Forceps and Caesarean Deliveries and Informed Consent: New Issues and Dangers in Child Delivery Methods

Richard M. Bogoroch & Simone A. Levine
Bogoroch & Associates
March 26, 2002

Forceps and Caesarean Deliveries and Informed Consent: New Issues and Dangers in Child Delivery Methods

Richard M. Bogoroch & Simone A. Levine
Bogoroch & Associates
March 26, 2002

TABLE OF CONTENTS

PAGE

1. The Timing and Conduct of Forceps Deliveries and Caesarean Sections 4

1. Delay in Carrying out a Forceps Delivery

2. The Time Span between Attempting a Forceps Delivery and Performing a Caesarean Section 6

3. Delay in Performing a Caesarean Section 9

4. The Relationship between Long Labour, Caesarean Sections and Cerebral Palsy 13

2. Informed Consent - Ensuring Consent is Informed in the Context of Induced Labour and Caesarean Deliveries 17

3. Conclusion: What Constitutes Negligence during Delivery - The Impact of Recent Case Law 23

Forceps and Caesarean Deliveries and Informed Consent: New Issues and Dangers in Child Delivery Methods

Richard M. Bogoroch & Simone A. Levine
Bogoroch & Associates
March 26, 2002

In a medical malpractice action against a physician, the plaintiff must establish on a balance of probabilities that the physician departed, in a blameworthy way, from the normal standards of skill, judgement, or knowledge prevailing in the medical community at the material time. Where the physician holds himself or herself out as a specialist, a higher degree of skill is required, and the physician is judged based on the conduct of the average specialist in the filed who has acquired the knowledge, competence and skill expected of that specialist at the material time.[1] Once the injured plaintiff has proven the requisite standard of care and that this standard was negligently breached by the physician, the plaintiff must then prove that the breach was the actual cause of the plaintiff's injuries.

This paper provides insight into the standard of care required of hospitals, nurses and obstetricians regarding child delivery methods and informed consent in the context of child delivery. My co-presenter Dr. Jon Barrett has addressed some of the medical issues involved in the risks of delivery with forceps and vacuum extraction, as well as the timeliness of a caesarean section. To gain an understanding of how the Courts approach causation in this context, the following is a brief summary

[1]*Allen (Next Friend of)* v. *University Hospitals Board,* [2000] A.J. No. 880 (Q.B.) (QL) [hereinafter *Allen*].

of recent court decisions from Canada and the United Kingdom.

1. The Timing and Conduct of Forceps Deliveries and Caesarean Sections

1. Delay in Carrying out a Forceps Delivery

In *Carr* v. *Stockport Health Authority*[2], a decision of the Court of Appeal of England and Wales, the infant was born at **19:20** by forceps delivery. He was brain damaged at birth and suffers from cerebral palsy. The brain damage was consistent with an hypoxic event lasting between **20** and **30** minutes; therefore, Lord Justice Henry was satisfied that the damage started between **18:50** and **19:00**, and the infant would not have been brain damaged if he had been born at any time up to **19:10**.[3]

At **18:55** Dr. Anakwe, the obstetrician, made his decision to perform a forceps delivery. Lord Justice Henry found that a safe forceps delivery would have been possible at that time, and would have left the infant with no brain damage, but Dr. Anakwe negligently delayed the forceps delivery.[4] Shortly after **18:55**, the mother's uterine scar started to rupture. At **19:15** Dr. Anakwe applied the forceps to the head of the baby and the baby was born at **19:20**. Lord Justice Henry concluded as

---

[2][1999] E.W.J. No. 1349 (C.A.) (QL) [hereinafter "*Carr*"].

[3]*Carr, ibid.* at para. 2.

[4]*Ibid.* at para. 3.

follows,

> In my judgement, having decided at about 18:55 to carry out an immediate forceps delivery, Dr. Anakwe failed to take appropriate steps to implement that decision with due expedition. This delay was inexcusable and in clear breach of the duty of care which was admittedly owed to Jason.[5]

The critical question of fact in this case was the time at which Dr. Anakwe decided that delivery was

[5] *Ibid.* at para. 49.

to be by forceps.[6] The application of forceps 20 minutes after the decision had been made to deliver the baby by way of forceps, was a delay which breached the duty of care owed to the infant.

B. Time Span between Attempting a Forceps Delivery and Performing a Caesarean Section

In *Commisso et al.* v. *North York Branson Hospital et al.*[7], a decision of the Ontario Superior Court of Justice, Swinton, J. found that the infant plaintiff suffered hypoxic ischemic encephalopathy due to an asphyxial insult following the application of forceps in 1989. As a result, the infant suffers from cerebral palsy.[8] The decision to attempt a trial of mid-forceps was not called into question by any of the medical experts and there was no suggestion that the forceps were applied improperly or used inappropriately.[9] While the baby was ultimately delivered by caesarean section, Justice Swinton found that a caesarian section was not an alternative course of treatment that Dr. Handysides, the obstetrician, could have offered to the mother at the time of the trial of the forceps delivery. Dr. Handysides, was found to have met the standard of care in the circumstances.[10]

[6] *Ibid.* at para. 37.

[7] [2000] O.J. No. 1866 (S.C.J.) (QL) [hereinafter *Commisso*].

[8] *Commisso*, *ibid.* at para. 45.

[9] *Ibid.* at para. 70.

[10] *Ibid.* at para. 98.

Upon examination of the mother at **16:45**, Dr. Handysides decided to perform a trial of mid-forceps due to the long labour and apparent tiredness of the mother. The trial of forceps began at **17:00**, but failed. At approximately **17:04** Dr. Handysides decided that it would be necessary to perform a caesarean section. The mother was rushed into the operating room. The operation began at **17:20** and the baby was delivered at **17:24**.

The plaintiffs' main argument was that Dr. Handysides failed to exercise the degree of skill expected of a specialist in the field of obstetrics by performing an elective trial of mid-forceps without ensuring that all preparations for a caesarean section had been made before the vaginal delivery was attempted. More particularly, it was argued that the standard of care in 1989 required a double set-up, that is, the trial of forceps should have been conducted in a room prepared for an immediate caesarean section.[11]

Based on the expert evidence, Swinton, J. held that the standard of care in 1989 did not require a double set-up.[12] The issue before Justice Swinton then became whether the standard of care required delivery within a particular period of time because of the likelihood of serious brain damage or death

---

[11]*Ibid.* at para. 69.

[12]*Ibid.* at para. 76.

to the fetus.[13] In this case, the caesarean section was completed in 10 minutes. Justice Swinton found a fixed ten-minute standard of care for delivery to be inappropriate and stated the following,

[13] *Ibid.* at para. 77.

> **I find that the standard of care in 1989 required that an obstetrician should have an operating room immediately available before attempting a mid-forceps delivery and where a fetus is at risk, as it was here because of the bradycardia, the doctor must move as expeditiously as possible to deliver the baby, having due regard for the safety of both patients -- baby and mother.**[14]

Swinton, J. went on to state that "[d]etermining whether a doctor has met that standard must turn on the facts of the particular case".[15] In this case, Justice Swinton found that the facilities necessary to perform the caesarean section were immediately available when Dr. Handysides commenced the trial of forceps because there was an operating room available a short distance away down the hall and an operating room staffed with nurses was assigned to the assisting anaesthetist.[16] Swinton, J. further determined that Dr. Handysides moved expeditiously as the time between the removal of the forceps and delivery of the baby was about 17 minutes. Dr. Handysides met the standard of care in the steps he took to determine the condition of the fetus, and that he then went on to deliver the baby as expeditiously as possible in the circumstances.[17]

C. Delay in Performing a Caesarean Section

In *Allen (Next Friend of)* v. *University Hospitals Board*[18], a decision of the Alberta Court of Queen's Bench, the baby was delivered by caesarean section and had to be resuscitated, intubated and bagged

---

[14] *Ibid.* at para. 81.

[15] *Ibid.*

[16] *Ibid.* at para. 82.

[17] *Ibid.* at para. 98.

[18] *Allen, supra* note 1.

with oxygen. It was the prevailing view that the infant had suffered from birth asphyxia. Justice Perras found several actions at various stages of the delivery to be below the standard of care expected of an obstetrician and gynecologist in 1990. Of particular relevance to this paper is the final stage, that is, the delay in conducting the caesarean section.

Dr. Boyd and Dr. Mueller had a "shared-care" approach with obstetrical patients. Both doctors saw the patient during pre-natal care and then the doctor on call on the day of the birth would handle the labour and delivery of the patient. At **7:50 a.m.** on the day in question, Dr. Mueller performed an artificial rupture of the membrane. At **9:20 a.m.** Dr. Boyd observed the fetal heart strip, ordered an intravenous and noted the possibility of a caesarean section. At **10:00 a.m.** Dr. Mueller consulted with the nurses and ordered morphine, but did not examine or speak with the mother. At this point the fetal monitor was unhooked and then reattached at **10:30 a.m.** by the mother herself. At **11:00 a.m.** the mother called for a nurse as she was concerned about the pattern on the monitor. Dr. Muir, a resident, was called in, examined the mother, found a compound presentation, and then administered an ultrasound. At **11:20 a.m.** the mother was advised that a caesarean section was necessary on an urgent basis. She was prepared and wheeled into the operating room at **11:40 a.m.**, the caesarean section was commenced by **11:54 a.m.** and the baby was delivered at **12:01 p.m.**.

Dr. Boyd testified that it took longer than anticipated to get the caesarean section because of the unavailability of an operating room. Justice Perrass did not accept this explanation as causing any delay for performing the caesarean section and stated the following,

While the hospital had no dedicated operating theatre for performing the C-sections, there

> were nevertheless on December 11, 1990 14 operating theatres in use. Dr. Boyd was himself alerted after his examination of Ms. Allen at 9:20 that there was a distinct possibility that a C-section would be needed for Ms. Allen. He even took the precaution of ordering an I.V. at the time in anticipation of a C-section; hence in my view, if as Dr. Boyd contends, it was difficult to get operating rooms, it behooved him at that time or shortly thereafter to check into that possibility. He did not do so and in my view this failure to communicate the potential need and to explore the potential need with the appropriate administrative personnel was substandard care afforded to Ms. Allen when in the end result it took from 11:10 till 12:01 to complete the C-section. In the circumstances, 45 to 50 minutes to do an urgent C-section in a tertiary care hospital is substandard care. The evidence indicates a 10 to 30 minute time frame is acceptable and I so find.[19]

Justice Perrass found that the negligence of the doctors at the very least materially contributed to the neurological damage sustained by the infant, even if she was prone to be autistic and even if autism is caused by faulty genes.[20] Perrass, J. was satisfied that the clinical symptoms displayed by the infant upon birth were consistent with a mild to moderate intermittent hypoxic eschemia that materially contributed to her condition.[21]

In *Oliver (Public Trustee of)* v. *Ellison*[22], a decision of the British Columbia Supreme Court, the infant plaintiff had many handicaps, including cerebral palsy and a seizure disorder. As a consequence of the mother's general practitioner's negligent failure to diagnose and properly control her gestational diabetes during her pregnancy, the risk of a caesarean was increased.[23] Two fetal

---

[19] *Ibid.* at para. 109.

[20] *Ibid.* at para. 160.

[21] *Ibid.*

[22] [1998] B.C.J. No. 589 (B.C.S.C.) (QL), varied [2001] B.C.J. No. 1040 (B.C.C.A.) (QL), leave to appeal dismissed [2001] S.C.C.A. No. 409 (S.C.C.) (QL) [hereinafter *Oliver*].

[23] *Oliver, ibid.* at para. 28.

monitoring tests had shown that the baby had a fetal heart strip with diminished fetal variability and movement. Following the second fetal monitoring test, Dr. Mitchell, the obstetrician, decided to immediately admit the mother to the hospital to induce labour. Notwithstanding this decision, Justice Boyd noted that,

> ...[H]e took no steps to prioritize Ms. Oliver as a patient requiring either an immediate induction or the performance of a Caesarean section. The labour continued for a number of hours with no progress. Despite the rupturing of the membranes, revealing amniotic fluid stained with meconium, no steps were taken to order an immediate Caesarean section.[24]

The baby was eventually delivered by caesarean section on the same day. Boyd, J. found that the obstetrician breached his duty of care to the mother in delaying the caesarean section; however, the plaintiff had failed to prove, on a balance of probabilities, that the doctors' negligence **caused or contributed to the injuries** suffered by the child.[25] The majority of the British Columbia Court of Appeal dismissed the plaintiffs' appeal against Dr. Mitchell.

4. The Relationship between Long Labour, Caesarean Sections and Cerebral Palsy

In *Bauer (Litigation guardian of)* v. *Seager*[26], a decision of the Manitoba Court of Queen's Bench, the infant plaintiff was not breathing when she was delivered, and as a result she was born with severe brain damage, suffers from cerebral palsy and is significantly mentally and physically

---

[24] *Ibid.* at para. 14.

[25] *Ibid.* at para. 39.

[26] [2000] M.J. No. 356 (Q.B.) (QL) [hereinafter *Bauer*].

impaired and disabled. Among other things, the plaintiffs alleged that the doctors failed to consider or implement a caesarean section delivery on a timely basis. Justice Clearwater was satisfied that the cause of the infant's injuries was asphyxia which commenced prior to her birth, at approximately 0010 hours, continued during the delivery process and during the resuscitation process thereafter.[27] Clearwater, J. noted that if a caesarean section would have been elected, the infant would probably have been born with no injuries.

At the outset, it was known to the nurses that the mother was a high risk patient because the fetus was in a breech position. At **0010** hours the nurse noted that the mother was fully dilated and the second stage of labour had started. At **0025** hours the fetal heart monitor record showed deep decelerations with contractions. At **0030** hours pushing commenced. At **0040** hours the fetal heart strip showed deep variables with contractions and the fetal heart beat dropping to 75-80 bpm for 30-40 seconds. It was at this time that the nurse called in Dr. Black, the resident. At **0045** hours the nurse applied oxygen, and at **0100** hours, the mother was taken to the caseroom for delivery. At **0112** hours, the buttocks and body were delivered. At **0119**, Dr. Seager, the obstetrician, and Dr. Black attempted to use forceps to deliver the head, but they were unable to properly attach the forceps and, ultimately, the baby's head was delivered manually.

Justice Clearwater was satisfied that the nurses' actions and inactions in failing to notify the doctors in a timely fashion of problems with the fetus from and after the commencement of the second stage

[27] *Bauer, ibid.* at para. 34.

of labour at 0010 hours until after 0040 hours, was conduct which fell below the standard of care for each nurse.[28] Clearwater, J. was further satisfied that this negligence caused or contributed to the

[28]*Ibid.* at para. 43v.

hypoxia and resulting injuries to the infant.[29]

Justice Clearwater was satisfied that a caesarean section could have and probably should have been performed at or as shortly after 0025 or 0030 hours as reasonably possible, or probably within 15-20 minutes if the proper steps had been taken. Clearwater, J. concluded that some brain damage probably occurred by 0045-0050 hours; however, a caesarean delivery then, or very quickly thereafter, would have probably reduced the degree or extent of brain damage.[30] If the doctors had been notified at or before 0030 hours, the mother would have been in the caseroom and, at the very least, ready for an imminent caesarean section by 0045 or 0050 hours at the latest. Justice Clearwater stated that "[t]ime is of the essence and it simply took too long for the nurses to alert the doctors as to the emergent status of this fetus".[31]

The issue then became whether Dr. Black was negligent in how she managed the situation at around 0045 hours. It took her more than 15 minutes to notify Dr. Seager of the critical situation that was apparent at 0045 hours. By the time Dr. Seager was notified, she responded promptly to the caseroom and decided that the labour had progressed to the point where a caesarean section was not

---

[29] *Ibid.*

[30] *Ibid.* at para. 43u.

[31] *Ibid.* at para. 43v.

the best option. The issue then became whether the option of performing a caesarean section was effectively taken away from Dr. Seager because she was not notified until after 0010 hours. While Clearwater, J. was satisfied that Dr. Black was put in a very difficult emergency situation by the delay of the nurses in calling her to the labour room after 0010 hours, she should have responded differently and more quickly at or very shortly after 0045 hours, in immediately notifying Dr. Seager and getting the mother to the double set-up room more quickly for immediate examination and decision by Dr. Seager. While Dr. Black was not negligent in her decision to defer the decision as to the method of delivery to the obstetrician, she was a little too slow in getting Dr. Seager involved and getting the mother to the case room.[32] Justice Clearwater concluded as follows,

> In finding that Dr. Black did not meet the acceptable standard of care at or shortly after 0045 hours and before Dr. Seager was finally notified, I remain strongly convinced that the negligence of the obstetrical nurses, was the chief contributing cause of the hypoxia and resulting brain damage...More timely action by Dr. Black at or very shortly after 0045 hours, which would have permitted a caesarean section, would only have reduced the length of the period of hypoxia and probably reduced the degree of brain damage; it would not likely have prevented brain damage.[33]

The nurses, and, hence, the Hospital, were found to be 80% at fault and the resident was 20% at fault for the infant's injuries.[34]

2. <u>Informed Consent - Ensuring Consent is Informed in the Context of Induced Labour and Caesarean Deliveries</u>

The law requires doctors to answer any specific questions posed by the patient as to the risks

---

[32] *Ibid.* at para. 43aa.

[33] *Ibid.* at para. 43cc.

[34] *Ibid.*

involved in an operation, and should, without being questioned, disclose the nature of the proposed operation, its gravity, any material risks and any special or unusual risks, attendant upon the performance of the operation.[35] The scope of the duty of disclosure and whether or not it has been breached are matters which must be decided in relation to the circumstances of each particular case.[36]

While expert evidence is relevant to determine the risks associated with a procedure and their materiality, the question of whether the doctor breached the duty of disclosure is not to be determined only by medical evidence.[37] Evidence of a physician's practice as regards providing information and obtaining an informed consent is both admissible and important in deciding whether the physician did so on any particular occasion.[38] Even if a physician is negligent in failing to make the required disclosure and obtaining an informed consent from a patient, the patient will not succeed against the physician in an action in negligence unless the plaintiff can establish causation.[39]

The Supreme Court of Canada has adopted a modified objective test regarding causation, which asks whether a reasonable person, in the plaintiff's particular circumstances, would have proceeded

---

[35] *Hopp v. Lepp*, [1980] 2 S.C.R. 192 at p.10 (QL) [hereinafter *Hopp*]

[36] *Ibid.*

[37] *Reibl v. Hughes*, [1980] 2 S.C.R. 880 (QL) [hereinafter *Reibl*].

[38] Ellen I. Picard and Gerald B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3rd ed. (Toronto: Carswell, 1996) at 157.

[39] *Arndt* v. *Smith*, [1997] 2 S.C.R. 539 (QL) [hereinafter *Arndt]*.

with the treatment, given proper disclosure. If that is the case, then there is no liability.[40] This test requires the court to consider the particular circumstances of the patient and give reasonable weight to these concerns or circumstances. The plaintiff's reasonable views, fears, desires and expectations are evaluated, as well as any particular concerns of the patient and any special considerations affecting her in determining whether she would have revised the treatment if given all the

[40]*Arndt, ibid.*. See also *Reibl, supra* note 37 at p. 11.

information about the possible risks.[41]

In *Bauer, supra,* the plaintiffs also alleged that the doctors failed to obtain an informed consent as to the method of delivery (vaginal delivery instead of a caesarean section). The mother testified that none of the doctors gave her information on which she could have made an informed decision as to the method of delivery. She claimed that if she had been told of the risks to her baby of proceeding with a vaginal delivery instead of a caesarean section, she would have elected a caesarean section at the outset. Justice Clearwater accepted that Dr. Black had followed her usual procedure regarding discussing methods of delivery and risks with the mother. Even though Dr. Black told the mother about "lower APGAR scores" without a detailed explanation, and did not discuss the risk of hypoxia, which was the ultimate cause of the infant's injuries, Justice Clearwater was not prepared to find that her explanation was so deficient that the consent given was not informed.

Dr. Black's explanation to the mother of the risks and consequences was adequate to permit the mother to come to an informed decision. Clearwater, J. was further satisfied that even if the explanation was inadequate, a reasonable person with the mother's characteristics (including her education, her general knowledge of the possible risk, her relationship and conversations with her sister-in-law, who had two vaginal breech deliveries, and her friends at or immediately prior to the labour) would have accepted Dr. Black's recommendations and proceeded with a trial labour on the understanding that there would be a change to a caesarean section if it became necessary at any given

[41] *Arndt, ibid.* at p. 6.

point in time.[42] Therefore the plaintiff did not succeed on the issue of informed consent.

In *Commisso, supra,* Dr. Handyside's normal practice was to explain that he wished to use forceps to facilitate delivery, but not to discuss the risks inherent in a mid-forceps delivery. There are certain risks associated with the use of forceps, including cord occlusion, but this is a very rare event. Justice Swinton found that given the general consent to obstetrical delivery signed by the patient, the fact that forceps are commonly used to assist vaginal delivery, and the evidence before the Court on the risks associated with a mid-forceps delivery, Dr. Handyside met his duty to disclose.[43] In addition, Swinton J. found that even if the disclosure was not adequate, a reasonable person in the plaintiff's position would have proceeded with the forceps attempt.[44] The possibility of cord occlusion was very remote and an operating room was immediately available if a caesarean section was needed. A successful forceps delivery would obviate the need for a caesarean section, which is major surgery with known risks to the mother. The plaintiff had experienced a low forceps delivery with her first child. A reasonable person in her position would have agreed to the trial of mid-forceps had she been fully informed of the material risks.[45]

[42] *Ibid.*

[43] *Commisso, supra* note 7 at para. 117.

[44] *Ibid.* at para. 118.

[45] *Ibid.*

3. Conclusion: What Constitutes Negligence during Delivery - The Impact of Recent Case Law

Recent judicial consideration of forceps deliveries, caesarean sections and informed consent emphasizes the paramount importance of **timing, communication and adequacy** in the context of the obstetrician's and/or nurse's negligence during delivery and, ultimately, the liability for the infant plaintiff's injuries.

The Courts have found the standard of care expected of an obstetrician to have been breached where an obstetrician failed to take immediate action to implement a forceps delivery after having made the decision to perform a forceps delivery 20 minutes prior [46], and in circumstances where it took 45 to 50 minutes to perform an urgent caesarean section.[47] While one Court found a 10 to 30 minute time frame for the performance of an urgent caesarean section to be acceptable, [48] another has confirmed that the standard of care does not require a double-set up wherein the trial of forceps is conducted in a room prepared for an immediate caesarean section, and that the standard is met where an operating room is immediately available before attempting a mid-forceps delivery and the

[46] *Carr, supra* note 2.

[47] *Allen, supra* note 1.

[48] *Ibid.*

obstetrician moves as expeditiously as possible to deliver the baby.[49]

The Courts have emphasized the importance of timely communication between nurses and doctors in the context of deliveries. Not only is it essential that a nurse contact the obstetrician immediately upon the happening of a critical situation, but even where such communication is delayed, the doctor will still be found to have breached the standard of care where he or she does not respond

[49] *Commisso, supra* note 7.

immediately.[50]

It is important to note that in all but one of the cases discussed above, the Court found that the negligence of the obstetrician in delaying delivery by either forceps or caesarean section caused or contributed to the injuries suffered by the infant.

In the cases cited in this paper regarding informed consent, the Courts concluded that the doctor met his or her duty to disclose and that even if disclosure was not adequate, a reasonable person in the position of the plaintiff would have proceeded with the procedure recommended by the obstetrician.[51] Nonetheless, it must be borne in mind that there may be circumstances in which the duty to disclose is not met, having regard to the medical evidence and particular circumstances and concerns of the plaintiff.[52]

While the standards of care as determined by the Courts in these cases are informative and likely indicative of the standard of care expected of an obstetrician in 2002, it must be borne in mind that

---

[50] *Bauer, supra* note 26.

[51] *Bauer, ibid.* and *Commisso, supra* note 7.

[52] *Reibl, supra* note 37 and *Arndt, supra* note 39.

while these cases were decided in 2000 and 2001, they concern births and, hence, standards of care, dating back to 1989. Therefore, hospitals and doctors would be well advised to take all precautions regarding immediacy in the delivery of a baby regardless of the method of delivery and the adequacy of information given to their patients.