Case Name:

Crawford (Litigation guardian of) v. Penney

Between
Melissa Crawford, by her Litigation guardian Jeanette Crawford, Jeanette Crawford and Barry Crawford, plaintiffs (respondents), and
Dr. Brian Penney and Dr. Greg Healey, defendants (appellants)

[2004] O.J. No. 3669

26 C.C.L.T. (3d) 246

134 A.C.W.S. (3d) 719

Docket: C39523

Ontario Court of Appeal
Toronto, Ontario

Labrosse, Sharpe and Cronk JJ.A.

Heard: June 7-8, 2004.
Judgment: September 10, 2004. Released: September 10, 2004.

(73 paras.)

Medicine -- Liability of practitioners -- Negligence or fault -- Standard of care -- Causation -- Obstetrical or gynaecological care -- Practice -- Appeals -- Duty of appellate court re findings of credibility by trial judge -- Grounds of appeal -- Objection to reasons for decision.

Appeal by the defendant doctors, Penney and Healey from a trial decision awarding Crawford $10 million in damages. Crawford suffered permanent brain injuries at birth after her shoulders became impacted in the birth canal and she was deprived of oxygen for 15 minutes. She brought an action against the delivery doctors, Penney and Healey, for damages for medical malpractice. At trial, Crawford was awarded $10 million. The trial judge found that the doctors had breached the standard of care, and that the resulting harm was reasonably foreseeable. In particular, the judge

found that Penney's decision to increase the flow of oxytocin to Crawford's mother after fetal distress was noted was contraindicated. Further, Penney, a family physician, should have detected warning signs earlier in the pregnancy, and should have referred the pregnancy to an obstetrician or managed it differently. His eventual decision to call for help from Healey came too late. Healey failed to exercise independent judgment before authorizing an induction of labour, in that he failed to conduct a physical examination of the mother. The judge found that the trial evidence of both doctors contradicted their evidence on examination for discovery, and that their credibility was suspect. The doctors appealed, arguing that the judge's reasons were insufficient, and that the judge disregarded or misapprehended the evidence of their expert witnesses.

HELD: Appeal dismissed. While the reasons for judgment lacked a detailed analysis of much of the expert evidence, the frailties in the reasons did not justify interfering with the ultimate result. The case ultimately turned on credibility, and the trial judge's adverse findings of credibility against the doctors were devastating. The judge's credibility findings were adequately explained in the reasons and fully supportable on the evidence. Further, some of the expert evidence proffered by the doctors not only failed to support their position, but supported Crawford's position that their conduct fell below the requisite standard of care. Costs of the appeal of $255,000 were awarded against the doctors.

Appeal From:

On appeal from the judgment of Justice Denis J. Power of the Superior Court of Justice, sitting without a jury, dated January 15, 2003.

Counsel:

Paul J. Pape and Robert Roth, for the respondents.

Domenic A. Crolla and Daniel Boivin, for the appellants.

The following judgment was delivered by

THE COURT:--

Introduction

1 Melissa Crawford was almost nineteen years old at the time of trial. She was born at the Smiths Falls Hospital on December 27, 1983. During the delivery, she sustained catastrophic injuries. After her head delivered, Melissa's shoulders became impacted in the birth canal and, for a critical period of time, her brain was starved of oxygen. As a result, she suffered extensive and permanent brain

injuries. Her parents, the respondents Jeanette and Barry Crawford, sued the delivery doctors, the appellants Dr. Brian Penney and Dr. Greg Healey, for medical malpractice. After hearing 57 days of evidence, and in reasons for judgment released on January 15, 2003, Power J. found the appellants liable for causing Melissa's injuries. The trial judge awarded damages in excess of $10 million. The appellants appeal the judgment and ask that it be set aside and a new trial ordered. For the reasons that follow, we would dismiss the appeal.

2 The appellants submit that, contrary to the principles established in R. v. Sheppard (2002), 162 C.C.C. (3d) 298 (S.C.C.) and R. v. Braich (2002), 162 C.C.C. (3d) 324 (S.C.C.), the reasons for judgment are so inadequate as to amount to an error in law and, further, that they prevent meaningful appellate review. They also submit that the reasons demonstrate that the trial judge simply disregarded or misapprehended the expert evidence adduced by the defence at trial and that this, in turn, brings into question his findings of negligence and the process by which he arrived at them. The appellants acknowledge that the reasons for judgment do not reflect any express misstatement of the law of negligence. They also concede that, in light of this court's recent decision in Waxman v. Waxman, [2004] O.J. No. 1765 (C.A.), the trial judge's findings of credibility (which were generally adverse to the two appellants) are unassailable on this appeal.

3 In contrast, the respondents submit that the reasons for judgment are not infected with legal error and ultimately do justice between the parties. They argue that all of the trial judge's findings of negligence were clearly supported by the evidence and, in some cases, virtually uncontradicted on the facts as found by the trial judge. Accordingly, there is no basis for appellate intervention.

4 In some respects, the reasons for judgment are less than perfect. Most importantly, they do not contain a fulsome analysis of much of the expert evidence adduced by the parties in relation to some of the standard of care and causation issues. Nonetheless, on a review of the reasons as a whole, including, in particular, the factual and credibility findings of the trial judge, we conclude that the frailties in the reasons do not justify interfering with the ultimate result.

5 The trial judge made numerous findings of negligence against both appellants. Some of these are unaffected by any failure in the reasons to analyze expert evidence. They do not turn on a true contest between the experts and were virtually inevitable given the way the evidence unfolded at trial and the findings of credibility made by the trial judge. Several of these findings of negligence, on their own, are sufficient to sustain the result in this case.

6 Accordingly, it is unnecessary to review in detail the evidence adduced in the proceedings concerning the contentious issues related to the standard of care and causation. Instead, we will focus on some of the key findings of negligence made against both appellants and the extent to which these ultimately turned on credibility and other findings of fact not related to the content of expert opinion. However, some review of the lengthy and complicated evidence adduced at trial is necessary to put the issues on appeal into proper context.

The Facts

7 Jeanette Crawford was born on December 28, 1943. Throughout her adult life, she was a working mother. She gave birth to her first child of an earlier marriage, Maureen, in 1966. This pregnancy went to full term. Maureen weighed 6 lbs. 7 oz. at birth following a "duration of labour" of three days. The delivery was vaginal and forceps were used. Jeanette gave birth to her second child, Ken, in 1971. Again, the pregnancy was full-term; however, Ken's birthweight was 9 lbs. 10 oz. following a "duration of labour" of four hours. No forceps were used.

8 Dr. Penney is a family physician who had been practising in Smiths Falls since 1975. He received his medical degree in 1970 and his practice covered emergency medicine, anaesthesia, assisting in the operating room, paediatrics, and obstetrics.

9 Dr. Healey is also a family physician. He had been practising in Smith Falls since approximately 1979. He received his medical degree in 1977, then completed two years of post-graduate training in family medicine leading to a CCFP diploma. This included training in obstetrics and gynaecology. At the time of trial, his practice included the management of 50 to 100 pregnancies yearly.

10 No obstetricians or neonatologists practised medicine in Smiths Falls between 1975 and 1983. Family physicians looked after the obstetrical work.

11 On April 12, 1977, Jeanette consulted Dr. Penney for the first time. Jeanette was basically a healthy woman who had always experienced difficulty controlling her weight. A history was taken by Dr. Penney's nurse. According to Jeanette, she informed the nurse that her mother and father were both diabetic. Her urine was tested and some sugar found in it. She asked Dr. Penney whether she was a diabetic. He sent her for a random blood sugar test. The resulting report indicated that her blood sugar level was normal. However, Dr. Penney decided to go one step further and he ordered a glucose tolerance test ("GTT") since he was aware that diabetes is the most common cause of sugar in blood for someone of Jeanette's age. The GTT results were within the normal range and Dr. Penney concluded that Jeanette did not have diabetes at that time.

12 On January 19, 1981, Jeanette visited Dr. Penney again, complaining that she was not feeling well and that she was experiencing dizziness, pins and needles in her left arm, and obesity. This time Dr. Penney prescribed an appetite suppressant to assist her in dieting. He ordered a urinalysis, which did not reveal the presence of any glucose or protein. A "fasting glucose" test was also ordered and Dr. Penney found the results to be within the normal range. However, a blood test showed that Jeanette's triglycerides were somewhat elevated and Dr. Penney referred her to an endocrinologist at the Ottawa Civic Hospital.

13 At her December 11, 1981 appointment, Jeanette indicated her desire to start another family with Barry. Dr. Penney testified that he advised her of all of the risks associated with a late-life pregnancy, to both the mother and the baby. Jeanette testified that he only explained the risks associated with genetic abnormalities. Dr. Penney's chart supports Jeanette's recollection of the discussion and her evidence on this issue was accepted by the trial judge.

14 In January 1983, Jeanette learned that she was pregnant. In February, she informed Dr. Penney that she had experienced three episodes of vaginal bleeding and had been admitted to the Smiths Falls Hospital on an emergency basis. Dr. Penney referred her for an ultrasound, the results of which indicated some concerns. On February 16, she miscarried.

15 In May 1983, Jeanette learned that she was pregnant again -- this time with Melissa. She re-attended on Dr. Penney and discussed who would take care of the pregnancy. Dr. Penney told her he would manage the pregnancy. The trial judge accepted Jeanette's evidence that she asked Dr. Penney whether she should be seen by another physician, given her previous miscarriage, but he assured her that this was unnecessary and told her that if any concerns developed, he would refer her to an obstetrician. At no time during the pregnancy did Dr. Penney make such a referral. The trial judge accepted Jeanette's evidence that had she known of the risks of something going wrong, especially the risks associated with having a large baby, she would have decided to have her pregnancy managed by an obstetrician and the baby delivered at a location with better facilities than those available at the Smith Falls Hospital. The trial judge found that Jeanette was a compliant patient, one not inclined to go against her doctor's advice.

The Course of the Pregnancy

16 Dr. Penney agreed that the fact that Jeanette's mother was a severe diabetic made him "aware that there is a possibility that Mrs. Crawford might develop diabetes in pregnancy and that I would be aware of that and watch for it". He testified that he told Jeanette to maintain her diet because he realized that her weight placed her at increased risk. Dr. Penney acknowledged that, from the outset, the risks associated with this pregnancy were "slightly above average". He sent Jeanette to a genetic counsellor and had a random blood sugar test performed. The results were normal. Subsequently, Dr. Penney became aware that Jeanette's weight had returned to a pre-pregnancy level.

17 In August 1983, Jeanette complained of some swelling of her feet and headaches. During a visit with Dr. Conway, while Dr. Penney was on holidays, Dr. Conway charted Jeanette's dizziness, her slight ankle edema and swelling of fingers, no pitting edema, and her normal blood pressure. He concluded that there was "probably postural hypo tension".

18 By October, Dr. Penney was expecting that Jeanette would have a large baby, though not one as large as 4,950 grams (just under 11 lbs) -- Melissa's actual birthweight. From October to December, Jeanette started to experience rapid weight gain. As well, her blood pressure was elevated. Dr. Penney stated that there was "a little note of concern beginning to arise".

19 At the December 13 visit, Dr. Penney observed that Jeanette had gained another 5 lbs in one week, and his concerns increased. As well, he discovered a trace of protein in her urine, but concluded that this was common. At one reading during that visit, her blood pressure was up to 134/78 and her hands were slightly puffy. Dr. Penney testified: "I recognized that she was in danger of becoming hypertensive at term ... and that this may be of some significance." His advice to Jeanette was to get more rest.

20 At the December 19 visit, there had been no change in Jeanette's weight but, again, there was a trace of protein in her urine. Dr. Penney thought that her increased blood pressure, at 146/80, was not associated with any proteinuria, but that she needed to be watched because this "could possibly degenerate into pre-eclampsia." The term "pre-eclampsia" refers to a condition of pregnancy, characterized by high blood pressure, that can result in a potentially life threatening illness. Dr. Penney again told Jeanette to rest. In the preceding four weeks, Jeanette had gained 13 lbs. Notwithstanding this history and Dr. Penney's concerns, Dr. Penney made the following note in her chart: "prenatal no problems".

The December 1983 Hospital Admission

21 By December 21, Jeanette had gained another 3 lbs and her urine again showed a trace of protein. Her blood pressure remained elevated. Dr. Penney decided to admit her to hospital for rest and testified that it was his plan to induce her if her blood pressure did not settle. The trial judge found that Dr. Penney did not inform Jeanette that this was his plan. The hospital chart records Dr. Penney's admitting diagnosis as follows: "[n]ow has toxaemia of pregnancy, it is getting worse and she had been admitted to hospital for bed rest".

22 Dr. Penney testified in chief that when he referred to "toxaemia of pregnancy", he meant hypertension, not pre-eclampsia. However, Dr. Braithwaite, an obstetrician/ gynaecologist, testified for the respondents at trial that "toxaemia" is another word for "pre-eclampsia". Dr. Penney agreed with this during cross-examination.

The "Consultation" with Dr. Gillieson

23 In 1983, Dr. Gillieson was in charge of the high-risk maternal fetal medicine unit and the Director of the Obstetrical Ultrasound Section at the Ottawa General Hospital. That hospital had a specialist Neonatal Intensive Care Service and provided tertiary consultative services to many hospitals in the region. Smiths Falls is 75 kilometres from Ottawa. Dr. Gillieson and Dr. Penney knew each other professionally and socially. Dr. Penney testified that, on December 21, 1983, he contacted Dr. Gillieson because he was concerned about the potential risks in Jeanette's pregnancy. Dr. Gillieson testified that he could not recall such a consultation. The trial judge found that the consultation did not take place.

The Delivery

24 By December 26, 1983, Jeanette's blood pressure remained elevated, and Dr. Penney decided to induce her. As required by hospital protocol, he consulted another physician who practised obstetrics, Dr. Healey, on the merits of proceeding with an induction. Dr. Healey advised on December 27, 1983 that, based on his assessment, there was no reason to delay induction any further.

25 Labour was induced by the use of a drug known as oxytocin shortly after 13:00 on December

27, 1983. By 14:50, the labour was underway. At 21:55, Melissa's head delivered without difficulty. However, her shoulders became impacted in the birth canal, a condition known as "shoulder dystocia". At 21:55, one of the nurses recorded that Dr. Penney was unable to deliver the shoulders and that, "[S]pontaneous respirations occurred on two occasions. However, it was at this point that the shoulders became impacted. Traction was attempted on the head and neck trying to bring down the anterior shoulder coincident with maternal contractions and pushing, there was no movement." Jeanette and Melissa were facing a grave emergency.

26 Dr. Penney testified that he made his first call for help five minutes after the shoulder dystocia was recognized. At 22:00, the nurse recorded "[B]oth Dr. Healey and Dr. O'Neil [the anaesthetist] called to the case room." During Dr. Penney's efforts to free the shoulders, Melissa's head remained in the same position, as did her shoulders. She had been deprived of oxygen for five minutes and was in serious distress. Dr. Penney ordered that the oxytocin infusion be increased. This did not assist.

27 While waiting for assistance, Dr. Penney continued to perform manoeuvres to deliver Melissa, including an unsuccessful attempt at fracturing her right clavicle (collarbone). He then administered a local anaesthetic so that he could perform a large left mediolateral episiotomy to allow him to "get better access to the posterior shoulder". While waiting for the anaesthetic to take effect, Dr. Penney made another unsuccessful attempt to move the anterior shoulder.

28 Following the episiotomy, Dr. Penney attempted to move the posterior shoulder, unsuccessfully. Dr. Healey, who had been at his cottage, arrived at 22:04, four minutes after being called and nine minutes after the baby's head had delivered and the shoulders became impacted. Dr. Penney described the situation to Dr. Healey. More time passed. Everyone present recognized that they were dealing with a potentially life-threatening situation. Dr. Healey placed both hands in the vagina and tried rotation and disimpaction efforts similar to those performed by Dr. Penney. According to Dr. Healey, there was no give at all, "it was like stone against stone". At the same time, Dr. Penney placed his hands on Jeanette's abdomen and pressed down on the area where he could feel the baby's shoulder. He attempted, unsuccessfully, to push the baby's shoulder underneath the pubic brim by a combination of downward pressure and rotation.

29 When Dr. Healey was not able to deliver the baby, it became apparent that a desperate situation had developed and Dr. Penney prepared to conduct a symphysiotomy, a procedure intended to increase the size of the pelvic outlet to permit delivery of the baby. Dr. Penney injected the pubic mound with local anaesthetic. However, because he had not previously performed a symphysiotomy, and the procedure was dangerous, Dr. Penney made one more attempt at delivering the baby vaginally. He took over from Dr. Healey. He attempted more traction, which did not work. He attempted another rotation. That did not work either. He then attempted on several occasions to fracture the right/anterior clavicle. Although he thought that he had fractured the clavicle, nothing happened. He then turned his attention to the left/posterior clavicle. He testified that he repeated the same manoeuvres and, "This time I felt a give. The posterior shoulder went up, the anterior shoulder

came down. I put my fingers into the axilla to bring the shoulder underneath ... and then I delivered the rest of the baby by traction." The time was 22:10. It was, therefore, unnecessary to complete the symphysiotomy.

30 When Melissa was delivered she "was basically dead". Jeanette was exhausted and distressed. Dr. O'Neil was waiting to perform resuscitation procedures. Melissa was limp and white and her head and face were a dark blue. Eventually, Dr. Penney heard a heartbeat. Melissa's birthweight was greater than the 97th percentile as she weighed 4,950 grams. Dr. Penney instructed a nurse to make arrangements to transfer Melissa to the Children's Hospital of Eastern Ontario ("CHEO") in Ottawa. Dr. Penney and Melissa arrived at CHEO just after midnight on December 28. Melissa was admitted to the Neonatal Intensive Care Unit. On December 29, Dr. Penney dictated a detailed report, in which he concluded:

> This was a case of severe shoulder dystocia, probably caused by a prediabetic tendency in the mother which was not diagnosed during pregnancy, but in view of the infant's large size and the macrosomia in comparison to the head, this seems to be the most likely explanation and the mother will undergo glucose tolerance test in the post-partum period.

31 Fifteen minutes passed between the delivery of Melissa's head and her birth. The trial judge found that Melissa suffered hypoxic ischaemic encephalopathy caused by shoulder dystocia due to excessive birthweight caused by untreated diabetes in pregnancy. The delay during the delivery resulted in acute near total asphyxia (lack of oxygen). As a result, Melissa has athetoid or extra-pyramidal cerebral palsy. In addition, she suffered a right brachial plexis injury and a fractured right clavicle.

The Issues at Trial

32 The respondents alleged at trial that Melissa's injuries were caused by the negligence of the appellants, Drs. Penney and Healey. It was their position that before Jeanette agreed that Dr. Penney would manage her May 1983 pregnancy, she asked him whether, in light of her previous miscarriage, another doctor (a specialist) should care for her. Dr. Penney assured her that this was not necessary and that if any problems arose, he would refer her to an obstetrician. Serious problems did arise. The respondents argued that Jeanette became diabetic, which led to Melissa's macrosomia, Jeanette's pre-eclampsia and the disastrous shoulder dystocia, all of which Dr. Penney should have anticipated. They also maintained that Dr. Penney breached his commitment to Jeanette by failing to refer her to a specialist and that breach led inescapably to the catastrophe, which was entirely preventable and caused solely by the appellants' negligence.

33 In contrast, the appellants took the position that Melissa's injuries were not the result of any negligence but, instead, were the result of an unforeseeable emergency -- i.e. an extraordinary event that was unpredictable. They argued further that, when presented with the emergency, they undertook reasonable and expeditious efforts to attempt to avoid the disaster that ensued.

34 At trial, the parties divided over the critical issue of assigning a level of risk to the pregnancy. The respondents said that it was a pregnancy at such risk that Jeanette should have been referred to an obstetrician for consultation. The appellants said that the risk was low and that Jeanette could be managed by Dr. Penney, or a midwife, without referral. The parties agreed that there were a number of risk factors apparent in Jeanette's pregnancy, including the fact that her second child was very large, her age (40), her obesity, her family history of diabetes, and the fact that the fetus she was carrying was a large one. However, they disagreed on whether these factors combined to increase the overall grade of risk.

35 The parties also disagreed on whether Jeanette became diabetic and pre-eclamptic late in her pregnancy. The appellants said that she did not. The respondents claimed that gestational diabetes mellitus ("GDM") developed and ought to have been diagnosed and, furthermore, that Dr. Penney, in fact, had diagnosed pre-eclampsia. The trial judge found that Dr. Penney had diagnosed pre-eclampsia, as reflected in the hospital records. He also found that, when the risks of pre-eclampsia were added to Jeanette's known pre-existing risk factors, the pregnancy became "high risk" and should have been managed differently. The failure to provide different management led directly to the tragic outcome.

The Trial Judge's Findings of Negligence

36 The trial judge was aware that the applicable standard of care in this case was the standard that existed in 1983. He found numerous breaches of the standard of care. His findings of negligence include the following (para. 261):

(a) both doctors were, or should have been, aware in 1983, that shoulder dystocia was associated with macrosomia which, it turn, was associated with maternal obesity, family history of large gestational age infants, and gestational diabetes or diabetes. In addition, they were, or should have been, aware of the obstetrical principles reported in the literature concerning the following: fetal macrosomia, diagnosis of fetal macrosomia, management etiology and effects on the fetus;

(b) in the face of various pregnancy risks, some of which were identified by him, Dr. Penney failed to recognize his lack of skill and experience in his care of Jeanette and Melissa and, in particular, failed to refer Jeanette to an expert(s) for opinions and/or care;

(c) Drs. Penney and Healey made no inquiry into a possible explanation for the three day labour and the use of forceps that Jeanette underwent when giving birth to her first child, Maureen. This delay and the use of forceps could have suggested obstructed labour;

(d) both doctors failed to consider that a woman's ability to deliver a macrosomic baby without difficulty on an earlier occasion did not dictate that she could successfully do so again;

(e) both doctors failed to appreciate that the large discrepancy between the birthweights of Jeanette's first two children constituted a warning that she tended to have diabetes in pregnancy;

(f) Dr. Penney was one of the first physicians to make extensive use of ultrasound technology in obstetrical practice. He knew that the baby would be a large one and, notwithstanding the various risk factors, he did not employ timely ultrasound technology in this case;

(g) given the risk factors that were present, Dr. Penney was negligent in failing to properly test Jeanette for gestational diabetes by way of either, or both, a glucose challenge test or a glucose tolerance test, especially between twenty-four and twenty-eight weeks of pregnancy;

(h) Dr. Penney failed to give instructions to the hospital to check for proteinuria in an appropriate manner after Jeanette's admission to the hospital on December 21;

(i) Drs. Penney and Healey failed to consider seriously a caesarean section as an alternative to a vaginal delivery. This alternative should have been discussed with Jeanette at an early stage during her pregnancy, near the end of her pregnancy and, certainly, during her hospitalization;

(j) in the alternative, Dr. Penney failed to induce labour in a timely fashion. He should not have waited after Jeanette's December 21st admission;

(k) Dr. Penney failed to ensure that Dr. Healey was properly briefed regarding the risk factors associated with Jeanette's pregnancy;

(l) Dr. Penney failed to stop the injection of oxytocin after normal contractions began and, as well, after the shoulder dystocia was discovered;

(m) Dr. Penney should have, but did not, investigate current medical literature with respect to macrosomia, gestational diabetes, and shoulder dystocia given his lack of expertise and his decision to continue to manage Jeanette's pregnancy;

(n) Drs. Penney and Healey failed to stipulate an adequate plan of action in the event that shoulder dystocia was encountered during delivery;

(o) the risk of shoulder dystocia, a true obstetric emergency that may be anticipated, requires a carefully considered plan of action in the event that shoulder dystocia does occurs. Such a plan was not in place at Melissa's delivery;

...

(q) Dr. Healey failed to conduct a physical examination of Jeanette upon being asked for a consultation on whether to induce labour. He did not exercise

an independent opinion concerning the propriety of a decision to induce labour; and

(r) Dr. Penney failed to diagnose shoulder dystocia in a timely manner. He delayed his decision to seek assistance. He was aware that every second counted. By the time Drs. Healey and O'Neil arrived, it is likely that serious brain damage had already occurred.

37 The trial judge further found that Dr. Penney did not take reasonable steps to keep abreast of ongoing developments in an area of medicine that he devoted a substantial part of his practice to. He found that the negligence detailed above constituted departures from the applicable standard of care that materially caused or contributed to the injuries and loss suffered by the respondents. The trial judge concluded that the harm that occurred to Jeanette and Melissa was reasonably foreseeable by the appellants. The harm was the reasonable consequence of the appellants' acts and failures to act.

Grounds of Appeal: Reasons for Judgment

Positions of the Parties

38 Although the appellants raise several grounds of appeal, their core argument is that the trial judge failed to adequately explain his key findings concerning both causation and negligence in his reasons for judgment. In particular, the appellants submit that, in arriving at his findings of fact, the trial judge ignored, disregarded or misapprehended the evidence of their expert witnesses. In support of this submission, they rely on the Maynard v. West Midlands Health Authority, [1985] 1 All ER 635 (H.L.) and Lapointe v. Hôpital Le Gardeur, [1992] 1 S.C.R. 351 line of cases for the proposition that, if the defendants are able to put forward proof that a sizeable portion of the community of practising physicians in Ontario at the time of the incident would support the conduct and decision making of the defendant, then the trial judge is virtually compelled to accept that evidence and find against negligence. The appellants claim that by ignoring or misapplying these authorities, the trial judge misdirected himself on the law of negligence, leading to his disregard of the defence expert evidence, and that the failure to adequately consider this evidence led to palpable and overriding errors of fact on both negligence and causation issues.

39 The respondents submit, and it is basically agreed, that they led evidence on each and every point relating to the trial judge's findings of numerous breaches of the standard of care. In addition, they point out that critical evidence in support of their case came directly from Dr. Penney's own charts and the evidence of the appellants' experts. They argue that the appellants do not and cannot say that there was no evidence to support the trial judge's findings. The respondents submit further that, based on a review of the evidence as a whole, it is clear that on the evidence before him the trial judge was virtually compelled to make the findings of fact that he did in relation to at least some of the breaches of the standard of care. Finally, the respondents maintain that, in the end, the reasons for judgment are adequate and do justice between the parties. They assert that any isolated

deficiencies in the reasons are not sufficient to require a new trial in this case.

Analysis

40 In his lengthy reasons, the trial judge made clear findings of negligence but he did not carefully analyze the competing expert evidence on each and every contested standard of care issue. However, after a careful review of the reasons for judgment and the issues and evidence to which they responded, we conclude that the reasons do provide justice between the parties. In the words of counsel for the respondents, they "get the job done". In the end, this case very much turned on findings of credibility. The trial judge's adverse findings of credibility against both appellants were devastating. With respect to Dr. Penney, the trial judge found that:

* Dr. Penney's evidence at trial contradicted certain of his evidence on examination for discovery;
* his testimony was at substantial odds with his own record keeping and that of others;
* although he admitted that he did not have a good recollection of the details of the events, he nevertheless went into considerable detail of what he said transpired and, in particular, what happened during the delivery;
* although he contemporaneously recorded some events in detail, there was no recording of the alleged conference with Dr. Gillieson;
* his evidence of why he gave up the practice of obstetrical deliveries was contradicted by his letter of resignation;
* throughout his testimony, he demonstrated a tendency to state events as facts that he recollected rather than as conjecture; and
* his evidence of some events was contradicted by Jeanette and Barry, whose evidence was accepted.

41 With respect to Dr. Healey, the trial judge found that:

* his evidence was also at odds with his examination for discovery;
* much of his evidence was reconstructed as a result of his reading the various records prior to trial; and
* he had very little independent recollection of the events.

42 In our view, these findings of credibility are adequately explained in the trial judge's reasons for judgment and fully supportable on the evidence.

43 Furthermore, in numerous instances, much of the opinion evidence offered by the appellants' experts at trial diminished in significance given the underlying findings of fact made by the trial judge. These are some examples:

1. The appellants' experts testified that the pregnancy was not likely a high

risk one and that, therefore, a consultation with an obstetrician was unnecessary. However, Dr. Penney testified that he consulted with an obstetrician, Dr. Gillieson, because he had concerns about his plan of management for the pregnancy. Dr. Gillieson testified that he could not recall such a consultation, and neither he nor Dr. Penney had any note in relation to it. The trial judge found that the consultation did not take place.

2. The appellants' experts also testified that Jeanette did not have gestational diabetes, a known risk factor in pregnancy. However, the trial judge found that Dr. Penney's own charts reveal that he was aware of gestational diabetes as a risk factor and, despite his testimonial denials, he diagnosed Jeanette as having gestational diabetes. Dr. Penney agreed that, had such a diagnosis been made, the appropriate standard of care dictated a referral. At no time did he make such a referral.
3. The appellants' experts further testified that Jeanette did not have pre-eclampsia, a known risk in pregnancy. The respondents' experts testified that she did have pre-eclampsia and that it is clear from a review of Dr. Penney's charts that he was aware that she had pre-eclampsia. Although Dr. Penney said that he did not diagnose Jeanette as having pre-eclampsia, he agreed that the pregnancy would have to be handled differently had such a diagnosis been made. Despite his testimony, when Jeanette was admitted to hospital in December 1983, Dr. Penney's admitting diagnosis, for which the admitting physician has sole responsibility, was pre-eclampsia. This diagnosis appears in several places in the charts reviewed by Dr. Penney and was not corrected. In Dr. Penney's own notes, he refers to Jeanette as having "toxaemia", which he acknowledged is a virtual synonym for pre-eclampsia.

44 In the face of the trial judge's adverse credibility findings and Dr. Penney's admissions as to the appropriate standard of care in 1983, the significance of the trial judge's failure to analyze the evidence of the appellants' experts in detail is diminished.

45 The contentious issues at trial related to (a) whether Jeanette had GDM, which Dr. Penney failed to diagnose and treat, (b) the level of risk that should have been assigned to her and (c) whether Dr. Penney diagnosed Jeanette as pre-eclamptic and what steps he should have taken in that regard. The trial judge made adverse findings against Dr. Penney in relation to each of these issues.

46 Moreover, the trial judge found that Dr. Penney and Dr. Healey's handling of the induction and delivery was itself negligent. Those findings do not turn on the opinions of competing experts. Accordingly, even if his reasons fail to explain why he preferred the respondents' experts to those of the appellants on certain other issues, we are not persuaded that his ultimate finding of liability is undermined by this omission.

The Management of the Delivery

Overview

47 The trial judge found that Dr. Penney's overall management of this pregnancy involved a failure to properly assess all the risk factors associated with the pregnancy, as well as an unrealistic view of his own ability to handle its management, including the delivery. In other words, in addition to Dr. Penney's failure to diagnose and treat Jeanette's GDM, which failure led directly to the outcome, the trial judge found that causation was also established by Dr. Penney's failure to transfer Jeanette to a tertiary care centre on December 21, 1983. He held that Dr. Penney should have referred Jeanette to an obstetrician. Where there was a failure to refer, there should have been a plan in place to deal with the foreseeable complications associated with this delivery, including shoulder dystocia. No such plan existed here. The trial judge found that the failure of Dr. Penney to have a plan of proper management in place also led directly to the outcome. He held that, had such a plan been in place:

(a) the induction would have occurred on December 21, when Melissa was smaller. In the event, Melissa continued to grow in utero, exacerbating the disproportionate size of her shoulders, which became apparent on December 27;

(b) provision may well have been made for a caesarean section;

(c) an obstetrician experienced in high risk pregnancies and one who anticipated shoulder dystocia in a mother with these risk factors would have delivered Melissa;

(d) there would have been no delay in calling for help upon the diagnosis of shoulder dystocia;

(e) help would have been immediately available, either in the delivery room or on the delivery floor, and certainly not a quarter mile away, thereby avoiding the four-minute wait for Dr. Healey's arrival. Dr. Healey, in fact, arrived nine minutes after the diagnosis of shoulder dystocia;

(f) an anaesthetic to relax the uterus to permit easier manoeuvres would have been administered (Dr. O'Neil, the anaesthetist, arrived at 22:10, contemporaneous with delivery);

(g) the oxytocin would not have been increased at 22:00 (i.e. when help was called), but shut off, allowing for easier manoeuvres; and

(h) it would not have taken fifteen minutes from the time of the diagnosis of the dystocia at 21:55 to deliver Melissa. Instead, Melissa would have been delivered six minutes from the diagnosis (Dr. Healey arrived at 22:04 and Melissa was delivered at 22:10), but probably in less time given the negligence of the appellants.

48 As the trial judge observed (at para. 177):

> Dr. Penney admitted on cross-examination that in a case of shoulder dystocia, "every second counted" because asphyxia can result and cause brain damage in five to seven minutes (or seven to ten or seven to fifteen -- there is a difference of opinions regarding the time period). Dr. Penney felt comfortable with seven to ten minutes.

The Failure to Administer Anaesthesia and the Administration of Oxytocin

49 The trial judge was critical of Dr. Penney's failure to call for anaesthesia, as well his handling of the oxytocin drip during the delivery. As with other findings concerning the standard of care, the appellants take issue with these findings of negligence on the basis of the alleged inadequacy of the reasons and the trial judge's purported failure to properly consider the evidence of the appellants' experts.

50 Examination of the trial judge's conclusions regarding these two delivery issues -- Dr. Penney's administration of additional oxytocin at 22:00 hours and his failure to arrange earlier for anaesthesia -- provide a compelling illustration of the fatal flaw in the appellants' argument that the trial judge erred by disregarding, ignoring or misapprehending critical expert defence evidence, leading to unsustainable reasons for judgment. In fact, on close scrutiny of the defence expert evidence on these key issues, it is apparent that this evidence not only failed to support the appellants' position but, instead, buttressed the respondents' claim of negligence. Accordingly, it is useful to review the evidence on these issues in detail.

51 The basis for the trial judge's findings of negligence on the oxytocin issue is clearly articulated in the reasons and supported by the evidence. It is therefore unassailable on appeal. The trial judge found as follows:

> Dr. Penney was aware that oxytocin was contraindicated [sic] in 1983 in the face of fetal compromise/distress. Indeed, the oxytocin was increased at 22:00 to one hundred drops per minute from sixty drops per minute (para. 180).
>
> ...
>
> Dr. Penney failed to stop the injection of oxytocin after normal contractions began and, as well, after the shoulder dystocia was discovered (para. 261(1)).

52 The appellants allege that, as with their experts' evidence in relation to other matters relating to the standard of care, the trial judge simply ignored helpful evidence proffered by the defence to the effect that the standard of care did not call for the administration of anaesthesia and that the continued administration of oxytocin was not inappropriate after shoulder dystocia had been diagnosed. In particular, the appellants point to the evidence of Drs. Livingstone and Sermer, which

they say supported their position that the increase in oxytocin after the diagnosis of shoulder dystocia was not contraindicated and that anaesthesia would not have assisted. This, the appellants submit, is an illustration of the manner in which the trial judge proceeded to make findings of fact based on the evidence of the respondents' experts without regard to the respectable body of conflicting opinion attested to by the appellants' experts. The appellants assert that this approach to the evidence is contrary to the principles that flow from Maynard, supra, and constitutes reversible error.

53 To examine this submission, it is necessary to look to the evidence to ascertain whether, in fact, there was expert evidence that contradicted the findings of the trial judge and that was simply ignored, misapprehended, or disregarded by him. Put another way, was there "uncontroverted, reliable evidence" which stood between the trial judge and his findings of fact in relation to this issue.

54 In our view, this submission cannot succeed. The respondents' experts clearly testified that the increase in oxytocin at 22:00 fell below the standard of care in 1983. For example, based on his review of the nursing notes (the accuracy of which was not challenged on this point), Dr. Farine testified that the oxytocin was started at 1:30 p.m. and that it was appropriate to continue the administration of oxytocin until the head was delivered and the dystocia was recognized. Once it was recognized, the right thing to do was not to make the uterus contract, but to relax the uterus with anaesthesia.

55 Dr. Farine also testified, however, that administering oxytocin with continuous increases actually blunts the ability of the attending physician to recognize any slowing of the progress of labour, explaining that it "may actually shorten the first stage of labour as opposed to make it longer and, therefore, prevent picking up this specific indicator for possible shoulder dystocia". In cross-examination, the only questions asked of Dr. Farine in relation to his opinion on this matter were whether or not he could refer to any literature supporting his opinion that the giving of oxytocin was contraindicated in a situation of shoulder dystocia. Dr. Farine testified, and was not contradicted, that there is a great deal of literature saying that, in shoulder dystocia, you have to relax the uterus as well as "lots of literature" that oxytocin does the exact opposite, which is contract the uterus. Therefore, Dr. Farine testified that one can readily infer that one would not use oxytocin in a case of shoulder dystocia. One would not find a directive to this effect in the literature because such a directive simply would not make sense. Dr. Farine analogized the search for such a directive to looking for a directive in a driver's manual on whether you should speed up when you arrive at a stop sign.

56 Dr. Braithwaite also testified that the decision to continue and, indeed, increase the oxytocin at 22:00 was inappropriate. It is telling that he was not cross-examined on his testimony in chief that the administration of oxytocin was contra-indicated:

> [M]y point there is ... if the physician attending is trying to move the shoulders

> and at the same time you're driving the uterus harder, you're driving that shoulder into the pubic bone harder, so in fact what you are doing is you're working against yourself. You are going to, in fact, make it more difficult to move the shoulder if it is being driven into the pubic bone at the same time.

57 On the other hand, the appellants rely upon the evidence of Dr. Livingstone, which they say supports their position that, by increasing the oxytocin, Dr. Penney's conduct did not fall below the standard of care. In fact, in our view, Dr. Livingstone's evidence does not support this submission.

58 During his testimony in chief, Dr. Livingstone was asked to comment on a ten-page hypothetical question, one line of which related to the decision of Dr. Penney to increase the oxytocin. In relation to this broad hypothetical question, Dr. Livingstone opined that Dr. Penney met the overall standard of care. However, later in his evidence in chief, Dr. Livingstone was asked to comment specifically on Dr. Penney's decision to increase the oxytocin. He testified that it would be indicated if administered "to establish contractions which had disappeared or were insufficiently infrequent [sic]. If the patient was having repetitive contractions which were interfering with manipulations it would have been contra-indicated". This expert opinion must be seen in light of the trial judge's unchallenged finding that Jeanette's contractions were strong and regular and had not ebbed at 22:00 hours. This finding is supported by the nursing entries in Jeanette's chart, introduced at trial, concerning the course and frequency of Jeanette's contractions. Based on these findings, Dr. Livingstone's expressed opinion regarding the use of oxytocin during the delivery supports the respondents' assertion, and the trial judge's conclusion, that its administration at 22:00 hours was inappropriate.

59 The appellants also point to the evidence of Dr. Sermer. It is clear from a reading of the reasons as a whole, that the trial judge had difficulty with his evidence. Dr. Sermer had stated that Jeanette's pregnancy could have been managed by a midwife and his evidence did not accord with the authority he was relying on for GDM screening. In any event, Dr. Sermer's testimony did not particularly assist the appellants on the critical issue of the appropriateness of Dr. Penney's decision to increase oxytocin. Dr. Sermer had the same ten-page hypothetical question put to him that had been put to Dr. Livingstone. He testified, based on the hypothetical question, that Dr. Penney met the requisite standard of care. Counsel then broke down many of the components of the hypothetical question and asked Dr. Sermer to comment upon each specific component, for example, the adequacy of the manoeuvres made in an effort to disimpact Melissa's shoulders. Importantly, unlike Dr. Livingstone, Dr. Sermer was not asked to comment on the oxytocin issue. Accordingly, his opinion on this issue is neither precise nor clear from the record. He was not cross-examined on this issue, no doubt because he offered no specific opinion upon it.

60 Dr. Drummond, a third expert who testified for the appellants at trial, was also asked to comment on the same hypothetical question that was put to Drs. Livingstone and Sermer. The question again included a brief reference to Dr. Penney increasing the oxytocin at the same time that he called for the assistance of other physicians. Dr. Drummond testified that Dr. Penney's

management of the delivery was appropriate. However, when asked specifically whether or not the increase in oxytocin was appropriate, Dr. Drummond testified that, "I'm not familiar with the use of oxytocin in those circumstances." He provided no further opinion on the matter. As well, Dr. Drummond testified, as had the other experts, that the administration of anaesthesia would relax the maternal musculature and, further, that it was recognized as part of the standard approach to the management of shoulder dystocia in 1983 that "anaesthesia may be helpful".

61 The trial judge found, based on Dr. Penney's own testimony, that Dr. Penney was fully appreciative that Jeanette had risk factors for shoulder dystocia, but that he had no appreciation whether these risk factors were cumulative. Moreover, he made no effort to find out. Dr. Penney testified that he was aware that oxytocin was contra-indicated in the face of fetal compromise/distress. Yet, he decided to increase the oxytocin at 22:00 hours to one hundred drops per minute from sixty drops per minute. The trial judge found, as Dr. Braithwaite had suggested, that when Dr. Penney continued with and increased the oxytocin, he essentially was working against himself. By driving the uterus harder, and also driving the baby's shoulder into the pubic bone harder, he made it more difficult to move the shoulders and disimpact them.

62 Dr. Penney's decision to administer the oxytocin at 22:00 hours thus exacerbated the dangerous presentation condition of the baby, and made it more difficult to remedy the situation. Critical time was lost. Moreover, Dr. Penney failed to call on a timely basis for the administration of anaesthesia which, the experts indicated, may have alleviated the shoulder dystocia or at least made it possible to successfully move the shoulders through the birth canal. The trial judge's findings of negligence concerning this conduct by Dr. Penney, and his conclusion that this negligent conduct caused or contributed to the appellants' injuries, are amply supported by the evidence, including the defence evidence.

63 In summary, the trial judge's key findings regarding Dr. Penney's conduct during or in relation to the delivery include: Dr. Penney failed to ensure that an adequate plan of action was in place for the possibility that shoulder dystocia might be encountered during delivery; Dr. Penney failed to anticipate and take precautions for the occurrence of shoulder dystocia during delivery, although it may be anticipated; Dr. Penney failed to investigate current medical literature concerning macrosomia and shoulder dystocia, among other matters; Dr. Penney failed to ensure that anaesthesia was readily available for Jeanette, should the need for it arise during the delivery; Dr. Penney failed to stop the injection of oxytocin after normal contractions began and, again, after the shoulder dystocia was discovered; and Dr. Penney failed to diagnose shoulder dystocia in a timely manner and delayed seeking assistance.

64 Based on a review of all the expert evidence in this case, we are satisfied that these findings are adequately grounded in the evidence. We are also persuaded that these findings, by themselves, are dispositive of Dr. Penney's negligence in this case. Finally, given the nature of the evidence on these issues and the trial judge's treatment of them in his reasons for judgment, we reject the appellants' contention that the alleged inadequacies in the reasons compel appellate intervention. To

the contrary, the reasons permit appellate review and, in our view, ultimately "do justice between the parties" in relation to the respondents' claims against Dr. Penney.

Dr. Healey's Negligence

65 We reach a similar conclusion regarding Dr. Healey. The trial judge found that Dr. Healey was negligent in several respects but, most importantly, for failing to exercise independent judgment prior to authorizing an induction of labour on December 27, at the Smiths Falls Hospital. This finding did not turn on competing expert testimony. Rather, it turned on findings of fact and, in this case, the adverse findings of credibility made by the trial judge in relation to Dr. Healey's account of events.

66 In his consultation note, Dr. Healey made no observation about the fact that Jeanette was obese, that she had "a large for dates infant" from her previous pregnancy, that she was carrying "a large for dates infant", and that she had a three-day labour for her first baby, with the use of forceps. There is also no reference in his note to the position of the baby, i.e. whether the baby was occiput anterior or occiput posterior or transverse. In addition, the note does not record Jeanette's weight gain during pregnancy. Dr. Healey did not know that on the last three occasions when Jeanette saw Dr. Penney, she demonstrated some trace proteinuria. He was aware of the family history of diabetes but did not think it was pertinent to the induction. He was also aware in 1983 that if a woman had a family history of diabetes, she might develop diabetes during pregnancy and that diabetes "might cause all sorts of problems with the fetus -- including causing the baby to grow large". He was not able to satisfactorily explain how he had determined that the size of the baby seemed normal.

67 Dr. Healey testified that he knew that there was an association between macrosomic babies and shoulder dystocia and that both conditions were associated with older women (i.e. old for pregnancy), short women, obese women, and women who had given birth previously to large babies. Dr. Healey had never encountered an episode of shoulder dystocia prior to Melissa's. He was aware, however, that if a baby sustained shoulder dystocia, every second counted in terms of the delivery because, if it is delayed, brain damage will result. He also knew that oxygen deprivation of more than six or seven minutes duration would result in the commencement of brain damage and that the longer hypoxia persists, the more severe the resulting brain damage would be. During his testimony, Dr. Healey agreed that by the time he arrived during the emergency, Melissa was probably already brain damaged.

68 Jeanette and Barry testified that they knew Dr. Healey as he was at one time Jeanette's physician and that Dr. Healey did not examine Jeanette at any time prior to consenting to the induction of her labour.

69 The trial judge concluded that Dr. Healey was negligent in several respects, especially for failing to conduct a physical examination of Jeanette upon being consulted on whether to induce labour. Dr. Healey could not have met the requirements of his mandate without a physical

examination. The trial judge found that Dr. Healey did not exercise an independent opinion concerning the propriety of a decision to induce labour. We agree. His conduct in this regard clearly fell below any reasonable definition of the applicable standard of care.

Conclusion

70 The trial judge made multiple findings of negligence against both appellants. Many of those findings are capable of standing alone in support of the result at trial. Apart from the findings of negligence that led to the delivery of Melissa on December 27, 1983 at the Smiths Falls Hospital, the management of the delivery by both Drs. Penney and Healey was found to be negligent in many respects and conducted in a manner that led to the catastrophe. The trial judge's findings of fact on the delivery issues are clear, supported by the evidence and, in some cases, uncontrovertible. Accordingly, any alleged frailties in the reasons for judgment are not responsible for, related to, or reflective of, error in the fact-finding process that lead to the ultimate result. At the end of the day, it was the findings of fact and not the opinions of experts that dictated the outcome of this action.

Other Issues

Melissa's Life Expectancy

71 With respect to damages, the appellants raise one issue in relation to Melissa's life expectancy. There was conflicting evidence on this issue before the trial judge and he preferred the evidence of the experts called by the respondents because their opinions focused more directly on Melissa's particular circumstances. There was probative evidence on which the trial judge could reasonably base his conclusion and we see no error.

The Fresh Evidence

72 After the close of evidence, the appellants sought to admit as fresh evidence a clinical practice guideline dated November 2002. In detailed reasons, the trial judge recognized that he had a discretion to receive the fresh evidence and concluded that the appellants had not met their burden of demonstrating that the proposed evidence would either have probably changed the result reached by him or, even applying a lower threshold, that the evidence might/may change the result. We see no error in the trial judge's exercise of his discretion.

Disposition

73 Accordingly, we would dismiss the appeal. The parties have provided extensive submissions on costs. As the respondents point out, this was a very complicated and factually difficult appeal. Preparation for the appeal required detailed examination of the lengthy evidentiary record and the written submissions. The appeal required two days to be heard. Having taken into consideration the objections raised by the appellants, we would award the respondents their costs of the appeal, fixed on a partial indemnity basis at $255,000, inclusive of disbursements and G.S.T.

LABROSSE J.A.
SHARPE J.A.
CRONK J.A.

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