drug.⁸⁶

Paxton v. Ramji

Trial Level

⁸⁵ *Bovingdon*, *supra* note 3 at para. 71.

⁸⁶ The standard of care of this duty would be crucial; it is proposed that it would be equivalent to the existing standard of care owed to Carolyn, thus preventing any new conflict of interest. This proposal is further explained in Part II.

Dawn Paxton, a married woman with three children, had suffered from acne since her teenage years. She underwent several acne treatments including topical therapy, but continued to be concerned about her level of acne. After learning about the acne drug Accutane from a friend, she requested the prescription of Accutane from her family doctor, Dr. Ramji. Dr. Ramji did not prescribe Accutane at that time because Dawn intended to take part in a surrogate pregnancy and Accutane is a known teratogenic drug that can cause severe birth defects when taken during pregnancy.

Once her plans for taking part in a surrogacy pregnancy fell through, Dawn returned to Dr. Ramji and again requested Accutane. Dr. Ramji prescribed the drug, after warning Dawn to not become pregnant while on the drug and after conducting a pregnancy test on January 15th that tested negative. Dr. Ramji relied on the fact that Dawn was in a monogamous relationship with her husband, who had a vasectomy that had been working effectively for four and a half years. After beginning the Accutane therapy, a “statistically remarkable piece of bad luck occurred” as her husband’s vasectomy failed and Dawn became pregnant.⁸⁷ Dawn returned for a one month follow-up meeting and pregnancy test on February 14th, which again, against the odds, failed to determine that she had recently become pregnant.

Dawn felt unwell and stopped taking Accutane in March out of her own accord. When she visited Dr. Ramji in April, he determined that she was

⁸⁷ *Paxton Trial*, *supra* note 4 at para. 89.

pregnant. Dawn elected to keep the pregnancy and gave birth to a daughter, Jaime Paxton. Jaime was born with serious physical and mental disabilities caused by the exposure to Accutane during pregnancy. Jaime's parents brought forward a claim of negligence on her behalf against Dr. Ramji, while filing derivative claims under the *Family Law Act*.⁸⁸ This had important consequences for the framework of the case, as the success of the parental claim was entirely dependent on the success of Jaime's negligence claim. The alleged negligence was that Dr. Ramji failed to properly inform Dawn Paxton of the risks involved in becoming pregnant while taking Accutane and that he failed to follow the appropriate standard of care for prescribing Accutane. The case was decided by Eberhard J. of the Ontario Superior Court of Justice.

On the first day of the trial, counsel for the plaintiff dropped the informed consent claim.⁸⁹ This is significant because the duty of care to properly inform Dawn or any other patient of the relevant risks of taking a drug is present in every drug therapy. Regardless of the dropping of the informed consent claim, Eberhard J. concluded that Dawn knew that "Accutane and pregnancy did not mix" and was informed or at least aware that Accutane carried the risk of causing birth defects if taken during pregnancy.⁹⁰

The primary duty of care situation left to determine at trial was related to the drug prescription: whether Accutane was an appropriate drug to prescribe

⁸⁸ *Ibid.* at para. 74; *Family Law Act*, R.S.O. 1990, c. F.3.

⁸⁹ *Paxton Trial*, *ibid.* at para. 78.

⁹⁰ *Ibid.* at paras. 122-125.

given Dawn's medical circumstances and whether the standard of care for Accutane prescription was met. Doctors can be found negligent for prescribing drugs which are "inappropriate having regard to the patient's condition or particular circumstances."⁹¹ Eberhard J. considered whether Accutane was an appropriate drug to treat Dawn's acne in the circumstances and noted that the prescription of medical drugs is a decision made by a doctor after a risk benefit analysis based on the doctor's clinical judgment.⁹² Eberhard J. heard expert evidence from both sides and considered Dawn's history of acne and her subjective concern about treating it. Eberhard J. determined that it was reasonable to prescribe Accutane in the circumstances and that Dr. Ramji met the standard of care for appropriate drug selection.⁹³

Despite Accutane being an appropriate drug for the circumstances, the question remained whether Dr. Ramji met the standard of care accompanying a proper prescription of Accutane. The relevant standard of care for prescribing Accutane to a female patient of reproductive age and capacity would be to request agreement that she take proper birth control steps to prevent pregnancy while on the drug. The question was whether Dr. Ramji fell below the standard of care by relying on the fact that Dawn was in a monogamous relationship with her husband who had a vasectomy four and a half years prior to the Accutane prescription.

⁹¹ Picard & Robertson, *supra* note 45 at 339.

⁹² *Paxton Trial*, *supra* note 4 at para. 105.

⁹³ *Ibid.* at para. 113.

Counsel for the plaintiff argued that Dr. Ramji failed to meet the industry guidelines for prescribing the drug Accutane. The Pregnancy Protection Mainpro-C Program (“PPP”) guideline provided by the manufacturer of the drug listed the following:

*Effective contraceptive measures must be used for at least one month before Accutane treatment during and/or at least one month following the discontinuation of treatment. It is recommended that two reliable forms of contraception be used simultaneously unless abstinence is the chosen method. Pregnancy occurring during treatment with Accutane and for one month after its discontinuation, carried the risk of fetal malformation. Females should be fully counseled on the serious risk to the fetus, should they become pregnant while undergoing treatment.*⁹⁴

In regard to industry guidelines, it is important to note that it does not automatically set the legal standard of care. A judge is free to require more or less than the guidelines when determining the standard of care and there are times where industry guidelines or practice are inherently negligent.⁹⁵ For example, the PPP mentions the importance of informing female patients, but even if it did not, this would still be a required by the legal standard of care. Dr. Ramji deviated from the manufacturer’s guideline by not suggesting two forms of birth control and by not waiting for a month before prescribing Accutane. While Dr. Ramji did not fully follow the manufacturer’s guideline, this deviation does not necessarily mean that Dr. Ramji failed to meet the legal standard of care.

⁹⁴ *Ibid.* at para. 134 [emphasis added].

⁹⁵ *ter Neuzen*, *supra* note 22.

Indeed, Eberhard J. concluded that Dr. Ramji had met the standard of care, as a reasonable doctor in the circumstances could have relied on Dawn Paxton's monogamous relationship and Mr. Paxton's vasectomy as an effective form of birth control.⁹⁶ The ultimate purpose of the PPP was to prevent pregnancy from occurring while a female patient is taking Accutane.⁹⁷ A vasectomy without failure for four and a half years was statistically greater protection against pregnancy than several of the recommended contraception combinations listed in the PPP guideline.⁹⁸

In relation to the fact that Dr. Ramji did not wait for a month before prescribing Accutane, Eberhard J. concluded that the one month period was to ensure that the newly started contraceptive methods, some of which may be drug based, would have the time to take effect. Dawn's form of contraception, her husband's vasectomy, had in fact been followed for four and a half years and did not require that one month wait period.⁹⁹ It is important to note that Eberhard J. considered the particular facts of the case when determining the standard of care, namely Dr. Ramji's relationship with Dawn as her family doctor and his past dealings with her, which made relying on the vasectomy and her monogamous relationship reasonable. If Dr. Ramji had been prescribing Accutane for a new patient, Eberhard J. may have required closer adherence to

⁹⁶ *Paxton Trial*, *supra* note 4 at paras. 142, 154.

⁹⁷ *Ibid.* at para. 119

⁹⁸ *Ibid.* at para. 137.

⁹⁹ *Ibid.* at para. 132.

the PPP, such as recommending two methods of contraception from the provided list.¹⁰⁰

It is important to consider a hypothetical situation where a doctor fully informs a female patient of Accutane's risk of causing birth defects during pregnancy, but she rejects the need for any contraceptive methods to prevent pregnancy. Is the doctor under any *legal* duty to avoid prescribing the drug and if he does, who is he responsible to? To put it in the context of the case, the first time that Dawn requested Accutane from Dr. Ramji, he did not prescribe it because of her recent intention to become pregnant as part of a surrogacy pregnancy that was later abandoned. Was Dr. Ramji under a legal duty to avoid prescribing Accutane in that scenario, even if he had acquired Dawn's apparently informed consent?

Eberhard J. thought so, noting that "[a]ny reasonable observer not bedazzled by the complications of tort analysis would conclude that reasonable and competent doctors address the potential for pregnancy before prescribing Accutane because they are under a duty to do so."¹⁰¹ Eberhard J. conducted a duty of care analysis and concluded that a duty of care to the future child existed. She considered the argument from the defendant that this duty was merely one of informed consent:

¹⁰⁰ *Ibid.* at paras. 125-126, 212-215.

¹⁰¹ *Ibid.* at para. 188.

Defendant counsel submits that if there is a potential duty to the child, it must be that the potential child's mother must know about the child's potential birth defects if Accutane is taken. Defendant counsel argue that withdrawal of the claim based on duty to inform represents an admission that Dawn Paxton knew about the teratogenicity of Accutane. I have found that she did know that but, particularly as a child has no claim against mother for pre-natal negligence, and the doctor would have no claim over against the mother for contributory negligence, I cannot agree that telling the mother would be sufficient to meet a duty to the child if such duty exists. Surely a duty to a potential child would be to not expose it to Accutane ... If the woman of child bearing potential demonstrated an intention to decline, or inability to follow birth control methods, I find on all the medical and physician evidence before me, that Accutane would remain contraindicated. It must follow that the duty, which all the doctors observe and all the evidence supports, is not to the mother, as it persists even if she would forfeit it and take the Accutane notwithstanding the known risks to her potential child.¹⁰²

Eberhard J. was essentially trying to add tort law consequences to the medical guidelines which already required doctors to consider the interests of both female patient and future child.¹⁰³ Eberhard J. believed that the informed consent duty was not sufficient to protect Jaime's interests, but it must be noted that this informed consent duty could protect the interests of both female patients and future children in many medical care situations.¹⁰⁴

Separate from the informed consent duty were other potential duties to Jaime, including a duty not to prescribe Accutane to Dawn unless she agreed to take birth control methods to prevent a pregnancy while on Accutane. Eberhard

¹⁰² *Ibid.* at paras. 191, 194. The issue of contributory negligence is considered further in Part IV.

¹⁰³ It is proposed, however, that tort law consequences already exist, in the form of the duty and accompanying standard of care owed to the mother in relation to proper drug prescription. Arguably, the standard of care owed to the mother would already include a consideration of the interests of both mother and future child. This concept is further developed in Part II.

¹⁰⁴ In addition, if properly informed of the risks, a female patient may decide not to consent to an otherwise suitable treatment that poses risk to a future child, see Picard & Robertson, *supra* note 45 at 334.

J. acknowledged the concern for a doctor's conflict of duties in this situation; however, she noted that the professional medical standards in this context already required a doctor to avoid prescribing Accutane unless it was evident that the female patient would take appropriate birth control methods:

In the abstract, there is a concern about conflict between the interest of a potential child and the woman of child-bearing potential where the mother wants a strong medication for her acne though the drug causes birth defects. However, in the real world of the actual practice of medicine, doctors are already dealing with that conflict with a standard of care developed in the medical community, not imposed by the legal community. That standard of care demands that protections must be put in place to avoid pregnancy before Accutane can be given. Though *Dobson* says the mother has no duty to the unconceived or in *utero* child to forego harmful drugs, by medical standards, the drug is contra-indicated absent protections against pregnancy.¹⁰⁵

Eberhard J. concluded that this duty did not exist in the abstract but was there specifically to protect future children:

It would be falsely esoteric to suggest that the doctors are observing this imperative out of a duty to society or to save expense to the medical system. Rather, I find that doctors are observing a duty to the potential child.¹⁰⁶

Wrongful Life Reasoning

It is important to emphasize that Eberhard J.'s primary reason for accepting a duty of care to future children was essentially to robustly protect future children from teratogenic drugs like Accutane. This motivation is

¹⁰⁵ *Paxton Trial*, *supra* note 4 at para. 196; *Dobson*, *infra* note 266.

¹⁰⁶ *Paxton Trial*, *ibid.* at para. 195. Eberhard J. was focused on the potential duty owed to the future child. It is possible to accept her conclusion, but to take it a step further and contend that the duty and accompanying standard of care are reflections of what is already owed to the female patient. Again, this proposal is further developed in Part II.

particularly relevant when reviewing her wrongful life analysis. Eberhard J. accepted that if the case was a wrongful life scenario, it could not succeed in Canada. However, she found that it did not fall within the wrongful life classification. In regards to the dropped informed consent claim, a lack of causation already showed that Dawn would have taken the drug Accutane and relied on the same birth control, the latter fact ensuring that Jaime Paxton would have been born.¹⁰⁷

The main possibility of a wrongful life scenario stemmed from Dr. Ramji's potential duty to avoid prescribing Accutane to Dawn unless she agreed to take the appropriate birth control methods. Dr. Ramji relied on Dawn's monogamous relationship with her husband and her husband's vasectomy when prescribing Accutane. One of several scenarios could have followed from this situation. Dr. Ramji may have met the required standard of care, but a pregnancy occurred anyway despite the odds of the vasectomy failing, which is what actually happened in the case. Then Dr. Ramji was not negligent and would not be held legally responsible for the consequences. On the other hand, if reliance on the vasectomy had been found to fall below the standard of care, then the case would potentially fall under wrongful life; for if Dr. Ramji had followed the more onerous standard of care, such as recommending condom use along with relying on the vasectomy, then the odds are that Jaime would not have been conceived at all.

¹⁰⁷ *Ibid.* at paras. 201-202, 209-210.

Eberhard J. noted this conundrum and tried to sidestep it by focussing on a duty to avoid exposing Jaime to Accutane. She attempted to place it within the first category of cases involving directly caused harm suggested in *Lacroix*:

Dawn Paxton testified she would have complied with advice to use a condom from which it can be inferred that she would have continued the Accutane but Jaime Paxton would not have been born. As indicated earlier, a claim based on failure to follow the PPP when prescribing Accutane fails as compliance would result in Accutane being prescribed and no life for Jaime Paxton. If it is a question of indication however, Accutane is never prescribed and the mother's willingness to accept conditions for having it does not come into play.¹⁰⁸

Eberhard J. specifically argued that if the duty was to avoid prescribing Accutane to "a woman of childbearing potential" then the wrongful life issue would be avoided:

With this duty not to prescribe Accutane to a woman of child bearing potential because it is contraindicated, the circumstance could have transpired that Jaime Paxton could have been conceived and had no exposure to Accutane. Unlike the failure to follow the Pregnancy Protection Program which resulted in Jaime's being conceived when, but for the failure she would not have been conceived which must be characterized as a "wrongful life" claim, the prescribing of Accutane in the face of a direct contra-indication to a woman of child bearing potential creates a scenario where but for the contra-indicated drug, Jaime Paxton would have had life without birth defects. That would not be a "wrongful life" claim.¹⁰⁹

What did Eberhard J. mean when using the term "a woman of childbearing potential"? She did not mean that women of reproductive age and

¹⁰⁸ *Ibid.* at para. 201.

¹⁰⁹ *Ibid.* at paras. 202, 209.

capacity should never be prescribed Accutane; instead, she meant that the doctor could fulfil the duty of care here under the following circumstances:

The evidence indicates and I find that a doctor may be satisfied that the woman is not of child bearing potential if she is abstinent. A doctor may be satisfied that the woman is not of child bearing potential if he follows the Pregnancy Protection Program and puts 2 effective forms of birth control in place in the PPP sequence designed to eliminate clinical error. A doctor may be satisfied that the woman is not of child bearing potential if she has had a hysterectomy or if she is menopausal and therefore no longer of child bearing potential. As I have found earlier in this judgment, the Ontario standard of care is that a doctor may be satisfied that the woman is not of child bearing potential if she is surgically sterilized. I have found that the Ontario standard of care is that a doctor may be satisfied that the woman is not of child bearing potential if her only partner has a 4^{1/2} year vasectomy.¹¹⁰

While a valiant effort to avoid falling under wrongful life, Eberhard J.'s reframing of the duty and standard of care would still fall under a wrongful life scenario in the facts at hand in *Paxton*. No liability was found in *Paxton*, so wrongful life was a moot issue. However, as noted earlier, if the standard of care did not include reliance on a vasectomy, then the other options for avoiding prescription to a woman of childbearing potential would have resulted in Jaime never being born. With one breath Eberhard J. said that “[a] doctor may be satisfied that the woman is not of child bearing potential if he follows the Pregnancy Protection Program” and with another that reliance on the PPP “would result in Accutane being prescribed and no life for Jaime Paxton.”¹¹¹

¹¹⁰ *Ibid.* at paras. 212-213.

¹¹¹ *Ibid.* at paras. 201, 212.

It is not the framing of the duty of care alone that determines whether a case falls under wrongful life, but also the evidence presented and facts accepted in a particular case. For example, the duty of care based on informed consent could have been successful under different circumstances and at the same time avoided being a wrongful life scenario. Suppose that Dawn had established that she was not properly informed about Accutane and that, if properly informed, a reasonable person in her circumstances would have consented to a different and perhaps less effective drug or treatment that was not teratogenic. Then there would have been no wrongful life issue and a potentially successful claim in negligence.

Eberhard J.'s framing of the duty of care as one of avoiding exposing a future child to Accutane is an attempt to switch the focus from Dawn and her parental decisions and actions to the actions of Dr. Ramji. If the focus of concern is placed on Dr. Ramji alone, then there are circumstances where his actions could have prevented the drug prescription while allowing Jaime or another child to be born. For example, when Dawn first requested Accutane while intending to become pregnant for the surrogacy, this was a situation where his actions of deciding of whether to grant the drug may have been relevant if a surrogacy pregnancy had actually occurred afterwards. If he had prescribed the drug and damage was done, the child could have pointed a finger to the decision and asked why Accutane was prescribed despite the intended surrogacy pregnancy.

However, medical decisions are not made by the doctor alone; they also involve, ideally, a properly informed patient. Both the medical profession and the law give the doctor the residual power to avoid prescribing a contraindicated drug.¹¹² However, in the case of a female patient requesting Accutane, how often would the end result be that the doctor unilaterally refused to prescribe it? In the surrogacy pregnancy situation, Dawn understood that she should not take the drug while intending to become pregnant and later returned once the surrogacy pregnancy plans had ended. The doctor has a duty to properly inform the patient of the risks involved and the patient can then choose to agree to comply with the prescription requirements (avoid becoming pregnant in this case) and receive the drug, or to do without the drug.

If the doctor fails to inform about the teratogenic dangers of the drug and other consequences a reasonable patient would want to know, then the consequence would be that the patient is robbed of the opportunity of making this decision. What decision the patient would have made, regardless of whether it was made, is crucial to determining whether the facts of a case fall under a wrongful life classification. In many and perhaps most cases, this consideration cannot be bypassed by simply turning the sole focus of attention to the doctor's actions.

Appeal Level

¹¹² This factor is discussed further in Part II.

Eberhard J.'s rulings on standard of care and damages were appealed by the plaintiff to the Ontario Court of Appeal. Feldman J.A. wrote the decision for the 3 judge panel. Feldman J.A. was the same Justice who authored the appeal decision for *Bovingdon*, and she took the opportunity to conduct a more thorough duty of care analysis in *Paxton*.¹¹³ The focus on duty of care and the Court of Appeal's resulting decision made the standard of care and damages issues moot.

Feldman J.A. considered whether Dr. Ramji owed a duty of care "to the future child of Dawn Paxton."¹¹⁴ She determined that the question could not be resolved simply by trying to file a case under one of the two *Lacroix* categories:

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.¹¹⁵

Feldman J.A. focussed on the duty of care question, rather than the question of wrongful life:

In order to determine whether Dr. Ramji can be liable in negligence to Jaime Paxton, the question confronting the court is not whether her claim is one that should be characterized as wrongful life, but whether he owed her a duty of care.¹¹⁶

¹¹³ Interestingly, Feldman J.A. admonished the respondents for challenging the duty of care issue via cross-appeal, which may have denied the plaintiffs the full opportunity to defend the duty of care, see *Paxton*, *supra* note 3 at para. 4.

¹¹⁴ *Paxton*, *supra* note 3 at para. 24.

¹¹⁵ *Ibid.* at para. 51.

¹¹⁶ *Ibid.* at para. 53.

In contemplating the potential duty of care, Feldman J.A. considered whether the claim fell within or was analogous to a recognized duty of care. She reviewed the appellate decisions of *Cherry*, *Lacroix* and *Bovingdon*, concluding that there is “no settled jurisprudence in Canada” on this question and that “the proposed duty of care thus does not fall within an established category of relationship giving rise to a duty of care.”¹¹⁷ There was also no analogous duty of care situation.¹¹⁸

Treating the new duty as a novel duty, Feldman J.A. considered stage one of the *Anns* test. The requirement of reasonable foreseeability of harm was met quite easily, as it “is clearly foreseeable” that a fetus *in utero* could be damaged by a teratogenic drug like Accutane.¹¹⁹ Whether the pregnancy in a particular case is foreseeable or not is a question that goes to the subsequent standard of care analysis.¹²⁰ It is sufficient for the foreseeability analysis in this step that the harm be foreseeable, if a pregnancy occurs.

Having met the reasonable foreseeability hurdle, the next consideration was whether there was sufficient proximity between the doctor and future child. Feldman J.A. concluded that there was not sufficient proximity due to an “inevitable conflict of interest” if the doctor owed duties to both the female

¹¹⁷ *Ibid.* at para. 53; *Webster*, *supra* note 12 was not reviewed or mentioned, despite being reviewed and utilized in the trial court decision.

¹¹⁸ *Ibid.* at paras. 56-58. See text accompanying note 153, below.

¹¹⁹ *Ibid.* at para. 60.

¹²⁰ *Ibid.* at para. 62.

patient and future child.¹²¹ Other potential issues were an “undesirable chilling effect” that the duty would have on doctors prescribing Accutane and the “necessarily indirect” relationship such a duty would entail, being mediated through the female patient.¹²² Even if sufficient proximity existed, it would be negated by policy concerns related to the impact on female patient autonomy.¹²³

While Feldman J.A. utilized different terms, there is arguably one primary concern that underlines all these listed policy concerns, which is that teratogenic drugs like Accutane may not be prescribed to female patients who medically require it. She specifically highlighted that the “impossible conflict of interest” occurs between the “best 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 such a drug.”¹²⁴

Feldman J.A. was concerned that doctors would let the concern of pregnancy affect the drug indication analysis. This would mean doctors would treat female patients different from male patients in the same circumstances, which reflects the secondary policy concerns about the impact on a woman’s “bodily integrity, privacy and autonomy rights.”¹²⁵

Whether the possibility of a future pregnancy should be considered during drug indication and the effects of doing so are important questions that

¹²¹ *Ibid.* at paras. 65-66.

¹²² *Ibid.* at paras. 68-71.

¹²³ *Ibid.* at para. 77.

¹²⁴ *Ibid.* at para. 66.

¹²⁵ *Dobson, infra* note 266, cited in *Paxton, supra* note 3 at para. 79.

are considered subsequently.¹²⁶ The mere fact that female and male patients might be treated differently during drug prescription is not *inherently* problematic. After all, male and female patients would be treated differently in regards to the standard of care required during the actual prescription of Accutane, with male patients able to access Accutane without engaging in birth control or being mentioned by the PPP's strict drug guidelines.

Feldman J.A.'s concern about conflicting duties also shines a different light on the decision by plaintiff's counsel to drop Dawn's informed consent claim on the first day of trial. What is often viewed as a mistake akin to the concession of causation by defendant's counsel in *Bovingdon* might actually have been a tactical move, rather than a simple blunder. Despite the dropping of the claim at trial, Eberhard J. went ahead to determine that Dawn would have taken Accutane, even if fully informed. If that were the case, then Dawn's claim would fail and Jaime would need a tort law duty beyond the informed consent of her mother to achieve any potential compensation at trial. Jaime's claim that Dr. Paxton should not have prescribed the drug, independent of Dawn's decision, would ostensibly conflict with a claim based on Dawn's informed decision on whether to take the drug.

Plaintiff's counsel may have dropped the informed consent claim not only because it was potentially weak due to the facts of the case, but also because it highlighted a potential conflict of duties. Whether this is an "irreconcilable"

¹²⁶ A detailed discussion is contained in Part II.

conflict of duties is another question, and it must also be stressed that the doctor retains the ability to avoid prescribing a contraindicated drug, even if the patient does requests or demands it.¹²⁷ The doctor's overall gateway control over prescription, despite the patient's request, may be uncomfortable given our society's dedication to the informed consent model. Nevertheless, the doctor's prescription power is present in every prescription drug situation, regardless of the potential of patient pregnancy. The Court of Appeal's underlying issue was that the doctor's power of prescription might be abused in the future pregnancy scenario, if faced with a legal duty to the future child, leading to a neglect of the "doctor's existing legal obligation, which is to the patient."¹²⁸

An important difference between the trial decision and Court of Appeal in *Paxton* is the resolution of society's interest in preventing teratogenic drugs like Accutane from harming future children. Eberhard J. did not believe that the existing medical standards were sufficient for protecting the interests of future children and believed that they needed legal teeth in the forms of a tort law duty. In contrast, the Court of Appeal concluded that the "professional standards of practice" in the medical community regarding Accutane and other teratogenic drugs were sufficient to protect future children's interests.¹²⁹ Any legalization of

¹²⁷ Picard & Robertson, *supra* note 45 at 345-346. The interaction of the doctor's duty to diagnose and informed consent are discussed further in Part II; see text accompanying note 249, below.

¹²⁸ *Paxton*, *supra* note 3 at para. 79.

¹²⁹ *Ibid.* at para. 84.

these protections or provision of a remedy for born alive children harmed due to substandard preconception care would be left to the legislature to provide.¹³⁰

The policy concerns highlighted by the Court of Appeal are considered in depth during the full *Anns* analysis in Part II. It is worth noting now that the Court of Appeal's policy concerns are not temporally limited to the preconception time frame and are all potentially present during the prenatal time frame. An underlying question during the *Anns* analysis is whether drug prescription before conception is laden with any more policy concerns that do not already exist and are dealt with suitably during the prenatal timeframe. It is the broadness of these policy concerns coupled with some of the wording used during *Paxton* that led to an uncertain impact on duties owed during pregnancy after the *Bovingdon* and *Paxton* decisions.

Cases after Bovingdon and Paxton

While the facts of *Bovingdon* and *Paxton* involved potential preconception duties, the policy concerns mentioned in both cases and the wording in *Paxton* initially cast some doubt on whether a doctor could owe a duty of care to a born alive child for medical care provided during the prenatal timeframe. Specifically, in *Paxton* the Court of Appeal referred at times to a child

¹³⁰ *Ibid.* at paras. 81, 84. This division may be a false dichotomy. It is proposed that the legal standard of care owed to Dawn would have already mandated a consideration of both Dawn's interests and that of a future child. This standard of care could be reflected as part of a co-extensive duty owed to the future child. This argument is further explored in Part II.

“not yet conceived or born” and a child “conceived or not yet conceived.”¹³¹ The issue was contested during a preliminary duty of care hearing in *Liebig v. Guelph General Hospital*, a case involving a doctor’s alleged negligence during the labour and delivery of the infant plaintiff.¹³²

W.U. Tausendfreund J. of the Ontario Superior Court of Justice interpreted the ratio from *Bovingdon* and *Paxton* to be limited to the novel duty of care proposed in the preconception context. The facts of *Liebig* were found to be sufficiently analogous to past cases establishing a doctor’s parallel duties to mother and fetus during labour and delivery, as well as other maternal-foetal treatment.¹³³ W.U. Tausendfreund J. stated that the Supreme Court of Canada in *Cooper* did not intend to significantly overhaul or re-evaluate the established categories of tort law duties.¹³⁴ Previously analogous categories such as the labour and delivery cases are well established; a novel duty of care analysis is not required in these cases.

The Ontario Court of Appeal upheld the lower court’s decision in *Liebig*, though with an interesting caveat. The Court of Appeal limited *Paxton* and *Bovingdon* to the “precise facts” and “proper legal context” of those cases.¹³⁵ The Court of Appeal firmly established that the doctor’s co-extensive duties in

¹³¹ *Ibid.* at paras. 38, 53, 76, referred to in *Liebig Appeal*, *infra* note 135.

¹³² *Liebig v. Guelph General Hospital*, 2009 CarswellOnt 6279, 71 C.C.L.T. (3d) 315 [*Liebig*].

¹³³ *Ibid.* at paras. 33-35.

¹³⁴ *Ibid.* at para. 14, citing Allen M. Linden & Bruce Feldthusen, *Canadian Tort Law*, 8th edition, (Markham: Lexus Nexus Canada. Inc., 2006) at 302.

¹³⁵ *Liebig v. Guelph General Hospital*, 2010 ONCA 450 at para. 13 [*Liebig Appeal*].

labour and delivery cases were unaffected by the reasoning in *Paxton* and *Bovingdon*. However, while the lower court spoke broadly and in favour of established maternal-foetal treatment cases, the Court of Appeal spoke firmly only in terms of labour and delivery cases. The Court of Appeal recognized that “the reasoning in *Bovingdon* and *Paxton* may be brought to bear in other cases involving post-conception negligence.”¹³⁶

The Court of Appeal found it unnecessary and undesirable to “venture into less familiar territory or speculate as to how the law might evolve with respect to other scenarios.”¹³⁷ Nevertheless, given that most other prenatal care scenarios have precedents and categories similar to labour and delivery, it seems that the prenatal timeframe is relatively unaffected by *Bovingdon* and *Paxton*. Professor Klar believes that “*Bovingdon* and *Paxton* did not change the law regarding those well established duties for post-conception negligence.”¹³⁸

Other Canadian jurisdictions have reinforced the dual duty scheme in the prenatal care area, such as in the British Columbia case of *Ediger (Guardian ad litem of) v. Johnston*.¹³⁹ *Ediger* involved alleged negligence during labour and delivery. The defendant argued that there was no duty owed to the child, citing the reasoning in *Bovingdon* and *Paxton*. The British Columbia Court of Appeal confined the reasoning from *Bovingdon* and *Paxton* to the preconception area

¹³⁶ *Ibid.* at para. 14.

¹³⁷ *Ibid.* at paras. 15-17.

¹³⁸ Lewis N. Klar, *Tort Law*, 5th ed. (Toronto: Carswell, 2012) at 439.

¹³⁹ *Ediger (Guardian ad litem of) v. Johnston*, 2011 BCCA 253 (CanLII), [2011] B.C.W.L.D. 4974, 2011 CarswellBC 1279 [*Ediger*].

and firmly upheld previously established co-extensive duties from post-conception right up to birth.¹⁴⁰ Significantly, the Court of Appeal said that *Cherry v. Borsman* was still the binding case in this area.¹⁴¹ The same conclusion was restated in *Cojocarú (Guardian ad litem of) v. British Columbia Women's Hospital & Health Center*, another labour and delivery case in British Columbia.¹⁴²

As demonstrated, the judicial and academic focus after *Bovingdon* and *Paxton* was on the potential effect on medical duties in the prenatal timeframe. This is not surprising given the words used in *Paxton*, which was clarified in *Liebig*, but also the policy arguments that are present during pregnancy as well as before conception. The Ontario Court of Appeal's conclusion on preconception duties was largely unchallenged and thus is the focus of this thesis.¹⁴³

Part II: Duty of Care Analysis (Stage 1)

Introduction

Part II of this thesis begins the *Anns* test analysis of the proposed duty to born alive children for preconception care. As reasonable foreseeability was

¹⁴⁰ *Ibid.* at paras. 30-33. *Ediger* was appealed to the Supreme Court of Canada, but the Court only considered and ruled on the subject of causation, not duty of care. See *Ediger v. Johnston*, 2013 SCC 18.

¹⁴¹ *Ediger, ibid.* at para. 33; *Cherry, supra note 41*.

¹⁴² *Cojocarú (Guardian ad litem of) v. British Columbia Women's Hospital & Health Center*, 2011 BCCA 192, 2011 CarswellBC 886, at paras. 102-104.

¹⁴³ Professor Klar disagreed with the Court of Appeal's conclusion in *Bovingdon* regarding preconception prescription. His commentary is considered in Part II.

easily accepted by the Ontario Court of Appeal in *Bovingdon* and *Paxton*, considerations of the limits of foreseeability are reserved for Part IV. Instead, the policy factors mentioned in *Bovingdon* and *Paxton* are first considered thoroughly, as well as other relevant policy factors. Two hypothetical scenarios are defined and used for this analysis: preconception medical care and general medical care.

The preconception medical care scenario is when a patient intends to have children and seeks the care of medical professionals before conception in trying to ensure a healthy pregnancy. This includes preconception genetic counselling, which counsels individuals or couples intending to conceive about the risks of genetically inheritable conditions or diseases that they may pass on to their children. This scenario also includes other preconception medical advice, such as the fertility consultation in *Bovingdon* and the epilepsy consultation in *Lacroix*.¹⁴⁴ In both cases, the female plaintiffs were intending to become pregnant and sought medical consultation from their doctors to do so in a safe and healthy manner.

The general medical care scenario is where a patient of reproductive capacity, usually female, requests medical care related to their own health, rather than in the preparation for having children.¹⁴⁵ This includes preconception

¹⁴⁴ *Bovingdon*, *supra* note 3; *Lacroix*, *supra* note 57.

¹⁴⁵ At present, this will predominantly be a female patient and the policy concerns related to this scenario will thus affect female patient autonomy. The gendered language used in this thesis

drug prescription, such as the acne consultation and prescription in *Paxton*. Unlike the preconception medical care scenario, the patient may not be intending to have children any time soon, if at all. Another difference from the limited preconception medical care scenario is the expansive breadth of the general medical scenario: it can cover essentially any type of medical consultation or treatment, beyond drug prescription to any medical care that could affect the health of a future pregnancy. Naturally, the impact of accepting preconception duties for general medical care is larger and attracts greater scrutiny.

Categorization

When determining whether a duty of care exists, the first step is to consider whether the proposed duty of care falls within an established duty of care category or is analogous to a recognized category.¹⁴⁶ This process of categorization is quite important, as it can lead to a *prima facie* duty of care, subject to residual policy considerations:

As a preliminary matter, is the alleged duty of care within an established category or analogous to an established category? If so, then it will not generally be necessary to proceed through the *Anns/Cooper* analysis. Proximity is established, and overriding policy considerations will rarely arise. Thus, a duty of care exists.¹⁴⁷

reflects this reality. However, as medical knowledge and technology progresses in the future, male patients may also fall under this scenario.

¹⁴⁶ Klar, *supra* note 138 at 183.

¹⁴⁷ Robert M. Solomon *et al.*, *Cases and Materials on the Law of Torts*, 8th ed. (Toronto: Carswell, 2011) at 312.

While Canadian tort law was on an “expansive” path prior to *Cooper v. Hobart*, since that Supreme Court of Canada decision, courts have been more conservative in developing new tort law duties.¹⁴⁸ This makes the process of categorization important, as duty of care will rarely be an issue in cases involving established categories.¹⁴⁹ The process of categorization is an early battleground between plaintiffs asserting a duty of care and defendants denying it. Professor Klar noted the discretion granted by this process to trial judges:

It gives trial judges great discretion in defining the issue in a specific dispute as raising a question of proximity and hence law, thereby allowing them to strike out negligence claims on preliminary motions without ever having to decide the case based on its facts.¹⁵⁰

The Court of Appeal in *Paxton* considered whether the infant plaintiff’s claim fell within or was analogous to a recognized duty of care.¹⁵¹ *Cherry, Lacroix*, and *Bovingdon* were considered, with the conclusion that there was no settled jurisprudence in this area and that the proposed duty of care did “not fall within an established category of relationship giving rise to a duty of care.”¹⁵² It is safe to say that there is no established duty of care category directly involving a doctor’s duty to a born alive child for preconception care. However, there may

¹⁴⁸ Solomon *et al.*, *supra* note 147 at 302-303. *Cooper*, *supra* note 6.

¹⁴⁹ Solomon *et al.*, *ibid.* at 312.

¹⁵⁰ Klar, *supra* note 138 at 184. The same discretion is also granted to higher courts like the Ontario Court of Appeal in *Paxton*.

¹⁵¹ *Paxton*, *supra* note 3 at para. 38.

¹⁵² *Ibid.* at para. 53.

be categories that are analogous to the proposed duty, or at least close enough to provide guidance for the duty of care analysis.

The Court of Appeal did consider whether there was an established category that could be found analogous to the proposed duty of care. The Court of Appeal reviewed whether the duty owed by a third party to a woman's future child, such as the driver of a motor vehicle established in *Duval v. Seguin*, was analogous to this situation.¹⁵³ The Court concluded that it was not, due to the special relationship between doctor and patient, leading to policy considerations that distinguish the proposed duty of care from the general duty established in *Duval*.¹⁵⁴ Similarly, a doctor's potential duty to non-patient third parties was not found to be analogous due to the same policy concerns, as well as the tenuous theoretical foundation of that form of duty.¹⁵⁵

However, the Court of Appeal did not consider another established category that is closer to preconception drug prescription: prenatal drug prescription. It is well established that a doctor owes a duty of care to both pregnant patient and future child in relation to prenatal drug prescription.¹⁵⁶ This scenario is similar to the preconception drug scenario in terms of policy, with the policy concerns highlighted by the Court of Appeal in *Bovingdon* and *Paxton* just

¹⁵³ *Ibid.* at para. 56; *Duval v. Seguin* (1973), 1 O.R. (2d) 482 (Ont. C.A).

¹⁵⁴ *Paxton, ibid.* at para. 57.

¹⁵⁵ *Ibid.* at para. 58.

¹⁵⁶ *Webster, supra* note 12 is an example covering a duty owed to both pregnant patient and future child during pregnancy.

as present in the prenatal situation as they are in the preconception situation.¹⁵⁷

It is not surprising then that the Court of Appeal in *Paxton* seemed to blur lines by using the words “conceived or not yet conceived” and other broad language during the duty of care analysis and that the impact of *Paxton* on prenatal care in general was uncertain until clarified by the *Liebig* decision.¹⁵⁸

If the policy concerns mentioned by *Bovingdon* and *Paxton* are not inherently detrimental for prenatal drug prescription, then why should they be of greater concern for preconception drug prescription? Similarly, the preconception medical care hypothetical could be compared to medical care given during and related to pregnancy. Both invoke situations where patients intend to have a healthy pregnancy and subsequent birth, the preconception care is just earlier on the time spectrum.

It is true that many of the precedential prenatal decisions, including *Webster*, were decided before *Cooper*, and did not face the more “rigorous” proximity analysis that *Cooper* installed.¹⁵⁹ Professor Klar notes that this makes it “somewhat artificial to compare and apply pre-*Cooper* judgements to post-*Cooper* cases.”¹⁶⁰ Nevertheless, the post-*Cooper* scheme does allow these categories to be found to be analogous to a proposed duty of care.

¹⁵⁷ The comparison of policy concerns in prenatal and preconception medical care is considered subsequently.

¹⁵⁸ *Liebig Appeal*, *supra* note 135; *Paxton*, *supra* note 3 at paras. 38, 53, 76.

¹⁵⁹ Klar, *supra* note 138 at 184-185

¹⁶⁰ *Ibid.* at 185.

The mere fact that preconception cases are arising in the post-*Cooper* era does not mean that they could not be found to be sufficiently analogous to established prenatal medical scenarios. However, as a matter of practicality, it is unlikely that future courts will accept preconception medical duties owed by a doctor to a born alive child without going through a full *Anns* analysis. There are also benefits from going through a full *Anns* analysis, to properly consider policy factors mentioned in *Bovingdon* and *Paxton* and other policy factors that may not become apparent until going through a full analysis. While the established prenatal precedents may not be close enough to be analogous categories, they may lessen the gap for courts to establish novel duties to born alive children covering preconception care.

There is a primary difference between prenatal and preconception medical care situations. Specifically, it is the point and impact of conception itself; for preconception cases, no relevant 'entity' exists, while in the prenatal timeframe, a fetus exists, though not yet a legal person until birth. This distinction could play a role in balancing the existing policy concerns and generating novel policy concerns. In relation to timelines, prenatal medical care is subject to the relatively uniform and set timeframe of pregnancy, while the preconception timeline extends back without a set end from conception, which has consequences for the limits of reasonable foreseeability and is discussed subsequently in Part IV.

While on the subject of timelines, it is worth noting that, as a matter of practicality and determining facts, preconception drug prescription and prenatal drug prescription may be quite close in the timeline of events involving pregnancy. Despite advances in medical technology, conception dates cannot always be determined precisely and are sometimes given in short time ranges rather than individual dates. Ending up on one end or the other of this potentially close timeframe results in being placed in a significantly different tort law situation.

One logical consequence of accepting a duty of care to born alive children for prenatal medical care, but no duty to children for preconception medical care is that defendants under this regime can benefit from an uncertainty of timelines. As the burden of proof is on the plaintiffs, if an infant plaintiff is unable to establish on the balance of probabilities that the point of negligence occurred on the prenatal side of the conception divide, then the claim will fail.

Proximity Analysis

Proximity is a question of law determined by the judge and can be established through the process of categorization.¹⁶¹ In the absence of an established or analogous category, proximity entails a consideration of the relationship between plaintiff and defendant and “whether it would be ‘just and

¹⁶¹ *Ibid.* at 183-185.

fair' to impose a duty of care on the defendant for the plaintiff's protection.¹⁶²

The factors to consider in the examination of the relationship are "expectations, representations, reliance and the property or other interests."¹⁶³

Proximity was the halting point in the duty of care analysis of a potential duty to born alive children for preconception medical care in *Bovingdon* and *Paxton*. The Court of Appeal listed several policy concerns that prevented the necessary proximity between infant plaintiff and defendant: the necessarily indirect relationship through the parental intermediate, a conflict of interest, and a chilling effect. While listed separately, the three arguments are related as different "aspects of the same reality."¹⁶⁴ The interconnectivity of the three policy concerns is illustrated during this review.

Necessarily Incidental Argument

Starting with the necessarily incidental argument, the Court of Appeal's essential comments on the policy issue were the following:

For legal proximity to exist, the relationship must be both "close and direct". Although a doctor's actions can, in some cases, directly harm a future child, the doctor's relationship with a future child is necessarily indirect.

... The doctor acts by providing advice and information to the mother including, where teratogenic drugs are being prescribed, the potential effects on a fetus. In the case of a drug that is not teratogenic, and where the only issue is informed consent, the patient takes the information and makes the decision. Although women take care to ensure that their babies will be born healthy, they

¹⁶² *Ibid.* at 185, citing *Cooper*, *supra* note 6 at para. 34.

¹⁶³ *Ibid.*

¹⁶⁴ *Paxton*, *supra* note 3 at para. 76. The Court of Appeal's reference was between the conflict of interest and necessary incidental relationship, but the chilling effect can also be related to these arguments.

may decide that certain risks of possible harm to a fetus, such as the risk of multiple births and possible prematurity involved with fertility drugs, are minimal and are worth taking to obtain the benefit of the drug. Because women are autonomous decision makers with respect to their own bodies, they neither make the decision on behalf of the future child, nor do they owe a duty to act in the best interests of a future child ... In the case of a teratogenic drug, the issue is more complicated. The woman must still make an informed decision about whether to take the drug but, in the case of Accutane, the doctor may not prescribe the drug without also enlisting the agreement of the woman not to become pregnant. That agreement is implemented through the PPP program, which includes pre-prescription pregnancy tests and the use of sufficient birth control protection to try to prevent conception. In relation to the use of birth control, the doctor can do no more than enlist the agreement of the woman that she will use the necessary precautions not to become pregnant. The doctor cannot ensure that she will follow through with that agreement.

In that way, the doctor's relationship with a future child is necessarily indirect. Not only can the doctor not advise or take instructions from a future child, the doctor may not be in a position to fulfill a duty of care to take all reasonable precautions to protect a future child from harm caused by a teratogenic drug. Could a doctor ever be sufficiently confident that his or her female patient (and her partner) will always diligently use effective birth control, or practice abstinence, which is one of the accepted birth control methods under the PPP?¹⁶⁵

A problem with the necessarily incidental argument is that it fails to distinguish preconception medical care from prenatal care and in some ways post-birth medical care given to infants in the custody of their parents.¹⁶⁶ As noted in the British Columbia Supreme Court decision in *Ediger*, during the entire pregnancy, the “mother acts as ‘intermediary’ between physician and fetus, and

¹⁶⁵ *Ibid.* at paras. 71-75.

¹⁶⁶ The presence of two duty of care relationships is recognized right up to the well established labour and delivery cases. It is obviously present after birth, as the child acquires full legal status upon being born alive. The comparison to care after birth is only in relation to the standard of care taking into account that parents often administrate prescription drugs and other treatments at home, under the instruction of doctors.

makes medical decisions for the fetus and herself.”¹⁶⁷ There is nothing inherently problematic about this intermediacy in the prenatal situation. The doctor is not in a position to give instructions to or advise a fetus or even a newborn child; instead, the doctor must rely on conveying information to the child’s parents.

The female patient is under no duty before pregnancy or during pregnancy to her future child, but her shield from liability is not a bar to the doctor’s duty to the future child, whether for preconception care or prenatal care. The doctor’s reliance on the female patient in relation to following drug prescription requirements is something that is reflected in the standard of care, not the formation of or blocking of a duty.¹⁶⁸ In the case of birth control and a teratogenic drug, the doctor is not able to absolutely guarantee the proper following of birth control, but such a guarantee is not part of the required standard of care. An absolute guarantee of following drug prescription requirements is not the standard for prenatal drug prescription and would not be the standard for preconception drug prescription.

In relation to post-birth care, parents do have duties to their born alive children, while doctors and the state do have legal means of gaining custody of

¹⁶⁷ *Ediger v. Johnston (Guardian ad litem of)*, 2009 BCSC 386 (CanLII), at para. 211, 65 C.C.L.T. (3d) 1 [*Ediger Trial*].

¹⁶⁸ *Ediger Trial*, *supra* note 167 at para. 212, which noted that the doctor’s necessary reliance on the mother as an intermediary is recognized in determining the standard of care required. Richard Halpern, focusing on the potential impact on prenatal case law from *Paxton*, argued that standard of care is the appropriate route for courts to balance the doctor’s responsibilities, not duty of care. See *Halpern*, *infra* note 190 at 8-9, 14.

the child and providing medical care in the child's best interests.¹⁶⁹ However, the majority of infant medical care will involve doctors relaying instructions to parents and expecting parents to follow these instructions, a reliance which is reflected in the standard of care involved in meeting the duty owed by the doctor to the newborn child.

Guaranteeing patient compliance with contraceptive methods or any medical treatment is not possible even in relation to duties owed to adult plaintiffs. There is always the chance that an adult patient will willingly or negligently deviate from a treatment plan that they have accepted. As long as the doctor has met the required standard of care, this is something beyond the potential realm of liability.¹⁷⁰

Conflict of Interest and Chilling Effect

While the necessarily incidental relationship has greater impact on the standard of care rather than duty, the conflict of interest argument is one that is truly focused upon duty of care and considers the direct impact on the female patient's health care. The proposed chilling effect is a symptom or result of the potential conflict of interest, rather than a standalone problem. Specifically, the argument is that if the doctor owed a duty of care to the future child along with

¹⁶⁹ For example, see the child protection context of *Syl Apps*, *infra* note 176.

¹⁷⁰ A complication does arise in situations where the doctor is negligent for prenatal care, but the harm is compounded by the 'negligence' of the pregnant patient. Presumably this would also be an issue for preconception care. This issue is examined in the coverage of contributory negligence in Part IV.

an existing duty to the female patient, then this would place an irreconcilable conflict of interest on the doctor during the provision of medical care to the female patient.

One possible consequence of this conflict is the doctor taking defensive medicine steps to avoid liability to the future child, a chilling effect that can limit the female patient's medical options:

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. 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.

In *Bovingdon*, the court recognized the same policy issue in holding that a doctor does not owe a duty of care to a future child when prescribing Clomid, a fertility drug, to the mother. To impose a duty of care to the future child not to cause harm to such a child could have created an incentive for the doctor to refuse to prescribe Clomid and to deny women the choice of taking fertility drugs to assist them in becoming pregnant and having children.¹⁷¹

It is important to note that the defensive medicine argument is generally asserted against the expansion of any new duty in the medical context.¹⁷² Indeed, defensive medicine is a possibility during pregnancy as well; it is not unique to the preconception timeframe. Despite the possibility of defensive medicine, doctors do owe born alive children duties covering prenatal care.

¹⁷¹ Paxton, *supra* note 3 at paras. 68-69.

¹⁷² Mark A. Hall, Mary Anne Bobinski & David Orentlicher, *Health Care Law and Ethics*, 7th ed. (New York: Aspen Publishers, 2007).

One possible distinguishing factor is that a fetus exists during the prenatal care stage, whereas there is no entity present during preconception care, just the possibility of a future child. This difference could affect the defensive medicine argument in two possible ways. Perhaps defensive medicine is a greater concern when a fetus actually exists, as probability wise there is a higher chance of a born alive child when there is already a pregnancy, other factors kept the same. On the other hand, perhaps the threat of defensive medicine is a more tolerable concern during pregnancy since there is a fetus present, rather than the scenario where a female patient is subject to the possibility of negatively impacted medical care due to a pronatalist bias or undue assumption of future pregnancy.¹⁷³

The chilling effect and threat of defensive medicine are subsets of the greater concern of a conflict of interest possible if a duty of care to the born alive child for preconception care were to be recognized. It is true that “one leading reason for denying proximity is the existence of a conflict of interest for the defendant in considering the risk to the plaintiff.”¹⁷⁴ What is of primary concern is whether there is a conflict of interest placed on the doctor and whether it is an irreconcilable conflict of interest that warrants denying proximity, as was done in *Bovingdon* and *Paxton*. If the conflict of interest is not likely or is reconcilable,

¹⁷³ Pronatalist bias and undue assumption of pregnancy are further explained and considered subsequently in Part III.

¹⁷⁴ Allen M. Linden & Bruce Feldthusen, *Halsbury's Laws of Canada – Duty of Care* at HNE 54 (QL).

then the chilling effect and defensive medicine argument loses significant impact.

The Court of Appeal in *Paxton* referenced the Supreme Court of Canada case of *D. (B.) v. Children's Aid Society of Halton (Region)* as an example of an irreconcilable conflict conclusively determining the proximity analysis:

In *Syl Apps*, the Supreme Court identified the potential for conflicting duties as a policy consideration and, indeed, "the deciding factor" weighing against a finding of a relationship of proximity (para. 41). In that case, the issue was whether a treatment centre, which was treating a child apprehended by the Children's Aid Society, owed a duty of care to the family of that child. The court held that, because of the statutory duties that the treatment centre owed to the child to act in her best interests, there would be an inevitable conflict of interest if the treatment centre also owed a duty of care to the family. Faced with that conflict, the treatment centre might well hesitate to pursue the child's best interests for fear of breaching its duty to the family.

The prospect of conflicting duties is similarly present here. 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 best 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 such a drug.¹⁷⁵

The Court of Appeal placed the potential preconception duty of care to a born alive child in the same class of untenable duties as the duty to parents in child protection situations proposed and rejected in *Syl Apps*. This classification can be challenged in two ways: by distinguishing *Syl Apps* and by clarifying the

¹⁷⁵ *Paxton*, *supra* note 3 at paras. 65-66, referring to *Syl Apps*, *infra* note 176.

nature of the proposed preconception duty. On the first front, the child services were the agency with power in *Syl Apps*, in a “highly adversarial” context.¹⁷⁶

The British Columbia Supreme Court in *Ediger* distinguished *Syl Apps* from the prenatal medical care context, which arguably distinguishes it from preconception medical care as well:

[*Syl Apps*] did not involve potential conflicts between the interests of mother and fetus ... Since the parents were in an inherently adversarial relationship with the child protection authorities, such a duty would have created an intolerable conflict. As both case authorities and obstetrical medicine recognize, the relationship between mother and fetus is entirely different.¹⁷⁷

The relationships at play and power balance in prenatal and preconception care are different from the child protection context of *Syl Apps*. Child protection agencies hold a statutorily granted purpose, power, and “overriding duty” of care that generates an inherently adversarial situation.¹⁷⁸ The Supreme Court of Canada noted that a potentially positive overlap of parental and child interests is possible in this context, but rare:

¹⁷⁶ *D. (B.) v. Children's Aid Society of Halton (Region)* (2007), 39 R.F.L. (6th) 245, 49 C.C.L.T. (3d) 1, 284 D.L.R. (4th) 682, *sub nom. Syl Apps Secure Treatment Centre v. B.D.*, 2007 SCC 38, [2007] 3 SCR 83 [*Syl Apps*].

¹⁷⁷ *Ediger Trial*, *supra* note 167 at para. 205. The Court went on to compare the situation to a physician’s ability to fulfill a duty of care to an infant child in the mother’s care. This was a step too far, as the impact on standard of care may be similar in terms of reliance on parental agreement, but the infant child’s health is no longer inexorably tied with the health of the mother and does not in fact have the same conflict of interest level potentially present in either prenatal or preconception care. Nevertheless, the Court did distinguish the different context of child protection actions, differentiating between medical care provided in conjunction with child protection law and medical care provided in a regular doctor-patient relationship.

¹⁷⁸ *Syl Apps*, *supra* note 176 at paras. 2, 20, 42. Child protection agencies often have to act quickly to protect children in danger from physical and psychological abuse.

The fact that the interests of the parents and the child may occasionally align does not diminish the concern that in many, if not most of the cases, conflict is inevitable.¹⁷⁹

Preconception and prenatal medical care scenarios, on the other hand, involve the private and personal medical interactions between doctor and patient, based on the informed consent model. The doctor does have residual powers and professional duties related to medical care, but the balance of power and object of intent differs from the child protection agency context. The interests of potential parent and child are less likely to be in conflict and more likely to be in alignment during preconception and prenatal care. The possibility for conflict is real and must be considered, but it is on an entirely different scale than the child protection context.

Co-extensive Duties and Independent Duties

While the first step was to distinguish *Syl Apps*, the second step is to clarify the proposed preconception duty of care. The dividing point proposed is between co-extensive duties and independent duties, the latter of which may be conflicting and inherently problematic. The proposed framework can be applied equally to both the prenatal and preconception timeframes.¹⁸⁰

¹⁷⁹ *Ibid.* at para. 43.

¹⁸⁰ Given the similarities between prenatal and preconception care and the attempt to analogize the two situations whenever possible, it is important that the proposed framework be applicable in both situations.

The term co-extensive is used in this thesis to refer to a duty of care owed to the future child that naturally parallels a duty of care already owed to the female patient.¹⁸¹ It is proposed that the principled method for identifying co-extensive duties is that they will have the same standard of care as the duty owed to the female patient, or at the least, a non-conflicting standard of care.

In theory, a co-extensive duty does not have to have exactly the same standard of care as the duty it parallels to be inherently non-conflicting. A co-extensive duty is also guaranteed to be non-conflicting when its accompanying standard of care adds nothing new to the defendant's tort law responsibilities, and so may be less onerous than the standard of care owed to the original plaintiff. In contrast, if the standard of care were more onerous, then it has the potential to be conflicting, because of the addition of additional elements added to the standard of care and faced by the doctor. This conflict is not certain, but it is a distinct possibility.

By this definition, co-extensive duties owed to the future child include the duty to disclose and the duty to treat with reasonable care related to medical treatments and procedures consented to by the female patient.¹⁸² These duties include a standard of care that is equivalent to the standard of care

¹⁸¹ As always, all duties to the future child require the child to be born alive to be actualized.

¹⁸² There may be a distinguishing of treatments done with the future child in mind and general treatments. This possible distinction is explored throughout Part II and Part III.

accompanying the existing duty of care to the female patient.¹⁸³ It is the non-conflicting standard of care that binds together duties owed to the female patient and the future child. By their very nature then, a conflict of interest for the doctor would be minimal or non-existent.

In contrast to co-extensive duties, independent duties place a different standard of care on the involved doctor.¹⁸⁴ As the standard of care is different, independent duties have the innate potential for standing in opposition to and conflicting with duties owed by the doctor to the female patient. The conflict may not be irreconcilable, but the likelihood for conflict is of a higher magnitude than the co-extensive context. This is highlighted by the fact that a tort law claim based on an independent duty could be successful even if the female patient's theoretical claim would fail, due to the differing standard of care owed.

It is important to clarify that the infant plaintiff's negligence lawsuit under a co-extensive duty is not the same thing as derivative tort law claim. Derivative claims are tort law claims that are inherently dependent on a particular plaintiff's active and successful tort law claim.¹⁸⁵ The derivative claim is

¹⁸³ The details of these duties and the debate around the standard of care involved are discussed thoroughly throughout the remainder of the proximity and policy concerns analysis.

¹⁸⁴ The term *independent* is used to refer to these duties because of their independent standard of care; it is an alternative to using the bulky "non-co-extensive" as a classifying term. Alternative terminology could be "unconnected" or "separate" duties, but the ultimate intention is to divide co-extensive duties from other theoretically duties.

¹⁸⁵ The primary examples involve compensation granted "in trust" for past voluntary care provided to the plaintiff. This is further discussed in the review of compensation; see text accompanying note 301, below.

for a third party that that was not owed a duty by the defendant and could not launch his or her own tort law action.

The infant plaintiff with a co-extensive duty, on the other hand, is owed a duty of care and can bring forward a lawsuit, even if the female patient declines to pursue her own tort law claim. The similarity is caused by the fact that the infant's co-extensive duty can only succeed in situations where the female patient would also have a successful claim for negligence, simply because the co-extensive duty involves an equivalent standard of care.¹⁸⁶

It is important to consider the relevant proximity and policy concerns related to both co-extensive duties and independent duties. This review begins with situations where the female patient consents to a treatment that is medically indicated for the circumstances. Examples are considered under both the preconception medical care and general medical care scenarios. Following this analysis, the full details of the informed consent process and the doctor's diagnosis considerations are considered.¹⁸⁷

Co-extensive Duties and Consensual Treatments

Once the female patient consents to a reasonably indicated treatment in any medical scenario, the doctor has the duty to execute reasonable care in the

¹⁸⁶ Therefore, the female patient's claim only has to be successful in theory; it does not have to be brought to court.

¹⁸⁷ It is proposed that both the informed consent process and the duty to diagnose support co-extensive duties. However, they are complicated subjects; the starting point for this review is best located in considerations of treatments already determined to be reasonably indicated and consented to.

execution of the treatment.¹⁸⁸ A failure to meet the standard of care associated with a preconception treatment would result in potential liability to the female patient. Arguably, a breach of the standard care in regards to the same preconception treatment should similarly result in potential liability to the subsequently born alive child.

The proposed liability is most easily established in the preconception medical care situation. Preconception medical care is not limited to informed discussion, but also includes tests and treatments specifically taken in preparation for a future pregnancy. The female patient has decided to become pregnant and is consenting to these actions with the best interests of the future child in mind. In this situation, the conflict of interest is minimal and there is no substantial impediment to liability to both female patient and future child, if the doctor fails to meet the mutual standard of care required and causes injury to the future child.

Co-extensive Duty Examples

The general formula for successful co-extensive duties applies when the female patient has made an informed decision to undergo a treatment, whether immunization, drug therapy, surgery, or other some other treatment, with the intent of protecting or benefiting the future child. In doing so, the doctor owes

¹⁸⁸ Picard & Robertson, *supra* note 45 at 213.

the duty to the female patient to take appropriate care during treatment.¹⁸⁹ It would not cause an irreconcilable conflict to have a co-extensive duty to the future child in these cases.

This form of preconception liability would match the situation in prenatal law where the pregnant patient seeks fetal related healthcare. In this situation, the doctor can be liable to both mother and future child for negligently provided treatment. It matches the fact there exists a plethora of fetal oriented tests and procedures present during the prenatal time frame:

Pregnant women engage the services of obstetricians primarily to ensure the birth of a healthy child. Many of the tests and procedures women are subjected to during pregnancy have the objective of fetal well-being in mind. Ultrasounds, amniocentesis, non-stress tests, biophysical profiles, scalp sampling, and other tests are focused on fetal well-being. Mothers consent to all kinds of invasive procedures, including forceps delivery, vacuum delivery and csections, all with a view to fetal health. If she felt the obstetrician's obligation to provide the highest level of care to her fetus might be compromised in any way, she would seek out another physician willing to assume a duty of care to her unborn child.¹⁹⁰

An example of non-conflicting co-extensive duties during preconception medical care can be provided with the case of the viral disease Rubella. Pregnant women who suffer from a Rubella infection in the first two trimesters of pregnancy face the risk of their child developing Congenital Rubella Syndrome (CRS). Specifically, this involves damage to the fetus during pregnancy, resulting

¹⁸⁹ For example, to use the correct vaccine in immunization, to prescribe the correct dosage range in drug therapy, and to follow the appropriate steps of pre-surgery and post-surgery care.

¹⁹⁰ Richard C. Halpern, "Birth Trauma and the Duty of Care" (Paper presented to the Ontario Trial Lawyers Association Spring Conference, 27 May 2010) [unpublished] at 24.

either in a miscarriage or a born alive child with physical and mental disabilities.¹⁹¹

There is a vaccine available for Rubella that can significantly lower the chance of CRS occurring during a subsequent pregnancy.¹⁹² Through the application of preconception medical care provided by a doctor, if a female patient intending to become pregnant consents to the offered immunization, then the doctor has a duty owed to the patient to immunize the patient according to the standard of care. This duty to take proper care during immunization that is an example of a duty that could be owed to both female patient and future child without conflict.

In the process of completing preconception medical care, other third parties may be drawn into a duty of care relationship with the future child. For example, when the doctor prescribes a drug during pregnancy, the patient will often have to take the prescription to a pharmacist who will distribute that drug. If the pharmacist provides an incorrect dosage or even the wrong drug, then the pharmacist could be liable to both female patient and born alive child for damages caused by that negligence. Similarly, it would not be inherently

¹⁹¹ *Canadian Immunization Guide (Part IV: Active Vaccines – Rubella Vaccine)*, online: Public Health Agency of Canada <http://www.phac-aspc.gc.ca/publicat/cig-gci/p04-rube-eng.php>; Pan American Health Organization, *Elimination of Rubella and Congenital Rubella Syndrome* (PAHO Scientific Publications, 2006); Carlos Castillo-Solorzano, *et al.* "Elimination of Rubella and Congenital Rubella Syndrome in the Americas" (2011) 204(2) *J Infect Dis.* 571; World Health Organization, *Eliminating Measles and Rubella and Preventing Congenital Rubella Infection: WHO European Region Strategic Plan 2005-2010* (Denmark, 2005); Matthew Browne, "Preconception Tort Law In An Era Of Assisted Reproduction: Applying A Nexus Test For Duty" (2001) 69 *Fordham L.Rev.* 2555 at 2572-2573.

¹⁹² *Ibid.*

conflicting for the pharmacist to be liable to both in the preconception medical care situation for the same type of negligence in fulfilling the professional responsibilities required.¹⁹³

It may be more difficult to apply co-extensive duties in the general medical care scenario. In this situation, the female patient has not requested care in relation to an intended future pregnancy. The care provided can be quite broad, from drug prescription to surgery, for a variety of medical ailments and diseases. Does the doctor owe a co-extensive duty of care to a future child affected by treatment provided to the female patient in these cases?

On the basis of foreseeability alone, it seems within the range of reasonable foreseeability that negligent general treatment could cause harm to a fetus in a future pregnancy. However, this situation lacks the open intent of the female patient to become pregnant and the focus of her personal interests in that direction. With the absence of intention, there may be a greater chance for conflicting duties, let alone the greater chance for remoteness of damages issues related to pregnancies occurring years in the future.

A useful example can again be provided from the Rubella scenario. Women who have a rubella infection in a short time period before conception

¹⁹³ Similar liability may apply to nurses or hospitals for negligent care. All liability would be subject to the limits of foreseeability and remoteness, but would not be inherently untenable due to a conflict of interest.

also have an elevated risk of their future child developing CRS.¹⁹⁴ If a female patient sought treatment of Rubella, it is possible that the doctor may have a duty to warn about the potential effects of the infection on a future pregnancy in the relevant time range.¹⁹⁵

If it fell within the informed consent duty, then the duty would be co-extensive to the future child. The general suggestion would probably be to avoid pregnancy for a limited time period, but assume for the moment that reasonable alternates were possible or recommended, such as treatment for the Rubella, that would similarly lower the risk of CBS.¹⁹⁶ If the female patient elected to have the treatment, this would be another treatment that could support a co-extensive duty owed to the future child.¹⁹⁷

As this example illustrates, if a particular general medical care scenario entails a duty of care to inform the patient about the potential effects on a future pregnancy, then there is a possibility of subsequent treatment being taken with the consent of the female patient and with a future pregnancy in mind. If

¹⁹⁴ *Canadian Immunization Guide*, *supra* note 191.

¹⁹⁵ This potential liability would depend on the circumstances of the case and the accepted informed consent standard.

¹⁹⁶ This is not the general medical practice, but it is used as a hypothetical example. For the general practice, see *Guidelines for Vaccinating Pregnant Women* (March 2013), online: Centers for Disease Control and Prevention <<http://www.cdc.gov/vaccines/pubs/preg-guide.htm#mmr>>.

¹⁹⁷ If the relevant practice would be to avoid pregnancy, then the child's claim would fall under wrongful life.

that happens, then the co-extensive duty can exist without conflict for that treatment.¹⁹⁸

This is a rule that would be consistent with prenatal medical care. As a fetus exists during prenatal care, it is more difficult to separate care that is solely meant for the pregnant patient's benefit, because the fetus is generally dependent on the pregnant patient's good health. Nevertheless, if a pregnant patient came in for care non-related to the pregnancy and the doctor suggested an indicated treatment that involved risks to the fetus, then it could fall under the informed consent duty to inform the patient of the risks. If she decided to go ahead with the treatment, then the doctor can generally owe a co-extensive duty to the born alive child without fear of conflict in the provision of that treatment.

When the possibility for conflict arises, the co-extensive duty can be blocked. An abortion procedure, for example, would suggest an inherent conflict of interest preventing a co-extensive duty. However, it is interesting to note that a co-extensive duty was potentially supported in British Columbia's *Cherry* case.¹⁹⁹ The *Cherry* duty could be interpreted either as a duty not to harm or implicitly as a duty to perform the abortion with diligent care.²⁰⁰ Under the latter

¹⁹⁸ This is in practice a conversion of the general medical scenario to the preconception medical care scenario. However, a distinction is still possible in regards to the intention of the treatment. The treatment may still have no relation to an intended pregnancy, but still have detrimental consequences on both the female patient and future child if performed negligently.

¹⁹⁹ *Cherry*, *supra* note 41.

²⁰⁰ As reviewed earlier, the former is arguably the more likely interpretation, particularly for the trial level decision. However, the latter interpretation is considered to illustrate the non-conflict present if the standard of care owed to female patient and future child is the same during a medical procedure.

interpretation, the abortion procedure is simply another medical procedure taken with the informed consent of the female patient that could successfully support a co-extensive duty of care owed to the fetus during the medical procedure.²⁰¹

An interesting scenario is the situation where the female patient is pregnant, but care is provided that not only affects the current fetus, but also future pregnancies. The possibility for conflict between the interests of future children exists. For example, caesarean births can affect the viability of future pregnancies and deliveries in several ways. If performed negligently, then future harm can occur. But even a caesarean performed with the appropriate standard of care can increase the risk of harm to future children.²⁰² If a caesarean is performed negligently, then there can be an argument in favour of co-extensive duties owed to fetus and future children, though tempered by the doctrines of causation and remoteness, if necessary.

However, the increased risk from a diligently performed caesarean suggests the potential for a conflict of interest between fetus and future children, in that what may be in the best interests of the current fetus is not necessarily in the best interests of other future children. On the other hand, the scenario is similar to prenatal medical care situations that involve more than one

²⁰¹ The concerns with the later interpretation of this duty are related with wrongful life and the oddness of a duty which is essentially a duty to terminate fetal life with appropriate care.

²⁰² Rageth JC, Juzi C & Grossenbacher H., "Delivery After Previous Cesarean: A Risk Evaluation." (1999) 93 *Obstet Gynecol.* 332.

current fetus, such as the case of twins. In those cases, it is up for the pregnant patient to decide the final balancing of interests by deciding which indicated treatment to consent to. The situation is similar here, as the female patient may decide, once properly informed, to proceed with a caesarean and then the appropriate standard of care would apply with liability to present and future children if the caesarean is performed negligently and causes injury to the children.

Wills and Beneficiaries Analogy

While considering the potential for other non-conflicting co-extensive duties, it is useful to briefly refer to a category of established negligence cases, specifically the “disappointed beneficiary” cases.²⁰³ These cases involve third party beneficiaries affected by negligent legal care related to wills provided to a testator. The related jurisprudence has relevant conclusions related to potential conflicts of interest and the strengthening, rather than weakening, of the interests of the party of concern.

A particularly useful case is *Ross v. Caunters*, which involved negligent advice during the preparation and execution of a will that led to a loss of benefits to a beneficiary after the testator’s death.²⁰⁴ The High Court of England and Wales made several conclusions in *Ross v. Caunters* that are relevant to the discussion at hand. Subsequent decisions have not broadly applied *Ross* in terms

²⁰³ This terminology is from Klar, *supra* note 138 at 273.

²⁰⁴ *Ross v. Caunters*, [1979] 3 All E.R. 580 (Ch. D.) [*Ross*].

of liability and have instead followed more limited avenues of reasoning.²⁰⁵ Nevertheless, the case's statements in relation to potential conflicts of interest remain useful for comparison.

What is similar in the disappointed beneficiary cases and in prenatal and preconception care is that the testator and the female patient do not owe any duty of care to the beneficiaries of a will and to future children, respectively. They both may decide to provide benefits to or act in the best interest of the beneficiaries or future children and they both may rely on professional expertise to do so, whether legal or medical. In both circumstances, the argument is asserted that the professional, whether lawyer or doctor, is put into an irreconcilable conflict of interest situation when recognizing co-extensive duties to beneficiaries or to future children.

The High Court found that there was no irreconcilable conflict of duties with the facts at hand in *Ross*.²⁰⁶ The High Court noted that the duty owed to the testator was a "paramount duty" that was above the duty owed to the beneficiaries.²⁰⁷ There was a "sufficient degree of proximity" between the solicitors and beneficiaries without a problematic conflict of interest.²⁰⁸ The duty to the beneficiaries was to take proper care in executing the intentions of the

²⁰⁵ Klar, *supra* note 138 at 271-274, including a review of *White v. Jones*, [1995] 1 All E.R. 691 [*White*].

²⁰⁶ *Ross*, *supra* note 204 at 580.

²⁰⁷ *Ibid.* at 599.

²⁰⁸ *Ibid.* at 580.

testator, which, “far from diluting the solicitor's duty to his client, marches with it, and, if anything, strengthens it.”²⁰⁹

Testators do not have any duties to their intended beneficiaries and may in fact make decisions that are “hostile and injurious” to the interests of the beneficiaries in a will, such as when changing the number of beneficiaries in a will or changing the distribution of property contained within a will.²¹⁰ The solicitor’s requested advice may even be inherently opposed to the beneficiaries’ interests, as “sometimes the greater the injuries the better he will have served his client.”²¹¹

Nevertheless, when the testator does decide to do something for the best interests of a beneficiary, then there can be a duty of care owed to the beneficiary by the solicitor in relation to properly executing these wishes that is co-extensive with the greater and “paramount” duties owed to the testator.²¹² The standard of care owed to the beneficiaries is non-conflicting and in alignment with the existing standard of care owed to the testator.²¹³

²⁰⁹ *Ibid.* at 599.

²¹⁰ *Ibid.*

²¹¹ *Ibid.* This is inherently a more conflicting situation than that is generally present during preconception and prenatal medical care.

²¹² The High Court concluded that “a solicitor who was instructed by his client to carry out a transaction to confer a benefit on an identified third party owed a duty to that third party to use proper care in carrying out the instructions.” *Ross, supra* note 204 at 580.

²¹³ Since negligence was admitted by the defendant, the standard of care was not delved into deeply in *Ross*. This may be an example of a non-conflicting standard of care that may be less onerous than the standard of care owed to the testator.

Subsequent to *Ross*, courts were more conservative in disappointed beneficiary cases, as they were concerned with indeterminate liability and whether beneficiaries could protect their interests in other ways.²¹⁴ These concerns are less of an issue in prenatal and preconception care due to the differences from the disappointed beneficiary scenario. First, there are countless potential beneficiaries in a will and the interests of these beneficiaries, past and future, may also conflict during will changes.²¹⁵ Whereas, in the medical context, there is, for the most, part a limited number of future plaintiffs and conflict is far less likely.²¹⁶

Second, beneficiaries generally have the possibility of interacting with the testator while he or she is alive, of seeking legal counsel, and other alternatives to relying on the particular third party duty of care owed by the solicitor. In contrast, future children have no choice but to rely on the informed consent of their parents and the quality of the medical care provided to them; they have no alternate route of protecting their interests. Third, there is a concern in the disappointed beneficiary cases that the true interests of the testator might be

²¹⁴ Klar, *supra* note 138 at 273-274.

²¹⁵ *Ibid.*

²¹⁶ It is, however, possible that the interests of more than one future child might be considered during medical care, in particular prenatal care. For example, the choice of labour and delivery for one child may impact a future child, as was discussed earlier; see text accompanying note 202, above. The key factor in comparing current and future pregnancies is that there does not appear to be an inherent conflict of interest, compared to the beneficiary cases involving multiple beneficiaries. Disappointed beneficiary cases involve an inherently limited financial estate and the potential for inevitable conflict over that estate.

misunderstood or overruled, as he or she is no longer alive and available to testify in court.²¹⁷

Related to the testator's true intentions, there is a concern about courts overruling the requirements set for wills by provincial legislatures, as well as creating scenarios where the solicitor's liability provides a total compensation level for all beneficiaries that is greater than what would have been provided by the testator's estate.²¹⁸ Finally, the losses claimed in beneficiary cases are typically questionable economic losses, whereas medical cases typically include physical injuries caused by the alleged negligence. All these concerns are limited to the disappointed beneficiary cases and have been used to limit the growth of cases in this area.²¹⁹ These concerns are not present in the prenatal and preconception context, which arguably has greater proximity between plaintiff and defendant. Therefore, the specific conclusions on duty of care and conflict of interest from the beneficiary cases reinforce the non-conflicting aspect of co-extensive duties in the prenatal and preconception medical context.

Informed Consent

²¹⁷ Klar, *supra* note 138 at 273.

²¹⁸ *Ibid.* at 273-274.

²¹⁹ As an alternative to using tort law, Professor Klar argues in favour of legislation granting judges the flexibility to interpret wills and the "true intentions of the testator." See *ibid.* at 274.

Informed consent refers to the doctor's duty to disclose relevant medical information to the patient.²²⁰ The standard of care for disclosure is patient friendly, specifically what a reasonable person in the patient's circumstances would want to know.²²¹ The disclosure involves the discussion of any "material, special or unusual" risks involved with a proposed medical treatment, as well as the consequences if the risks were to materialize.²²² The disclosure also includes the discussion of alternative medical treatments that are medically appropriate, with similar coverage of risks and consequences.²²³

The doctrine of informed consent can be an important power balancer in the doctor-patient relationship:

The most prominent legal tool used by those seeking to reform the physician-patient relationship is the doctrine of informed consent. It is believed that requiring physicians to provide more information to their patients will help to redress the power imbalance problems created by the inequality of knowledge.²²⁴

The informed consent preconception duty of care to a born alive child is proposed as a duty co-extensive to the informed consent duty owed to the female patient. It is in the best interests of both female patient and future child for the female patient's decision to be an informed one. The proposed informed

²²⁰ The term informed consent is also used broadly to refer to the modern, patient focused approach to medicine, see *Bobinski*, *supra* note 172 at 201.

²²¹ *Reibl v. Hughes* [1980] 2 S.C.R. 880, [Reibl]

²²² *Hopp v. Lepp*, [1980] 2 S.C.R. 192; Picard & Robertson, *supra* note 45 at 131.

²²³ Picard & Robertson, *supra* note 45 at 150. The medically appropriate requirement is important and is discussed further in the comparison of informed consent with the duty not to provide a contraindicated treatment.

²²⁴ *Bobinski*, *supra* note 172 at 197.

consent duty is simply to provide the female patient with the requisite information to make an informed decision regarding medical treatment. Such a duty is similar to the existing co-extensive informed consent duty present during prenatal care.

The preconception co-extensive duty to obtain informed consent was rejected by the Court of Appeal in *Bovingdon* and *Paxton*. The rejection was based on the idea that the female patient owes no duty of care to the future child and can decide what to do once properly informed, even if the decision conflicts with the interests of the future child. Her decision is freely made and need not be what the reasonable person would do.²²⁵ This situation is what prompted Eberhard J. at the trial level of *Paxton* to search for a duty beyond that of informed consent, in the interest of protecting unborn children from teratogenic drugs.²²⁶

There are situations where there is conflict between the medical interests of the female patient and the medical interests of the future child, whether in prenatal care or preconception care. However, it is up for the “mother, and not the physician, to resolve” the conflict in deciding whether to consent to the proposed medical treatment, once properly informed.²²⁷ Professor Klar explains

²²⁵ *Bovingdon*, *supra* note 3 at para. 66.

²²⁶ *Paxton Trial*, *supra* note 4 at para. 193.

²²⁷ *Ediger Trial*, *supra* note 167 at para. 186; It is, however, the doctor who takes a central role in determining which treatments are indicated and thus would be reasonable to propose to the patient. This role is discussed subsequently.

the potential informed consent duty in the situation where the female patient consents to taking a reasonably indicated drug:

If the patient is fully informed of the risks and makes the decision to take the drug, this should satisfy the duty to the offspring, even if such a duty were recognized. It is clear that a woman's autonomy to make lifestyle or medical choices trumps the rights of unborn children under current Canadian law.²²⁸

There are many situations where the female patient does make decisions that are in alignment with the best interests of the future child, or would have made such decisions if properly informed.²²⁹ In these circumstances, a co-extensive duty of care related to informed consent would benefit both the female patient and the future child.

Circumstances where the interests of the female patient and the future child are in alignment are most likely to occur during the preconception medical care hypothetical. This is because the female patient is specifically consulting the doctor in relation to an intended pregnancy and will often choose to take reasonable steps to ensure that the intended pregnancy is as healthy as possible. In this context, the duty of informed consent is one that could be quite useful in safeguarding and enhancing the quality of preconception medical care provided for both the female patient and the future child. Far from being a conflict of duties, the interests of both parties are generally in alignment during

²²⁸ Klar, *supra* note 138 at 439.

²²⁹ In addition, the female patient has the freedom to refuse treatments that are in her best interests, but not those of the future child. See Picard & Robertson, *supra* note 45 at 334.

preconception medical care, with the female patient retaining the ability to make informed decisions about whether to consent to a particular treatment.

There is simply little threat to the health care of the female patient with a co-extensive informed consent duty of care to the future child to properly inform the female patient during preconception medical care. Not only does it reinforce the doctor-patient relationship, but it is in alignment with our society's enshrinement of the informed consent model of medicine.

The co-extensive informed consent duty is also compatible with the general medical care scenario.²³⁰ As long as the standard of care required matches the standard of care already owed to the female patient, then a co-extensive duty of care can be owed to the future child. Again, the duty of care to the female patient is reinforced and it is in the future child's best interests for the female patient's medical decisions to be fully informed. Any potential conflict of interest that could arise is related to supplementary duties beyond informed consent, which are discussed subsequently.²³¹

Informed Consent and Conflict of Interest

²³⁰ As discussed earlier in the categorization discussion, the general medical scenario is where the female patient seeks medical care that is not related to an intended future pregnancy, such as the acne consultation in *Paxton*.

²³¹ Several issues not present in the preconception medical care scenario, but relevant to the general medical care scenario are the potential impact of pronatalist bias and assumption of future pregnancy. However, these issues can be resolved satisfactorily and are considered subsequently; see text accompanying note 274, below.

It is useful to view the potential conflict of interest for the co-extensive duty of informed consent through the lens of drug therapy. First of all, drug therapy matches the circumstances in *Paxton*, where a teratogenic drug provided potential benefits to the female patient in regards to acne treatment, but was not necessary for the future child and in fact posed a grave risk to the future child. Second, drug indication and prescription are two sides of drug treatment and reflect the two sides of any medical treatment. Medical treatments, including drug therapy, have both an indication phase, where the doctor decides whether a certain treatment is indicated by the medical facts at hand, and a treatment phase, where the treatment is actually applied.²³² Finally, drug therapy is an important branch of modern medicine and is a relatively common medical procedure present in both preconception and prenatal care, with useful case laws precedents.²³³

The Court of Appeal in *Paxton* was concerned about situations where a particular drug is reasonably indicated under the circumstances, but the doctor nevertheless chooses not to prescribe or even mention the drug, as part of a conflict of interest or concern of liability to the future child.²³⁴ There are two forms of this concern: when the doctor knowingly withholds an indicated drug and when the doctor's indication analysis is unknowingly impacted by the duty owed to the future child, to the possible detriment of the female patient.

²³² Drug prescription is part of the treatment phase for drug therapy.

²³³ *Bovingdon*, *Paxton*, *Lacroix*, and *Webster* all involved drug prescription, as do prenatal drug therapy cases such as *Pozdrik*, *infra* note 240.

²³⁴ *Paxton*, *supra* note 3 at para. 68.

The doctor would be in breach of the duty of care owed to the female patient by avoiding the prescription or even mentioning of a drug that he or she knows is indicated by the circumstances. In trying to avoid liability to the future child, the doctor would not only be taking excessive and contradictory steps not required in meeting the duty of care to the future child, but would become liable to the existing adult patient.

Whether the interests of the child should be considered during the drug indication analysis is an important question to ask. Professor Klar states that the doctor would consider the “potential harm to the child for the offspring (or to others)” not only during the drug prescription, but also in considering whether the drug was “contraindicated” or “whether to ... [give] the mother the choice to take it.”²³⁵ The Court of Appeal, on the other hand, was concerned about such considerations influencing and improperly affecting both drug indication and prescription.

In comparison to the prenatal care scenario, it is clear that an existing pregnancy and the interests of the future child affect the drug indication analysis in the prenatal medical care scenario. The medical interests of both the female patient and the fetus will be considered by the diagnosing doctor, with the medical interests of the female patient taking priority.²³⁶ The case of *Hunt*

²³⁵ Klar, *supra* note 138 at 439. Professor Klar’s full analysis is considered subsequently.

²³⁶ Picard & Robertson, *supra* note 45 at 334.

(Guardian ad litem of) v. Szirmay-Kalos illustrates that a consideration of both interests takes place, with the mother's interests taking precedence.²³⁷

In *Hunt*, the female patient, Angela Hunt, had been 31 weeks pregnant when she became seriously ill due to complications from an emergency colon surgery. There was a serious risk of injury to the fetus unless a caesarean was performed, but the defendant physician waited a couple of days for Angela's health to stabilize before performing a caesarean. The child was born alive, but had a catastrophic brain injury that was caused by the delay. Both mother and child launched claims for negligence against the defendant doctor, Dr. Kalos, with the primary claim being that that the doctor should have performed the caesarean at the earlier date.

At trial, counsel for the plaintiffs and the defendant presented expert testimony on the appropriate standard of care for the circumstances. A primary issue was the extent of the risk of death for the mother if the caesarean had been performed at the earlier date.²³⁸ Martinson J. of the British Columbia Supreme Court considered the expert evidence and the medical interests of the mother and child. Martinson J. concluded that the defendant had not been negligent in deciding that the caesarean was contraindicated at the earlier date:

Dr. Kalos recognized the seriousness of the baby's condition. He was faced with a very difficult and unusual situation. He sought a second opinion from an expert perinatologist. ... Based on the information available to him at that time

²³⁷ *Hunt (Guardian ad litem of) v. Szirmay-Kalos*, [2005] B.C.J. No. 737, 2005 CarswellBC 766 (S.C.) [*Hunt*].

²³⁸ *Ibid.* at paras. 5, 176-179.

he concluded that performing a caesarean section was not a viable option given his assessment of the risk to Ms. Hunt. He exercised his clinical judgment and did so appropriately. He properly assessed the risk to Ms. Hunt. He balanced the risk to the mother against the risk to the baby, taking into account the general obstetrical practice of not endangering the mother's life for that of the baby."²³⁹

Other prenatal case law decisions demonstrate that the interests of both the female patient and fetus are considered during the indication analysis in prenatal medical care.²⁴⁰ This consideration of both interests, with the female patient's interests taking priority, is contained within the standard of care owed by the doctor to the female patient. It is proposed that the reason why a co-extensive duty of care is owed to the fetus during the treatment indication analysis for prenatal medical care without a serious conflict of interest is because the standard of care owed for the co-extensive duty is equivalent to the standard of care already owed to the pregnant patient.

If the standard of care was not equivalent, such as demanding that the interests of the fetus take priority even when the pregnant patient's life were at risk, then this would irreconcilably conflict with the standard of care. The doctor would truly be placed in an irresolvable conflict of interest in factual circumstances similar to *Hunt*, because a breach of one standard of care or the

²³⁹ *Ibid.* at paras. 177-178.

²⁴⁰ *Pozdrik (Next friend of) v. Wilson*, 2002 ABQB 351, [2002] A.J. No. 450 [Pozdrik]; *Strachan (Guardian ad litem of) v. Reynolds*, 2004 BCSC 915, [2004] B.C.J. No. 1418; *Meyers (Next friend of) v. Stanley*, 2003 ABQB 468, [2003] A.J. No. 685, rev'd on other grounds, *sub nom. Meyers (Next Friend of) v. Moscovitz*, 2005 ABCA 114, [2005] A.J. No. 277. In general, judges in prenatal negligence cases determine the standard of care owed to the pregnant patient and future child within a single analysis, reflecting the shared standard of care owed.

other would be guaranteed. Therefore, it must be that the standard of care for any co-extensive duty owed to the fetus during pregnancy accepts the primacy of the pregnant patient's position and reflects the standard of care owed to her.

Similar to prenatal care, a co-extensive duty could be owed to the future child during the preconception medical care scenario for the doctor's treatment indication analysis. This is possible as long as the accompanying standard of care similarly reflects the standard of care owed to the female patient, which arguably involves a consideration of the interests of both the female patient and the future child.

The general medical care scenario may be different, as the lack of pregnancy or intended pregnancy distinguishes it from both prenatal medical care and the preconception medical care scenario. Nevertheless, if future court decisions do find that the duty owed to the female patient for the doctor's treatment indication analysis during general medical care has a standard of care that involves considerations of the interest of a future child, then this reality could be reflected in a co-extensive duty of care owed to that future child.

A critical difference for both the preconception medical care and general medical scenarios is that a developing fetus exists during prenatal care. This reality should be reflected in the balancing of interests present in the doctor's standard of care owed in the two different situations. An example of this

difference can be illustrated through the context of the prescription of Accutane or other teratogenic drugs.

If a pregnant patient were to seek treatment for acne during pregnancy, it would be quite likely that a prescription drug like Accutane, with very serious side effects for the developing child, would not be found to be a reasonably indicated treatment. Arguably, the standard of care owed by the doctor to both the pregnant patient and fetus would exclude Accutane.

In contrast, a female patient who is not pregnant, such as Dawn Paxton in *Paxton*, should be able to access Accutane. The balancing of interests concludes that Accutane can be an indicated treatment, as long as female patient agrees to follow appropriate contraceptive methods, if there is a chance of pregnancy occurring during the Accutane treatment.²⁴¹ This is arguably reflected in the standard of care owed for the duty owed to the female patient as well as the co-extensive duty owed to the future child.²⁴² The standard of care does not contain a complete ban of access to Accutane for female patients, despite the fact that the requisite forms of contraception leave a chance for pregnancy. While the standard of care considers both the interests of female patient and future child, it is by necessity more deferential to the interests of the female patient than the balancing done during pregnancy, which reflects the difference from prenatal medical care.

²⁴¹ As noted earlier, the doctor is not expected to nor can guarantee actual compliance, nor is that required in the standard of care.

²⁴² If a future child is consequently conceived and born alive.

As noted by Eberhard J. in *Paxton*, the standard of care reflects the appropriate balancing of interests in the prescription of Accutane:

[In] the real world of the actual practice of medicine, doctors are already dealing with that conflict with a standard of care developed in the medical community, not imposed by the legal community. That standard of care demands that protections must be put in place to avoid pregnancy before Accutane can be given.²⁴³

The conflict of interest argument ultimately comes down to whether there is any extra conflict put on the doctor by having co-extensive legal duties, when there is already a legal consideration and balancing of both interests to be made by the doctor in the original duty owed to the female patient. There is no additional conflict placed in the existing co-extensive system for prenatal medical care. It is proposed that there would be no additional conflict placed by recognizing co-extensive duties during preconception medical care, as long as the standard of care owed to the future child reflects that which is already owed to the female patient.

It could be argued, however, that any standard of care owed by the doctor to female patient during the preconception timeframe could include a consideration of both the interests of female patient and future child, but should *not* include a balancing of both interests. If this argument is accepted by courts,

²⁴³ *Paxton Trial*, *supra* note 4 at para. 196. The difference between Eberhard J.'s conclusion and the currently proposed co-extensive system is that she viewed this duty and accompanying standard of care as owed only to the future child. Her conclusion on the contents of the expected standard of care is correct, but it is actually a shared standard of care that accompanying duties owed to both female patient and future child.

then a co-extensive duty to the future child would not be applicable during the treatment indication analysis. However, it could still be present during the duty to obtain informed consent and through the proper execution of consented treatments.

Independent Duties of Care

As defined earlier, independent duties are prospective duties owed to the future child that have would impose a different standard care on the doctor than what is already required by the duty owed to the female patient. Due to the different standard of care, there is significant chance of the doctor being placed in a conflict of interest. Even if the conflict is not irreconcilable, independent duties would have an impact on the female patient's medical care that is not present with co-extensive duties.

There were independent duties related to drug therapy argued by counsel for the infant plaintiffs in both *Bovingdon* and *Paxton* that were deemed to be irreconcilably conflicting duties. Counsel in *Bovingdon* asserted that there was a right for the children "to have a drug-free conception, with a reduced risk of disability."²⁴⁴ This asserted right was correctly deemed to irreconcilably conflict with the doctor's duties owed to the female patient.²⁴⁵ It also makes a pre-emptive judgement on standard of care and whether drugs may actually be required for conception.

²⁴⁴ *Bovingdon*, *supra* note 3 at para. 62.

²⁴⁵ *Ibid.* at paras. 63, 68.

Eberhard J. proposed at the trial level in *Paxton* a duty not to prescribe Accutane, unless the prescription requirements were met, which could also be framed as a duty not to prescribe a contraindicated drug.²⁴⁶ Is a duty owed to the born alive child not to prescribe a contraindicated drug during preconception care an independent and conflicting duty? It depends on how a drug is determined to be contraindicated, which reflects, once again, whose interests are to be appropriately considered during the drug indication analysis.²⁴⁷ The female patient is already owed a duty by the doctor not to prescribe a contraindicated drug. It is proposed, as argued earlier, that if the standard of care for the proposed duty to the future child matches that which is already owed to the female patient, then it can exist as a non-conflicting co-extensive duty.

If a drug is medically in the best interests of the female patient, but not the future child, can that be a contraindicated drug? The answer according to medical and legal standards would be no.²⁴⁸ As long as the accompanying standard of care accepts this reality and matches the standard of care owed to

²⁴⁶ *Paxton Trial*, *supra* note 4 at paras. 185-186.

²⁴⁷ The duty not to prescribe a contraindicated drug is simply another way to phrase the duty to provide reasonable care during drug prescription, including prescribing only reasonably indicated drugs. This mirror reality explains why the earlier analysis on drug indication and the Accutane hypothetical is relevant and revisited here.

²⁴⁸ With the caveat that there were no reasonable alternatives equally beneficial to female patient and less harmful to future child. However, if there was an alternative treatment available that was equally beneficial but less detrimental, then arguably that alternative would be the treatment that is actually in the best interests of the female patient. See *Pozdzik*, *supra* note 240 at paras. 3, 124, where this was alleged by the plaintiffs, but the judge determined that there no other reasonable options in the factual circumstances and that the suggested alternatives did not have to be mentioned by the doctor.

the female patient, then a duty to the future child to not to prescribe a contraindicated drug is a co-extensive rather than independent duty.

The beneficial and detrimental impacts of drug therapy can be complex. There is a spectrum of effects that a potential drug could have on both the female patient and future child, particularly interests that do not threaten the actual life of the female patient. It is this middle ground that is most difficult, where it not a balance of the life of the patient and child, but lesser interests of the patient and the child. For example, the interests of treating a female patient's acne with Accutane in comparison to preventing the exposure of future children to the teratogenic drug.

What about a preconception situation where the female patient refuses to agree to the requisite birth control or a prenatal situation where a pregnant patient requests Accutane? A drug can be contraindicated, even if the patient requests it. The doctor's extensive medical knowledge and training is specifically relied upon to determine whether a drug or any other treatment is appropriate for the medical circumstances. Picard and Robertson's *Legal Liability of Doctors and Hospitals in Canada* outlines the legal requirements related to inappropriate care:

Once a doctor-patient relationship is formed, the doctor's obligation is to treat the patient. However, this does not mean that the doctor has a duty to provide (and the patient a correlative right to receive) whatever treatment the patient may request. If a patient requests treatment which the doctor considers to be inappropriate and potentially harmful, the doctor's overriding duty to act in the patient's best interest dictates that the treatment be withheld. A doctor who

accedes to a patient's request (or demand) and performs treatment which he or she knows, or ought to know, is contraindicated and not in the patient's best interests, may be held liable for any injury which the patient suffers as a result of the treatment.²⁴⁹

A distinction in the Accutane hypothetical is that it is the best interests of the future child that are under threat and the future child that would be physical harmed by the teratogenic drug, which is something more extensive than the best interests of the female patient. However, it could be argued that it is also not in the female patient's best interests to prescribe the drug.

While reviewing the informed consent duty proposed in *Bovingdon*, Professor Klar's analysis implied that a drug could be contraindicated based on considerations beyond just the patient's interests:

If, on the other hand, the drug should not have been prescribed at all because any benefit to the mother was outweighed by the *potential harm to the offspring (or to others)*, it would seem to be negligent vis-a-vis both mother and child for the doctor to have prescribed it or to have given the mother the choice to take it. A doctor's duty to his or her patient is to treat her with reasonable care: prescribing a drug which is contraindicated for that patient is not reasonable.²⁵⁰

Ultimately, if the standard of care owed to the female patient would deem a drug to be contraindicated, then the doctor may be similarly liable for prescribing the drug, even if the female patient requests it. If the female patient could be successful in such a claim, then arguably the future child could be owed

²⁴⁹ Picard & Robertson, *supra* note 45 at 345-346.

²⁵⁰ Klar, *supra* note 138 at 439 [emphasis added].

a similar duty with an equivalent standard of care and similar claim for negligence.

There are two reasons why many potential preconception duties become framed in an independent and conflicting way. One situation is an attempt to avoid being framed as a wrongful life duty. For example, the “drug-free right” asserted in *Bovingdon* was a way to avoid being classified as a “right not to be born.”²⁵¹ The trial judge in *Paxton*, Eberhard J., tried to avoid a framing of the duty that would have resulted in wrongful life.²⁵² In *Cherry*, one issue with articulating the duty to the fetus as one to take proper care during the abortion would be that it would seemingly place the case in a wrongful life situation.²⁵³ In the effort to avoid being classified as wrongful life, plaintiffs have stumbled into framing the duties owed as independent and conflicting duties.

A second situation that is likely to generate conflicting preconception duties is when the female patient’s own claim would fail on its merits. In *Paxton*, the mother’s potential informed consent claim was dropped by counsel at trial and rejected by the judge. For the infant plaintiff to succeed, an alternate duty was required, described by Eberhard J. as a duty to avoid prescribing a teratogenic drug like Accutane to “a woman of childbearing potential” that could

²⁵¹ *Bovingdon*, *supra* note 3 at para. 62-66.

²⁵² *Paxton Trial*, *supra* note 4.

²⁵³ *Cherry Trial*, *supra* note 29.

be discharged at the preconception stage by recommending the appropriate level of contraception to the female patient.²⁵⁴

However, this was not successful in the *Paxton* case, as the doctor met the requisite standard of care. Accutane was not contraindicated under the factual circumstances, so both the mother's and child's claims would have failed, arguably reflecting the innate connection between the standard of care owed to female patient and future child.

Conclusion

Before a final conclusion can be made for co-extensive duties, it is important to consider the residual policy arguments referenced in *Bovingdon* and *Paxton*. While the form of the Court of Appeal's argument was centered on proximity and the doctor's allegedly irreconcilable conflict of interest, an underlying concern related to female patients' personal autonomy and to what extent this autonomy may be restricted during medical care.

It is not surprising that the conflict of interest argument present during the proximity analysis is related to the general concern of patient autonomy typically present in the residual policy considerations. The Supreme Court of Canada has noted that the policy arguments in either stage are not always easily divisible and it does not necessarily matter where the policy analysis is held, as

²⁵⁴ *Paxton Trial*, *supra* note 4 at paras. 185-186, 208.

long as it is held.²⁵⁵ The effect of a conflict of interest in a single case is not only a potential chilling effect, but ultimately an unjustified limitation on patient autonomy. Once a single case forms case law precedent, it has the ability to impact patient autonomy generally in other medical circumstances.

The protection of patient autonomy reflects both Canadian case law and the constitutional values of the *Charter of Rights and Freedoms*.²⁵⁶ The advent of the *Charter* led to a lasting impression on the subsequent development of tort law.²⁵⁷ Tort law is expected to develop in a way that is respectful of and in alignment with *Charter* values.²⁵⁸ Judges making tort law decisions are influenced by the existence of the *Charter* and this was reflected in the *Winnipeg* and *Dobson* cases.²⁵⁹ The impact of this jurisprudence for the proposed system of co-extensive preconception duties must be considered and is reviewed in Part III.

Part III: Duty of Care Analysis (Stage 2)

Introduction

²⁵⁵ Klar, *supra* note 138 at 187, citing *Syl Apps*, *supra* note 176 at para. 33.

²⁵⁶ *Canadian Charter of Rights and Freedoms*, s. 15, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11.

²⁵⁷ *Hill v. Church of Scientology of Toronto*, [1995] 2 SCR 1130.

²⁵⁸ *Ibid.*

²⁵⁹ *Winnipeg*, *infra* note 266; *Dobson*, *infra* note 266.

If proximity is established in the course of an *Anns* test analysis, a *prima facie* duty of care arises.²⁶⁰ However, this *prima facie* duty of care is still subject to residual policy considerations that may negate the duty of care. As the Supreme Court of Canada stated, the “policy concerns raised against imposing a duty of care must be more than speculative; a real potential for negative consequences must be apparent.”²⁶¹

The Ontario Court of Appeal considered the potential negative impact on women’s constitutionally protected “bodily integrity, privacy, and autonomy rights” in *Paxton*.²⁶² In doing so, the Court of Appeal admitted the potential overlap between policy considerations during the two stages of the *Anns* test:

As the Supreme Court noted in *Cooper*, because policy considerations form part of a balancing of factors to determine whether there is a duty of care in any case, policy considerations may often be applied at either stage of the analysis. The policy issues of conflicting duties and the indirectness of the relationship are also relevant at the second stage of the *Anns* test, which is concerned with “the effect of recognizing a duty of care on other legal obligations, the legal system and society more generally.”²⁶³

The Court of Appeal asserted the negative policy impacts associated with accepting a duty of care:

Recognizing a duty of care by a doctor to a future child of a female patient would affect the doctor's existing legal obligation, which is to the patient. Recognizing the proposed duty would also have implications for society as a

²⁶⁰ *Cooper*, *supra* note 6.

²⁶¹ *Hill v. Hamilton-Wentworth (Regional Municipality) Police Services Board* (2007), 50 C.C.L.T. (3d) 1 (S.C.C) at para. 48.

²⁶² *Paxton*, *supra* note 3 at para. 79.

²⁶³ *Ibid.* at para. 78, citing *Odhavji Estate v. Woodhouse*, 2003 SCC 69, 3 SCR 263 at para. 51.

whole for several reasons. One is that our legal and medical systems recognize that a woman has the right, in consultation with her doctor, to choose to abort a fetus. Imposing a duty of a care on a doctor to a future child would interfere with the exercise of that right. Another implication for society as a whole is that, until a child is born alive, a doctor must act in the best interests of the mother. This obligation is consistent with society's recognition of the need to preserve a woman's "bodily integrity, privacy and autonomy rights": Dobson.²⁶⁴

The argument on abortion is more relevant to prenatal care than to preconception care and even then would be limited to preventing inherently conflicting duties such as a duty not to abort. The reality of access to abortion in Canada does not negate the dual duty system present in prenatal care and similarly should not negate preconception duties.

The second argument focuses on the doctor's necessity to act in the best interests of the female patient. The proposed co-extensive preconception duty scheme, like the co-extensive duties present in prenatal care, accepts this fundamental tenet of pre-birth medicine. The Court of Appeal's target was the duty not to prescribe a contraindicated drug, which was deemed to be an irreconcilably conflicting duty. However, there would not be any conflict when following the proposed co-extensive duty not to prescribe a contraindicated drug. As argued earlier, the co-extensive duty's standard of care would be equivalent to the standard of care already owed in the doctor's existing legal obligation to the female patient.²⁶⁵

²⁶⁴ Paxton, *ibid.* at para. 79, citing *Dobson, infra* note 266 at paras. 23-24.

²⁶⁵ See text accompanying note 247, above.

The two important cases referred to in *Paxton* were *Winnipeg* and *Dobson*.²⁶⁶ The two Supreme Court of Canada cases firmly established that a mother owes no duty of care to her fetus or born alive child for her conduct during pregnancy. The question is how does this maternal immunity affect the doctor's relationship with the future child? Is there something special about the doctor-patient relationship that distinguishes doctors from other third party members of society and requires doctors to be shielded from liability in the same way?

The relationship between the doctor and the future child is more similar to that of third parties than to the *sui generis* relationship between female patient and future child. While comparing third party negligence during pregnancy, the Supreme Court of Canada in *Dobson* highlighted the uniqueness of the mother-child relationship, which arguably distinguishes it from doctors as well as other third parties:

The unique relationship between a pregnant woman and her foetus *is so very different from the relationship with third parties*. Everything the pregnant woman does or fails to do may have a potentially detrimental impact on her foetus. Everything the pregnant woman eats or drinks, and every physical action she takes, may affect the foetus. Indeed, the foetus is entirely dependent upon its mother-to-be. Although *the imposition of tort liability on a third party for prenatal negligence advances the interests of both mother and child, it does not significantly impair the right of third parties to control their own lives*. In contrast to the third-party defendant, a pregnant woman's every waking and sleeping moment, in essence, her entire existence, is connected to the foetus she may potentially harm.²⁶⁷

²⁶⁶ *Dobson (Litigation Guardian of) v. Dobson*, [1999] 2 S.C.R. 753 [*Dobson*]; *Winnipeg Child and Family Services (Northwest Area) v. G. (D.F.)*, [1997] 3 S.C.R. 925 [*Winnipeg*].

²⁶⁷ *Dobson, ibid.* at para. 27 [emphasis added].

It is interesting to note that in the American cases covering preconception duties, the doctor-patient relationship is one of the primary third party relationships where preconception liability has been consistently found.²⁶⁸ In the disparate American jurisprudence, it has been argued that the doctor-patient relationship is a relationship that is in favour of finding a duty of care, because it is more foreseeable and predictable that negligent medical care could affect a future child, particularly medical care specially targeted for the best interests of a future child.²⁶⁹ Absent this highly foreseeable interaction, American courts have been hesitant to find preconception duties.²⁷⁰

There are other policy factors against and for the proposed co-extensive system of duties that must be considered before a final conclusion can be made. Some of these policy factors were considered in *Paxton*, while others are relevant during the formation of new torts in general.

Policy Arguments Against

Effect on Insurance

²⁶⁸ Browne, *supra* note 191. Another relevant relationship is between manufacturer and consumer.

²⁶⁹ *Ibid.*

²⁷⁰ *Ibid.*; *Hegyves v. Unjian Enter. Inc.* (1991), 286 Cal. Rptr. 85 (Cal. Ct. App.). Primarily for reasons listed under foreseeability or remoteness, perhaps because the courts lacked a contemporary proximity test comparable to *Cooper* or the English equivalent, *Caparo Industries plc v Dickman*, [1990] UKHL 2, [1990] 2 AC 605.

A residual policy concern not mentioned by the Court of Appeal in *Paxton*, but potentially relevant is the effect of preconception liability on medical insurance fees. The field of obstetrics is already a “higher risk” field with one of the highest insurance rates.²⁷¹ The imposition of new duties of care for preconception care may be argued to risk raising the rates even higher or to deter doctors from practicing in this area.

Assuming that it is a valid policy consideration, there are several answers to this concern. First, the preconception medical care sphere is already growing, similar to the development of prenatal medical care. It is a highly technical area with many potential benefits, both medical and financial. It is doubtful that the field will be seriously curtailed simply because there is liability for preconception negligence. Second, any deference to the developing state of the practice of preconception medicine could be established in the standard of care, which could be suitable deferrable as the standard practice and respectable minority practices are established. The preconception medical sphere needs the room for tort law to adapt and develop, rather than be stifled by an unnecessarily broad denial of duties.

Indeterminate Liability

Another residual policy concern considered for new tort law duties is the potential for indeterminate liability. As noted in *Cooper*, indeterminate liability is

²⁷¹ Picard & Robertson, *supra* note 45 at 528-529.

a serious concern in some cases and can be used to negate a *prima facie* duty of care.²⁷² As warned by Cardozo J, courts must keep an eye on preventing the “floodgates of litigation” that may be opened by indeterminate liability.²⁷³

The spectre of indeterminate liability is not a serious problem for the preconception duty scheme. The injuries suffered by infant plaintiffs are most often physical injuries, which tightens the knot of liability. The doctor’s negligence may only involve medical advice rather than action in some cases, but this is not a problem in the prenatal negligence claims and should not be a problem in preconception negligence claims.

A potential dividing point is available once again in the difference between preconception medical care and the general medical care scenarios. In the preconception medical care scenario, both doctor and patient are aware that the care is being taken for the benefit of a future child. This limits the potential new liability and number of cases, assuaging any lingering concerns of indefinite liability.

The general medical care scenario is broader and may be dependent on a case by case review. However, the close relationship between a co-extensive duty and the duty and accompanying standard of care already owed to the female patient places an inherent constraint on co-extensive duties, even in the

²⁷² *Cooper*, *supra* note 6 at para. 37.

²⁷³ Cardozo C.J. in *Ultramares Corp. v. Touche* (1931), 174 N.E. 441 at 444 (N.Y.C.A), cited in Klar, *supra* note 138 at 188.

general medical care scenario. Nevertheless, a distinction could be supported between the two scenarios, if necessary.

Pronatalist Bias and Assumption of Pregnancy

A potential concern related to recognizing an informed consent duty or other co-extensive duties owed to a born alive child for preconception care is the issue of pronatalist bias and the assumption of pregnancy. The potential bias of doctors, lawyers, and society in general toward pregnancy was thoroughly discussed during the development of torts known as wrongful pregnancy and birth.²⁷⁴ Professor Langevin explained pronatalist bias:

By pronatalist, I refer to the ideology according to which adults, both men and women, fulfill themselves by becoming parents. In this ideology, children constitute sources of joy, the family in its traditional conception is the basis of society, women fulfill themselves through motherhood, and they are ready to put aside their personal aspirations to raise a child for which they had not planned.²⁷⁵

This potential bias has been recognized by Canadian courts.²⁷⁶ In the medical context, it is relevant in two ways. First, when dealing with a female patient who is not pregnant, the doctor may unduly assume that she intends to become pregnant at some point in her life, when she may have no plans to ever

²⁷⁴ Despite being discussed in another context, the details of pronatalist bias are also relevant in preconception care.

²⁷⁵ Louise Langevin, "The Compensation of Wrongful Pregnancy in Quebec Civil Law" (1999) 14 Can. J.L. & Soc. 61 at 78.

²⁷⁶ *Suite v. Cooke*, [1993] R.J.Q. 514, 15 C.C.L.T. (2d) 15 (S.C.) aff'd. [1995] R.J.Q. 2765 (C.A.), cited in *ibid.* at 80.

do so. Second, particularly during pregnancy, but also before conception, the doctor might make undue assumptions about how female patients may view certain risks or treatment options, from drug prescription to abortion. The doctor might exclude certain options rather than allow the patient to make an informed decision about it, not as a mechanism for defensive medicine, but rather as a result of making undue assumptions about the patient's likely response.²⁷⁷

The preconception medical care scenario is able to suitably handle these concerns. First, when a female patient requests advice or care specifically with the intention to become pregnant, then there is no assumption required as the patient has made her objectives clear. Second, in relation to disclosure, the doctor must follow the standard of what the reasonable person in the patient's circumstances would want to know.²⁷⁸ It may be a difficult standard to meet, but it is already present in all medical situations. Escaping the pronatalist bias is just one bias among other biases to escape during the informed consent process, including cultural bias, sexual orientation bias, or socioeconomic bias.²⁷⁹ There is nothing special about preconception medical care that makes pronatalist bias unmanageable.

²⁷⁷ For example, the doctor may make undue assumptions about the patient's future intentions and decisions they may make in regards to various treatment options.

²⁷⁸ *Reibl, supra* note 221; Picard & Robertson, *supra* note 45 at 133-134.

²⁷⁹ Doctors are also trained to deal with such issues as part of their medical education. For example, the first and second year medical curriculum at the University of Alberta contains two courses "dealing with the social, sociological, ethical, legal, and public-health aspects of medicine." *Curriculum* (2013), online: Faculty of Medicine & Dentistry, University of Alberta <<http://www.med.ualberta.ca/programs/md/curriculum/year1>>.

The general medical care scenario is the more likely situation for concerns about undue assumptions about pregnancy. Should the doctor think about the impact on a potential pregnancy whenever treating a female patient with reproductive capacity? While the notion is uneasily close to a pronatalist bias, there are scenarios where it should be discussed. For example, the prescription of teratogenic drugs, such as Accutane in *Paxton*, includes manufacturer guidelines to specifically warn women of the dangers involved.²⁸⁰ It would fall below the standard of care owed to the female patient not to do so. When the standard of care already owed to the female patient involves considerations of the impact on a future child, assumptions of pregnancy are not increased by a co-extensive duty owed to the future child.

While the doctor should not make undue assumptions about pregnancy, the solution to avoiding undue assumptions is to engage in actual discussion with the patient to provide the appropriate care for the circumstances. For example, in *Paxton*, the doctor's past interactions with the plaintiff and knowledge of the plaintiff's monogamous relationship with her husband who had a vasectomy was an important factor for determining the appropriate contraceptive methods to accommodate a prescription of Accutane.²⁸¹ The standard of care for a patient in a different sexual situation may have required the doctor to advise different

²⁸⁰ *Paxton*, *supra* note 4 at para. 134.

²⁸¹ *Ibid.* at paras. 142, 154.

contraceptive methods. It is the healthy discourse and discussion of the doctor-patient relationship that will dispel undue assumptions and even bias.

A related concern with assumption of pregnancy is that the informed consent discussion may be hampered by discussions of drug or other treatment impact on pregnancy. During prenatal medical care, the patient is already pregnant and such discussions are immediately relevant. For a patient who is not pregnant, particularly a patient who has no intention of ever becoming pregnant, such discussions may add yet another level of disclosure and corresponding time drain to the doctor-patient interaction. While accepting and promoting the informed consent model of medicine, the reality of contemporary Canadian medical care is that doctors and patients often have limited time for conversation.

The answer to this concern is that doctors already are legally required to discuss the impact on a future pregnancy when it is materially relevant, whether or not any duties are owed to born alive children for preconception care. Courts such as the Court of Appeal in *Bovingdon* and *Paxton* have recognized that doctors owe a duty of care before conception to adult patients, including the informed consent model. As outlined in *Paxton*:

[A] doctor owes a duty of care to the patient to properly prescribe Accutane and provide full information about the material risks that the drug poses to herself and to a future child if she were to become pregnant. If the doctor breaches that duty to the mother by failing to meet the standard of care for prescribing

Accutane, the doctor will be liable to the mother for damages she suffers as a consequence of giving birth to a child with disabilities caused by the drug.²⁸²

The particular facts of *Paxton* did not establish medical negligence, but there could have been negligence under different circumstances. In *Lacroix*, the parents would have had a valid informed consent claim, if not barred by the statute of limitations.²⁸³ Therefore, recognizing a duty of care to born alive children adds no extra burden to the doctor-patient discussion in the context of informed consent. Like in other circumstances of preconception medical care, the co-extensive duty owed to the born alive child covering preconception care merely reflects and reinforces the duty already owed to the female patient, sharing an equivalent standard of care.

Policy Arguments in Favour

Compensation

A residual policy argument to consider is the compensation of born alive children for harm caused by the doctor's preconception negligence. The importance of this consideration was highlighted by the Court of Appeal in *Paxton*, in considering the impact of denying a duty of care to the born alive child:

²⁸² *Paxton*, *supra* note 3 at para. 83.

²⁸³ See text accompanying note 53, above.

A child born with disabilities as a result of medical treatment that would have been actionable in negligence if a duty of care were recognized will not be able to receive full compensation for the damage suffered, including the cost of lifetime care, loss of income and pain and suffering. This is a serious concern, which is only somewhat mitigated by the compensation that can be claimed by the parents from the doctor for the breach of duty to them both, or only to the mother, at least for the ongoing cost of the care of the child: see *Krangle (Guardian ad litem of) v. Brisco*, [2002] 1 S.C.R. 205 (S.C.C.).²⁸⁴

The case of *Krangle* involved a wrongful birth situation, where the mother was successful in establishing a breach of informed consent regarding the lack of information about the possibility of Down's Syndrome testing for women over the age of 35 and the subsequent loss of opportunity to abort a fetus that had Down's Syndrome.²⁸⁵ The decision was appealed to the Supreme Court of Canada on the issue of whether the parents could be compensated for the costs of caring for the child beyond the age of majority.²⁸⁶

The Supreme Court of Canada decided against the plaintiffs, which put into question whether parents can be compensated for the costs of raising children with disabilities beyond the age of majority. However, commentators distinguished the *Krangle* decision from other potential cases and argued that such compensation was possible:

The *Krangle* decision must be understood in the context of the evidence led at trial and the particular wording of the B.C. legislation that was in issue. The *Family Relations Act* provides that parents have an obligation to support their adult child only if the child "is unable, because of illness, disability or other cause, to withdraw from their charge or to obtain the necessaries of life." The

²⁸⁴ *Paxton*, *supra* note 3 at para. 80, citing *Krangle SCC*, *infra* note 286.

²⁸⁵ *Krangle (Guardian ad litem of) v. Brisco*, [1997] B.C.J. No. 2740, 154 D.L.R. (4th) 707 [*Krangle*].

²⁸⁶ *Krangle (Guardian ad litem of) v. Brisco*, [2002] 1 S.C.R. 205 (S.C.C.), 2002 SCC 9 [*Krangle SCC*].

evidence at trial indicated that when he reached the age of majority the Krangles' son would most likely move to a group home. Hence, the Supreme Court concluded that he would then no longer be in his parents' "charge" and consequently they would not have a legal obligation to support him. In the absence of this type of evidence the *Krangle* decision would be distinguishable and the parents' claim might well extend beyond the age of majority.²⁸⁷

This reasoning was applied by Pardu J. in a separate ruling at the trial level of *Bovingdon* regarding the mother's claim for damages beyond the age of majority. Pardu J. distinguished *Krangle* by noticing that "both the facts and the law pointed in the same direction" in that case, denying compensation to the parents for costs that they were very unlikely to face.²⁸⁸ He noted that the 5% contingency award granted at trial was upheld by the Supreme Court of Canada, arguably on a basis "to allow for the contingency that the law might be amended to require parents to support adult disabled children."²⁸⁹

Pardu J. concluded that "parents are not barred as a matter of law from asserting a claim for the extraordinary costs of care of disabled adult children."²⁹⁰ The Court of Appeal in *Bovingdon* agreed with this ruling:

The facts in this case are quite different from those in *Krangle*. The twins are profoundly disabled, and although the parents will not be legally responsible for their support after age eighteen, they do not intend to place the twins in a group home. A group home could only provide for their physical care but not their emotional well-being. Nor would the group home be able to give them intellectual stimulation and pleasure. The parents' assertion that it was in the children's best interests to remain with them beyond age eighteen was not challenged at the trial. The costs the parents are claiming are for extraordinary

²⁸⁷ Picard & Robertson, *supra* note 45 at 265-266.

²⁸⁸ *Bovingdon (Litigation Guardian of) v. Hergott*, [2006] CarswellOnt 6237 at para. 15 [*Bovingdon II*].

²⁸⁹ *Ibid.* at para. 21.

²⁹⁰ *Ibid.* at para. 22.

expenses for nursing care, medications and supplies connected with the children's disabilities for the balance of their lives, projected to be a further seventeen and forty-four years respectively, not for basic sustenance.

... I agree with the trial judge that according to *Krangle*, the parents were entitled to have the jury determine on the evidence what losses they would reasonably be likely to incur for the cost of the care of the twins beyond the age of majority, whether or not they were legally obliged to continue to care for the twins after that time, and to award those costs as part of their damages in this case.²⁹¹

It is therefore likely that parents will be able to successfully claim for damages beyond the age of majority when it can be shown that they are likely to incur costs for caring for their children beyond the age of majority. However, this is not the end of the inquiry in relation to compensation for children harmed by preconception negligence. First of all, only the child could have a valid claim for the pain and suffering caused to them, as noted by the Court of Appeal.²⁹² In addition, two important points need to be considered in detail: the difference between parents and the child receiving funds, as well as the limitations of the “normal child” and “disabled child” dichotomy.

Parent and Child Awards

The Court of Appeal in *Bovingdon* and *Paxton* would deny the born alive child any direct compensation for preconception negligence, whether before or after the age of majority. This puts such children in a different category from children injured during negligent prenatal care, who have claims independent of

²⁹¹ *Bovingdon*, *supra* note 3 at paras. 82, 85.

²⁹² *Paxton*, *supra* note 3 at para. 80.

their parents for compensation for negligent prenatal care. The children in the preconception class are entirely dependent on their parents' management of these compensatory awards, particularly for distribution past the age of majority.

This dependency, while not always a problem, can leave children vulnerable in the wrong circumstances. Parents will often use their compensatory funds as intended to pay for the child's upbringing, but what if they do not?²⁹³ As *Syl Apps* and the child protection context demonstrate, parents do not always act in the best interests of their children, to the point that the state may have to intervene and take children away from their parents in abusive circumstances. Paru J. in the *Bovingdon* trial decision noted the danger of leaving compensation only within parental tort law claims:

[I]t would be anomalous to allow the parents recovery for future costs of the children, but to deny that recovery to the persons injured. Recovery by the parents rather than the children may expose the children to a risk of loss of funds awarded for the cost of future care because of death, divorce or bankruptcy of the parents.²⁹⁴

It is important to note that in the separate trial ruling in *Bovingdon* on the application of *Krangle* and parent's claiming damages beyond the age of

²⁹³ There may be legal avenues for the infant for compensation before the age of majority if the parents misused funds, as parents are required by law to support their children. However, parents do not generally have a legal obligation to support their children past the age of majority. There are circumstances such as child support legislation that may extend a legal obligation past majority for certain costs, but the two situations are not yet comparable. For example, see *Family Law Act*, S.A. 2003, c. F-4.5.

²⁹⁴ *Bovingdon*, *supra* note 4 at para. 14.

majority, Pardu J. suggested that “[i]n the event there are any issues as to use of the funds for the benefit of the children, these issues may be dealt with by the imposition of a trust.”²⁹⁵ However, arguably this answer was Pardu J’s response to the defendant’s concern about parents benefitting unjustly from a claim for damages for costs that they were “not legally obligated to incur” rather than a response to the potential impact on the child.²⁹⁶ Pardu J. noted the defendant’s concern earlier in the ruling:

The Defendant argues that such claims are not available as a matter of law when the parents are not legally obliged to support their children under the applicable provincial family law legislation, except for some contingency to reflect the possibility that the law will be changed.²⁹⁷

Pardu J. accepted that the parents were not legally obliged to care for their children with disabilities past the age of majority, but noted that the parents’ claim “that it was in the children’s best interests to reside in their parents’ home was not challenged” by the defendant.²⁹⁸ The potential imposition of a trust was discussed to assuage the defendant’s concerns regarding the use of the funds, rather than the potential concerns of the children born with disabilities.²⁹⁹ The fact that the trust was suggested with the intent to ensure that the award did not overcompensate the parents, rather than to make

²⁹⁵ *Ibid.* at para. 22.

²⁹⁶ *Ibid.* (case summary at page 1).

²⁹⁷ *Ibid.* at para. 2.

²⁹⁸ *Ibid.* at para. 5.

²⁹⁹ As a general principle, damages in tort are intended to monetarily position the plaintiff as if the wrong had not occurred, no more and no less.

sure that the children were compensated, explains why Pardu J. did not mention a trust as a solution when considering the danger of leaving children with no claim for damages. It also matches the consideration of using a trust to remedy the unjust compensation concern in *Krangle*, where the parents argued the far “more tenuous” moral obligation “to reimburse the state for basic living expenses.”³⁰⁰

Certain damages can be claimed “in trust” by the plaintiff to compensate third parties who provided voluntary services to the plaintiff in the time between the injury and the trial, services that helped the plaintiff cope with the injuries suffered.³⁰¹ This type of “in trust” claim is for these past services provided to the plaintiff, guaranteeing that the award does not overcompensate the plaintiff by ensuring that the award goes to the third parties. The award for future care does not need to be awarded “in trust” because the plaintiff has the freedom to choose who to pay to provide future services not yet rendered.

There are a few examples of “in trust” awards covering future loss of income and they are quite limited. For example, in *Preston v. Chow* the mother of a child catastrophically injured by prenatal negligence had an “in trust” claim covering the lost income she experienced while taking care of the infant plaintiff

³⁰⁰ *Bovingdon II*, *supra* note 288 at para. 17.

³⁰¹ This is care provided *for* the injured plaintiff, rather than care provided *by* the plaintiff for another party.

The third party providing voluntary support is often a spouse, parent, grandparent, or child.

up to trial.³⁰² Because the mother was delayed from completing her education and entering the workforce, there were also damages calculated “in trust” covering loss of future earnings for the three years it would take to undertake the appropriate schooling and achieve a competitive job.³⁰³ However, this loss of future work income was directly related to past services provided up to trial, which were the reason why the mother had her schooling and start of employment delayed by three years.³⁰⁴

The majority of the British Columbia Court of Appeal noted the limitations of “in trust” awards and attempted to create an “extension of that concept” in *Krangle*.³⁰⁵ The majority determined that the parents in *Krangle* were likely to be legally required to pay for taking care of their son Mervyn past the age of majority and that the award to cover that timeframe could be awarded in a trust.³⁰⁶ However, McEachern C.J.B.C. provided a strong dissent that highlighted the unusualness of the proposed trust remedy:

In my judgment, there is no authority justifying the imposition of such a trust in a case such as this. *It must be remembered that Mervyn (the proposed*

³⁰² *Preston v. Chow*, 2007 MBQB 318, [2007] M.J. No. 484, 2007 CarswellMan 534 [*Preston*].

³⁰³ *Ibid.* at paras. 349-350.

³⁰⁴ *Ibid.* at para. 95. In *Bosard v. Davey*, Mr and Mrs. Bosard asserted a wrongful birth claim for a child born with Down’s syndrome. The doctor was held to have met the standard of care to the mother and the claim was dismissed. Mr. Bosard was deemed to have no duty of care owed to him and thus no independent claim, but did have a potential “in trust” claim dependent on his wife’s duty. There was a brief consideration of Mr. Bosard’s future loss of income during the damages calculation, which was dismissed due to the lack of any established loss of future income. See *Bosard v. Davey*, 2005 MBQB 80, [2005] M.J. No. 85 at paras. 95, 180-182.

³⁰⁵ *Krangle (Guardian ad litem of) v. Brisco*, 2000 BCCA 147, [2000] B.C.J. No. 465 at para. 27, 2 C.C.L.T. (3d) 13 [*Krangle BCCA*]

³⁰⁶ The ruling on whether the parents were likely to incur legal liability for age of majority care was overturned by the Supreme Court of Canada, as noted earlier. See *Krangle SCC*, *supra* note 286 and text accompanying note 286, above.

beneficiary of the trust) has no claim to damages. If the parents have a claim, it is to assist them to discharge their legal obligation to support their child after he attains the age of 19 years under legislation that does not affect the defendant. But as already mentioned, Mervyn is not likely to need that assistance from the plaintiffs. Thus, the creation of a trust in these circumstances would serve only to protect a fund that will not likely be needed ... *Because Mervyn does not have a cause of action, there is no parallel between this case and the so-called "in trust" claims for housekeeping and other assistance.* Those claims are paid in trust for replacement services required while a parent looks after an injured spouse, parent or child who themselves have a cause of action.

It cannot be disputed, in view of *Ratych v. Bloomer*, [1990] 1 S.C.R. 940 at 978-983 that the trust concept may be used to provide compensation for voluntary services when necessary and appropriate in the interests of justice. The purpose of the trust here, however, is to impose an unnecessary liability upon the defendant *for the benefit of a person who has no claim against him.* It has been said, wisely, I think, that new equitable rights should be created only with the greatest possible care.³⁰⁷

The Supreme Court of Canada declined to decide the trust issue during appeal, as it became a moot issue with the conclusion that the parents would not be held financially liable beyond the age of majority for Mervyn, the infant plaintiff in *Krangle*.³⁰⁸ McEachern C.J.B.C.'s dissent at the Court of Appeal is persuasive. Adult plaintiffs in other tort law circumstances typically do not have their compensatory awards placed in trusts. They are free to mismanage the funds provided to compensate for their physical or economic losses at their own peril.

Mervyn did not have a valid claim in *Krangle*, because his claim fell under a wrongful life situation. If it is accepted that there is no duty to any born alive child for negligent preconception care, then these children will be placed in the

³⁰⁷ *Krangle BCCA*, *supra* note 305 at paras. 93-95 [emphasis added].

³⁰⁸ *Krangle SCC*, *supra* note 286 at para. 44.

same situation. The suggestion of placing a trust on the parental claim as a patchwork solution would be similarly subject to McEachern C.J.B.C.'s concerns.

The tool of a trust would be useful for the protection of the child before and possibly after the age of majority, but in relation to damages granted for the child's claim, rather than the parental claim.³⁰⁹ It makes sense for an infant child to have their compensatory award for damages to be placed under the protection of a suitable trust. The British Columbia Court of Appeal in *Krangle* highlighted the established appropriateness of a trust in this situation where the child has an independent claim:

If the damages claimed had been based on a catastrophic birth, the cause of action would have been Mervyn's and the damages would routinely be held in trust for his benefit.³¹⁰

"Normal" and "Disabled" Children

The remaining point to discuss in relation to compensatory damages is the false dichotomy suggested by separating children into "normal" and "disabled" groups. In reality, children with disabilities fall along an extensive spectrum of differing abilities. While not intentional, legal placement of children into two categories can be stereotypical or even discriminatory.

³⁰⁹ The requirement for a trust after the age of majority would depend on the circumstances. For catastrophic brain injury or other situations where the child would lack mental competency, it would be appropriate.

³¹⁰ *Krangle BCCA*, *supra* note 305 at para. 24.

This spectrum of abilities is relevant to compensation and the calculation of damages. A successful medical negligence claim must have a verified injury caused by the negligence of the doctor. By necessity, damages must be compared to the situation where the child would not have been injured, which involves comparing to statistically “normal” or “average” children. The issue is not this comparison, but the potential assumption that all children with disabilities will need to be relegated to the support of their parents, guardian, or the state past the age of majority.

This undue assumption is driven by the fact that much of the relevant case law deals with children who suffered catastrophic injuries and have serious disabilities that do necessitate permanent wardship. This prevalence is partly explained by the fact that medical negligence lawsuits are very expensive to bring forward. The prospect of large awards and contingency fees in cases involving very serious physical and mental disabilities assists plaintiffs in bringing forth and winning these cases. Cases involving children injured by medical negligence, but with less catastrophic injuries, may be less likely to pass the financial hurdle for reaching a court decision.

Nevertheless, it is a reality that some children with disabilities caused by a doctor’s negligence will be able to support themselves after the age of

majority.³¹¹ They may, however, have medical costs during that time that require compensation, just not to the extent of the major cases. There are medical costs that can extend past the age of majority, but may not be funded by state medical programs.³¹² These damages are something that the infant plaintiff will face as an adult, but fall into that middle range where they are independent members of society and are not eligible to receive full funding for their injuries. Certain injuries may be deemed too remote for compensation depending on the circumstances, but it is inevitable that some damages are within the reasonable ambit of the defendant's negligence and would be compensated, if the plaintiff had an established claim for negligence.

The factors discussed in this section highlight the fact that denying born alive children any duty of care covering preconception negligence could place children in a "lacuna in the law" similar to and more perilous than the plaintiffs in the disappointed beneficiaries cases.³¹³ While focussed on negligence during pregnancy, the Supreme Court of Canada in *Montreal Tramways Co. v. Léveillé* highlighted the injustice that can occur when pre-birth negligence is not compensable:

³¹¹ For example, children who have Down's syndrome have a chance of securing employment and some financial independence in our society. *CDSS Brochures* (2011), online: Canadian Down Syndrome Society <<http://www.cdss.ca/>>.

³¹² For example, in *Paxton* some of the damages calculated by the trial judge included hearing and protective devices, as well as speech and language training services, all of which had costs which extended past the age of majority. See *Paxton*, *supra* note 4 at para. 63,

³¹³ *White*, *supra* note 205 at 692. In addition, the child arguably has a more legitimate claim to compensation than a disappointed beneficiary. See text accompanying note 219, above.

If a child after birth has no right of action for pre-natal injuries, we have a wrong inflicted for which there is no remedy, for, although the father may be entitled to compensation for the loss he has incurred and the mother for what she has suffered, yet there is a residuum of injury for which compensation cannot be had save at the suit of the child. If a right of action be denied to the child it will be compelled, without any fault on its part, to go through life carrying the seal of another's fault and bearing a very heavy burden of infirmity and inconvenience without any compensation therefor. To my mind it is but natural justice that a child, if born alive and viable, should be allowed to maintain an action in the courts for injuries wrongfully committed upon its person while in the womb of its mother.³¹⁴

Protection of future children

The Court of Appeal in *Paxton* considered another residual policy concern that supported a duty of care to born alive children for preconception care:

The other issue that arises if a doctor does not owe a duty of care to a future child, is how to protect society's interest in ensuring that doctors meet the standard of care when prescribing a teratogenic drug to a woman of childbearing capacity. One may ask, if the doctor does not owe a duty to a future child, then to what duty does the standard attach? In order to allow teratogenic drugs to be available for prescription, society must be confident that such drugs are prescribed responsibly, having in mind the protection of future children.³¹⁵

This concern is not limited to teratogenic drugs. It could be viewed broadly as society's interest in preventing harm to future children from contraindicated treatments, whether in drug therapy or in other circumstances.

³¹⁴ *Montreal Tramways Co. v. Léveillé*, [1933] S.C.R. 456 at 464. While dealing the negligence of a third party who was not a doctor, is also an interesting case in terms of the actual injury suffered, which was being born with club feet. Even in the context of the 1930s, the infant plaintiff could grow up to become an independent member of society past the age of majority. If there were ongoing costs for treating or living with club feet that were not covered by the government's compensation plans, then the patient would face the problems highlighted by the Supreme Court of Canada, if left without a tort law remedy.

³¹⁵ *Paxton*, *supra* note 3 at para. 82.

Children suffering catastrophic damages from pre-birth negligence might have to rely on state funding, providing a financial impetus for concern, beyond the moral concern about the health, happiness, and wellbeing of future children.

The Court of Appeal posited two solutions for this concern. One solution is the existing informed consent duty owed to the mother, which includes informing about the relevant risks to a future child. The second solution is that the doctor's professional and ethical responsibilities will protect future children. In the case of Accutane, there were rigorous prescription guidelines developed by the Food and Drug Administration (FDA) in the United States that served as modules for similar guidelines in Canada.³¹⁶

It is true that these safeguards do help protect future children. In addition, if the doctor's medical and ethical responsibilities would exclude a drug, then it is likely that the drug would be contraindicated and it would be a breach of the standard of care owed to the female patient. Prescription drugs are potentially dangerous materials when used improperly, in particular teratogenic drugs, which reflects society's interest in having doctors act as a gateway to access them. The general protection of future children does not absolutely necessitate the presence of a co-extensive system of duties for preconception medical care, but it is in alignment with such a system, as it is in alignment with co-extensive duties for prenatal medical care.

³¹⁶ *Ibid.*

Conclusion: The Argument against Denying All Duties for the Sake of Extreme Cases

It has been established that a conflict of interest would be non-existent in many situations, particularly in the preconception medical care scenario. What the Court of Appeal essentially accepted in *Bovingdon* and *Paxton* is that the impact is negative enough in some circumstances to deny any potential duty of care to a future child during the preconception timeframe. A similar argument was faced by the High Court in *Ross v. Caunters* when dealing with potential conflict of interest between the interests of testator and beneficiary:

[W]here there was no possibility of any conflict ... counsel was obliged to content that the rule for cases where there is a possible conflict must also govern cases where there is none.³¹⁷

This form of argument was used by the Supreme Court of Canada's majority decision in *Dobson* to deny any duty of care owed by pregnant women for prenatal conduct:

If such an action were allowed, even in the narrow context of negligent driving, it would have to recognize a duty and articulate a standard of care for the conduct of pregnant women. As a matter of tort law, this carries the risk that

³¹⁷ *Ross*, *supra* note 204 at 19.

the duty would be applied in other contexts where it would impose unreasonable obligations upon pregnant women.³¹⁸

In contrast to the majority, Justice Major argued that it would be possible to distinguish between conflicting and non-conflicting duties owed by the mother to born alive child for prenatal actions. For example, in situations where the mother already owed a duty to third parties, such as when driving:

Where a pregnant woman already owes a duty of care to a third party in respect of the same behaviour for which her born alive child seeks to find her liable, policy considerations pertinent to the pregnant woman's freedom of action cannot operate so as to negative the child's prima facie right to sue. The duty of care imposed on the pregnant woman is not more onerous because of her potential liability to her born alive child.³¹⁹

Justice Major's dissenting argument is essentially that the standard of care involved in such a duty to the born alive child, to drive with reasonable care, matched the existing standard of care already owed to third parties. This argument is similar to the argument currently proposed in favour of co-extensive medical duties for the preconception timeframe, which accepts that duties owed to the future child have a standard of care equivalent to the standard of care already owed to the female patient. The key difference from *Dobson*, however, is that the doctor is the potential defendant in this context, not the mother who was involved in the *sui generis* relationship during pregnancy.

³¹⁸ *Dobson*, *supra* note 266 at para. 65. It is not surprising then that the Court of Appeal in *Paxton*, *supra* note 3 cited the decision as support for the application of the argument here.

³¹⁹ *Dobson*, *ibid.* at para. 116, Major J., dissenting.

A factor mentioned in *Dobson* and in *Winnipeg* was the ubiquity of pregnancy and how it would be the pregnant women that are amongst the most vulnerable in society that are most likely to be affected by the proposed duties of care.³²⁰ In contrast, doctors undertake years of training to become part of an elite profession. They do not require the same protections that pregnant women might need from tort law liability for negligent actions.

In *Dobson*, the majority warned about the threat of the legal system contorting the duty of care to apply to undue aspects of the mother's personal life. There was no ability to avoid being inexorably connected to the fetus with every action that she took.³²¹ In contrast, with preconception duties, the potential defendant is the doctor, who has professional responsibilities and guidelines to follow to avoid liability.

In addition, there is a convenient dividing point that can be utilized, if necessary, to limit the liability scheme for preconception care. A division could be placed between the preconception medical care scenario and the general medical care scenario. Preconception liability for born-alive children could be limited to preconception medical care, though there are good reasons for accepting co-extensive duties in the general medical care scenario, at the very least in regards to the female patient's informed consent.

³²⁰ *Dobson*, *supra* note 266; *Winnipeg*, *supra* note 266.

³²¹ *Dobson*, *ibid.* at para. 85.

There does not need to be a blunt denial of any preconception duty to born alive children. To deny duties in this matter would stand in contrast with prenatal medical care, which can handle the co-extensive system of duties. To do so would unfairly distinguish preconception medical care merely because it was later to develop scientifically and medically in the modern timeline of pre-birth care.³²² To do so would create separate classes of children injured by pre-birth negligence in an arbitrary way.

Prenatal medicine itself still remains a developing field; as noted by Martinson J. in *Hunt*, the “mystery of birth and its complications will continue to perplex medical professionals, judges and lay people alike.”³²³ Preconception care is still at a more rudimentary level, but will develop over time. The tort law scheme that will govern it requires time to gestate and develop, rather than having its evolution stunted by a catch-all denial of preconception duties to born alive children. It is said that difficult cases make bad law, but to follow the full denial of duty argument in the preconception timeframe is to allow the mere possibility of difficult cases in the future to create an unjust distinction in the present tort law system.

Part IV: Auxiliary Topics

³²² For a list of historical developments in prenatal care, see Solomon *et al.*, *supra* note 147 at 396.

³²³ *Hunt*, *supra* note 237 at para. 9.

Introduction

Having examined the proposed co-extensive framework of duties for medical care in the preconception timeframe, it is important to investigate some of the auxiliary details involved with these duties. Part IV reviews the boundary limits of liability placed by reasonable foreseeability in duty of care and remoteness. There is a discussion of relevant issues related to contributory negligence and apportionment of damages. Finally, there is concluding commentary upon the potential for wrongful life scenarios in preconception negligence cases.

Limits on Liability: Foreseeability in Duty of Care and Remoteness

Foreseeability is relevant to several different aspects of a negligence case, specifically duty of care, standard of care, and remoteness of damages:

First, a court will impose a duty of care only if the defendant's conduct created a foreseeable risk of injury to the plaintiff. Second, the probability of injury is one of several factors considered in determining whether the defendant breached the standard of care. Finally, the plaintiff's losses will be held to be too remote if they were not a foreseeable result of the defendant's breach of the standard of care. The courts do not always draw a clear distinction between those three concepts.³²⁴

The trial judge in *Paxton* made the mistake of mentioning foreseeability of the pregnancy in the particular facts of the case (standard of care) when

³²⁴ Solomon *et al.*, *supra* note 147 at 318.

intending to discuss foreseeability of harm if a pregnancy were to occur (duty of care). This blurring of the different applications of foreseeability was criticized by the Ontario Court of Appeal, though it ultimately did not affect the decision.³²⁵ Professor Klar notes the Court of Appeal's emphasis on distinguishing "between foreseeability of pregnancy in general as a matter of duty and foreseeability in a specific case as a matter of standard."³²⁶

This section focuses on the limiting role of foreseeability in duty of care and remoteness in relation to medical negligence in the preconception timeframe. Professor Klar describes the essential difference between reasonable foreseeability in duty of care and remoteness:

Traditional negligence law has ... kept these concerns separate, designating foreseeability of the plaintiff as a victim of any type of injury as a duty question, and foreseeability of the type of injury itself as one of remoteness.³²⁷

Duty of Care

The first branch of the *Anns* test includes a requirement of reasonable foreseeability. It is a broad question of law, "whether as a general proposition the type of relationship in issue gave rise to a foreseeable risk of injury."³²⁸ Reasonable foreseeability was accepted by the trial courts and the Court of

³²⁵ *Paxton*, *supra* note 3 at paras. 60-63. See text accompanying note 120, above.

³²⁶ Klar, *supra* note 138 at 181.

³²⁷ *Ibid.*

³²⁸ *Ibid.*

Appeal for the facts in *Bovingdon* and *Paxton*.³²⁹ In the first scenario of preconception medical care, the requirement of reasonable foreseeability is generally easily met, as the entire point of the medical care is to prepare for an intended pregnancy. It is quite foreseeable that harm might result from negligent preconception care.

In contrast, foreseeability is a potential problem for the second scenario, general medical care. The issue is that while there is an inherently limited timeframe for pregnancy, there is not a similarly determined timeframe on how far back from the conception date the doctor would have a duty to the born alive child for preconception medical care. Is the period of concern several months or several years before conception? Should a doctor really be concerned about a potential future child when treating any patient with reproductive capacity? The causal chain of events affecting a future child can extend back even before puberty, but tort law has boundary checks to reasonably limit the liability of toward doctors and other potential defendants.³³⁰

For the general medical care scenario, the range of a duty to a born alive child for preconception care should be limited by matching it to the similar duty owed to the adult plaintiff. Therefore, foreseeability can limit the extent of preconception duties to a born alive child, but it should be used as a trimming or

³²⁹ See the case reviews in Part I, above.

³³⁰ There is also the potential for harmful consequences through multiple generations going forward, if there is physical or genetic damage; see Browne, *supra* note 191 at 2574-2578. Tort law must set reasonable limits in either direction of the timeline.

controlling factor in this way, rather than to bluntly deny the existence of any preconception duty. Whatever the limit that reasonable foreseeability places on a potential duty of care to born alive children for preconception care, it is no greater than the limit placed on the duty of care owed to parents for the same preconception medical care.³³¹

One possible distinguishing factor in this proposed matching is that the class of plaintiffs is noticeably different between adult parents and born alive children. Reasonable foreseeability for a successful duty of care requires a foreseeable class of plaintiffs.³³² In the case of a duty to the adult patient, they are obviously foreseeable, already being in existence and in a medical relationship with the doctor, leaving concerns of foreseeability primarily to the standard of care and remoteness analysis. On the other hand, the born alive children were not even conceived until after the medical care and perhaps are not foreseeable in some situations.

However, this distinction is of little practical consequence when it comes to the ultimate success or failure of a preconception negligence claim. If a subsequent pregnancy and born-alive child was not foreseeable in a particular case, both the adult and infant claims will fail, regardless of whether the failure occurs due to lack of foreseeability in the duty of care or standard of care. The

³³¹ While this comparison treads close to mixing considerations of foreseeability in duty and standard of care, the ultimate point in this section is that the standard of care foreseeability requirement is the higher hurdle to meet, so the lower foreseeability hurdle in duty of care is not an issue.

³³² Klar, *supra* note 138 at 181-182.

type of relationship that the doctor has with the future child is necessarily intertwined with the relationship owed to the adult patients, already sharing the same standard of care. It is also together that the two claims will succeed or fail in relation to the hurdle of reasonable foreseeability.

Remoteness

Remoteness sets the limits of liability for otherwise negligent conduct, determining which injuries are “too remote” to be compensated under the framework of tort law.³³³ Remoteness determines “the *extent* or *scope* of liability (not its *basis*) [and] demands delicate value judgments and the drawing of fine lines.”³³⁴ As Andrews J. explained in *Palsgraf v. Long Island Railway Co.*, “[remoteness] is not logic. It is practical politics.”³³⁵ “Not surprisingly . . . the content of [remoteness] has tended to vary from time to time, and from place to place, as judicial perceptions of societal values have shifted.”³³⁶

In both the preconception medical care and general medical care scenarios, there will be injuries that are too remote to compensate. Courts that accept preconception medical duties, whether limited to parents or provided to both parents and children, will have to develop the limits of remoteness in a case by case basis. What is similar to reasonable foreseeability in duty of care is that

³³³ Allen M. Linden & Bruce Feldthusen, *Canadian Tort Law*, 9th ed. (Markham: LexisNexis Canada Inc., 2011) at 362-363.

³³⁴ *Ibid.* [emphasis in original].

³³⁵ *Palsgraf v. Long Island Railroad Co.*, 248 N.Y. 339, 162 N.E. 99 (N.Y. 1928), at para. 352, cited in Solomon *et al.*, *supra* note 147 at 599.

³³⁶ Solomon, *ibid.* at 600.

the limits placed on compensation to infant plaintiffs due to remoteness are generally matched by the limits on liability placed on compensation to the parents of the child due to remoteness.

It will be up to courts to determine the cutting lines of remoteness in the factual context of future cases, as both law and medical science develops. While some potential damages may be considered too remote to award to a born alive child, remoteness is a tool to tailor the manageable expansion of preconception negligence and the resulting damage awards, rather than to fully deny compensation for preconception negligence.

Contributory Negligence and the Apportionment of Liability

There is a potential apportionment of liability issue with infant tort law claims for prenatal negligence related to the mother's own 'negligent' actions. While this is a current topic for prenatal negligence, it would potentially be relevant for preconception negligence cases as well, if a similar co-extensive system of duties were accepted for preconception care. While a full analysis of this issue is beyond the scope of this thesis, it is worth outlining and commenting on the potential concerns.

When a mother and born alive child both bring forward claims for prenatal medical negligence, the mother's claim for damages can be reduced, if she is found to be contributory negligent. However, given that the child has an

independent claim, the child cannot have his or her claim similarly reduced by the mother's contributory negligence. The burden is on the doctor to seek contribution from the mother, but given *Dobson*, this may not be possible.

This question came to light in *Preston v. Chow*.³³⁷ The infant plaintiff suffered severe brain damage as a result of contracting herpes, which was contracted by coming into contact with the mother's herpes sores during labour and delivery. The doctor alleged contributory negligence in regards to the mother's unprotected sex that led to her initial contraction of herpes before the pregnancy, as well as a failure of disclosure in regards to her medical history and potential exposure to herpes. The contributory negligence claim was eventually dismissed by the judge at trial based on the particular facts of the case.³³⁸ However, in the interim, the doctor's accompanying claim for contribution from the mother under Manitoba's *Tortfeasors and Contributory Negligence Act* in relation to the infant plaintiff's claim was considered by the Court of Appeal of Manitoba.³³⁹

A three justice panel considered the legal issue in the light of the Supreme Court of Canada's decision in *Dobson* that had been released several years earlier.³⁴⁰ The Court of Appeal's unanimous decision highlighted that

³³⁷ *Preston*, *supra* note 302.

³³⁸ The trial judge convincingly dismissed both alleged grounds of contributory negligence, see *ibid.* at paras. 199-207.

³³⁹ *Tortfeasors and Contributory Negligence Act*, R.S.M. 1987, c. T90.

³⁴⁰ *Dobson*, *supra* note 266; *Preston v. Chow*, 2002 MBCA 34, [2002] M.J. No. 105, 211 D.L.R. (4th) 758 [*Preston MCA*].

Dobson prevented a mother from being held liable to her child for her conduct before the child's birth. The doctor's claim was dependent on legislation, as "at common law there was no requirement for contribution and/or indemnity between tortfeasors."³⁴¹ As the legislation required that the person being targeted for contribution be potentially liable to the plaintiff, the doctor could not seek contribution from the mother in relation to the infant plaintiff's claim.³⁴²

The Court of Appeal accepted that this could lead to the odd situation where a mother's tort law claim was reduced by her own contributory negligence, but the same conduct could not be used to lessen the doctor's final liability to the infant plaintiff:

Counsel for the defendants submits that it would be unfair to strike out these allegations because that could lead to a situation where the defendants would be liable to pay for all of the infant plaintiff's damages, notwithstanding that the defendants might have been only partly or even only slightly at fault. In response, I can do no better than adopt the words of Jewers J., the motions court judge, at para. 24, "That is no doubt true and it is unfortunate. But it cannot be helped."

The law has made a choice based on certain rationales. The result is no different than if the infant plaintiff had sued both her mother and the other defendants. The action against the mother would inevitably have been dismissed and the defendants would still be liable to pay all of the damages. In practical terms, it would be no different from the situation where a co-defendant and joint tortfeasor is judgment-proof.³⁴³

³⁴¹ *Preston MCA, ibid.* at para. 19.

³⁴² *Ibid.* at paras. 19-26; *Tortfeasors and Contributory Negligence Act*, R.S.M. 1987, c. T-90, s.2(2).

³⁴³ *Preston MCA, ibid.* at paras. 17-18.

The Court of Appeal noted that this sort of issue could arise in other situations that involve any form of tort law immunity:

This is not a unique situation. The question of the availability of contribution arises any time an immunity or special defence frees a "wrongdoer" from being legally liable. It arises, for example, in workers' compensation claims where a non-employer third party may be partly responsible for a work-related injury or in situations of governmental immunity. Historically, it arose in cases of spousal immunity from tort actions.³⁴⁴

There was other Manitoba case law based on the relevant contribution legislation that supported the Court of Appeal's decision regarding the legislation.³⁴⁵ Also, the history of the legislation showed that it had contained a section in the past that dealt with contribution from immune spousal tortfeasors, when spousal immunity had still been accepted as a valid defence in Manitoba.³⁴⁶ In reviewing this past section, the Court of Appeal noted one possible route for dealing with the potential unfairness of the ruling, specifically that the legislation could be amended to cover other areas of immunity or to give judges more freedom and flexibility in difficult cases.³⁴⁷

This is not an issue limited to negligent prenatal medical care. It is potentially present in any situation where a third party is negligent and causes

³⁴⁴ *Ibid.* at para. 22.

³⁴⁵ *Fraternal Order of Eagles Winnipeg Aerie No. 23 v. Blumes and Rurak* (1994), 95 Man.R. (2d) 92 (C.A.), cited in *Preston MCA*, *supra* note 340 at para. 27.

³⁴⁶ *Tortfeasors and Contributory Negligence Act*, R.S.M. 1970, c.T90, s. 6; *Preston MCA*, *supra* note 340 at paras. 22, 25-26. The Court noted that the previous requirement and presence of a section to deal with spousal immunity showed that the overall legislation itself did not grant judges the flexibility to get around the potential liability requirement for spousal immunity or other forms of immunity.

³⁴⁷ *Preston MCA*, *ibid.* at para. 24.

harm to a pregnant mother and her result born alive child, with the accompanying fact that the pregnant mother also acted in a negligent manner. The mother's claim for damages could be reduced by contributory negligence, but the third party would be fully liable to the born alive child, despite the mother's conduct.

Arguably, *Dobson* made the situation conceptually similar to that in *Athey v. Leonati* and other cases where the plaintiff's injuries are caused by a combination of tortious and non-tortious causes.³⁴⁸ Even if the tortious activity were comparable slight, if it were necessary to cause the damages, then the defendant is entitled to full compensation. *Dobson* made the mother's potentially negligent actions non-tortious in regards to the infant plaintiff's losses.

The Court of Appeal in *Preston* did mention the example of the *Congenital Disabilities (Civil Liability) Act 1976* in the United Kingdom, which covers negligent driving and could be a model for future legislation in this area.³⁴⁹ It creates a legal scheme "whereby a negligent mother does not contribute, but the liability of the third party to a child born disabled is reduced to the extent of the mother's fault."³⁵⁰

³⁴⁸ *Athey v. Leonati*, [1996] 3 S.C.R. 458, 140 D.L.R. (4th) 235.

³⁴⁹ *Congenital Disabilities (Civil Liability) Act 1976* (U.K.), 1976, c. 28.

³⁵⁰ *Preston MCA*, *supra* note 340 at para. 23.

It is interesting to note that despite the Supreme Court of Canada's concern in *Dobson* about a mother's conduct during pregnancy being examined in the harsh light of the courtroom, it is being examined regularly during any contributory negligence defence.³⁵¹ The difference is that the spotlight may reduce her claim for negligence, rather than support a claim for negligence (or contribution) against her, but the same conduct may be formally judged to be essentially at fault.

The law in this area is complex and developing. What is important to note is that this is an issue currently present in all prenatal negligence cases that involve an allegation of contributory negligence related to the mother's actions. This is not a unique issue to potential preconception duties and should not stand as a reason to block the acceptance of co-extensive duties for preconception medical care.

Wrongful Life

There has been much discussion and debate in judicial and academic circles in relation to wrongful life claims.³⁵² At this date, wrongful life claims have not been successful in Canada. It is beyond the scope of this thesis to enter the wrongful life debate; the current legal status is accepted. The Ontario Court of Appeal in *Bovingdon* and *Paxton* ultimately sidestepped the issue of wrongful life

³⁵¹ *Dobson*, *supra* note 266 at paras. 27, 85.

³⁵² Linden & Feldthusen, *supra* note 333 at 315; Solomon *et al.*, *supra* note 147 at 385-387; Shaun D. Pattinson, "Wrongful Life Actions as a Means of Regulating Use of Genetic and Reproductive Technologies" (1999) 7 Health L. J. 19; *Lacroix*, *supra* note 57 at paras. 24-36.

by denying the proposed preconception duty.³⁵³ What is worth examining is the interrelation between wrongful life claims and potential preconception duties owed to born alive children.

The fact that the alleged negligence in preconception cases occurs before conception makes it possible for some preconception cases to fall under the wrongful life sphere. Similar to prenatal negligence, whether a particular case falls under wrongful life depends on the determined facts of the case. If the end result of avoiding negligence would have been an avoidance of conception and/or birth of the child, then this should generally trigger the wrongful life label in either preconception or prenatal care.³⁵⁴ Some prenatal and preconception claims will be barred via wrongful life based on the facts, while other prenatal and preconception claims will succeed.

Wrongful life will often be a battleground for plaintiffs and defendants. Plaintiffs seeking to avoid the wrongful life label may stray from co-extensive duties into the realm of independent and conflicting duties.³⁵⁵ Defendants facing an otherwise successful claim in negligence would do well to argue that the particular facts of a case fall under wrongful life. Judges will have to contemplate and determine patient “what if?” scenarios similar to those considered in

³⁵³ See the case reviews in Part I, above.

³⁵⁴ There are exceptions to this general rule that have been criticized, such as *Cherry*, *supra* note 41, reviewed in Part 1, above.

³⁵⁵ See text accompanying note 251, above.

informed consent cases, cases that themselves often contain potential wrongful life scenarios when based in the prenatal or preconception context.³⁵⁶

The threat of wrongful life does not block all preconception claims, though it certainly does leave a large shadow in the area. As preconception torts continue to develop, the increased focus on this shadow may stimulate further judicial and legislative developments related to wrongful life in Canada. In any rate, with the current state of wrongful life claims in Canada there are still many situations where a born alive child owed a co-extensive duty could bring forward a successful claim for preconception negligence without falling into the wrongful life trap.

Conclusion

The preconception medical care scenario, at the very least, is an appropriate location for co-extensive medical duties owed to born alive children that parallel the duties already owed to their parents. Doctors and the patients are both aware of an intended pregnancy in this situation, with the medical care oriented toward benefitting the future child. “It should not come as a surprise” that negligent care under these circumstances could lead to liability owed to both parents and born alive children.³⁵⁷

³⁵⁶ For an example, see Wrongful Life Reasoning, under the trial level review of *Paxton* in Part I.

³⁵⁷ *Bovingdon Trial*, *supra* note 4 at para. 17.

The general medical scenario, on the other hand, is a more complex situation. As displayed throughout the *Anns* analysis, the general medical scenario is potentially more vulnerable to policy concerns and other criticisms. Nevertheless, there is still room for co-extensive duties in the general medical care scenario, whenever they can still successfully parallel duties already owed to parents for the same medical care.

It is important to consider the effect that accepting a broad ratio from *Bovingdon* and *Paxton* and blanket denial of duties may have on the developing area of preconception medical care. The preconception sphere is a growing area of medical care that will continue to attract the attention of law broadly and tort law specifically in the future. Assisted reproduction technology (ART) is already an important medical development in Canada, which is helping both male and female patients. Preconception genetic counselling is also growing in importance, as developing science unravels information that will be vital in preventing or controlling genetically inherited diseases.³⁵⁸

Future medical developments will expand the importance of preconception medical care. The growing impact that preconception medical care can have on a person's health for their entire lifetime emphasizes the importance of leaving room for the development of preconception medical duties of care. Like prenatal medical care, preconception medical care can

³⁵⁸ *Bobinski, supra* note 172 at 804-805.

constructively sustain an emerging tort law system of co-extensive medical duties.

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