CITATION: Noel v. Hawrylyshyn, 2024 ONSC 4525
COURT FILE NO.: CV-17-00569881-0000
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2024 ONSC 4525 (CanLII)

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:	
Janelle Noel and Mylo Noel, by his Litigation Guardian Janelle Noel Plaintiffs	Duncan Embury, Daniela Pacheco, and Lianna Woollard for the plaintiffs
– and –	
Dr. Peter Hawrylyshyn, Dr. Samuel Ko, Dr. Lisa Allen, Dr. Nanette Okun, Dr. Romy Nitsch, Dr. Ivor Fleming, Dr. John Doe, Nurse Marie Dennis, Nurse Guinard, Nurse Ostapenko, Nurse Hue, Nurse Jane Doe, Nurse Linda Doe, and Mount Sinai Hospital Defendants	Frank McLaughlin, Sam Rogers, and Hayley Goldfarb, for the defendants Dr. Peter Hawrylyshyn, Dr. Lisa Allen, and Dr. Nanette Okun.
	HEARD: April 18, 19, 22, 23, 24, 25, 26, 29, and 30, May 1, 2, 3, 6, 7, 13, 14, and 31, 2024

ROBERT CENTA J.

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1. Overview

[1] In this action, Janelle Noel and her son Mylo Noel sue three obstetricians, Dr. Lisa Allen, Dr. Peter Hawrylyshyn, and Dr. Nanette Okun for damages in connection with Mr. Noel's birth.

[2] Early in the morning of June 11, 2005, Ms. Noel went into labour and travelled to Mount Sinai Hospital. Dr. Allen, who had provided prenatal care to Ms. Noel, was the first attending obstetrician at the hospital. Dr. Allen transferred Ms. Noel's care to Dr. Hawrylyshyn at 0900h.

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[3] Ms. Noel's labour progressed slowly but steadily over the course of the day. At 1840h, her cervix was fully dilated, and she began to push. Fifteen minutes later, at 1855h, a nurse noticed sudden and concerning changes in the fetal heart rate. Three minutes later, Dr. Hawrylyshyn was back in the delivery room examining Ms. Noel. He concluded that the health of the fetus was in serious danger and an urgent delivery was required.

[4] At 1910, Dr. Hawrylyshyn applied the vacuum to the fetal skull over three contractions, but the attempted delivery was not successful. Dr. Hawrylyshyn sought a second opinion from Dr. Okun about the advisability of attempting a forceps-assisted delivery. At 1925h Dr. Hawrylyshyn attempted to apply forceps to the fetal skull, but he could not get them into the proper position or lock them. Dr. Hawrylyshyn then recommended an emergency Caesarean section and Mr. Noel was delivered at approximately 1953h.

[5] Mr. Noel was born in distress, with low apgar scores, and he needed to be resuscitated. He suffered from intracranial and extracranial bleeding and seizures immediately after birth and on day six of his life. He was intubated several times and ultimately required bronchial surgery. Mr. Noel is now 19 years old. He is a talented soccer player, graduated from high school, and lives with executive functioning problems, and neurodevelopmental limitations.

[6] The plaintiffs advance a number of different causes of action.

[7] First, Ms. Noel submits that she never wanted the vacuum or forceps used during the delivery and did not consent to Dr. Hawrylyshyn applying those instruments. She submits that Dr. Hawrylyshyn is liable to her for medical battery. I disagree. While I accept that Ms. Noel had a preference for those instruments not to be used, I find as a fact that she did consent to Dr. Hawrylyshyn using the vacuum and forceps in an attempt to expedite the delivery after the fetal heart rate became extremely concerning.

[8] Second, Ms. Noel submits that she did not provide informed consent to the use of the vacuum and forceps because Dr. Hawrylyshyn did not provide her with sufficient information regarding the risks associated with sequential use of vacuum and forceps. I disagree. I find that in the urgent circumstances they faced, Dr. Hawrylyshyn adequately explained the risks and benefits of attempting to use the vacuum and forceps to expedite delivery. Ms. Noel provided informed consent to the use of those instruments. I also find that Dr. Okun, who only provided a second opinion to Dr. Hawrylyshyn, was not obliged to obtain the informed consent of Ms. Noel before Dr. Hawrylyshyn applied the forceps.

[9] Third, the plaintiffs submit that the three defendant doctors are liable to them in negligence for the obstetrical care they provided to plaintiffs. They assert that the defendants breached the standard of care in several ways:

a. Dr. Allen's antenatal record keeping fell below the standard of care because she did not record Ms. Noel's statement that she did not want the vacuum or forceps used during her delivery;

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b. Dr. Hawrylyshyn breached the standard of care at 1700h when he failed to recommend that Ms. Noel deliver by Caesarean section;

c. Dr. Hawrylyshyn breached the standard of care when he attempted a vacuum-assisted delivery at 1910h instead of recommending an immediate delivery by Caesarean section;

d. Dr. Hawrylyshyn breached the standard of care when he attempted to use the forceps after the failed vacuum-assisted delivery and Dr. Okun breached the standard of care in confirming his opinion; and

e. Dr. Hawrylyshyn breached the standard of care in his application of the vacuum and the forceps to the fetal head.

[10] I do not accept these submissions. I find that each of the defendants met the standard of care in each of the situations described above. These findings are sufficient to dispose of the negligence claims.

[11] In case I am wrong, and the defendants did breach the standard of care, I consider whether those breaches were the cause in fact and in law of Mr. Noel's neonatal injuries. I reached the following conclusions:

a. The plaintiffs did not prove that Dr. Allen's antenatal record keeping caused any of Mr. Noel's injuries because Dr. Hawrylyshyn knew about Ms. Noel's preferences by about 0940h.

b. The plaintiffs proved that Dr. Hawrylyshyn's failure at 1700h to recommend a Caesarean section caused the injuries Mr. Noel suffered during the labour and delivery. Those injuries would have been avoided if a Caesarean section delivery had been recommended and performed at 1700h.

c. The plaintiffs proved that Dr. Hawrylyshyn's use of the vacuum caused Mr. Noel's subgaleal hemorrhage, but no other neonatal injuries.

d. The plaintiffs did not prove that Dr. Hawrylyshyn's decision to attempt to use the forceps caused any of Mr. Noel's injuries because the forceps were never locked, and they were not used to apply any torsion or traction.

[12] I also find that the plaintiffs did not prove that any of Mr. Noel's neonatal injuries caused any of his later neurodevelopmental challenges.

[13] I dismiss the action against each of Dr. Allen, Dr. Hawrylyshyn, and Dr. Okun.

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2. The parties and their witnesses

A. The plaintiffs and their witnesses

Janelle Noel

[14] Janelle Noel was 27 years old at the time of the events that give rise to this action. She works as a service coordinator in the Sexual Assault and Domestic Violence Care Centre at Women's College Hospital. On June 11, 2005, Ms. Noel gave birth to her son, the plaintiff Mylo Noel. She had not previously given birth. Ms. Noel testified at trial.

Mylo Noel

[15] Mr. Noel is now 19 years old. At the time of the trial, he was playing soccer internationally as a student of the FC Malaga City Academy in Malaga, Spain. Mr. Noel lives with certain focal cognitive and executive functioning deficits. These deficits manifest themselves in various ways and he struggles with his behaviour, memory, self-control, friendships, social situations, school attention, awareness, and self-direction. Mr. Noel has required significant academic and personal accommodations to allow him to demonstrate his abilities and to graduate high school. Mr. Noel did not testify at trial.

[16] The plaintiffs called two other fact witnesses: Jacqueline Noel and Sharon Addison. As I will discuss below, the plaintiffs did not call Tyrone Sibblies as a witness. Mr. Sibblies is Mr. Noel's father and was present during Ms. Noel's labour. He may have been present for a crucial conversation between Ms. Noel and Dr. Hawrylyshyn.

Jacqueline Noel

[17] Jacqueline Noel is Ms. Noel's older sister. Jacqueline and Ms. Noel were and remain very close, often speaking six to nine times each day. Jacqueline is the Director of Practice Management at the Ontario Medical Association. Jacqueline Noel testified about conversations she had with her sister about Ms. Noel's birth plan and her own observations of the events in the delivery room.

Sharon Addison

[18] Sharon Addison was a Registered Nurse and social worker who works with Ms. Noel as the Director of the Sexual Assault Domestic Violence Program and Director of Social Work at Women's College Hospital. She is also Mr. Noel's godmother. Ms. Addison testified about conversations she had with Ms. Noel about Ms. Noel's birth plan and her own observations of events in the delivery room.

[19] The plaintiffs called four expert witnesses: Dr. Neal Shone, Dr. Michael Marrin, Dr. Wayne Langburt, and Dr. Carolyn Lemsky.

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Dr. Neal Shone

[20] Dr. Neal Shone is an obstetrician and gynecologist. He was qualified to give opinion evidence on the standard of care to be met by Dr. Hawrylyshyn, Dr. Okun, and Dr. Allen. He also provided opinion evidence on the mechanics of Mr. Noel's neonatal injuries.

[21] Dr. Shone is a member of both the Society of Obstetricians and Gynecologists of Canada and the American College of Obstetricians and Gynecologists. Dr. Shone obtained his medical degree and rotational internship in South Africa. In 1991, Dr. Shone moved to Canada where he practiced as a primary care obstetrician. From 1998 to 2002, Dr. Shone competed his residency in Obstetrics and Gynecology at the Foothills Hospital at the University of Calgary. Dr. Shone currently works at Abbotsford Regional Hospital, a regional referral centre with a level 2 nursery, where he has regularly served as Department Head of Obstetrics. I had no difficulty accepting that Dr. Shone was an appropriate expert to provide opinion evidence to the court.

[22] I found that Dr. Shone stayed within the limits of his expertise and testified in a helpful, forthright, and non-partisan manner. However, I found that many of his opinions on standard of care were not consistent with the standards expressed in the guidelines and literature that he accepted as authoritative. While I have no doubt that Dr. Shone sincerely believed in the practices he described, his views were often subjective, idiosyncratic, and did not reflect the standards of practice in a tertiary care hospital in Ontario in 2005. These features of his testimony caused me to place less weight on his evidence than the evidence of Dr. Gregory Davies, the expert obstetrician called by the defendants. Not only was Dr. Davies a more experienced and accomplished obstetrician than Dr. Shone, I find that Dr. Davies' evidence more accurately reflected the authoritative guidelines and literature presented to the courts.

[23] As I will explain, I do not accept Dr. Shone's opinion that Dr. Hawrylyshyn, Dr. Okun, and Dr. Allen breached the standard of care.

Dr. Michael Marrin

[24] Dr. Michael Marrin is a neonatologist. Dr. Marrin has been on the faculty at McMaster University since 1986. He has practised as a neonatologist for 37 years and has served as the clinical director of the Neonatal Intensive Care Unit at the McMaster Children's Hospital. In his clinical role, Dr. Marrin focused on the care of newborns who were ill or born before term. He would occasionally provide care to newborns with complex cases for about a year, although typically the neonatal care spanned only the first month of life. Dr. Marrin's clinical role included examining the potential causes of illness and the potential outcome of those illnesses.

[25] The plaintiffs sought to qualify Dr. Marrin to testify about three issues:

a. the nature and causes of Mr. Noel's neonatal complications;

b. the effect of Mr. Noel’s neonatal complications on his neurodevelopmental outcome; and

c. the causes of Mylo’s neurodevelopmental limitations.

[26] The defendants raised two objections to Dr. Marrin’s qualification to provide opinion evidence on issues (b) and (c).

[27] First, the defendants submitted that Dr. Marrin’s evidence on issues (b) and (c) would fall outside of his expertise. They noted, correctly, that except for children undergoing prolonged hospital stays, Dr. Marrin’s interaction with newborns is confined to first 30 days of life. He does not follow patients outside of the neonatal unit and has no experience with populations other than very young children. The defendants stated that Dr. Marrin would be outside of his expertise if he gave evidence on topics (b) and (c).

[28] In my mid-trial ruling, I held that the defendants’ first objection may well go to weight, but not to admissibility. In my view, Dr. Marrin was able to provide useful evidence to the court on the perspective of a neonatologist on those issues. Dr. Marrin explained that he treats and teaches about a wide range of the issues Mr. Noel faced as a newborn. This includes understanding and teaching about the long-term impact of those injuries and symptoms on patients. Relatedly, the defendants submitted that Dr. Marrin could not provide useful evidence on why Mr. Noel developed his present symptoms at or after the age of five years because he does not treat those populations. The force of that submission, however, turns on accepting the defendants’ theory that those outcomes are not linked to the issues Mr. Noel experienced at birth. In my view, that was one of the ultimate issues in the case. I held that I was entitled to receive an expert neonatologist’s opinion on the connection between the issues Mr. Noel experienced at birth and his neurodevelopmental outcome. I held that whether I accepted Dr. Marrin’s opinion, or preferred the evidence of the pediatric neurologists, was a matter of ultimate weight and the defendants did not persuade me that I should exclude Dr. Marrin’s evidence using my gatekeeper role.

[29] The defendants’ second objection was that there would be duplication between Dr. Marrin and other experts to be called by the plaintiff. I did not accept that submission. I held that it would likely be helpful for me to hear the evidence of an expert neonatologist on these points to evaluate the plaintiffs’ theories of causation. While there might be some overlap, I did not see meaningful duplication with the plaintiffs’ other experts, particularly given the time that has passed between Mr. Noel’s birth and trial.

[30] In my view, the scope of Dr. Marrin’s proposed evidence was appropriate and fell within his expertise. I qualified Dr. Marrin as an expert neonatologist to give evidence within the scope and on the issues set out above.

[31] As I will explain below, I do not accept Dr. Marrin’s opinion on the role the forceps may have played in causing Mr. Noel’s injuries as I do not think it reflects the facts of this case. I also do not accept his opinion regarding whether the anti-seizure medicine or the general

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anaesthetic caused Mr. Noel's neurodevelopmental limitations. Dr. Marrin did not cite any authoritative literature for his opinion, which was rejected by Dr. Langburt, the expert pediatric neurologist called by the plaintiffs, and his opinion failed to refer to literature that cast serious doubt on his conclusions.

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Dr. Wayne Langburt

[32] Dr. Wayne Langburt is pediatric neurologist. He was qualified as an expert in pediatric neurology and pediatric epilepsy to provide opinion evidence on Mr. Noel's neurological status and the cause of his neuropsychological injuries and impairments.

[33] Dr. Langburt received his medical degree from McGill University in 1991. He subsequently completed a residency in pediatrics at the University of Chicago, a fellowship in child neurology and pediatric neurology at the Cleveland Clinic and then a further fellowship in epilepsy at the Hospital for Sick Children. In his clinical role, he assesses and treats children with neurologic disorders, which includes reviewing children's prenatal and birth history to determine the cause of their neurological impairments. In addition, Dr. Langburt lectures on various issues, including mild traumatic brain injury, epilepsy, developmental disorders, the use of anti-epileptic medications and general head injuries experienced by children. He also treated Mr. Noel in 2011-2012. The defendants raised no concerns about this treating relationship.

[34] I had no difficulty accepting that Dr. Langburt was an appropriate expert to provide opinion evidence to the court. However, as I will explain below, I do not accept Dr. Langburt's opinion on whether Mr. Noel's seizures caused any of his neurodevelopmental limitations.

Dr. Carolyn Lemsky

[35] Dr. Carolyn Lemsky is a clinical neuropsychologist with a practice in neuropsychology and rehabilitation psychology. She graduated in 1993 from the Illinois Institute of Technology with a doctoral degree in clinical psychology. Dr. Lemsky does not have a medical degree. She is a member of the College of Psychologists of Ontario and is certified by the American Board of Clinical Neuropsychology. Dr. Lemsky is an assistant professor in the department of psychiatry at the University of Toronto.

[36] Dr. Lemsky is currently the Clinical Director of the Community Head Injury Resource Centre in Toronto. The Centre is a muti-service agency that provides support to people living in the community who have survived a moderate to severe brain injury. In this role, Dr. Lemsky provides clinical leadership to a group of neuropsychologists who are assessing patients, provides training to assessors, and maintains some direct clinical intervention for clients presenting a particularly complex case.

[37] Dr. Lemsky conducted neuropsychological assessments of an 18-year-old Mr. Noel on July 24 and August 24, 2023. Dr. Lemsky testified that, as part of her professional role, she formulates opinions on the underlying cause of a patient's neuropsychological impairment, including for patients who have suffered birth related injuries. She has testified in court

proceedings, most commonly in the context of whether a person's cognitive issues are related to an acquired brain injury or another condition.

[38] The plaintiffs sought to qualify Dr. Lemsky as an expert in neuropsychology to provide opinion evidence as to Mr. Noel's neuropsychological condition or status, and the cause of Mr. Noel's neuropsychological impairments.

[39] The defendants objected to Dr. Lemsky being permitted to give evidence on the cause of Mr. Noel's neuropsychological impairments. They pointed out that Dr. Lemsky did not have medical training and was not in any position to read or interpret the medical imaging and other source documents. They submitted that Dr. Lemsky did not have the training or experience to comment on the medical questions posed by the issue of causation in this case.

[40] In my ruling after the *voir dire*, I qualified Dr. Lemsky to testify as an expert witness. As I explained, I was satisfied that through her education, training, and daily practice, she was qualified to give an opinion within the scope articulated by the plaintiffs. The fact that her daily clinical work involved identifying and diagnosing a cause of brain injuries met the threshold to qualify her as an expert. I indicated, however, that how she used that expertise and training in forming her opinion on causation would better be addressed as a question of the weight to be given to that opinion. Since the defendants were only challenging part of the evidence to be given by Dr. Lemsky, I determined that it would assist me to hear all of her evidence so that I could consider the appropriate weight to be given to her evidence on causation.

[41] As I will explain below, I do not place any weight on Dr. Lemsky's evidence on causation. With the benefit of hearing her evidence, I am not satisfied that her experience and training permitted her to offer a reliable opinion on causation. In some respects, her opinion diverged significantly from the plaintiffs' other experts. In other respects, her causation opinion was not firmly rooted in the authoritative literature. Ultimately, I did not find her opinion on causation to be helpful or reliable.

B. The defendants and their witnesses

Dr. Lisa Allen

[42] Lisa Allen graduated from medical school at Western University in 1992. Dr. Allen completed a residency in obstetrics and gynecology and then a fellowship in advanced gynecologic and minimally invasive surgery at the University of Toronto. In 2005, Dr. Allen was practicing obstetrics, gynecology, and minimally invasive surgery in a private practice and she held privileges at Mount Sinai Hospital.

[43] Dr. Allen provided antenatal care to Ms. Noel starting in November 2004. Coincidentally, she was working at Mount Sinai Hospital when Ms. Noel presented in labour in the early hours of June 11, 2005. Dr. Allen was the most responsible physician providing care to Ms. Noel until her shift ended at 0900h on that day.

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Dr. Hawrylyshyn

[44] Peter Hawrylyshyn graduated from medical school at the University of Toronto in 1979. He then completed a four-year residency program in obstetrics and spent a fifth year completing a Ph.D. in fetal physiology. In 1984, Dr. Hawrylyshyn joined the full-time staff at Mount Sinai Hospital where he practised obstetrics until 2022. As of June 2005, he had delivered approximately 7,000 babies. In approximately 1,000 of those births, he used a vacuum to assist with the delivery. He estimated that he used forceps to assist a delivery several hundred times.

[45] Dr. Hawrylyshyn was working at the hospital on June 11, 2005, as the head of one of two obstetrical teams caring for patients. He was the most responsible physician providing care for Ms. Noel from 0900h until Mr. Noel was delivered by Caesarean section at 1953h.

Dr. Okun

[46] Nanette Okun graduated from medical school at the University of British Columbia in 1983. Since 1988, Dr. Okun has been a fellow of the Royal College of Physicians and Surgeons of Canada in obstetrics and gynecology. From 1991 to 2004, Dr. Okun worked at the Royal Alexander Hospital, which is a tertiary care centre associated with the University of Alberta. In 2001, Dr. Okun began working at Mount Sinai Hospital in a maternal-fetal medicine practice that included both low-risk and high-risk cases. During her career up to 2005, Dr. Okun estimated that she was performing about 200 deliveries per year.

[47] Dr. Okun was working at the hospital on June 11, 2005. She was the head of the second obstetrical team and was not the primary care provider for Ms. Noel. Dr. Okun did examine Ms. Noel at approximately 1200h that day. At approximately, 1925h, Dr. Okun also provided a second opinion to Dr. Hawrylyshyn on the advisability of attempting a trial of forceps following the failed attempt at a vacuum-assisted delivery, and she delivered Mr. Noel by Caesarean section at 1953h.

[48] The defendants called two expert witnesses.

Dr. Gregory Davies

[49] Dr. Gregory Davies is Professor Emeritus, Division of Maternal-Fetal Medicine at Queen's University, where he has held a position since 1996. He has held positions at Kingston General Hospital, a tertiary care centre similar to Mount Sinai hospital, since 1996 and continues to provide general obstetrics and gynecology and maternal-fetal medicine services on a part-time basis. Dr. Davies has published extensively about antepartum, intrapartum, and postpartum health issues. He has held many administrative and clinical positions over his career including as director of the fetal assessment unit for 23 years and director of labour and delivery for three years. For two years, Dr. Davies sat on the Society of Obstetricians and Gynecologists of Canada obstetrical care review committee. This committee had overarching responsibility for the SOGC guidelines of the type at issue in

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this case. Dr. Davies was the primary author of three sets of SOGC guidelines and was either a co-author or sat on the approval committee for another 10 sets of guidelines.

[50] I qualified Dr. Davies as an expert in the field of obstetrics and gynecology to provide opinion evidence within the scope of obstetrical care and to provide an opinion on the standard of care and the causation of Mr. Noel's physical injuries.

[51] I found Dr. Davies to be a very helpful witness. He testified in a careful and measured way. In particular, his opinions reflected and followed the applicable guidelines and authoritative work presented to the court. He was a very experienced practitioner and had spent many years working at a tertiary care centre that is similar to Mount Sinai Hospital. As I will explain below, where his opinions differed from those of Dr. Shone, I preferred the opinions of Dr. Davies. This is not just because Dr. Davies was a more experienced practitioner, who worked at a tertiary care centre in Ontario, and had a significantly more distinguished record of academic publications and contributions to the profession. In the end, I found that Dr. Davies' opinions more closely reflected the applicable standards and academic literature than did the opinions of Dr. Shone.

Dr. Simon Levin

[52] Dr. Simon Levin is a pediatric neurologist. He completed his medical degree in Rhodesia in 1974. He has held increasingly senior academic positions at McMaster University (1986 to 1997) and Western University (1997 to present), where he is currently Professor Emeritus in the faculty of medicine. For ten years, Dr. Levin was the head of the pediatric neurology section. Dr. Levin has published extensively in the area of neonatal and pediatric neurology.

[53] Until July 2020, Dr. Levin worked full-time as a staff pediatric neurologist at hospitals in London, Ontario. His duties include an outpatient pediatric neurology component as well as an in-patient role dealing with a broad range of critically ill patients. Dr. Levin was also the consulting neurologist for the neonatal unit and saw all infants with neurological problems who were admitted to the neonatal unit. He had experience diagnosing neonates with intracranial bleeding, extracranial bleeding, and seizures. To make these diagnoses, he would routinely review ultrasound, CT, and MRI images of the head, neck and spine.

[54] I qualified Dr. Levin qualify as an expert pediatric neurologist qualified to provide opinion evidence on the causation issues in this case. As I will explain, I accept Dr. Levin's opinions on causation.

3. Medical battery

[55] Ms. Noel alleges that she did not consent to Dr. Hawrylyshyn's application of the vacuum or the forceps and that he committed the tort of battery.

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A. Legal principles

[56] In the context of medical treatment, battery arises where the patient has not consented at all to the treatment.[1] A doctor commits the intentional tort of battery where the doctor performs the wrong operation or procedure or where the surgery or treatment the doctor performed went beyond that to which the patient consented.[2] The law protects a patient's right of self-determination and her decisive role in the medical decision-making process.[3]

[57] Ms. Noel has the onus to prove that Dr. Hawrylyshyn performed the impugned treatment, in this case the application of the vacuum and the forceps. She does not need to prove that Dr. Hawrylyshyn intended the consequences of his act.[4] Dr. Hawrylyshyn then has the onus to prove that he obtained Ms. Noel's consent to those treatments. Genuine consent, express or implied, is a complete defence to battery.[5] Although the law permits a doctor to infer consent in certain circumstances, as I will explain below, that defence is not available to Dr. Hawrylyshyn on the evidence before me.[6] Similarly, the parties agree that the emergency exception to the requirement of consent does not apply in the circumstances of this case.[7]

[58] Ms. Noel also alleges that Dr. Hawrylyshyn did not properly inform her of the risks associated with the use of the vacuum and forceps, whether used individually or in sequence. Whether Dr. Hawrylyshyn adequately disclosed the risks of these treatments is relevant to the question of informed consent, which will be discussed in the next part of the reasons for decision. It is not relevant, however, to the question of consent for the purposes of the tort of battery.[8]

[59] I must consider all of the relevant circumstances leading up to the application of the vacuum and forceps to determine if Ms. Noel consented to that treatment.[9] Given the way the parties presented this case, that will include the antenatal care provided by Dr. Allen long before Ms. Noel arrived at the hospital on June 11, 2005. Some of the facts set out below will also be relevant to the issue of informed consent.

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[1] *Bollman v. Soenen*, 2014 ONCA 36, at para. 18.
[2] *Reibl v. Hughes*, [1980] 2 S.C.R. 880, at pp. 890-892.
[3] *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (C.A.), at para. 17.
[4] *Mohsina v. Ornstei*n, 2012 ONSC 6678, at para 35.
[5] *Norberg v. Wynrib*, [1992] 2 S.C.R. 226, at p. 246; *Nelitz v. Dyck*, (2001), 52 O.R. (3d) 458, at paras. 30 to 32 (C.A.).
[6] *Astaphan v. Scarborough General Hospital*, 1996 CarswellOnt 2702 (Gen. Div.), at para. 41; *Glaholt v. Ross*, 2011 BCSC 1133, at paras. 188-193.
[7] *Health Care Consent Act*, S.O. 1996, c. 2, Sch A, s. 25; *Malette*, at paras. 20-21.
[8] *Bollman*, at paras. 18-19; *Reibl*, at pp. 890-892.
[9] *Tomeh v. Cheah*, 2013 ONSC 6074, at para. 92; *Astaphan*, at para. 38.

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B. Ms. Noel's discussions with Dr. Allen about mode of delivery

[60] Ms. Noel learned she was pregnant in September 2004. In response to her request, some of her colleagues at Women's College Hospital recommended Dr. Allen as an obstetrician to provide care during her pregnancy. Ms. Noel's family doctor provided a referral to Dr. Allen and they met for the first time on November 23, 2004. Dr. Allen provided antenatal care for Ms. Noel from that date until June 2005. In general, Ms. Noel trusted Dr. Allen and found her to be attentive and diligent.

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Ante-natal conversations

[61] Dr. Allen admitted that she did not have any independent recollection of assessing or treating Ms. Noel and relied on her medical records and standard practices in 2004-2005 to inform her evidence. Although I have considered all of the evidence about their interactions, for now I will highlight the key evidence relevant to the issues of medical battery and informed consent. I will return to a more detailed consideration of the interactions between Ms. Noel and Dr. Allen when I consider whether Dr. Allen met the standard of care.

[62] Ms. Noel testified that she spoke with Dr. Allen a few times about her birth plan. She recalled one conversation that took place fairly close to her delivery date. Ms. Noel placed this conversation at the time she was seeing Dr. Allen on a weekly basis. According to the antenatal records, Ms. Noel's weekly appointments started on May 11, 2005. Ms. Noel testified that she told Dr. Allen of her "wishes not to have a vacuum or forceps in my birth. And I would have a [Caesarean] section if that was what the alternative was to not using those instruments." Ms. Noel described this as a conversation about what she "did not want" to happen during her birth. Ms. Noel testified that she told Dr. Allen that she did not want to have a forceps or vacuum delivery and would "take the cut," which Ms. Noel testified meant a delivery by Caesarean section.

[63] Ms. Noel testified that she reached this conclusion after conversations with two of her friends: Beverly Sullivan, the coordinator of the neonatal intensive care unit at Women's College Hospital, and Ms. Addison.

[64] Ms. Noel testified that through her conversations with Ms. Sullivan, she came to believe that the use of a vacuum during birth led to irreparable damage to babies.

[65] Ms. Addison testified that she told Ms. Noel that she had a difficult pregnancy where forceps were used during birth. She testified that she told Ms. Noel that her son was born with a "very serious huge bump on his head." Ms. Addison stated that Ms. Noel was very worried about the use of forceps during delivery after she talked to her.

[66] Jacqueline Noel testified that Ms. Noel told her that she wanted to have a natural birth and did not want a vacuum used because one of Ms. Noel's nieces was born with an unattractive cone-shaped head after a vacuum-assisted delivery, but that the issue resolved itself in a couple of days with no long-term impact. I note that Ms. Noel did not testify that any of

her nieces were born using a vacuum or that any of them had any consequences of a vacuum-assisted birth.

[67] Ms. Noel admitted that before she arrived at the hospital to give birth, she did not understand that delivery by Caesarean section posed significant risks to herself and the fetus. Ms. Noel testified that because four of her nieces were born via Caesarean section, she felt there was less risk associated with that procedure, but she admitted that she did not know if the risks of a Caesarean section outweighed the risks of a vacuum or forceps-assisted vaginal delivery. Ms. Noel also testified that she was not interested in the knowing the risks of delivery by Caesarean section.

[68] In cross-examination, Ms. Noel was challenged on whether she reached this opinion as a result of internet research or because of conversations with friends. I will address the limited utility of the meeting notes that underpinned that cross examination in paragraphs [201] to [211] below. What matters for present purposes, in my view, is that Ms. Noel formed a preference for how she wanted to give birth as a result of limited anecdotal information obtained from friends (and possibly the internet) but not through study of scientific journals or informed consultations with experts about the range of risks that accompanied any mode of delivery. Whether or not her views aligned with the then current scientific consensus, she had a subjective concern or fear that a vacuum or a forceps-assisted delivery could cause irreparable or irreversible damage to the fetus.

[69] Ms. Noel testified that Dr. Allen responded to statement that she did not want a vacuum or forceps-assisted delivery by saying that she understood Ms. Noel's views, but that her pregnancy was progressing well and that it was not necessary to speak about vacuum or forceps-assisted delivery at that time. Ms. Noel confirmed on cross-examination that Dr. Allen told her that she did not need to make any decisions about the use of vacuum or forceps at that time because she was not at a stage of her pregnancy where that decision was necessary.

[70] Dr. Allen testified that she had no independent recollection of Ms. Noel saying anything about the possible use of vacuum or forceps during delivery. Dr. Allen explained that if a patient stated that she never wanted the vacuum or forceps applied during delivery, she would explore the individual's fears and concerns and explain that it is hard to make that decision before labour because it is a dynamic process and there could be a situation where using vacuum or forceps is the safest option. Dr. Allen testified that she would explain the importance of listening to the obstetrician at the time of delivery to try and understand the reasons for the recommendations for care that were being provided at that time.

[71] Dr. Allen emphasized that while it was common for her patients to express a preference to avoid operative delivery, it would be very unusual for a patient to state that she had made a final or irreversible decision that under no circumstances would she ever agree to the use of a vacuum or forceps during delivery. Dr. Allen testified that she would document such an unusual statement in the medical record and would talk to colleagues about how to

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transmit the patient's final decision to those who might be on call for the delivery. Dr. Allen confirmed that there were no such notes in Ms. Noel's chart.

[72] Dr. Allen agreed that if a patient was particularly adamant about any issue in her pregnancy, it would have been her usual practice to write that down in the medical record. On cross-examination, Dr. Allen stated that if Ms. Noel had "told [her] of her decision not to have vacuum or forceps for her delivery," she would have documented that "decision." Dr. Allen stated that while it was certainly possible that Ms. Noel expressed a preference not to have the vacuum or forceps used during delivery, it was unlikely that Ms. Noel ever expressed an adamant decision never to have those instruments used under any circumstances.

[73] Ms. Noel confirmed that she never prepared a written birth plan setting out her wishes for her labour and delivery. She stated that she did not know that was an option and did not "feel like writing [her birth plan] down," because she felt she had communicated it to Dr. Allen and she hoped that Dr. Allen would have written it down. The parties agree that Dr. Allen did not record discussing a birth plan with Ms. Noel in the antenatal record.

Conversations at the hospital

[74] Ms. Noel was admitted to the hospital in labour around 0300h on June 11, 2005. Coincidentally, Dr. Allen was on shift at the hospital at that time. Ms. Noel testified that she was excited to learn that Dr. Allen was on duty. Ms. Noel recalls speaking to Dr. Allen twice before her shift ended at 0900h. Dr. Allen testified that she had no independent recollection of speaking with Ms. Noel that day.

[75] The medical records contain a triage note signed by Dr. Nitsch, who conducted an initial vaginal examination and diagnosed Ms. Noel as being in labour. Under the heading "Plan," Dr. Nitsch wrote "admit" and "epidural." The note contains no reference to the use of a vacuum or forceps during delivery. At trial, Ms. Noel had no memory of this interaction, but agreed that she would have told Dr. Nitsch that she wanted to have an epidural.

[76] After she was seen in the triage room, Ms. Noel was moved into her labour room at approximately 0400h and no later than 0424h. At 0400h, the nurses caring for Ms. Noel made the first entry into the labour and delivery partogram. Under the heading "Birth plan," the nurse wrote "epidural." Ms. Noel agreed that she did not have a specific recollection of any conversations with a nurse regarding her preference not to a vacuum or forceps-assisted delivery.

[77] Ms. Noel testified that she spoke to Dr. Allen twice at the hospital about her preference not to have a vacuum or forceps-assisted delivery. Dr. Allen does not have a specific recollection of any such conversation. There are no notations in the nursing records that corroborate or support Ms. Noel's recollection of having two conversations with Dr. Allen.

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(a) The first conversation recalled by Ms. Noel

[78] Ms. Noel testified that she remembered that she wanted to receive her epidural before it was too late for it to be administered and she discussed that with Dr. Allen at the hospital. She also testified that, during this first conversation, she reminded Dr. Allen that she did not want the vacuum or forceps to be used during her delivery.

[79] According to the nursing progress notes, at 0445h an anaesthesiologist visited Ms. Noel, took her history, and obtained Ms. Noel's consent to apply an epidural. At 0502h the epidural was established and by 0545h, the nursing notes recorded that Ms. Noel was comfortable.

[80] If Ms. Noel's recollection is correct, that means her first conversation with Dr. Allen regarding her epidural and birthing plan had to take place before 0445h. The nursing notes, however, do not record a visit from Dr. Allen before that time. The first reference in the nursing notes to a visit from Dr. Allen appears at 0650h when the nurse recorded "Dr. Allen in to see [patient] and [fetal heart record] tracing, [patient] sleeping." The note at 0650h is the only record of Dr. Allen seeing Ms. Noel that day.

[81] Dr. Allen testified that she would personally write a note in the chart when there was something positive or negative regarding the progress of labour or the care provided. She did not make any notes in Ms. Noel's chart before the end of her shift and that indicates that she did not observe any concerns about the health of Ms. Noel or the fetus.

[82] Dr. Allen testified that, as in the antenatal care period, if during labour Ms. Noel had expressed a "hard-line" or adamant opposition to the use of vacuum or forceps during delivery, she would have had a further discussion with Ms. Noel to understand and attempt to address her concerns, and to discuss what indications might suggest that vacuum or forceps were appropriate instruments to assist with the delivery. There are no notes of any such conversation between Ms. Noel and Dr. Allen in the hospital medical records.

(b) The second conversation recalled by Ms. Noel

[83] Ms. Noel testified that she recalled a second conversation with Dr. Allen, which took place as Dr. Allen's shift was ending and Dr. Hawrylyshyn's shift was starting. Ms. Noel testified that she asked Dr. Allen if she had told the oncoming physician about "my request, my wishes for my birth." Ms. Noel testified that Dr. Allen told her that she was labouring fine, the everything was going to be okay, and not to think about that yet. Ms. Noel confirmed that she understood Dr. Allen to mean that it was not yet time to make those decisions, and the conversation should be deferred to a time when it might be necessary.

[84] Dr. Allen had no specific recollection of such a conversation and stated that if Ms. Noel expressed an adamant view on the use of vacuum or forceps, she would have documented that decision. Dr. Allen testified that the absence of such documentation suggested that Ms. Noel did not express an adamant decision to her.

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[85] Ms. Noel testified that she reminded Dr. Allen of her birth plan because she wanted to ensure that Dr. Allen had spoken to Dr. Hawrylyshyn because it was something that "really meant a lot to me." Ms. Noel rooted her desire to ensure that the information was communicated to the new doctor in her experiences as a Black woman in the health care system:

> And I felt that because Dr. Allen was my OB/GYN and I had a relationship with her, I just wanted her to make that connection, have that conversation to ensure that he -- that [Dr. Hawrylyshyn] understood that it wasn't just, you know, a decision just off of a whim. It was something that really meant a lot to me and I felt that she'd be the best person to communicate that.
>
> I don't think, sitting at the place I was, as, you know, a young black women, single, unwed, that sometimes our concerns, or my concerns are taken seriously. And as a result of that, I wanted to ensure that there was some allyship and some understanding with Dr. Allen, that I wanted that information communicated to the oncoming physician because [Dr. Hawrylyshyn] didn't know me and I didn't know him.

[86] On cross-examination, Ms. Noel stated that she recalled that her sister Jackie, her friends Ms. Sullivan and Ms. Addison were in the room with her when she had the second conversation with Dr. Allen. Ms. Noel confirmed that she never had a conversation about her birth plan when both Dr. Allen and Dr. Hawrylyshyn were present at the same time.

[87] Jacqueline Noel testified that she recalled Ms. Noel telling "her ob-gyn", who was female, that she was "okay" to deliver by Caesarean section. She put it this way:

> Q. So other than attending at the hospital and seeing that Michelle was there, what is the next thing that you recall about the hospital?
>
> A. I recall that Janelle was in labour and she was dilated, but it was not – she wasn't dilated to the full extent, and I don't know what the extent is, but she was not dilating, and they kept on saying she is not dilating, so they are going to just monitor her situation. …
>
> Q. Okay. And you mentioned that there was comments about Janelle not being fully dilated. What is the next thing that you recall?
>
> A. The next thing I recall, Janelle was getting upset, I mean, visibly upset because she was nervous. She was crying. And she mentioned something to the effect like, I'm okay to take -- do a C-section, if that is the case….

Q. Do you recall, the ob-gyn, was it a male or a female?

A. It was a female. Her ob-gyn was a female.

[88] Jacqueline Noel fairly acknowledged that she could not recall the details of that conversation with any particularity and that she does not recall what the female obstetrician said in response to Ms. Noel.

[89] I pause here to note two things. First, I am satisfied that Jacqueline Noel was referring to Dr. Allen, who was Ms. Noel's own obstetrician and who is a woman. Second, it is difficult to reconcile Jacqueline's version of what happened with the undisputed timeline of the day's events. If Ms. Noel was speaking to Dr. Allen, then it had to happen before 0900h, when Dr. Allen's shift ended. There is no evidence, however, that Ms. Noel was nervous or crying before 0900h or that the dilation of her cervix was anything other than normal during that period. I do not think Jacqueline Noel's recollection of this conversation is reliable because it is inconsistent with the documented facts.

Dr. Allen transitions Ms. Noel's care to Dr. Hawrylyshyn

[90] Dr. Allen testified that her shift ended at 0900h and that she handed Ms. Noel's care over to Dr. Hawrylyshyn at that time.

[91] Dr. Allen did not have a specific recollection of her conversation with Dr. Hawrylyshyn at the handover. Dr. Allen testified that, typically, she would run through the admitted patients, their pertinent medical history, the progress of the patient's labour, and any other information relevant to patient care.

[92] Dr. Hawrylyshyn recalled that during the handover Dr. Allen told him that Ms. Noel was giving birth for the first time, that she was GSB+, that she had a history of fibroids, and that Dr. Allen expected that Ms. Noel would give birth vaginally. Dr. Hawrylyshyn did not recall Dr. Allen mentioning anything further about a birth plan or Ms. Noel's preference for mode of delivery.

[93] From 0900h until the delivery at 1953h, Dr. Hawrylyshyn was the most responsible physician for Ms. Noel. There were two obstetrical teams working that day. Team A consisted of Dr. Hawrylyshyn, and a resident named Dr. Samuel Ko.[10] The defendant Dr. Okun led Team B, which dealt with the higher risk pregnancies at the hospital.

C. Ms. Noel's discussions with Dr. Hawrylyshyn about mode of delivery prior to 1855h

[94] Both Ms. Noel and Dr. Hawrylyshyn have specific recollections about some of their conversations that day. Dr. Hawrylyshyn testified that he never forgot Ms. Noel's delivery and that while he could not recall specific words used in some of those conversations, he

[10] The plaintiffs initially named Dr. Ko as a defendant but let him out of the action before trial. He did not testify.

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had a present recollection of the main sequence of events and what happened at each of those times. He relied on his review of the medical charts and his own operative note to refresh his memory. As will be discussed below, he recorded certain specific words spoken by Ms. Noel in his operative note but he would not otherwise remember those words.

[95] Ms. Noel testified that before 1855h, she spoke with Dr. Hawrylyshyn three times about her views on vacuum and forceps-assisted deliveries and delivery by Caesarean section.

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First conversation at 0940h

[96] Ms. Noel testified that after her second conversation with Dr. Allen, Dr. Hawrylyshyn and Dr. Ko entered her room and introduced themselves to her. The first reference in the nursing notes to Dr. Hawrylyshyn is timed at 0940 and reads "Dr. Hawrylyshyn and Team, [vaginal exam] to assess progress."

[97] Dr. Hawrylyshyn agreed that this note refers to the first time he met Ms. Noel and that he would have introduced himself and his team to her. He had an independent recollection of this visit. He observed that the medical records indicate that Dr. Ko conducted a vaginal examination of Ms. Noel at this time and that this would be typical for his management of care. Based on his review of his operative note and the medical records, Dr. Hawrylyshyn testified that Ms. Noel arrived at the hospital 3cm dilated and at 0940h was 6cm dilated, so she was progressing in her labour. I find that Ms. Noel first met Dr. Hawrylyshyn at 0940h.

[98] Ms. Noel testified that the first time that she ever met Dr. Hawrylyshyn, she told him that she would "take a cut" and he responded that she should not worry, she was labouring fine, and it was not yet time to make any decisions. She put it this way:

> And I said -- spoke with them and I just said, Hey, you know, Dr. Hawrylyshyn, you don't know me, but I'll take a cut if I'd rather no forceps, no vacuum. And he said, Don't worry, you're labouring fine, we're not there yet. And that was the first conversation with him.

[99] Ms. Noel testified that when she said "take a cut," she was referring to delivering by Caesarean section. She also confirmed that when Dr. Hawrylyshyn said "we're not there yet," he meant that the conversation should be deferred to a time when it might be necessary to have it.

[100] Dr. Hawrylyshyn testified that it would have been usual for him to discuss with his patient any findings from the initial examination and the management plan for the labour and delivery. He recalled that just before he left the room at the end of this first visit, Ms. Noel expressed concerns about operative deliveries, which would include the use of vacuum and forceps. Dr. Hawrylyshyn did not recall her exact words, but he recalled that he told her that she was progressing well and there was no indication that she would require an operative delivery. Dr. Hawrylyshyn told Ms. Noel that if her situation changed, he would then have a full discussion with her of the appropriate and available management options.

[101] Dr. Hawrylyshyn did not recall Ms. Noel saying at this time (or at any other time before her delivery) that she would refuse a vacuum or forceps-assisted delivery under any circumstances. He explained that if Ms. Noel had taken that position, it would have triggered a more extensive discussion and careful documentation of that decision in the medical chart. Dr. Hawrylyshyn stated that Ms. Noel would have had to sign an Against Medical Advice Form to confirm that she refused a vacuum or forceps-assisted delivery against medical advice. The parties agree that Ms. Noel never signed that form.

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Second conversation between 1230h and 1330h

[102] Ms. Noel described a second conversation with Dr. Hawrylyshyn regarding her views on vacuum and forceps-assisted deliveries and delivery by Caesarean section. Ms. Noel recalled that the conversation was in the afternoon, although she was not sure of the precise time. As I will explain below, I find that there were two conversations took place at 1230h and 1330h because there are two nursing notes at those times that document those conversations. I find that when Ms. Noel refers to the second conversation, she is referring to the two discussions at 1230h and 1330h.

[103] Ms. Noel testified that Ms. Addison, Jackie, and Ms. Sullivan were in the room at the time of the second conversation. Ms. Noel testified that Dr. Hawrylyshyn followed up with her about her concerns regarding vacuum and forceps-assisted deliveries, and she explained that she did not want those instruments used because she was worried about the irreversible effects of using them. She described the second conversation with Dr. Hawrylyshyn this way:

> Q. Following the administration of that medication, you mentioned there was a further conversation with Dr. Hawrylyshyn?
>
> A. Yes.
>
> Q. Can you tell us about that?
>
> A. He came -- it was in the room, in the labouring room. He came to me in the afternoon and he said that, you know, This morning you spoke about your disdain with the vacuum and forceps, what was that about? And then I explained to him that I was worried about the irreversible effects that these things could do and I was concerned about that and I didn't want them used in my delivery. And that if he knew that I was labouring for potentially if he could just do a C-section.
>
> Q. If he knew, sorry?
>
> A. If he knew that I wasn't labouring properly or I wasn't doing well, we could just do that. And he then said, It's fine. He said, What

> are you worried about? Both my kids were delivered by vacuum, my daughter Katie, and she's fine.[11]

[104] Ms. Noel testified that this conversation did not change her opinion on the use of a vacuum or forceps. She testified that at no time between 1230h and 1330h did Dr. Hawrylyshyn offer her the option of delivering by Caesarean section instead of continuing to labour.

[105] Dr. Hawrylyshyn recalled seeing Ms. Noel at 1230h and again at 1330h. With the benefit of the medical records, he recalled that he saw her at 1230h, conducted a vaginal examination, and noted that she was 9 cm dilated. Dr. Hawrylyshyn was concerned that Ms. Noel's rising temperature and an elevated fetal heart rate indicated that Ms. Noel was developing an infection known as chorioamnionitis. He was not certain whether he discussed the implications of that infection for the management of her care with Ms. Noel at 1230h or 1330h, but was sure that such a conversation took place. The nursing notes indicate two conversations took place. At 1230h a nurse recorded "Seen and assessed…Mode of delivery discussed." At 1326 there is a note that reads "Explanation given to patient and plan."

[106] Dr. Hawrylyshyn testified that he specifically recalled giving Ms. Noel the choice of delivering by Caesarean section or continuing to labour toward a vaginal birth. While he did not recall his specific words, it was his standard practice to explain why a patient would consider a Caesarean section and the risks that procedure posed to the mother and fetus. Dr. Hawrylyshyn testified that he would explain that the risks to the patient included infections, bleeding complications associated with uterine atony or infection, injury to adjacent structures including the bowel, bladder and the ureter, pulmonary emboli, and deep vein thrombosis. He would explain that the risks to the fetus included infection, respiratory difficulty requiring ventilation, and stays in the neonatal intensive care unit after delivery.

[107] Dr. Hawrylyshyn recalled that after his explanation and given the choice between a Caesarean section and a vaginal birth, Ms. Noel said that her preference was to continue to labour toward a vaginal birth. Dr. Hawrylyshyn stated that this was a reasonable plan since the fetal heart rate had returned to the normal range, the scalp pH was normal, indicating good oxygen supply to the fetus, and that all signs indicated that the fetus could continue to tolerate labour safely.

[108] At 1330, orders were signed to begin administering a low dose of synthetic oxytocin to Ms. Noel. Dr. Hawrylyshyn testified that synthetic oxytocin would increase the strength and frequency of Ms. Noel's contractions. Ms. Noel began to receive the synthetic oxytocin at 1400h.

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[11] Dr. Hawrylyshyn testified that his daughter is named Ashley, not Katie, and that his son was delivered by forceps not by vacuum. In my view, not much turns on this minor discrepancy. I find that Ms. Noel misremembered the name of Dr. Hawrylyshyn's daughter and what Dr. Hawrylyshyn told her about how his children were born.

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[109] I note that there would be no reason to administer synthetic oxytocin if the plan was to deliver by Caesarean section. Administering synthetic oxytocin only makes sense as part of a management strategy designed to maximize the likelihood of a vaginal birth. This management plan continued for some time. For example, at 1515, Dr. Ko made a note that they would be continuing to administer synthetic oxytocin and there was the possibility of a delivery by Caesarean section if there was no progress in the dilation of Ms. Noel's cervix or if the fetus did not descend down the birth canal.

<u>Third conversation at 1715h</u>

[110] Dr. Ko and Dr. Hawrylyshyn visited Ms. Noel around 1700h. Dr. Ko made a note that he timestamped at 1700h. He conducted a vaginal examination and determined that Ms. Noel's cervix had continued to dilate. He described her cervix as being in anterior lip or very close to fully dilated. Dr. Ko also noted that the presenting part of the fetus's head had descended to station zero, which is also called spines. The further dilation of Ms. Noel's cervix and the continued descent of the fetal head demonstrated that Ms. Noel's labour had continued to progress.

[111] Dr. Hawrylyshyn recalled arriving in the room after Dr. Ko had started his examination and that he subsequently confirmed Dr. Ko's observations.

[112] Dr. Hawrylyshyn recalled discussing the clinical circumstances and management of labour with Ms. Noel at this time. Dr. Hawrylyshyn recalled asking Ms. Noel whether, despite the progress of her labour, she wanted to deliver by Caesarean section or to continue with the labour. He testified that there was no discussion at this time of vacuum or forceps because Ms. Noel's cervix was still not fully dilated, and those options were not yet available. He noted that the test results indicated that the fetus was tolerating labour well and that there was no immediate indication to do a Caesarean section.

[113] Dr. Hawrylyshyn testified that after the discussion, Ms. Noel decided that she wanted to continue to labour toward a vaginal birth. Dr. Hawrylyshyn made a note that they would continue with the synthetic oxytocin and reassess the progress of Ms. Noel's labour in an hour or so. He believed that Ms. Noel would be fully dilated in another hour or two, given the continued progress of her labour. Dr. Hawrylyshyn testified that if Ms. Noel had decided that she wanted to deliver by Caesarean section instead of continuing to labour, he would have reviewed the importance and significance of that decision with her. After that discussion, if she still wanted to deliver by Caesarean section, he would have performed that procedure. He did not recall Ms. Noel saying anything at this time to suggest that she wanted a Caesarean section.

[114] Ms. Noel had no recollection of this conversation. She denied that Dr. Hawrylyshyn provided her with the option of a Caesarean section at 1715h.

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D. The critical events from 1855h to 1925h

[115] At 1840, Dr. Hawrylyshyn examined Ms. Noel and observed that her cervix was now fully dilated, and the presenting part of the fetal skull was 1 cm further down the birth canal to a position described as spines +1. This meant that Ms. Noel had entered the second stage of labour. He encouraged her to begin pushing with the contractions and left the room. Ms. Noel began to push with the assistance and under the observation of a nurse.

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[116] Many of the critical events in this action took place between 1855h and 1925h. During this time period, the fetus showed signs of significant distress and Dr. Hawrylyshyn concluded that it was essential to expedite the delivery. The records demonstrate that Dr. Hawrylyshyn applied the vacuum at 1910h over three contractions but that did not result in a delivery. At 1925h, Dr. Hawrylyshyn unsuccessfully attempted to apply the forceps to assist with the delivery. At 1931h, Ms. Noel was taken to the operating room for an emergency Caesarean section. Mr. Noel was delivered at approximately 1953h.

[117] In the sections immediately below, I will focus on the facts that are most relevant to the question of whether Ms. Noel consented to Dr. Hawrylyshyn applying the vacuum and the forceps. The issue of consent is of primary importance to Ms. Noel's action against Dr. Hawrylyshyn in battery.

[118] I will return to what Dr. Hawrylyshyn said to Ms. Noel, including what if any risks he disclosed to her about his recommended plan of care, in the next part dealing with informed consent.

1855 to 1900: identification of fetal distress

[119] At 1855h, which was only 15 minutes after Ms. Noel started pushing, a nurse observed significant variable decelerations with delayed recovery in the fetal heart rate. This was a concerning development because it indicated fetal distress and that the fetus was not tolerating the labour process. If it persisted too long, this abnormal heart rate pattern raised the concern of a hypoxic-ischemic injury to the fetus. In other words, this heart rate pattern was a strong signal to expedite the delivery of the fetus. The nurse applied an oxygen mask to Ms. Noel and immediately informed Dr. Hawrylyshyn of the development.

[120] Dr. Hawrylyshyn arrived back in Ms. Noel's room three minutes later, at 1858h. He testified that he would have immediately reviewed the fetal heart rate tracing to confirm for himself whether there was evidence of variable decelerations with delayed recovery. He would then have assessed how Ms. Noel was pushing during one of the contractions and if the fetus was descending. Dr. Hawrylyshyn testified that he concluded that despite Ms. Noel's best efforts, an unassisted vaginal birth was not imminent and that some kind of intervention would be required to expedite the delivery.

[121] Dr. Hawrylyshyn testified that he formed a plan of care that he would recommend to Ms. Noel. He testified that his primary and overriding goal was to complete the delivery as quickly as possible. In his professional judgment, using the vacuum to assist Ms. Noel to

deliver vaginally, if successful, would be the fastest way to complete the delivery. Based on his experience, he expected that there was an 80 to 90% chance of a successful vacuum-assisted delivery.

[122] He testified that all of this would have happened in the first minute or two after his arrival.

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1900 to 1910: the disputed ten-minute window

[123] Ms. Noel's claim that Dr. Hawrylyshyn committed medical battery turns largely on what happened in the crucial window between 1900h and 1910h, when Dr. Hawrylyshyn applied the vacuum. I will consider all of the evidence set out above in assessing whether Ms. Noel consented, but the most critical evidence is discussed below.

(a) Evidence of Dr. Hawrylyshyn

[124] Dr. Hawrylyshyn testified that between 1900h and 1910h he had a lengthy conversation with Ms. Noel and Mr. Sibblies about the urgent situation Ms. Noel and the fetus now confronted. He testified that he explained the significance of the fetal heart decelerations and that he believed that it would take Ms. Noel too long to deliver the fetus without any intervention. Dr. Hawrylyshyn recalled that Ms. Noel initially wanted to continue pushing but he told her that choice was not appropriate in the circumstances.

[125] Dr. Hawrylyshyn testified that he told Ms. Noel that she had three options: vacuum-assisted delivery, forceps-assisted delivery, or delivery by Caesarean section. He had a specific recollection of telling Ms. Noel that his first recommendation was to try the vacuum. Dr. Hawrylyshyn testified that he explained the risks associated with the options for treatment, and the pros and cons of using the vacuum as opposed to the forceps, but I will return to that evidence in the part of the reasons on informed consent.

[126] Dr. Hawrylyshyn testified that he had a specific recollection of giving Ms. Noel and Mr. Sibblies a detailed explanation of how the vacuum worked. He recalled showing her the vacuum pump and opening the packaging to show her the soft silicone cup that would be applied to the fetus's head. Dr. Hawrylyshyn recalled explaining to Ms. Noel and Mr. Sibblies that the vacuum was built so that it could not apply more pressure than was safe and that the cup would detach if he pulled too hard on it.

[127] Dr. Hawrylyshyn also testified that he told Ms. Noel that if the vacuum did not work, then there were two options: a trial of forceps or a Caesarean section. Dr. Hawrylyshyn testified that he told Ms. Noel that if it came to that he would assess the situation clinically and determine if a trial of forceps would be appropriate, although it was likely that forceps would be the better option because they were safer than proceeding to a Caesarean section.

[128] Dr. Hawrylyshyn testified that Ms. Noel expressed particular concerns and fears to him about the use of the vacuum. He had a specific recollection of that discussion, which he also recorded in his operative note, which he dictated later that evening, at about 2230h:

> The options were discussed with the patient and her husband. Given the progress and the extent to which the presenting part had descended, it was felt a trial at a vacuum delivery was warranted. The patient had expressed a fear about the vacuum, worried "it would suck the baby's brains out". There was discussion about the pros and cons of using a vacuum. I indicated it was safer than using forceps. I indicated that if properly applied, and with proper pressures, it was an accepted safe obstetrical procedure. The parents allowed me to proceed with the trial of vacuum.

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[129] Dr. Hawrylyshyn testified that he used quotation marks around Ms. Noel's expression of fear because, at the time he dictated the operative note, he had a specific recollection that Ms. Noel used those precise words.

[130] During cross-examination, Dr. Hawrylyshyn reiterated that Ms. Noel affirmatively consented to the entire treatment plan, not only the application of the vacuum:

> Q. Okay. And during that ten minutes, from [1900h] to [1910h], you had the discussion and we are going to go over it in a bit of detail. You have told us about in your examination in-chief. And then if I understood you correctly, you obtained Ms. Noel's consent?
>
> A. Correct.
>
> Q. And that was her consent to the use of a vacuum, sir?
>
> A. No, it was consent to the discussion we had where it also indicated that if the vacuum failed, consideration would be given to the forceps, and if everything failed, that the only last resort was a Caesarean, that that was a management plan and my understanding is that -- sorry, that that is what she was consenting to.
>
> Q. Okay. So during that ten minutes, according to your understanding, Ms. Noel was being consented for both vacuum and forceps, yes?
>
> A. The forceps, if required, yes.

[131] Dr. Hawrylyshyn testified that he could not remember the exact words Ms. Noel used to express her consent, but that he was absolutely certain that she consented to his recommended plan. Dr. Hawrylyshyn testified that if Ms. Noel had merely remained silent, he would have persisted until he obtained a definitive answer from her either consenting to his plan or not consenting to it. He testified that he could not remember the words Ms. Noel used, or if she nodded her head, but that he was certain that "there was something affirmative from her indicating that [I had her] permission to go forward…I would not have proceeded without it."

[132] Dr. Hawrylyshyn was adamant that if Ms. Noel had asked to deliver by Caesarean section, he would have ensured that she understood the risks of the Caesarean section compared to the vacuum but that he would have performed the Caesarean section.

[133] Dr. Hawrylyshyn testified that after Ms. Noel provided her consent to its use, he applied the vacuum, which was not successful. He obtained a second opinion from Dr. Okun and she supported attempting a trial of forceps. Dr. Hawrylyshyn testified that he then explained to Ms. Noel that he was going to proceed to a trial of forceps but agreed that he did not have a further conversation about consent to the forceps with Ms. Noel. His evidence was that Ms. Noel had already provided her consent to his application of the forceps if he concluded it was clinically recommended and the fastest way to deliver the fetus. Dr. Hawrylyshyn testified that Ms. Noel did not object to the use of forceps and he then attempted unsuccessfully to apply the forceps.

[134] Dr. Hawrylyshyn then advised Ms. Noel that a Caesarean section would be necessary. Ms. Noel consented to the Caesarean section and they all moved to the operating room.

(b) Evidence of Ms. Noel

[135] Ms. Noel testified that after she began to push at 1840h, she remembered that there "was some type of flurry or confusion happening" and she understood that "there was something happening again after pushing that was going wrong," even though she did not know what exactly was going wrong. Ms. Noel testified that she recalled Dr. Hawrylyshyn coming into the room and that there were many things happening at this time.

[136] Ms. Noel testified that Dr. Hawrylyshyn stood at the foot of her bed and talked to the other medical professionals but that "no one was really talking to me about some of the things that were going on." Ms. Noel testified that the vacuum was then applied without her consent and without any discussion with her. She testified that nobody discussed with her that the vacuum was needed to deliver the fetus. She specifically stated that Dr. Hawrylyshyn never asked for her permission to apply the vacuum. She testified that:

> So he was at the foot of the bed with other medical -- Dr. Hawrylyshyn was at the foot of the bed with other doctors or people, medical professionals and he was talking amongst them. They were all talking amongst themselves…. And then the next thing I saw was that they were talking amongst themselves and then there goes a suction cup comes up and I could see that from where I was. I couldn't see what was happening down, but it was high enough that I could see it. And then I said, What are you doing with that? What's going on? What's happening? What's going on? What's happening?
>
> And the conversation continued to be around them, amongst the other professionals at the foot of the bed. And the nurse kept assuring me, It's okay, it's okay.

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> And I said, I asked you, I don't want the vacuum, why are you using that? Why are you going to use that? And their words, We got to get the baby out. We have to get the baby out. I was like, I didn't want this. Why are you doing this to me? What's happening? And they just kept saying that they need to get the baby out. And that's all I got is that the baby's got to come out.

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[137] Ms. Noel testified that Dr. Hawrylyshyn did not say anything directly to her in response to her questions. She testified that the medical professionals just kept talking among themselves about having to get the baby out. Ms. Noel testified that there was "no conversation with me during this time. The conversations were had around me, about me, but not to me."

[138] Ms. Noel testified that Dr. Hawrylyshyn never asked for her consent to use the vacuum and that he neither showed the vacuum to her nor explained how the vacuum worked before he applied it. She specifically denied that Dr. Hawrylyshyn spent 10 minutes discussing with her the pros and cons of a vacuum or forceps, the use of a vacuum, or the possible use of a vacuum, forceps, and then a Caesarean section. Ms. Noel denied that Dr. Hawrylyshyn ever talked to her about a plan that included the use of a vacuum. She denied that Dr. Hawrylyshyn ever offered her the choice of delivering by Caesarean section instead of the vacuum or the forceps.

[139] Ms. Noel recalled that Dr. Okun entered the room to assist Dr. Hawrylyshyn. Ms. Noel testified that neither Dr. Okun nor Dr. Hawrylyshyn ever told her what they were doing or how they were planning to assist with the delivery.

[140] Ms. Noel testified that if she had been asked at any time for her consent for Dr. Hawrylyshyn to use a vacuum or forceps she would have refused because she had "made up her mind." She testified that if Dr. Hawrylyshyn had given her the choice between the use of the vacuum and the Caesarean section she would have chosen the Caesarean section because she felt it was a controlled procedure:

> I felt that a Cesarean section is a controlled procedure, and I felt that I wanted that type of control, that the doctors have that much control when they're delivering my baby. I didn't need to labour through it.

<u>(c) Evidence of Jacqueline Noel</u>

[141] Jacqueline Noel testified that she recalled Ms. Noel saying that "her preference would be a Caesarean section if she doesn't dilate fully, her preference would be a Caesarean section." She next recalled a doctor saying that Ms. Noel was still not dilating and the fetal heart rate was dropping. At around that time, Jacqueline Noel recalled the medical professionals talking about using a vacuum to deliver the fetus and she described what happened next as follows:

> Q. And so can you tell me after the discussion or the mention of a vacuum what you saw happening next?
>
> A. Janelle was crying and saying something to the effect like, No, no, I don't want that, no, no, no, and just -- it was just a crazy time and they -- I saw them trying to get Mylo out with the vacuum, but it seemed like it wasn't working. And that is -- yeah.

[142] In cross-examination, Jacqueline Noel agreed that the conversation that she recalled about the vacuum could have taken place earlier in the day, before Ms. Noel was fully dilated at 1840h. She also agreed that she could not recall what, if anything, the doctors said in response to Ms. Noel saying "no, no, no."

[143] Jacqueline Noel testified that no one asked for Ms. Noel's permission to apply the vacuum and that there was no 10-minute conversation about the vacuum while she was in the room. She did not recall whether the forceps were ever applied.

(d) Evidence of Ms. Addison

[144] Ms. Addison, who had worked in a delivery room as a Registered Nurse, testified that she was in the room when the vacuum was used. She did not hear Ms. Noel consent to the use of the vacuum but did not remember Ms. Noel saying anything during that time. Ms. Addison did not recall a ten-minute conversation between Dr. Hawrylyshyn and Ms. Noel. She did not recall the forceps being used. She did not recall saying anything to any of the doctors during the delivery process.

E. Conclusion

[145] Ms. Noel has met her burden to prove that Dr. Hawrylyshyn applied the vacuum and the forceps. The burden now shifts to Dr. Hawrylyshyn to prove that Ms. Noel consented to those treatments.[12]

[146] In my view, there is no way to reconcile the evidence of Ms. Noel and Jacqueline Noel, on the one hand, with the evidence of Dr. Hawrylyshyn. If I accept the evidence of Ms. Noel and Jacqueline Noel, Dr. Hawrylyshyn did not obtain her consent to apply either the vacuum or forceps. If I accept the evidence of Dr. Hawrylyshyn, then Ms. Noel consented to the very delivery techniques that he applied. Resolving this dispute requires me to assess the credibility and reliability of the witnesses.

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[12] *Norberg v. Wynrib*, [1992] 2 S.C.R. 226, at p. 246; *Nelitz v. Dyck* (2001), 52 O.R. (3d) 458 (C.A.), at paras. 30 to 32.

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<u>Assessing credibility and reliability</u>

[147] Credibility and reliability are different. Credibility has to do with the honesty or sincerity of a witness. Reliability describes the other factors that can influence the accuracy of testimony, such as the witness's ability to observe, recall, and recount events in issue.[13]

[148] Witnesses can sincerely believe their evidence is true, but that does not mean that what they are saying is reliable. Memory is fallible and becomes increasingly frail over time. Even an apparently convincing, confident, and credible witness may not be an accurate or reliable reporter. There is significant risk in placing too much emphasis on demeanour or the confidence with which a witness speaks where there are contradictions and inconsistencies inherent in the witness's evidence or where that testimony is inconsistent with contemporaneous records.[14]

[149] One of the leading decisions on assessing credibility is *Faryna v. Chorny*, where the court explained that:

> The credibility of interested witnesses, particularly in cases of conflict of evidence, cannot be gauged solely by the test of whether the personal demeanour of the particular witness carried conviction of the truth. The test must reasonably subject his story to an examination of its consistency with the probabilities that surround the currently existing conditions. In short, the real test of the truth of the story of a witness in such a case must be its harmony with the preponderance of the probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions.[15]

[150] Taking into account my assessment of reliability and credibility, I will assess the evidence before me according to many factors, including:

a. if the evidence makes sense by being internally consistent, logical or plausible;

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[13] *R. v. C.(H.)* 2009 ONCA 56, at para. 41; *R. v. Morrissey* (1995), 22 O.R. (3d) 514 (C.A.) at para. 33; *R. v. Sanichar*, 2012 ONCA 117, at paras. 36, 69 and 70, rev'd on other grounds, 2013 SCC 4, [2013] 1 S.C.R. 54; *Fitzpatrick v. Orwin*, 2012 ONSC 3492, at paras. 62-68, aff'd 2014 ONCA 124.
[14] *Sanichar*, at para. 35; *R. v. McGrath*, [2000] O.J. No. 5735 (S.C.), at paras. 10-14; *R. v. Stewart* (1994), 18 O.R. (3d) 509 (C.A.), at pp. 515-18, leave to appeal to S.C.C. refused, [1994] S.C.C.A. No. 290; *R. v. Norman* (1993), 16 O.R. (3d) 295 (C.A.), at pp. 311-15.
[15] [1952] 2 D.L.R. 354 (B.C.C.A.), at p. 357; see also *Phillips et al. v. Ford Motor Co. of Canada Ltd. et al*., [1971] 2 O.R. 637 (C.A.).

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b. if there are inconsistencies or weaknesses in the evidence of the witness such as internal inconsistencies, prior inconsistent statements, or inconsistencies with the evidence of other witnesses;

c. if there is independent evidence to confirm or contradict the witness's evidence, or a lack of such evidence;

d. the witness's demeanour, including their sincerity and use of language, although this must be considered with caution and I place little weight on demeanour; and

e. if the witness, particularly one that is a party in a case, may have a motive to fabricate.[16]

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[151] For the reasons that follow, I do not accept Ms. Noel's evidence that she did not consent to the use of the vacuum or forceps. I find that she expressly consented to Dr. Hawrylyshyn applying the vacuum and, if the vacuum failed and clinical circumstances warranted, then applying the forceps. Nineteen years after the events in question, it appears to me that she sincerely believes the core of her evidence. In my view, her evidence is not reliable or accurate. In addition, there were several parts of her evidence that undermined her overall credibility.

[152] I will explain below why I do not accept Ms. Noel's evidence. I can only explain my reasons one at a time. However, it is all of these elements taken together that lead me to my ultimate conclusion that she consented to the use of the vacuum and forceps.

Ms. Noel's evidence is unreliable

[153] First, I do not accept as reliable Ms. Noel's evidence that she had made up her mind to refuse the use of the vacuum or forceps under any circumstances and regardless of any advice she received during her labour. For example, Ms. Noel testified as follows:

> Q. Had you been asked for your consent to the use of the vacuum at any time on June 11th, 2005, what would you have said?
>
> A. No.
>
> Q. Why is that?
>
> A. Because I made up my mind. I made up my mind. This was my first child. I wanted things the way that I wanted them and I went in there knowing I did not want the vacuum, I did not want forceps,

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[16] *Caroti v. Vuletic*, 2022 ONSC 4695, at paras. 434-436; *1088558 Ontario Inc. v. Musial*, 2022 ONSC 5239, at para. 83.

> and I was prepared for a Caesarean section. So that's why I did not want that.

[154] I do not accept that Ms. Noel ever made a categorical decision to refuse to consent to the use of the vacuum or forceps in any circumstance. Instead, I find that she preferred a vaginal birth without the use of vacuum or forceps. In my view, this is consistent with the evidence of Jacqueline Noel and Ms. Addison who both testified that Ms. Noel had a preference not to have the vacuum or forceps used during her labour. Neither woman testified that Ms. Noel told them that she had made an unalterable or categorical decision. A preference for an instrument free delivery, even a strong preference, is not the same as a firm decision to refuse such treatments regardless of the circumstances of the delivery.

[155] I accept that Ms. Noel did not "want" the use of the vacuum or forceps as part of the delivery process. As Dr. Allen testified, this is a very common view among her patients. All things going smoothly, a patient may well be able to deliver a baby in manner consistent with her preferences. For example, a patient may say "I have made up my mind, I want to deliver my baby at home, without the assistance of a medical doctor." However, that does not mean that if that patient undergoes uterine rupture, she would not reconsider her preferences and seek further care at a hospital.

[156] I find that Ms. Noel never expressed a firm view to Dr. Allen that she would not, under any circumstances, consent to the use of the vacuum or forceps in delivery. I accept the evidence of Dr. Allen that it would have been very unusual for one of her patients to reject categorically the use of the vacuum or forceps and that such an unusual statement would have prompted a further detailed discussion with the patient. I also accept Dr. Allen's evidence that she would have documented any such adamant decision from one of her patients. I can see no reason for Dr. Allen not to document such an unusual statement from a patient. Equally, it does not make sense to me that, if Ms. Noel expressed such a firm decision, she would have accepted Dr. Allen's response that that her pregnancy was progressing well and that it was not necessary to speak about vacuum or forceps-assisted birth at that time. If Ms. Noel had formed and expressed a firm and unalterable decision there would be no reason to wait to discuss the matter.

[157] It seems much more likely to me that Ms. Noel expressed her preference to avoid an operative birth to Dr. Allen as a preference and nothing more. Dr. Allen testified that this was a very common preference among her patients. I do not find it surprising that Dr. Allen did not make a note of Ms. Noel's preference in the chart. Indeed, there is not a single note from any medical professional documenting Ms. Noel saying that she refused a vacuum or forceps under any circumstances. It is very unlikely that Dr. Allen and Dr. Hawrylyshyn each failed to record Ms. Noel expressing a categorical refusal on four or more occasions in both an antenatal and hospital setting.

[158] I also have some concerns about the reliability of Ms. Noel's recollection of her conversations with Dr. Allen. With the passage of time, Ms. Noel no longer remembers very important conversations with Dr. Allen. For example, the medical records clearly

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demonstrate that on March 29, 2005, Dr. Allen referred Ms. Noel to a social worker and psychiatrist due to her pervasive sadness, anxiety, and increased sleep, but Ms. Noel had no recollection of that referral.

[159] I am not certain if the conversations that Ms. Noel recalled having with Dr. Allen at the hospital about her preference not to have a vacuum or forceps-assisted delivery actually happened. The nursing records do not document any visits from Dr. Allen that match up with Ms. Noel's recollection. Ms. Noel recalls speaking to Dr. Allen the first time before she received her epidural, which records confirm took place at 0502h. The first and only reference to a visit from Dr. Allen in the nursing record, however, is logged at 0650h, while Ms. Noel was sleeping. I accept, however, that it is possible that Dr. Allen visited Ms. Noel when the nurse was out of the room or that the nurse did not log the visit. Nevertheless, I have concerns about the reliability of Ms. Noel's recollections about the early parts of her labour.

[160] In their written submissions, the plaintiffs describe Ms. Noel's evidence as "unshakable and unimpeachable in cross-examination." I disagree. On several occasions, Ms. Noel's evidence was significantly undermined on cross-examination. More than once, defence counsel successfully impeached Ms. Noel's evidence. As I will explain, Ms. Noel's credibility was undermined on a couple of significant points.

[161] Ms. Noel testified that she had a fairly good recollection of a conversation she had with Dr. Yasser, the anaesthesiologist who completed her epidural between 0445h and 0452h. She testified that she recalled him taking her medical history and asking if she had any allergies. Ms. Noel testified that she recalled Dr. Yasser explaining the risks of the epidural, which included long-term back pain, and a risk of paralysis if the needle was not inserted properly. She testified that she recalled asking questions about the risks and that she then consented to the epidural.

[162] Counsel for the defendants then confronted Ms. Noel with the transcript of her examination for discovery from October 2018 at which Ms. Noel stated that she remembered almost nothing about her conversation with Dr. Yasser:

> 215. Q. According to the records, the epidural was completed by a Dr. Yasser. Do you remember Dr. Yasser?
>
> A. No, I just remember the doctor that put the epidural in.
>
> 216. Q. What do you remember about the doctor who put the epidural in?
>
> A. Just the instruction was to lean forward and don't move. And – I was very nervous about the epidural because it was taking long. And I knew that there was a period that if after a certain number of centimetres, you couldn't receive

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> the epidural. And I had already been three centimetres dilated going into the hospital. And that was from my last appointment with Dr. Allen, she said I was three centimetres dilated…
>
> 219. Q. So, aside from what you've just told me. Is there anything else you remember about speaking with Dr. --- about the doctor who administered the epidural?
>
> A. No.

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[163] Ms. Noel confirmed that she gave those truthful answers on her examination for discovery. Had Ms. Noel left the matter there, it would have caused me some, but not too much concern. Defence counsel, quite properly and skilfully, impeached Ms. Noel with a prior statement that was inconsistent with her evidence at trial but it was about a peripheral issue. While it is always noteworthy when a witness's memory improves in the six years after the examination for discovery, that plays only one part in assessing the witness's reliability and credibility.

[164] Instead, Ms. Noel began to argue with counsel for the defendants. First, she said that during the examination for discovery, counsel only gave her the name Dr. Yasser and she did not remember his name but she did remember the doctor who gave her the epidural. Ms. Noel was not correct. As can be seen above, in questions 216 and 217 of the examination, counsel for the defendants did not rely on the name of the anaesthesiologist but asked a broad question about "the doctor that put the epidural in." Second, Ms. Noel stated that she was not asked during the examination for discovery about discussing risks with the doctor that gave her the epidural. When defence counsel pointed out that she was asked the very broad question "is there anything else you remember?", Ms. Noel said that "anything else" could mean a lot of things and then retreated further and said that she did not understand the question. Ms. Noel's handling of these questions undermined her credibility and causes me to place less weight on her testimony.

[165] In these circumstances, I find Ms. Noel's evidence that she told Dr. Allen during her antenatal appointments or at the hospital that she had decided to refuse the vacuum or forceps regardless of the circumstances of her labour to be unreliable. I do not accept it.

[166] I reach the same conclusion about Ms. Noel's conversations with Dr. Hawrylyshyn prior to 1855h. I find that Ms. Noel told Dr. Hawrylyshyn of her preference not to have the vacuum or the forceps used to assist her delivery. Ultimately, I think the evidence of both Ms. Noel and Dr. Hawrylyshyn is largely consistent on this point. Dr. Hawrylyshyn, like Dr. Allen, explained that if Ms. Noel had told him that she would refuse the vacuum or forceps in any clinical circumstance, it would have triggered further conversations, documentation, and the completion of an Against Medical Advice form. The fact that none of those things happened is evidence that Ms. Noel did not make such a categorical statement.

[167] Instead, I find that she expressed her preference for a vaginal birth without the use of vacuum or forceps. This makes sense because the entire course of care she received was designed to achieve that goal. The decisions to commence synthetic oxytocin, to conduct two scalp pH assessments, and to conduct an ultrasound were all to designed to maximize the chances of a vaginal birth and to ensure that the fetus was tolerating labour.[17] This course of treatment is one of the reasons I reject Ms. Noel's evidence that she spent all day asking for a Caesarean section. She testified as follows:

> Q. You understood that, right, Ms. Noel? It was open to you to ask Dr. Hawrylyshyn -- to tell him, you didn't wish to continue with the labour, let's just do a C-section. You could have said that?
>
> A. I asked for a C-section all day. That's what I wanted, sir. It was never given an option. If you're saying at 12:30 we discussed modes of delivery and scalp PH wasn't until 1:30? Like, what mode did we discuss if they didn't know about the baby? I don't understand what you're asking me. This is confusing to me.

[168] In the flow of the trial, Ms. Noel's evidence that she "asked for a C-section all day" surprised me. It was entirely inconsistent with her evidence in chief. Ms. Noel quickly retreated and said that she while she "wanted" a Caesarean section all day she did not tell Dr. Hawrylyshyn that. However, her initial answer causes me significant concern because it undermines her credibility. There is no other evidence that supports her testimony that she asked for a Caesarean section all day. It appeared to me that she was feeling the pressure of a focussed cross-examination on a fairly important point and provided an answer that she perceived to help her case regardless of its connection to what she recalled from that day. This answer caused me significant concerns about her credibility on crucial issues in this case.

[169] Ms. Noel gave other evidence that suggests she is not a reliable narrator. For example, she testified that her friend Beverly Sullivan suggested that Dr. Hawrylyshyn perform the ultrasound because Ms. Noel's hips were small. She testified that Dr. Hawrylyshyn did not want to perform the ultrasound because "it was not a normal practice" but that he said he would order the ultrasound just to rule that out. The implication of Ms. Noel's evidence was that Dr. Hawrylyshyn would not have ordered the ultrasound but for Ms. Sullivan's suggestion.

[170] This evidence is, on its face, implausible. It seems unlikely that Dr. Hawrylyshyn recommended tests based on the suggestions of Ms. Noel's friends. Indeed, when pressed

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[17] I accept that the ultrasound had two purposes. First, to see if fibroids were interfering with the descent of the fetus or would interfere with a vaginal birth. Second, if Ms. Noel had a Caesarean section the surgical team would need to prepare for the presence of fibroids, which could bleed heavily. The first purpose is consistent with labouring toward a vaginal birth. The latter purpose is consistent both with an immediate Caesarean section and with an informed back-up plan to a spontaneous vaginal birth.

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on cross-examination, Ms. Noel significantly changed her evidence to downplay any role for Ms. Sullivan in Dr. Hawrylyshyn's clinical decisions:

> Q. Beverly didn't suggest that he order an ultrasound.
>
> A. It was suggested by Beverly to him because my hips were small and I had a history of fibroids, he didn't want to do that. As he said, it was not a normal practice, but just to rule that out, he would order it.
>
> …
>
> Q. Your recollection is Beverly suggested he order the ultrasound?
>
> A. We discussed at some point why my labour was not progressing.
>
> Q. That's not responsive to the question I asked.
>
> A. I'm sorry.
>
> Q. The question was, are you saying -- you're saying, your evidence is that Beverly asked Dr. Hawrylyshyn to order an ultrasound or suggested that to Dr. Hawrylyshyn?
>
> A. What I'm saying is we had a conversation, a discussion in the room, about my labour and why it was not progressing and that's something that came out of it and that was ordered as a result of the discussion that happened in the room while I was labouring.

[171] Dr. Hawrylyshyn testified that he did not recall any of Ms. Noel's support persons mentioning her small hips. In addition, he offered a completely different explanation for conducting the ultrasound. Dr. Hawrylyshyn testified that he had a specific recollection that Dr. Allen had mentioned to him at the time of the handover that Ms. Noel had fibroids. Ordering the ultrasound would determine whether fibroids were obstructing Ms. Noel's labour. Dr. Hawrylyshyn also explained that if it became necessary to deliver by Caesarean section, the surgical team needed to know if fibroids were present because they could cause significant bleeding.

[172] While Ms. Noel may have come to believe that Ms. Sullivan suggested that Dr. Hawrylyshyn perform an ultrasound due to her small hips, I do not accept her evidence that this happened. It is implausible. It is so implausible that when pressed on cross-examination, Ms. Noel retreated from her previously clear evidence.

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[173] I am satisfied that, for the most part, Ms. Noel was doing her best to provide the court with her recollection of the events of that day. She candidly admitted that she did not make any notes or create a detailed written record of what happened on the day of the delivery shortly after the events in question. I also accept without hesitation that the labour and delivery were long, painful, stressful, and traumatic. I accept that the peripheral details of a traumatic event can be difficult to recall and accurately describe, especially 19 years later.[18] However, on balance, I find that Ms. Noel is not a reliable narrator for much of what transpired during her labour and the delivery.

<u>Dr. Hawrylyshyn's evidence is reliable</u>

[174] First, I accept Dr. Hawrylyshyn's evidence that he spent the ten minutes from 1700h to 1710h discussing the application of the vacuum and forceps with Ms. Noel.

[175] I have no doubt that the nursing notes provide accurate guideposts to what happened during this crucial period of time. Ms. Noel did not challenge the accuracy of these records in any way. Even if the notes are brief and obviously underinclusive, I find that they provide the most reliable evidence of what happened when. In my view, the inherent probability of any version of events will be determined in large measure by how well or how poorly that version of events accords with the nursing notes. For ease of reference, the notes read as follows:

> 1855 Variable deceleration. O2 mask. Dr. Hawrylyshyn informed
>
> 1858 In to assess
>
> 1910 Vacuum attempted

[176] I accept Dr. Hawrylyshyn's evidence that it would have taken him no more than a minute or two to enter the room, read the fetal heart tracing, conduct a vaginal examination, assess Ms. Noel's pushing during a contraction, and formulate his recommended plan of action. I also accept that the change to the fetal heart rate was very concerning and indicated that the delivery needed to be expedited.

[177] The plaintiffs correctly point out that the nursing notes do not document what happened between 1858h (when Dr. Hawrylyshyn arrived) and 1910h (when the Dr. Hawrylyshyn applied the vacuum). However, something must have been going on to delay the application of the vacuum. Considering the urgent circumstances, the fact that the vacuum was not applied until 1910h is unusual. Time was ticking. There was no evidence to suggest that it would take ten minutes from the time a patient consented to the use of the vacuum to its application. Dr. Hawrylyshyn provided a much more plausible and compelling explanation for what happened during those ten minutes than did the plaintiffs.

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[18] *R. v. A.A.*, 2023 ONCA 174, at para. 17; *R. v. G.M.C.*, 2022 ONCA 2, at para. 38

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[178] As set out above in paragraphs [124] to [134], Dr. Hawrylyshyn testified that he explained the significance of the change in fetal heart rate, the risks that change posed to the health of the fetus, and the need to expedite the delivery. He showed the vacuum to Ms. Noel and explained how it worked. He explained the options for delivery. Dr. Hawrylyshyn's testimony, while more detailed, was consistent with his operative note, which he dictated later that evening. The relevant portion of that note reads as follows:

> Add about 1900 hours, I was called back. The patient had now developed, with pushing, deep variable decelerations. They were repetitive with each contraction and show some showed a late recovery. The presenting part was now at +1. Caput with molding was visible at the introitus.
>
> The options were discussed with the patient and her husband. Given the progress and the extent to which the presenting part had descended, it was felt a trial at a vacuum delivery was warranted. The patient had expressed a fear about the vacuum, worried "it would suck the baby's brains out". There was discussion about the pros and cons of using a vacuum. I indicated it was safer than using forceps. I indicated that if properly applied, and with proper pressures, it was an accepted safe obstetrical procedure. The parents allowed me to proceed with the trial of vacuum.
>
> The vacuum was carefully applied at 1910.

[179] In her evidence at trial, Ms. Noel initially denied telling Dr. Hawrylyshyn that she was afraid the vacuum would "suck the baby's brains out." She was effectively impeached on her evidence at the examination for discovery and then agreed that she had said those words to Dr. Hawrylyshyn. That admission causes me to place more weight on Dr. Hawrylyshyn's note and causes me some concern about the reliability of Ms. Noel's recollection of what happened during that key period of time.

[180] Medical notes made shortly after the events at issue, even if brief, can be a more reliable representation of the medical encounter than a patient's recollection at trial, 19 years after the fact.[19] Dr. Hawrylyshyn dictated his operative note knowing that Dr. Ko and at least one nurse were in the room at the same time and would have their own observations and notes about what happened.

[181] The plaintiffs neither pleaded nor strenuously suggested that Dr. Hawrylyshyn deliberately created a knowingly false note. On this record, I would not have accepted such a submission. It would take significantly more evidence to persuade me that a doctor

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[19] *Henry v. Boiven*, 2023 ONSC 663, at para. 55.

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intentionally violated her or his fiduciary, statutory, and regulatory duties by creating a false note.

[182] In contrast, the plaintiffs' evidence does not provide a plausible explanation for what happened during the crucial ten-minute window from 1900h to 1910h. Ms. Noel, Jacqueline, and Ms. Addison either denied that Dr. Hawrylyshyn spoke to Ms. Noel for ten minutes about the pros and cons of vacuum or forceps or their possible use or did not recall such a conversation. Ms. Noel also denied that Dr. Hawrylyshyn showed and explained how the vacuum worked. None of Ms. Noel, Jacqueline Noel, or Ms. Addison, however, provided any explanation for what was happening during that ten-minute period if Dr. Hawrylyshyn was not having the conversation with her that he described in his testimony and in his operative note. During closing submissions counsel for the plaintiffs agreed it was "likely [that Dr. Hawrylyshyn] did explain a plan of management" during those ten minutes. That concession is at odds with Ms. Noel's evidence and causes me to doubt her reliability on this point.

[183] The closest that Ms. Noel came to explaining what was happening was her evidence that Dr. Hawrylyshyn was at the foot of the bed talking to other medical professionals. In her words, "the conversations were had around me, about me, but not to me." I do not accept this evidence.

[184] I have no doubt that at various points during the day, Dr. Hawrylyshyn, Dr. Ko, and the nurses discussed things among themselves. For example, at 1700h Dr. Ko made a note that he discussed the care plan with Dr. Hawrylyshyn. Also, Dr. Hawrylyshyn obtained a second opinion about the advisability of applying the forceps sometime after 1910h. I do not accept, however, Ms. Noel's evidence that such a discussion took place from 1900h to 1910h. While Ms. Noel may well remember times when the medical professionals discussed things among themselves without her direct involvement, I find that this did not happen between 1900h and 1910h.

[185] There was no reason for Dr. Hawrylyshyn to have a long conversation with any of the other medical professionals in the room at 1900h. He assessed the situation, determined it was urgent, and knew exactly what treatment plan he believed was most appropriate in the circumstances. There was nothing to discuss with Dr. Ko or the nurses. He did not need their consent to proceed. The health of the fetus was in jeopardy, and it was not the time for a teaching moment with Dr. Ko. The situation was urgent and there was only one person in the room to whom he needed to speak: Ms. Noel.

[186] Dr. Hawrylyshyn's note recorded that he spoke to Ms. Noel and Mr. Sibblies between 1900h and 1910h. Mr. Sibblies did not testify at trial. The defendants urge me to draw an adverse inference against the plaintiffs because he did not testify. I decline to do so. I observe only that Dr. Hawrylyshyn's version of events was committed to writing in 2005, mere hours after the conversation in question. The defendants produced that note in the litigation. I am inclined to give significant weight to Dr. Hawrylyshyn's evidence that is consistent with that contemporaneous note. The plaintiffs could have undermined the

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reliability and credibility of that Dr. Hawrylyshyn's evidence if they called Mr. Sibblies and he denied that any such conversation took place, but they did not do so. The plaintiffs' attack on Dr. Hawrylyshyn's evidence, therefore, stands or falls on the strength of the evidence called. I see no need to draw an adverse inference in the circumstances of this case.

[187] I found it very difficult to accept the evidence of Ms. Noel and Jacqueline Noel, and Ms. Addison. It seems highly implausible, to me, that after Dr. Hawrylyshyn provided careful and attentive care all day, he completely disregarded his fundamental obligation to obtain his client's consent to the application of the vacuum and forceps.

[188] In my view, the most probable explanation for what happened during this ten-minute window is that Dr. Hawrylyshyn spent that time discussing his recommended vacuum-assisted and, if necessary, forceps-assisted delivery plan with Ms. Noel. Dr. Hawrylyshyn knew that this was not Ms. Noel's preference, even though he believed it was the best plan. Taking the time to explain how the vacuum worked, showing her the equipment, answering Ms. Noel's concerns about the procedure (even if they were based on misinformation), and explaining why using the vacuum and then perhaps the forceps was his preferred procedure displays a high level of concern for patient autonomy and the right to consent or decline a treatment.

[189] To recap, I have found that Dr. Hawrylyshyn knew that Ms. Noel wanted a vaginal birth and wanted to avoid the use of the vacuum and forceps. I have also found that between 1858h and 1900h Dr. Hawrylyshyn came to the conclusion that the health of the fetus was in serious jeopardy, that the birth needed to be expedited, and that there was no time to allow Ms. Noel to continue to try and deliver through an unassisted vaginal delivery. Finally, I have found that between 1900h and 1910h, Dr. Hawrylyshyn had a conversation with Ms. Noel about the options, showed her the vacuum, and tried to address her concerns about the use of the vacuum and forceps.

[190] Bearing in mind those findings, I turn to the ultimate question of whether Dr. Hawrylyshyn proved on a balance of probabilities that Ms. Noel consented to the use of the vacuum and forceps.

[191] I accept Dr. Hawrylyshyn's evidence that at the end of the conversation, Ms. Noel consented to his plan to use the vacuum and then the forceps, if he believed that was clinically indicated. I accept his evidence that he did not and would not have proceeded without Ms. Noel's consent. It is not surprising to me that he does not remember the exact words Ms. Noel used to express her consent. What is most important is his conviction, which was unshaken on cross-examination, that Ms. Noel provided affirmative consent before he applied the vacuum and forceps. Indeed, he documented this consent in his relatively contemporaneous operative note. I also accept his evidence that if Ms. Noel was

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merely silent, he would have continued to ask questions until he received a clear answer.[20]

[192] It seems highly improbable to me that Dr. Hawrylyshyn spoke to Ms. Noel for ten minutes, showed her the vacuum and how it worked and then suddenly applied the vacuum without Ms. Noel's consent. It seems highly improbable that after Dr. Hawrylyshyn provided careful and attentive care all day that he completely disregarded his fundamental obligation to obtain his patient's consent to the application of the vacuum and forceps. Moreover, if Dr. Hawrylyshyn was indifferent as to whether he obtained Ms. Noel's consent, it seems more likely to me that he would have applied the vacuum at 1901h. It seems very unlikely that he would have had a lengthy conversation with Ms. Noel in urgent circumstances and at the end of it simply ignored Ms. Noel's objection or lack of consent to the very treatment plan they discussed.

[193] I do not accept the plaintiffs' submission that Dr. Hawrylyshyn is blaming Ms. Noel "for not saying no." I am satisfied that Ms. Noel provided affirmative consent to the treatment.

[194] I do not accept Ms. Noel's and Jacqueline Noel's evidence on the issue of consent. Ms. Noel testified as follows:

> And then the next thing I saw was that they were talking amongst themselves and then there goes a suction cup comes up and I could see that from where I was. I couldn't see what was happening down, but it was high enough that I could see it. And then I said, What are you doing with that? What's going on? What's happening? What's going on? What's happening?
>
> And the conversation continued to be around them, amongst the other professionals at the foot of the bed. And the nurse kept assuring me, It's okay, it's okay.
>
> And I said, I asked you, I don't want the vacuum, why are you using that? Why are you going to use that? And their words, We got to get the baby out. We have to get the baby out. I was like, I didn't want this. Why are you doing this to me? What's happening? And they just kept saying that they need to get the baby out. And that's all I got is that the baby's got to come out.

[195] Jacqueline Noel testified as follows:

> A. Janelle was crying and saying something to the effect like, No, no, I don't want that, no, no, no, and just -- it was just a crazy

[20] Because I accept Dr. Hawrylyshyn's evidence that if Ms. Noel was merely silent, he would have continued to ask questions until he received a clear answer, I do not base my finding on inferred or implied consent.

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> time and they -- I saw them trying to get Mylo out with the vacuum, but it seemed like it wasn't working. And that is -- yeah.

[196] I don’t accept this evidence for the following four reasons.

[197] First, as I have already found that Dr. Hawrylyshyn showed Ms. Noel the vacuum and the suction cup, I do not accept Ms. Noel’s that she was surprised by the appearance of the vacuum or that she would have reacted in that manner. While defence counsel attempted to impeach Ms. Noel on her examination for discovery transcript, I do not think there was a true inconsistency between her trial evidence and the prior examination. I reject Ms. Noel’s evidence not because of the alleged inconsistency, but because I accept Dr. Hawrylyshyn’s evidence as confirmed by his operative note. I do not believe that Ms. Noel made those comments at 1910h.

[198] Second, I do not find it plausible that none of the medical professionals in the room spoke out or made a note that Ms. Noel was saying out loud that she did not consent to the use of the vacuum. In addition to Dr. Hawrylyshyn, during the application of the vacuum, Dr. Ko, at least one nurse, and Dr. Okun were all in the room. None of them spoke out or made any notes that Ms. Noel was objecting to the application of the vacuum. Dr. Davies testified that he could not imagine a scene such as the one described by Ms. Noel or Jacqueline Noel without the nurse or resident saying something. I agree. It seems highly unlikely that these professionals would have failed to speak up or to make a record if such a shocking and disturbing scene had unfolded.

[199] Third, it seems improbable to me that none of Ms. Noel’s support people interjected or intervened if Ms. Noel was vocally objecting to the application of the vacuum. Ms. Addison, who was herself an experienced obstetrical nurse, did not recall Ms. Noel saying anything during this period of time. It seems implausible that an experienced nurse would not have noted her friend saying that she did not consent to the application of the vacuum and, apparently, took no steps to intervene or object. As noted above, Mr. Sibblies did not testify at all despite being very well placed to have made observations of whether Ms. Noel was saying “no, no, no” as Dr. Hawrylyshyn applied the vacuum.

[200] Fourth, and while this is a minor point, Ms. Noel’s statements immediately following the Caesarean section do not refer to Dr. Hawrylyshyn applying the vacuum without her consent. The post-natal medical reports record that Ms. Noel was upset, that she was upset that the vacuum had been used, was frustrated by the delivery outcome, and was worried about whether Mr. Noel would suffer brain damage as a result. The notes do not record Ms. Noel telling anyone that Dr. Hawrylyshyn applied the vacuum or forceps without he consent. I do not use this absence of evidence to undermine Ms. Noel’s credibility or reliability. I only note the absence of evidence in the contemporaneous medical notes that might have supported the reliability of her recollections.

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<u>The notes of the meeting on August 23, 2005</u>

[201] On August 23, 2005, there was a meeting at the hospital to allow Ms. Noel to summarize her birth experience at the hospital and to highlight her questions and concerns about the birth of Mr. Noel. The meeting lasted a little over one hour. Ms. Noel, Dr. Hawrylyshyn, Dr. Allen, Dr. Ko, Karen Meadwell, Kim Parker, Maureen McGillivray, Anne Jeffries, and two support people attended with Ms. Noel.

[202] The parties reached an agreement on the admissibility of the notes:

> The Meeting Notes dated August 23, 2005 are admitted to be an authentic copy of meeting notes and are admissible for *prima facie* truth that what was recorded was said during the meeting, but not the truth of what was said.

[203] Counsel for the plaintiffs urged me to place great weight on the notes because the meeting took place less than three months after the events of June 11, 2005. I disagree.

[204] I place very little weight on the content of the notes. The notes were taken by an unidentified person at the meeting. That person was not called to give evidence at trial, so I have no idea how they decided what to record or not record in the notes. I have no way of knowing whether the notetaker was trying to produce a verbatim record or was summarizing loosely, substituting their own choice of words for those of the speakers at the at the meeting. None of Ms. Noel, Dr. Allen, or Dr. Hawrylyshyn had the contemporaneous opportunity to review or correct the notes, which are obviously not a transcript of what was said at the meeting. In 2005, none of the witnesses had the chance to say that the notes omitted key information, contained erroneous information, or did not convey the correct and intended meaning.

[205] It appears that the notes may omit important information. In her evidence, Ms. Noel agreed that the notes record Dr. Hawrylyshyn saying that he showed her the vacuum and explained its safety features to her before it was used. She also agreed that the notes did not record her telling Dr. Hawrylyshyn that his statement was untrue and that he never showed or explained those things to her. Ms. Noel testified that she did say those things at the meeting and "[i]t's probably just not recorded in this."

[206] Ms. Noel raises a fair point. If she said those things in the meeting and they were not recorded, then the notes could be extremely misleading by omission. If she in fact disputed Dr. Hawrylyshyn's recollection, the notes paint an unfair and misleading picture of what happened at the meeting. In such circumstances, relying on the notes to undermine Ms. Noel's testimony would be unfair to her.

[207] It also appears that the notes may contain erroneous information. The following passages appear toward the end of the notes:

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> Janelle – stated at the time of delivery she was willing to take the cut and sacrifice for her baby…
>
> Janelle again made her point that she would have had an episitomy [*sic*] but did not want to have a vacuum or forceps delivery and that her whole voice was lost. Stated that she was not adamant enough.[21]

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[208] Ms. Noel did not discuss this passage in her evidence, but I raised this passage with counsel in closing argument. If I gave great weight to this note, as suggested by the plaintiffs, I could conclude that when Ms. Noel told the doctors that she was willing to "take the cut," she was actually referring to an episiotomy not a Caesarean section. That, in turn, could discredit most if not all of Ms. Noel's evidence.

[209] It may be that the notetaker simply misspelled episiotomy when the notetaker intended to write down Caesarean section. If that is the case, that is an enormous and consequential error, and the notes are plainly unreliable. I could place no weight at all on the notes and certainly not on any one word or phrase contained in the notes.

[210] I find that the notes are broadly consistent with each party's testimony at trial. I am not prepared to give the notes much weight where they are inconsistent with the evidence I heard at trial. For example, in the notes, Ms. Noel is recorded as saying that "she had done some research on the internet and felt very frightened about forceps and vacuum delivery" whereas at trial she testified that her concerns about the use of those instruments came from her conversations with friends. To take another example, the notes indicate that Dr. Hawrylyshyn "has thought about what we could do better and was it okay for him to assume informed consent after the explanation." At trial, Dr. Hawrylyshyn explained that he was attempting to be generous to Ms. Noel and bridge the discrepancy between her consenting on June 11 to the use of the vacuum and then later protesting its use.

[211] For all of the reasons set out above, in my view, the evidence at trial and the contemporaneous medical notes should be given far more weight than the notes of the August 2005 meeting. In my view, they do not effectively impeach or discredit the trial evidence of any of the witnesses.

Conclusion

[212] I find that Ms. Noel consented to Dr. Hawrylyshyn using the vacuum and then the forceps, if he considered that to be advisable. I accept that she wanted a vaginal birth and did not want to use either the vacuum or the forceps. She and her care team organized the day in pursuit of those goals. Unfortunately, as of 1845h, the fetus was no longer tolerating labour and its health was at great risk. Against this very changed backdrop, Dr. Hawrylyshyn exercised his best clinical judgment and recommended the use of the vacuum and possibly the forceps as the fastest and safest way to deliver the fetus. Dr. Hawrylyshyn addressed

[21] Emphasis added.

Ms. Noel's concerns about those instruments. Ms. Noel then faced and made a very difficult decision: she consented to the use of the vacuum and forceps.

[213] I dismiss Ms. Noel's claim against Dr. Hawrylyshyn for battery.

4. Informed consent

A. Legal principles

[214] Obtaining a bare consent is sufficient to defeat a claim in battery, but that is not the end of a doctor's obligation to a patient. A doctor must also obtain the patient's voluntary and informed consent to treatment and may be liable in negligence if the doctor fails to provide adequate information to a patient, including providing adequate disclosure of the risks of a proposed treatment.[22]

[215] To succeed in a claim of a lack of informed consent, Ms. Noel must establish a breach of the standard of care and prove causation. She must prove that:

a. Dr. Hawrylyshyn provided inadequate information to her;

b. she would not have undergone the procedure if she had been adequately informed; and

c. a reasonable person in her position would not have undergone the procedure if given adequate information.[23]

[216] A physician has a common law and statutory duty to provide adequate information to the patient by disclosing the nature of the proposed treatment and any material, special, or unusual risks of the treatment and answering any specific questions posed by the patient.[24] A material risk is one that a reasonable person in the patient's position would want to know about before deciding whether to proceed with the proposed treatment. Risks that are rare will be material if the consequences of those risks are serious.[25]

[217] The failure to make full disclosure of material risks constitutes a breach of the standard of care.[26] The physician has the obligation to make sure that the patient understands what the

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[22] *Denman v. Radovanovic*, 2024 ONCA 276, at para. 43.

[23] *Denman*, at paras. 45 to 47; *Bollman v. Soenen*, 2014 ONCA 36, at paras. 20-23; *Van Dyke v. Grey Bruce Regional Health Centre* (2005), 255 D.L.R. (4th) 397 (Ont. C.A.), at para. 47, leave to appeal to S.C.C. refused, [2005] S.C.C.A. No. 335.

[24] *Health Care Consent Act*, S.O. 1996, c. 2, Schedule A, s. 11; *Hollis v. Dow Corning Corp*., [1995] 4 S.C.R. 634, at para. 24; *Hopp v. Lepp*, [1980] 2 S.C.R. 192, at p. 210; *Malette*, at para. 18.

[25] *Van Dyke v. Grey Bruce Regional Health Centre* (2005), 255 D.L.R. (4th) 397 (Ont. C.A.), at para. 63, leave to appeal to S.C.C. refused, [2005] S.C.C.A. No. 335.

[26] *Reibl v. Hughes*, [1980] 2 S.C.R. 880, at p. 894; *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119, at p. 133.

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physician has said.[27] It is impossible to delineate the reach of a doctor's disclosure obligations without regard to the facts and circumstances of the specific case.[28] Where there is more than one viable treatment option, the doctor is to inform the patient of the relative and comparative risks and benefits between the options. The Court of Appeal put it this way:

> It is impossible to delineate the reach of a doctor's disclosure obligation without regard to the facts and circumstances of specific cases. The extent to which a doctor must disclose and discuss alternative treatments will depend on a myriad of factual circumstances. The proper approach to the scope of the disclosure obligations can, however, be stated in a generalized way. The ultimate decision whether to proceed with a particular treatment rests with the patient and not the doctor. The doctor must equip the patient with the information necessary to make an informed choice. Where there is more than one medically reasonable treatment and the risk/benefit analysis engaged by the alternatives involves different considerations, a reasonable person would want to know about the alternatives and would want the assistance of the doctor's risk/benefit analysis of the various possible treatments before deciding whether to proceed with a specific treatment. Put differently, a reasonable person could not make an informed decision to proceed with treatment "A" if that patient was unaware of the risks and benefits associated with treatment "B", a medically appropriate alternative treatment.[29]

[218] As noted, the scope of the disclosure obligation must be assessed in light of the facts and circumstances of the specific case. This case arose in the context of the labour and delivery process, which prior cases have held not to be an elective procedure.[30] Unlike the situation in *Denman*, for example, at 1900h Ms. Noel did not have the option to delay any treatment for 11 years.

[219] Courts have recognized that complicated delivery situations are stressful for the patient and that, while there are many risks and benefits to different modes of delivery, circumstances place practical limits on the appropriate level of detail to be discussed. Doctors are required to discuss the general and more common risks of the modes of delivery that are reasonable options in the circumstances. For example, in *MacGregor*, the trial judge put it this way:

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[27] *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119, at p. 132.
[28] *Van Dyke*, at para. 67.
[29] *Van Dyke*, at para. 67
[30] *Suwary (Litigation guardian of) v. Librach*, 2015 ONSC 2100, at paras. 128 to 134; *Kungl v. Fallis*, [1989] O.J. No. 15 (H.C.J.), at para. 152; *Goguen v. Crowe* (1987), 80 N.S.R. (2d) 36 (S.C. T.D.), at para. 10; *Look (Next Friend of) v. Himel*, [1991] O.J. No. 1073 (Gen. Div.).

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> The next issue relates to the risks and benefits of a forceps intervention. I accept that there are many of both that could have been discussed with Laura. However, I also accept the evidence from most of the obstetrical experts that it would not be appropriate to enter into a complicated detailed discussion with Laura at 12:55 p.m. on this particular day. As Dr. Cohen testified, this would be a complex discussion in a very stressful situation for the patient. Dr. Steinberg agreed that one would not get into a complicated discussion of all the different risks and benefits at that point in time. This sentiment was also generally agreed upon by Dr. Braithwaite and Dr. Barrett.
>
> Therefore, I accept that only the general and more common risks of forceps should have been discussed with Laura, including such things as potential bruising to the baby, marks on the baby's face, and lacerations of the vaginal wall or cervix. The benefits of forceps would be the potential faster delivery of the baby. The risks and benefits of continuing to push would be the opposite of those associated with forceps intervention. That is, the slower delivery of the baby without forceps would be offset by the benefit of avoiding the risks associated with forceps.
>
> Assuming that a forceps intervention was a reasonable option, Laura should have been informed of the risks and benefits of her two options in this general way. I find that Potts did not generally discuss these risks and benefits with Laura.[31]

[220] More importantly for the purposes of this case, in my view, was that the discussion between 1900h and 1910h took place during a period of heightened urgency and under significant time constraints.

[221] In *Suwary*, the plaintiff claimed that she had not given informed consent to the use of a vacuum to assist with an attempt at a vaginal birth where the fetal heart rate showed variable decelerations.[32] The defendant doctor did not have a specific memory of his discussion with the plaintiff about the use of the vacuum. He testified that his standard practice was to tell the patient that he was concerned about the baby, explaining what he thought the right option was in the circumstances, and obtaining the patient's consent. The trial judge accepted the doctor's evidence and held that the doctor had obtained informed consent. The trial judge held that, given the urgency, the doctor needed only to have told the patient of his intended course of action and his reasons for doing so:

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[31] *MacGregor v. Potts*, 2009 CanLII 44720 (Ont. S.C.), at paras. 231-233, aff'd 2012 ONCA 226.
[32] *Suwary v. Librach*, 2015 ONSC 2100.

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> I accept Dr. Librach's testimony with respect to his standard practice in such a situation, and I find that he advised Ms. Long-Suwary, however briefly, that he had concerns and would be proceeding with the vacuum….
>
> I also accept the testimony of Drs. Oppenheimer and Davies that all Dr. Librach would be required to convey in the circumstances to meet the standard of care is his intended course of action and his reasons for doing so. In cross-examination, Dr. Lightheart admitted that in an urgent situation there would not be time to engage in the type of discussion that would otherwise be preferable. Dr. Librach's brief interaction with Ms. Long-Suwary therefore discharged his obligations in the circumstances.[33]

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[222] The Court of Appeal for Ontario recently considered what information an obstetrician needed to provide to obtain informed consent in an urgent situation.[34] While the facts of *Farej* are not identical to this case, the cases are very similar. The decision of the Court of Appeal provides very important guidance regarding what constitutes adequate disclosure in an urgent obstetrical situation.

[223] In *Farej*, Ms. Idris arrived at the hospital at 7:30 pm in labour to deliver her third baby. The defendant, Dr. Fellows, had provided pre- and post-natal care to Ms. Idris during her first two pregnancies. In the first, the child was born via Caesarean section and the second was born vaginally. Dr. Fellows happened to be on-call when Ms. Idris arrived at the hospital for her third delivery, and he was the most responsible physician for her care.

[224] At 9:30, Ms. Idris began to experience significant pain despite an epidural and the fetal heart monitor began to show variable decelerations. By 10:24, her cervix was fully dilated. At 10:55 the fetal heart dropped precipitously and remained in a prolonged deceleration, indicating that blood flow to the fetus's brain had essentially stopped. The nurses paged Dr. Fellows at 10:55 and he arrived at 11:01.

[225] Dr. Fellows determined the fetus was in significant distress and was not getting oxygen to its brain. Dr. Fellows concluded he was facing an urgent obstetrical situation and had to take immediate action to deliver the fetus as quickly as safely possible. He ruptured the membranes to facilitate delivery and observed blood in the amniotic fluid. He suspected a placental abruption but also considered the possibility of a uterine rupture, which is life-threatening for both the mother and the fetus. He knew he had to expedite the delivery.

[226] Dr. Fellows decided that a vaginal delivery would be the fastest and safest way to deliver the baby. He told Ms. Idris to push but quickly concluded that pushing alone would not deliver the baby. He decided to use forceps to deliver the baby. He made two unsuccessful

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[33] *Suwary*, at paras. 133 to 134;
[34] *Farej v. Fellows*, 2022 ONCA 254, leave to appeal to S.C.C. refused, [2022] S.C.C.A. No. 180.

attempts to deliver the baby using the forceps, which took about five minutes. He then performed an episiotomy and made a third attempt to use the forceps to assist with the delivery. This time the baby, named Sabrin, was delivered.

[227] Ms. Idris pleaded that she did not give her informed consent to the use of forceps during delivery. Dr. Fellows conceded that he did not document any of his discussions with Ms. Idris or her husband after he arrived in the delivery room. He testified that he told them their baby was in serious distress and should be delivered as quickly as possible. He testified that he told them that he believed the safest way to proceed was by a trial of forceps and not by Caesarean section. On cross-examination he stated that he told them he could proceed using forceps or Caesarean section and that in his judgment, a forceps delivery was the most appropriate procedure. Dr. Fellows testified he emphasized the immediate risk to the baby's life, as at that point Ms. Idris' vital signs were stable but acknowledged that given the urgency, he probably did not discuss the risks and benefits of either a forceps delivery or a Caesarean section.

[228] During his examination for discovery, Ms. Idris's husband, Mr. Farej, testified that after Dr. Fellows examined Ms. Idris, he told them only that she was bleeding, and the situation was serious.[35] Mr. Farej recalled Dr. Fellows saying "I have to save your wife" by delivering the baby. Mr. Farej told Dr. Fellows, "yes. Just go," and that Dr. Fellows then delivered the baby using forceps.

[229] When the trial judge summarized the law of informed consent, she recognized that Dr. Fellows faced an urgent obstetrical situation. She recognized that the urgency of the situation was a circumstance to be considered in assessing the adequacy of the information provided to the doctor. The trial judge concluded as follows:

> When patients are in distress and the physician is making rapid assessments and judgments of the indicated alternative courses of action, it is not necessary or appropriate to require the physician to have a complicated, detailed discussion of all possible risks and benefits of each alternative procedure in such circumstances. In an obstetrical emergency, all the obstetrician is "required to convey in the circumstances to meet the standard of care is his intended course of action and his reasons for doing so".[36]

[230] The Court of Appeal noted that the trial judge accepted Dr. Fellows' evidence. The Court of Appeal held that in an urgent situation, advising Ms. Idris in general terms of the potentially dire consequences, identifying the delivery options available, and telling Ms.

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[35] Unfortunately, Mr. Farej died before trial and it appears that the transcript of his examination for discovery was read into the trial record: *Farej* ONCA, at para. 166.
[36] *Farej v. Fellows*, 2020 ONSC 3732, at para. 244, as cited in *Farej* ONCA at para. 168.

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Idris which of the two options should be followed, was sufficient and allowed Ms. Idris to make an informed decision as to mode of delivery:

> The trial judge was satisfied Dr. Fellows informed Mr. Farej and Ms. Idris that the situation was extremely urgent. He advised them in general terms of the potential dire consequences, especially to Sabrin. He identified the delivery options available, and told Mr. Farej and Ms. Idris which of those two options should be followed. In the context of a rapidly evolving, life and death medical emergency, and having regard to the existing relationship between Dr. Fellows, Ms. Idris and Mr. Farej, I am satisfied it was open to the trial judge to conclude the information provided by Dr. Fellows was sufficient and allowed Ms. Idris to make an informed decision as to the mode of delivery. It was also open to the trial judge to conclude that Ms. Idris, along with her husband, accepted Dr. Fellows statement that the baby had to be delivered immediately and a vaginal delivery was the best way to accomplish that end.[37]

[231] As I will explain below, I find that Dr. Hawrylyshyn provided more information to Ms. Noel about the relative risks of the three options available to her than Dr. Fellows provided to Ms. Idris. Given the rapidly evolving, urgent situation facing Ms. Noel and her fetus, I find that the information that Dr. Hawrylyshyn provided to Ms. Noel met the standard of care and that Ms. Noel provided informed consent to the treatment plan.

B. Relevant events and discussions from 0940h to 1840h

[232] Although the primary informed consent discussion happened between 1900h and 1910h, that was not the only conversation between Ms. Noel and Dr. Hawrylyshyn that is relevant to the assessment of whether Dr. Hawrylyshyn provided Ms. Noel with sufficient information for her to provide informed consent to the use of the vacuum and the forceps.

[233] First, I find that over the course of the day, Dr. Hawrylyshyn obtained Ms. Noel's informed consent to many significant procedures, including the following:

a. Dr. Hawrylyshyn explained to Ms. Noel at 1045h why he wished to apply a fetal scalp electrode to the fetal scalp to better monitor the fetus's heart rate and the risks of that procedure, to which Ms. Noel consented. The discussion was logged in the nursing notes although Ms. Noel testified that she had no recollection of it;

b. Dr. Hawrylyshyn explained to Ms. Noel at 1330h why he wished to obtain a scalp pH to assess the wellbeing of the fetus and to ensure it was tolerating labour well. He explained the risks involved, and how the procedure would be conducted. This discussion was documented in the nursing notes. Ms. Noel recalled the discussion

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[37] *Farej* ONCA, at para. 172.

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around the scalp pH but stated that she did not understand the purpose of the procedure. Dr. Hawrylyshyn testified that Ms. Noel consented to the scalp pH;

c. Dr. Hawrylyshyn recommended to Ms. Noel at 1330h that he administer synthetic oxytocin to her to augment her contractions. Dr. Hawrylyshyn testified that he could not recall the exact conversation, but his standard practice was to explain the risks of the treatment and why he was recommending it. Ms. Noel recalled that Dr. Hawrylyshyn explained the problem that her contractions were not frequent enough and that the synthetic oxytocin would stimulate her labour. She testified that she consented to this treatment;

d. Dr. Ko explained to Ms. Noel at 1930h the risks associated with a Caesarean section and obtained her informed consent to the procedure, which is documented in Dr. Ko's contemporaneous handwritten notes in the medical chart. Dr. Hawrylyshyn testified that it was hospital policy to document in writing a patient's consent to a Caesarean section. Ms. Noel recalled a brief conversation with Dr. Ko about the need for a Caesarean section but denied a conversation about the risks and benefits of a Caesarean section.

[234] The evidence satisfies me that Dr. Hawrylyshyn knew that he was obliged to obtain informed consent and that he did so throughout the day. His evidence that this was his invariable practice is admissible, persuasive, and strong evidence of what he did that day.[38] In addition, I am satisfied by the evidence at trial and the medical notes that he did obtain informed consent from Ms. Noel. Evidence of his prior acts, of course, does not prove that he obtained informed consent to the use of the vacuum and forceps between 1900h and 1910h. Just because a physician obtained informed consent on the first four treatments does not guarantee that the physician obtained informed consent for the fifth treatment. However, Dr. Hawrylyshyn's practice that day is some evidence that I will take into account in assessing his actions during the key window of 1900 to 1910h.

[235] Second, I find that over the course of the day, Dr. Hawrylyshyn discussed a Caesarean section with Ms. Noel at least twice. I accept his evidence about these discussions.

[236] The first discussion took place when Dr. Hawrylyshyn saw Ms. Noel at 1230h and 1330h. He testified that over those two visits he had a discussion with Ms. Noel about his concern that she was developing chorioamnionitis and raised the possibility of a delivery by Caesarean section because of those concerns. He testified that he would have discussed with Ms. Noel the reasons for considering a Caesarean section as well as the risks to the mother and the fetus. He did not recall the exact wording he used, but he routinely discussed Caesarean section with his obstetrical patients, which he described as follows:

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[38] *Turkington v. Lai*, 2007 CanLII 48993 (ONSC), 52 C.C.L.T. (3d) 254, at para. 93; *Lee (Litigation Guardian of) v. Southlake Regional Health Cenre*, 2015 ONSC 7509, at para. 117.

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> Q. And what was your -- did you have a routine discussion that you had with patients about the risks of Caesarean section in labour?
>
> A. Yes, for the -- you would outline what the maternal risks are, and those are usually infections, complications. She already had a [chorioamnionitis], but there could be further complications, bleeding complications associated with uterine atony or the infection. You can also get injury to adjacent structures; the bowel, bladder and the ureter are the ones principally. You can have pulmonary emboli or deep vein thrombosis, DVT, and the main risks to the infant or the fetus are, again, infection, and they sometimes have respiratory difficulties requiring ventilation or NICU stays.

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[237] This discussion is anchored to the nursing notes, which state at 1230h "mode of delivery discussed" and again at 1326h where there is a reference to a "explanation [of scalp pH results] given to [patient] + plan."

[238] The second discussion took place at around 1700h. Dr. Hawrylyshyn testified that he remembered the discussion at a high level and that he and Ms. Noel discussed whether she wanted to continue to labour toward a vaginal birth or to consider a Caesarean section. He explained that he did not see a clinical need for a Caesarean section at that time and did not recommend one. Ms. Noel denied that this conversation took place.

[239] I find that before the discussion during the critical time period from 1900h to 1910h, Dr. Hawrylyshyn had already obtained informed consent from Ms. Noel regarding several treatments and had discussed with her the risks and benefits of delivery by Caesarean section.

C. The critical time period from 1900h to 1910h

[240] After examining the fetal heart tracing and conducting the vaginal examination, Dr. Hawrylyshyn concluded that the fetus needed to be delivered quickly. In his judgment, using the vacuum to assist a vaginal birth, if successful, would be the fastest way to deliver the baby. Based on his experience, he thought there would be an 80 to 90% chance of successfully delivering the baby with the assistance of a vacuum. He was also of the view that using the vacuum posed fewer risks to Ms. Noel and the fetus than delivery by Caesarean section. Dr. Hawrylyshyn testified that he preferred to use the vacuum as opposed to the forceps because it causes less trauma to maternal tissue and the fetus than the forceps. The central inquiry, however, is not what Dr. Hawrylyshyn knew but what he communicated to Ms. Noel.

[241] Dr. Hawrylyshyn testified that he had a conversation with Ms. Noel and Mr. Sibblies between 1900h and 1910h. He testified that he explained that the fetal heart tracing signified that the fetus might be in jeopardy for hypoxic injury and that he believed Ms. Noel pushing alone would take too long to deliver the fetus. Dr. Hawrylyshyn testified that

Ms. Noel initially said she wanted to keep pushing but he reiterated that pushing alone would take too long. Dr. Hawrylyshyn testified that he had a specific recollection of telling her that she had three options: an assisted delivery with vacuum or forceps, or a Caesarean section.

[242] Dr. Hawrylyshyn also recalled telling Ms. Noel that his first recommendation was to proceed with the vacuum and that he explained to her why that was his recommendation. Although he could not recall the specific words he used, his standard management practice was to explain that delivery by Caesarean section posed the greatest number of potential complications for both the mother and the fetus and that the vacuum and forceps were generally considered both safe and safer than a Caesarean section. Dr. Hawrylyshyn testified that he discussed the risks and the benefits of the vacuum and compared them to the forceps. With respect to the risks posed by the vacuum, he would typically explain that the most common complications can be tissue trauma to the mother and bruising on the scalp or a cephalohematoma for the fetus. He stated that he would typically say that there is a lower risk of tissue trauma to the mother and the fetus with the vacuum than the forceps. The forceps posed a greater risk of tissue trauma and tears on the vaginal walls causing bleeding for the patient and facial trauma, facial nerve injuries, brachial plexus injuries, and nerve injuries, and skull fractures for the fetus. He was certain that he compared the risks of the vacuum to the risks of forceps because of Ms. Noel's specific concerns and the words she used to express her concerns.

[243] As discussed above, Dr. Hawrylyshyn testified that he showed Ms. Noel how the vacuum worked and how its features worked to ensure that pressure was kept within safe limits.

[244] Dr. Hawrylyshyn also recalled talking to Ms. Noel about a backup plan if the vacuum did not work. He testified that he told Ms. Noel that if the vacuum was not successful, there were two possible back-up plans: a trial of forceps or a Caesarean section. Dr. Hawrylyshyn testified that he told Ms. Noel that if the attempt to deliver with the vacuum failed, he would assess the clinical situation after the unsuccessful attempts and determine whether a trial of forceps was the preferable way to proceed. Dr. Hawrylyshyn recalled saying that the likelihood was that he would recommend a trial of forceps because that is safer for the patient than a Caesarean section, but that he would have to assess the circumstances and it was not an "automatic given" that the forceps would be the preferable approach.

[245] As described above in the section on consent, Dr. Hawrylyshyn described this conversation in his operative note, which was dictated later that evening:

> The options were discussed with the patient and her husband. Given the progress and the extent to which the presenting part had descended, it was felt a trial at a vacuum delivery was warranted. The patient had expressed a fear about the vacuum, worried "it would suck the baby's brains out". There was discussion about the pros and cons of using a vacuum. I indicated it was safer than using forceps. I indicated that if properly applied, and with proper

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> pressures, it was an accepted safe obstetrical procedure. The parents allowed me to proceed with the trial of vacuum.

[246] Dr. Hawrylyshyn testified that Ms. Noel consented to his recommended treatment plan, although he could not recall the specific words she used. He stated that:

> the patient would have understood that the first thing that was going to be attempted was the vacuum, and as I had outlined related to the management plan, that if that failed, you would give consideration to the forceps, and if all else failed, her only last resort was a C-section.

[247] He testified that he would have persisted with the patient until he got an answer one way or the other because he understood that his duty was to inform the patient and the patient got to make the decision about how to proceed.

[248] For the reasons set out in the section on consent, I do not accept Ms. Noel's evidence that Dr. Hawrylyshyn did not speak to her for about 10 minutes or discuss this the pros and cons of vacuum and forceps. I do not accept Ms. Noel's evidence that Dr. Hawrylyshyn did not provide her with any information that could discharge his duty obtain her informed consent. Ms. Noel's evidence is entirely inconsistent with Dr. Hawrylyshyn's approach to obtaining informed consent for the procedures earlier in the day and it cannot explain the 10-minute gap between 1700h and 1710h.

[249] The plaintiffs challenge the reliability of Dr. Hawrylyshyn's evidence that he had a 10-minute conversation with Ms. Noel because Dr. Hawrylyshyn testified that due to the urgency of the situation he did not have the "luxury of 10 to 15 minutes" to have the consent discussion. I do not see this as a serious inconsistency. In my view, Dr. Hawrylyshyn was merely attempting to convey that the urgency of the situation, which I do not understand the plaintiffs to be questioning, placed practical limits on the length of the conversation he could have with Ms. Noel. This one statement did not undermine the credibility of Dr. Hawrylyshyn's evidence or the reliability of his evidence that he had an approximately 10-minute conversation with Ms. Noel. I reject the plaintiffs' submission that Dr. Hawrylyshyn is attempting to have it both ways. Far from it. I find that Dr. Hawrylyshyn had a lengthy conversation with Ms. Noel under stressful circumstances, in a situation where Dr. Hawrylyshyn was concerned that valuable time was ticking away. Nevertheless, he provided a detailed explanation to Ms. Noel and addressed her specific fears about the procedure. The conversation took as long as it did not because Dr. Hawrylyshyn felt there was time for a leisurely chat, but because he was committed to ensuring that he obtained his patient's informed consent.

[250] I accept Dr. Hawrylyshyn's evidence about what he told Ms. Noel about the three options available to her and the relative pros and cons of these approaches. Even where he does not have a recollection of the precise words used, I accept his evidence about his standard practice regarding what he told his patients in similar circumstances, which I also find to

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be consistent with his operative note.[39] Where a physician has no specific recollection of the words used in an interaction, the physician is entitled to testify to the physician's ordinary or invariable practice.[40] That testimony is strong evidence that the physician acted the same way on the day in question.[41] I find that Dr. Hawrylyshyn had a conversation about all three options with Ms. Noel and documented that conversation, albeit imperfectly, in the operative note.

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[251] The plaintiffs submit that Dr. Okun's evidence supports their submission that Dr. Hawrylyshyn did not have a detailed discussion of consent about the forceps with Ms. Noel. It does not. Dr. Okun could only testify about what she observed when she was in the room. Dr. Hawrylyshyn's evidence, which I accept, was that he discussed the forceps and Ms. Noel consented to his treatment plan before he applied the vacuum and, therefore, before Dr. Okun arrived in the room. Dr. Okun's evidence that she did not observe a detailed discussion regarding consent while she was in the room does not undermine in any way Dr. Hawrylyshyn's evidence that such a conversation took place before Dr. Okun arrived.

[252] I accept that Ms. Noel was in a difficult situation between 1900h and 1910h. She had been at the hospital, in active labour, for 16 hours. She must have been physically tired. Moreover, the situation was no doubt stressful. She had finally started pushing and less than 20 minutes later there were sudden and serious concerns about the health of the fetus. Nevertheless, I am satisfied that Dr. Hawrylyshyn has proven on a balance of probabilities that Ms. Noel heard, processed, and understood what Dr. Hawrylyshyn told her.[42] The conversation took place over 10 minutes, Dr. Hawrylyshyn addressed her specific concerns about the "baby's brains being sucked out," and there were no linguistic barriers. If Ms. Noel required any additional information or explanation, I have no doubt that she would have asked for it and that Dr. Hawrylyshyn would have provided that information to her.

[253] The plaintiffs submit that Dr. Hawrylyshyn did not discharge his obligation to provide Ms. Noel with sufficient information to provide informed consent. They rely primarily on the evidence of Dr. Shone. In contrast, Dr. Davies testified clearly and persuasively that, in his opinion, Dr. Hawrylyshyn met the standard of care in obtaining Ms. Noel's informed consent to use the vacuum and then, if indicated, a trial of forceps, with Caesarean section as the final option.

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[39] *Turkington*, at para. 93.
[40] *Turkington*, at para. 93; *Lee*, at para. 117.
[41] *Martindale v. Bahl et al*, 2023 ONSC 4259, at paras. 47 and 80; *Levy v. Rubenstein*, 2022 ONSC 4547, at para. 54; *Sean Omar Henry v. Dr. Marshall Zaitlen*, 2022 ONSC 214, at para. 54; *Jones-Carter v. Warwaruk*, 2019 ONSC 1965, at para 266; *Lee v. Lee*, 2015 ONSC 7509, at para. 93; *Di Tacchio v. London Health Sciences Centr*e, 2013 ONSC 1274, at para. 16; *Suwary v. Women's College Hospital*, 2009 CanLII 31985 (Ont. S.C.), at paras. 226-227, aff'd 2011 ONCA 676.
[42] *Ciarlariello*, at pp. 55-56.

[254] I will address Dr. Shone's evidence on the issue of informed consent below. I will foreshadow that I place little weight on his evidence. In the section below on standard of care, I will explain in more detail why I think Dr. Shone's opinion on standard of care is incorrect. In my view, he misstates the standard of care in several material ways. In my view, his errors with respect to the standard of care issues infected his views on what information Dr. Hawrylyshyn needed to provide to Ms. Noel. Specifically, because he incorrectly rejected the use of the vacuum followed by the forceps, he did not correctly calibrate the information that Dr. Hawrylyshyn was obliged to provide to Ms. Noel.

[255] As I will explain below, I prefer the evidence of Dr. Davies on this issue, and I find that Dr. Hawrylyshyn met the standard of care.

<u>Dr. Hawrylyshyn tailored his standard of care discussion to Ms. Noel's specific concerns</u>

[256] The plaintiffs suggest that Dr. Hawrylyshyn breached the standard of care because his discussion with Ms. Noel was "devoid of any specificity to [her] situation, to the birth preferences that she had vocalized, to the risks of failed efforts with the vacuum or forceps, and to the fears that Dr. Hawrylyshyn admits he knew about." This submission fails on the facts. Dr. Hawrylyshyn's operative note demonstrates that his discussion with Ms. Noel was laser focussed on her specific concerns. Dr. Hawrylyshyn included in his note a specific reference to Ms. Noel's concerns. He wrote "The patient had expressed a fear about the vacuum, worried "it would suck the baby's brains out." There was discussion about the pros and cons of using a vacuum." He testified that he included that phrase in his note because Ms. Noel used it.

[257] In my view, that is strong evidence that Dr. Hawrylyshyn tailored his explanation sensitively and precisely to Ms. Noel's expressed concerns. Ms. Noel's had personal views that appear to have been based on misinformation provided in anecdotal conversations with her friends.[43] Nevertheless, Dr. Hawrylyshyn took them seriously and addressed them directly. Similarly, the fact that Dr. Hawrylyshyn showed Ms. Noel the vacuum, the suction cup, and explained the safety features on the vacuum demonstrate that Dr. Hawrylyshyn's discussion was specifically tailored to Ms. Noel's concerns. I do not accept the plaintiffs' submissions on this point.

<u>Dr. Hawrylyshyn explained the options available to Ms. Noel, including a Caesarean section</u>

[258] The plaintiffs suggest that Dr. Hawrylyshyn did not offer Ms. Noel an explanation of the alternative options. I disagree.

[259] I have found that Dr. Hawrylyshyn discussed a Caesarean section and its risks and benefits with Ms. Noel at 1230h and 1330h and discussed the availability of a Caesarean section again at 1700h. I also find that Dr. Hawrylyshyn discussed the relative pros and cons of using a vacuum, forceps, or Caesarean section between 1900h and 1910h. I find that Dr.

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[43] *Arndt v. Smith*, [1997] 2 S.C.R. 539, at para. 14.

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Hawrylyshyn did provide Ms. Noel with an explanation of the available options and the risks and benefits of each. I do not accept the plaintiffs' submission that Dr. Hawrylyshyn was patient blaming. He explained the options to Ms. Noel but recommended his preferred option to her and explained why. Ms. Noel was free to reject Dr. Hawrylyshyn's advice but she did not do so.

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Dr. Hawrylyshyn did not provide incorrect or misleading information to Ms. Noel about the safety of the vacuum and forceps

[260] The plaintiffs submit that Dr. Hawrylyshyn provided incorrect and misleading information to Ms. Noel when he said that the vacuum and forceps are safe if properly executed, and that the vacuum was safer than forceps. They rely on the evidence of their expert witness, Dr. Shone, who testified that:

> What I mean by that is that in the reports, Dr. Hawrylyshyn stated that vacuum was safer than forceps and that if properly executed, both vacuum and forceps are safe. Even if you apply and perform vacuum perfectly and meet all the requirements, likewise with forceps, if you apply them perfectly and meet all the requirements, there are still risks involved with it. Injury can still occur. So I feel that to minimize the risk of them is not providing appropriate information to the patient to allow her to make a choice.

[261] I do not accept Dr. Shone's opinion this point. I prefer the evidence of Dr. Davies.

[262] Dr. Hawrylyshyn did not provide incorrect or misleading information when he told Ms. Noel that the vacuum was safer than the forceps. Both parties accepted the August 2004 SOGC Guidelines for Operative Vaginal Birth as authoritative. The SOGC Guidelines stated that "Complication rates to the neonate were similar in both the forceps and vacuum-delivered groups." It also said that "It has been repeatedly shown that maternal injury is less frequent and less extensive with the use of vacuum compared to forceps." Dr. Shone conceded on cross-examination that the data in two authoritative studies concluded that while each instrument posed different risks, the vacuum and forceps were relatively equal in terms of safety to the fetus and that there is significantly less trauma to the mother from the use of the vacuum compared to the use of the forceps. In light of these authoritative statements from the SOGC Guidelines, the consensus in the academic literature, and Dr. Shone's concessions on cross examination, I find that Dr. Hawrylyshyn did not provide incorrect or misleading information when he told Ms. Noel that, on balance, the vacuum was safer than the forceps.

[263] Similarly, Dr. Hawrylyshyn did not provide incorrect or misleading information when he told Ms. Noel that, if properly executed, the vacuum and forceps are safe. Both parties accepted that the American College of Obstetricians and Gynecologists published authoritative bulletins. The ACOG bulletin on Operative Vaginal Delivery released in June 2000 provided clinical management guidelines for obstetricians and gynecologists. The

ACOG Bulletin reviewed a significant number of academic studies and then summarized its recommendations. The ACOG Bulletin assigned one of three levels to its recommendations and contained two level A recommendations that were based on "good and consistent scientific evidence." One of the level A recommendations stated that vacuum and forceps are acceptable and safe instruments. It stated:

> Both forceps and vacuum extractors are acceptable and safe instruments for operative vaginal delivery. Operator experience should determine which instrument should be used in a particular situation.

[264] On cross-examination, Dr. Shone agreed with this recommendation.

[265] I accept Dr. Shone's observation that every procedure carries some risk, but it is incorrect and unfair to say that Dr. Hawrylyshyn minimized those risks. Dr. Hawrylyshyn testified that he explained the risks of the vacuum and the forceps, and their comparative risks, to Ms. Noel. I find that he recognized and alerted Ms. Noel to some of the risks posed by each instrument but reassured her that the instruments were safe. After carefully sifting mountains of data related to the risks arising from the use of the vacuum and forceps, and with limitless time to wordsmith its recommendations, ACOG recommended, with the highest level of scientific confidence, that "both forceps and vacuum extractors are acceptable and safe." Dr. Hawrylyshyn framed his advice to Ms. Noel in exactly the terms used by the ACOG Bulletin. Given the ACOG Bulletin, I do not accept Dr. Shone's opinion that Dr. Hawrylyshyn provided misinformation to Ms. Noel. Dr. Shone's insistence on this point is puzzling and causes me to place less weight overall on his opinion.

<u>Dr. Hawrylyshyn did not need to disclose additional material risks about the use of the vacuum</u>

[266] The plaintiffs submit that Dr. Hawrylyshyn should have disclosed additional material risks related to the use of the vacuum to Ms. Noel. In their written submissions, they put it this way:

> 59. Dr. Hawrylyshyn never disclosed the material risks to the baby of mild scalp lacerations, severe subaponeurotic hemorrhage, intracranial hemorrhage, and death, despite the clear concerns that [Ms. Noel] had about the vacuum's potential impact on her baby's brain that he recorded in his own operative note.

[267] I do not accept this submission for four reasons.

[268] First, I do not accept the plaintiffs' submission that Dr. Shone testified that these additional risks, and in particular intracranial hemorrhages such as subarachnoid hemorrhage and subdural hemorrhage ought to have been disclosed. In my view, Dr. Shone was making a different point in the passage cited by the plaintiffs in support of their submission. He was explaining that there were sequential risks to using the vacuum and then the forceps and Dr. Hawrylyshyn should have disclosed those risks. Dr. Shone testified as follows:

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> Q. You also mentioned to us earlier the practice in Canada in 2005 was not to do sequential instrument delivery?
>
> A. Correct. That is my opinion.
>
> Q. To the extent that that carries with it additional risk, did you see any indication that those additional risks had been disclosed at any point to Ms. Noel?
>
> A. No.
>
> Q. And to the extent that such additional risks were not disclosed to Ms. Noel, how does that fit with the concept of informed consent?
>
> A. In my opinion, it does not meet the standard.

[269] I will address below the issue of the sequential use of vacuum and forceps and what risks needed to be disclosed below. However, Dr. Shone did not testify that that the material risks listed by the plaintiffs in paragraph 59 of their factum needed to be disclosed. There was no expert evidence that those risks were material or that they needed to be disclosed. This is fatal to the plaintiffs' submission on this point.[44]

[270] Second, the need to disclose a risk is attenuated significantly where the risk is present for all available options, even where that risk could lead to death. At 1900h, Dr. Hawrylyshyn concluded that Ms. Noel needed to deliver the fetus as soon as possible and that a spontaneous vaginal delivery would take too long. He identified three options: vacuum-assisted delivery, forceps-assisted delivery, and delivery by Caesarean section. The plaintiffs submit that Dr. Hawrylyshyn needed to disclose to Ms. Noel the risk of death associated with the vacuum. I disagree. I note that Dr. Shone did not testify that the standard of care required Dr. Hawrylyshyn to disclose the risk of death associated with the use of the vacuum. In addition, according to the ACOG Bulletin, which was citing the Towner study described below at paragraph [285], there was a risk of fetal death for each of the three available options. The relative risk of death was as follows:

Mode of delivery	Death/Deliveries
Vacuum only	1 in 3,333
Forceps only	1 in 2,000
Vacuum and forceps	1 in 1,666
Caesarean section during delivery	1 in 1,250

[271] I accept that there was a risk of fetal death from using the vacuum, but the Towner study suggests that the risk of death arising from the use of the vacuum was the lowest among

[44] *Cvjetkovic v. Gupta*, 2016 ONSC 2322, at paras. 36-37;

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the three available options. In addition, the SOGC Guidelines for Operative Vaginal Birth observe that "in women who deliver by Caesarean section, maternal mortality is 4-fold that of the maternal population that delivers vaginally."

[272] I do not think that Dr. Hawrylyshyn needed to discuss the risk of death of the fetus or maternal death with Ms. Noel when he was recommending attempting to deliver with the assistance of the vacuum. Ms. Noel needed to deliver her baby and each of the available options carried with it a small risk of death. I see little utility in disclosing such a risk in these circumstances. Moreover, if Dr. Hawrylyshyn had mentioned the risk of death arising from the use of vacuum, it would have also been necessary for him to advise Ms. Noel that the vacuum carried with it the lowest risk of fetal death among any of the available options. It is inconceivable that such a disclosure would have caused Ms. Noel to change her mind and not consent to Dr. Hawrylyshyn's recommended plan to try to deliver with the assistance of the vacuum. Given the urgency of the situation, I do not accept the plaintiffs' submission.

[273] Third, the plaintiffs submit that the Dr. Hawrylyshyn needed to disclose that "there was a higher likelihood of failure with a vacuum at station +1." I disagree. I do not think there is evidence that there is a higher risk of failure with the fetus at station +1 or that any risks associated with the fetus being in that position needed to be disclosed.

[274] Dr. Shone, the plaintiffs' expert obstetrician, testified that if the fetus was at station +1, as in this case, there was a lower likelihood of success and that the obstetrician needed to think through carefully the risks and benefits of that approach:

> Q. And the next relative contraindication is mid-pelvic station.
>
> A. So that would be a station of 0 or plus 1. And so, again, in my opinion a mid-pelvic position has to be carefully thought of in the risk and benefits as it is not a high likelihood of success when compared to an outlet or a lower presentation, and should only be performed by experienced practitioners.

[275] Dr. Hawrylyshyn correctly determined that the baby was at station +1. He also testified that in these circumstances, in his opinion, there was an 80 to 90% chance of a successful delivery using the vacuum and that it would result in a successful delivery in the shortest amount of time. Dr. Hawrylyshyn may have been even more optimistic if the fetus was further down in the birth canal but that was not Ms. Noel's situation. I have found that Dr. Hawrylyshyn warned Ms. Noel that there was a possibility that the vacuum would not succeed. It was that possibility that led him to explain that the forceps might well be the appropriate next step. The discussion of the possibility of using the forceps after the vacuum is predicated on the possibility of the vacuum failing.

[276] I accept that the SOGC Guidelines for Operative Vaginal Birth state that if the fetus is at mid-pelvic station (meaning that the leading point of the skull is above station +2 cm), that

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is a relative contraindication for a delivery with the assistance of the vacuum or forceps. However, the SOGC Guidelines did not advise that this fetal position was as an absolute contraindication to an assisted vaginal delivery. All of the experts agree that a relative contraindication is a feature that requires the obstetrician to exercise extra caution and very careful consideration before proceeding. If the SOGC wished to communicate that the vacuum should never be used if the fetus is in the +1 station, it would have listed it as an absolute contraindication, not a relative one.

[277] Dr. Hawrylyshyn and Ms. Noel were dealing with the reality that the fetus was at station +1. Dr. Hawrylyshyn was of the opinion that the vacuum was very likely to deliver the fetus and if successful, would deliver the fetus in the fastest and safest manner. The evidence does not support the proposition that Dr. Hawrylyshyn should have advised Ms. Noel that the vacuum was less likely to succeed than if the fetus was in a hypothetically more favourable position. Such a discussion would not have provided Ms. Noel with any more useful information in order to make her decision.

[278] Fourth, the plaintiffs submit that Dr. Hawrylyshyn should have disclosed the higher likelihood that that the vacuum-assisted delivery would fail because the fetus's head would have to rotate as it descended the birth canal for there to be a successful vaginal birth. I disagree.

[279] Dr. Hawrylyshyn knew that the fetus was in the left occipital transverse position, which meant the fetus's head would have to rotate if there was to be a successful vacuum-assisted vaginal birth. He knew that the vacuum could not be used safely to rotate the head, so he would have to rely on the shape and musculature of Ms. Noel's pelvis to rotate the head naturally as the fetus descended. Dr. Hawrylyshyn also knew that this type of rotation was a relative, but not an absolute contraindication for a vacuum-assisted vaginal birth.

[280] Dr. Hawrylyshyn believed that the vacuum was very likely to deliver the fetus and if successful, would deliver the fetus in the fastest and safest manner. The evidence does not support the proposition that Dr. Hawrylyshyn should have advised Ms. Noel that the vacuum was less likely to succeed than if the fetus was in a hypothetically more favourable position. Largely for the reasons set out in paragraphs [273] to [277] above that deal with the fetal position of +1, I find that Dr. Hawrylyshyn was not obliged to disclose any risks associated with the position of the fetal head.

[281] The plaintiffs' submissions on this point are inconsistent with the law as articulated by the Court of Appeal in *Farej* and by the Superior Court in *Suwary*. Dr. Shone and the plaintiffs pay insufficient attention to the distress of the fetus and Dr. Hawrylyshyn's need to make a rapid assessment of the few available alternative courses of action. In my view, it is not necessary or appropriate to require Dr. Hawrylyshyn to have a complicated, detailed discussion of all possible risks and benefits of each of the three alternatives with Ms. Noel. Dr. Hawrylyshyn identified the delivery options available to Ms. Noel and recommended a treatment approach to her. The information provided to her was sufficient to allow her to make an informed choice among those three options.

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[282] Ultimately, I do not accept Dr. Shone's opinion that more was required. It was not possible, necessary, or even appropriate for Dr. Hawrylyshyn to have a discussion with Ms. Noel of every possible relative and absolute risk of the three options. Both Dr. Shone and Dr. Davies agreed that where a delivery needs to happen as soon as possible, there is only a short timeframe in which a doctor and patient can discuss options and their relative risks. As Dr. Davies observed, correctly in my view, "the conversation [with the patient] about all the risks involved certainly are not going to get down to the level of detail that's getting discussed in this trial." In an urgent situation like this one, the law only requires that a doctor explain to the patient the urgency, the options available, and a recommendation.[45] Dr. Hawrylyshyn did far more than that.

<u>Dr. Hawrylyshyn obtained informed consent to the use of the vacuum and then the forceps</u>

[283] The parties agree that a physician may obtain consent to a course of treatment.[46] The plaintiffs submit that Dr. Hawrylyshyn did not provide Ms. Noel with sufficient information regarding the increased risks of intracranial injury in the event that the vacuum failed and the forceps were used subsequently and that Dr. Hawrylyshyn did not obtain Ms. Noel's informed consent to the use of forceps. I disagree.

[284] Dr. Shone testified that Dr. Hawrylyshyn should have disclosed to Ms. Noel that there is an increased risk of subarachnoid and subdural hemorrhages for infants delivered by a combination of vacuum and forceps as compared to a single instrument. He largely based his opinion on a 1999 study authored by Dr. Towner.[47] All parties accepted that Dr. Towner's article was authoritative.

[285] The Towner study looked at a large number of deliveries in order to determine the incidence of rare neonatal disorders and their association with various modes of delivery. The study examined 583,340 births in California between 1992 and 1994. The study grouped the births by mode of delivery being spontaneous vaginal delivery (66.5% of all deliveries), vacuum extraction (10.2%), Caesarean section (20.1%), forceps delivery (2.7%), and vacuum and forceps delivery (0.5%). The study broke the Caesarean section deliveries into sub-categories: Caesarean section with no labour, Caesarean section during labour, which was in turn broken down into Caesarean section during labour after a failed attempt using vacuum, forceps, or both, and during labour with no attempt at vaginal delivery.

[286] The study examined the incidence of the following conditions found in babies delivered by the various delivery methods described above: subdural or cerebral hemorrhage;

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[45] *Farej* ONCA at paras. 168 and 172; *Suwary* at para. 134; *MacGregor*, at paras. 231-237, finding on informed consent not varied at 2012 ONCA 226.
[46] *Health Care Consent Act*, s. 2; College of Physicians and Surgeons of Ontario, *Consent to Medical Treatment Policy*, p. 3.
[47] D. Towner et al., "Effect of Mode of Delivery in Nulliparous Women on Neonatal Intracranial Injury" (1999) 341 N Engl J Med 23 at pp. 1709-1714.

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intraventricular hemorrhage; subarachnoid hemorrhage; facial nerve injury; brachial plexus injury; convulsions; central nervous system depression; feeding difficulty; and mechanical ventilation.

[287] The study expressed the incidence of each condition being present following a specific mode of delivery as the number of cases per 10,000 infants and then calculated the odds of that condition being present compared to their presence following a spontaneous vaginal delivery. The data was then presented in a table containing nine rows and 17 columns of data. The table looked like this:

TABLE 2. INCIDENCE OF MAJOR NEONATAL MORBIDITY AND RISK ASSOCIATED WITH OPERATIVE PROCEDURES AS COMPARED WITH SPONTANEOUS DELIVERY.*

CONDITION	SPONTANEOUS (N=387,799)	VACUUM (N=59,354)		FORCEPS (N=15,945)		VACUUM AND FORCEPS (N=2817)	
	Incidence	*Incidence*	*Odds Ratio*	*Incidence*	*Odds Ratio*	*Incidence*	*Odds Ratio*
Subdural or cerebral hemorrhage	2.9	8.0	2.7 (1.9–3.9)	9.8	3.4 (1.9–5.9)	21.3	7.3 (2.9–17.2)
Intraventricular hemorrhage	1.1	1.5	1.4 (0.7–3.0)	2.6	2.5 (0.9–6.9)	3.7	3.5 (1.5–25.2)
Subarachnoid hemorrhage	1.3	2.2	1.7 (0.9–3.2)	3.3	2.5 (0.9–6.6)	10.7	8.2 (2.1–27.4)
Facial-nerve injury	3.3	4.6	1.7 (0.9–2.1)	45.4	13.6 (10.0–18.4)	28.5	8.5 (3.9–18.0)
Brachial plexus injury	7.7	17.6	2.3 (1.8–2.9)	25.0	3.2 (2.3–4.6)	46.4	6.0 (3.3–10.7)
Convulsions	6.4	11.7	1.8 (1.4–2.4)	9.8	1.6 (0.9–2.7)	24.9	3.9 (1.7–8.6)
CNS depression	3.1	9.2	2.9 (2.1–4.1)	5.2	1.4 (0.6–2.8)	21.3	6.9 (2.7–16.2)
Feeding difficulty	68.5	72.1	1.1 (1.0–1.2)	74.6	1.1 (0.9–1.3)	60.7	0.9 (0.5–1.5)
Mechanical ventilation	25.8	39.1	1.5 (1.3–1.8)	45.4	1.8 (1.4–2.3)	50.0	1.9 (1.1–3.4)

	CESAREAN									
	TOTAL (N=117,425)		DURING LABOR (N=84,417)		DURING LABOR, FAILED VAGINAL DELIVERY (N=2342)†		DURING LABOR, NO ATTEMPT AT VAGINAL DELIVERY (N=82,075)†		NO LABOR (N=33,008)	
	Incidence	*Odds Ratio*	*Incidence*	*Odds Ratio*	*Incidence*	*Odds Ratio*	*Incidence*	*Odds Ratio*	*Incidence*	*Odds Ratio*
Subdural or cerebral hemorrhage	6.7	2.3 (1.7–3.1)	7.4	2.5 (1.8–3.4)	25.7	8.8 (3.9–19.9)	6.8	2.3 (1.7–3.2)	4.1	1.4 (0.8–2.6)
Intraventricular hemorrhage	2.1	2.0 (1.2–3.3)	2.5	2.3 (1.4–4.0)	0.0	0.0 (0.0–1.1)	2.6	2.4 (1.4–4.1)	0.8	0.6 (0.1–2.5)
Subarachnoid hemorrhage	0.9	0.7 (0.4–1.4)	1.2	0.9 (0.4–1.9)	4.3	3.3 (0.5–23.9)	1.1	0.9 (0.4–1.7)	0.0	0.0 (0.0–19.7)
Facial-nerve injury	3.5	1.1 (0.7–1.5)	3.1	0.9 (0.6–1.4)	12.8	3.8 (1.2–12.1)	2.8	0.8 (0.5–1.3)	4.9	1.5 (0.8–2.6)
Brachial plexus injury	3.0	0.4 (0.3–0.5)	1.8	0.2 (0.1–0.4)	8.6	1.1 (0.3–4.4)	1.6	0.2 (0.1–0.4)	4.1	0.5 (0.3–1.0)
Convulsions	18.7	2.9 (2.4–3.6)	21.3	3.3 (2.8–4.1)	68.8	10.8 (6.5–17.8)	19.9	3.1 (2.6–3.8)	8.6	1.4 (0.9–2.1)
CNS depression	8.9	2.9 (2.2–3.7)	9.6	3.1 (2.3–4.1)	17.1	5.5 (1.7–15.5)	9.4	3.0 (2.3–4.0)	6.7	2.2 (1.3–3.6)
Feeding difficulty	114.7	1.7 (1.6–1.8)	117.2	1.7 (1.6–1.8)	94.8	1.4 (0.9–2.1)	117.9	1.7 (1.6–1.8)	106.3	1.6 (1.4–1.8)
Mechanical ventilation	96.0	3.7 (3.4–4.1)	103.2	4.0 (3.6–4.3)	156.1	6.0 (4.3–8.3)	101.7	2.6 (2.2–3.0)	71.3	2.8 (2.4–3.3)

*The incidence is expressed as the number of cases per 10,000 infants. Numbers in parentheses are 95 percent confidence intervals. CNS denotes central nervous system.

†Vaginal delivery refers to delivery with the use of vacuum extraction, forceps, or both.

[288] It is important to pause and note that none of the modes of delivery are risk free. Every mode of delivery poses risks for the patient and the fetus.

[289] After considering all of this data, the Towner study observed that the rates of intracranial hemorrhage were low with all modes of delivery but were higher for vacuum, forceps, or Caesarean section than they were for spontaneous vaginal birth. The Towner study

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concluded that the "method of delivery is not necessarily the primary factor associated with intracranial hemorrhage." Instead, the common risk factor for intracranial hemorrhage was abnormal labour:

> The rate of intracranial hemorrhage is higher among infants delivered by vacuum extraction, forceps, or cesarean section during labor than among infants delivered spontaneously, but the rate among infants delivered by cesarean section before labor is not higher, suggesting that the common risk factor for hemorrhage is abnormal labor.

[290] Dr. Shone testified that Dr. Hawrylyshyn should have disclosed the increased risk of subarachnoid and subdural hemorrhages to Ms. Noel given the findings in the Towner article that the rate of intracranial hemorrhage is highest in infants delivered by combined vacuum and forceps. I disagree.

[291] The plaintiffs do not suggest that, as of 1900h, Ms. Noel could have waited to attempt a spontaneous vaginal delivery. For that reason, the data related to the incidence of major neonatal morbidity following a spontaneous vaginal delivery is irrelevant to Dr. Hawrylyshyn's advice to Ms. Noel at 1900h. According to the Towner article, all of the available interventions for Ms. Noel carried an increased risk of intracranial hemorrhage as compared to a spontaneous vaginal delivery.

[292] The Towner study reveals that "the rates of intracranial hemorrhage were low with all modes of delivery" but that there was "an incremental increase in the rate of intracranial hemorrhage if more than one method of delivery was used. After considering all of the data, however, the study observed that its findings "suggest that the method of delivery is not necessarily the primary factor associated with intracranial hemorrhage":

> We found that the rates of intracranial hemorrhage were low with all modes of delivery but were higher with vacuum extraction, forceps delivery, and cesarean delivery during labor than with spontaneous vaginal delivery. The rates for the three types of operative delivery were similar. There was an incremental increase in the rate of intracranial hemorrhage if more than one method of delivery was used. The frequency of intracranial hemorrhage in infants born by cesarean delivery during labor with no attempt at operative vaginal delivery did not differ significantly from the frequency in infants born by operative vaginal delivery, and the frequency of hemorrhage was similar in infants born by cesarean delivery with no labor and those delivered spontaneously. These findings suggest that the method of delivery is not necessarily the primary factor associated with intracranial hemorrhage.

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[293] If, as the Towner study concluded, the method of delivery is not necessarily the primary factor associated with intracranial hemorrhage, that significantly weakens the argument that Dr. Hawrylyshyn needed to disclose the risk of intracranial hemorrhage arising from any one or more of the operative modes of delivery available at 1900h.

[294] In addition, I agree with the evidence of Dr. Hawrylyshyn and Dr. Davies that the Towner article demonstrates that risk of intracranial bleeding was low for all modes of delivery. For example, in every 10,000 live births, the following number of cases of subdural or cerebral hemorrhage were counted:

Mode of delivery	Incidence per 10,000 births
Vacuum only	8.0
Forceps only	9.8
Vacuum and forceps	21.3
Caesarean section, no vacuum or forceps	6.8
Caesarean section after vacuum or forceps	25.7

[295] Because subdural or cerebral hemorrhages occur so infrequently, the relative difference in frequency among the modes of delivery is not very significant. I accept the opinion of Dr. Davies that while there is a statistical difference among the modes of delivery from a research point of view, it is an inconsequential change in the risk for a patient. I do not think it was necessary for Dr. Hawrylyshyn to explain to Ms. Noel the difference in incidence rate of subdural hematoma among deliveries by vacuum (0.080%), forceps (0.098%), and Caesarean section (0.068%).

[296] This case is not at all like the situation in *Denman*. The trial judge found that if Mr. Denman consented to the recommended treatment, he faced a 30 to 50% cumulative upfront risk of suffering a permanent neurological deficit. On the other hand, if Mr. Denman did not undergo treatment, he had a 40 to 60% risk of a spontaneous bleed spread over his lifetime, of which only a fraction would have caused him serious harm.[48] Had the defendants made appropriate disclosure of these risks, neither Mr. Denman nor any reasonable patient in his circumstances would have elected to proceed with the multi-step course of elective medical intervention.

[297] In this case, however, the incidence rate of intracranial bleeding is much more similar among the three options than was the case in *Denman*. The similarity in incidence rate combined with the very low risk persuades me that it was not necessary in the urgent circumstances of this case for Dr. Hawrylyshyn to discuss the differential risk rates with Ms. Noel.

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[48] *Denman*, paras. 67 to 71.

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[298] I reach the same conclusion about the risks associated with sequential use of instruments, in this case an attempt at a vacuum-assisted delivery followed by an attempted forceps-assisted delivery. Recall that Dr. Hawrylyshyn recommended a vacuum-assisted vaginal birth because, if successful, that was the fastest way to deliver the fetus and because, in his view and experience, the vacuum was safer overall than the forceps. If the application of the vacuum did not result in a delivery, Ms. Noel had only two choices: a trial of forceps or delivery by Caesarean section.

[299] According to the Towner study, the incidence of subdural or cerebral hemorrhage for a vacuum and forceps assisted birth (21.3 per 10,000 births) was lower than that associated with an attempt with a vacuum followed by a Caesarean section (25.7 per 10,000 births). Some risk factors for other conditions were slightly higher for attempted vacuum-assisted delivery followed by forceps-assisted delivery than for vacuum followed by Caesarean section, others were lower. I do not think the Towner study supports Dr. Shone's opinion that Dr. Hawrylyshyn was required to disclose the specific risks associated with the sequential use of instrumentation. Indeed, based on Dr. Shone's own answers on cross-examination, he would advise a patient only that if an attempt at operative vaginal delivery failed, then a different procedure would have to be performed.

[300] Given the urgent circumstances, I do not think the law as set out by the Court of Appeal in *Farej* compelled Dr. Hawrylyshyn to walk Ms. Noel through each relative risks described in the Towner report. In my view, there is nothing to be gained and much to be lost by articulating a standard of care that required Dr. Hawrylyshyn either to hand Ms. Noel a laminated copy of Table 2 of the Towner study for her review or to describe verbally each and every statistic, complete with odds ratio and confidence intervals. Instead, it was for Dr. Hawrylyshyn to consider all of these risks when making his assessment of the appropriate treatment to recommend to Ms. Noel. He did so.

[301] I accept Dr. Davies opinion that Dr. Hawrylyshyn met the standard of care in his approach to obtaining informed consent.

[302] Finally, the plaintiffs submit that Dr. Hawrylyshyn needed to obtain a further informed consent from Ms. Noel to the use of the forceps after he consulted with Dr. Okun. I disagree.

[303] I have already found that Dr. Hawrylyshyn obtained Ms. Noel's consent to a course of treatment being an attempt at vacuum-assisted vaginal delivery and then, if clinically indicated, a trial of forceps. Dr. Hawrylyshyn called in Dr. Okun to provide her opinion regarding whether to try to apply the forceps. Dr. Okun confirmed Dr. Hawrylyshyn's opinion. I see no reason why Dr. Hawrylyshyn needed to go back to seek a further consent from Ms. Noel at that time. No expert testified that obtaining a further consent was required.

[304] In my view, given the urgent circumstances, I accept Dr. Davies' evidence and find that Dr. Hawrylyshyn adequately disclosed the risks of the vacuum and possible use of forceps

to Ms. Noel. I find that Dr. Hawrylyshyn's actions were consistent with the obligations placed upon him by the *Health Care Consent Act*, the 2004 SOCG Guideline for Operative Birth, or the 2004 Advances in Labor and Risk Management Course. I conclude Dr. Hawrylyshyn met all of his obligations and obtained Ms. Noel's informed consent to the course of treatment he proposed.

D. Dr. Okun did not need to obtain the informed consent of Ms. Noel

[305] The plaintiffs submit that Dr. Okun failed to obtain Ms. Noel's informed consent to the application of the forceps. The plaintiffs did not place significant emphasis on this submission, which I do not accept.

[306] The plaintiffs did not tender any expert evidence to suggest that Dr. Okun was required to obtain Ms. Noel's informed consent before Dr. Hawrylyshyn applied the forceps.

[307] The law is clear that the duty to obtain informed consent is not limited to only the physician administering the treatment. Depending on the circumstances, a physician not performing the procedure may have a duty of disclosure.[49] For example, in *Ferguson*, Dr. Murry was Mr. Ferguson's attending physician, examined him, and concluded that further investigations including an angiogram were necessary to determine the cause of the patient's symptoms.[50] Justice Krever held that Dr. Murray was under a duty to discuss the alternatives to the angiogram and their risks, even though the procedure was to be carried out by Dr. Isaac. I do not think this case assists the plaintiffs. Here, Dr. Hawrylyshyn was Ms. Noel's most responsible physician, he gave the advice to Ms. Noel, and he applied the forceps. Dr. Okun was not Ms. Noel's attending physician and did not propose any necessary treatment plan to Ms. Noel. Dr. Murray and Dr. Okun played very different roles in the treatment of Mr. Ferguson and Ms. Noel, respectively.

[308] Similarly, in *Denman*, the court found that Dr. ter Brugge and Dr. Radovanovic breached the duty to obtain informed consent even though Dr. Pereira performed the three embolization procedures on Mr. Denman. The roles of Drs. ter Brugge and Radovanovic, however, were very different that Dr. Okun's role:

a. Dr. ter Brugge participated in a multidisciplinary conference that provided a recommendation to Mr. Denman regarding his course of treatment and then met personally with Mr. Denman and proposed the treatment plant to him;

b. Dr. Radovanovic met with Mr. Denman and his wife to propose that Mr. Denman undergo a third embolization followed by surgical resection. He provided Mr. Denman with information about the risks associated with the combined procedure.

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[49] *Denman*, paras. 86, 91.
[50] *Ferguson v. Hamilton Civic Hospitals* (1983), 144 D.L.R. (3d) 214 (Ont. S.C.), aff'd (1985), 50 O.R. (2d) 754 (C.A.)

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[309] In contrast, Dr. Okun was called in urgently to provide Dr. Hawrylyshyn with a second opinion on the advisability of proceeding with a trial of forceps after a failed attempt at a vacuum-assisted delivery. She conducted a vaginal examination, noted the position of the fetal head in the pelvis and that it was rotated. The position of the fetus and the urgency created by its heart rate status, informed Dr. Okun's advice to Dr. Hawrylyshyn that it was appropriate to attempt a trial of forceps.

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[310] Dr. Okun played no role in obtaining Ms. Noel's consent to the use of forceps, which she did not apply. Although neither Dr. ter Brugge nor Dr. Radovanovic performed the third embolization, they played instrumental and fundamental roles in obtaining Mr. Denman's consent to that procedure. It was in those circumstances that the Court of Appeal held that they owed a duty to obtain informed consent from Mr. Denman. In my view, the principles articulated in *Denman* do not extend so far as to require Dr. Okun, in these circumstances, to obtain the informed consent of Ms. Noel.

[311] The plaintiffs submit that Dr. Okun was "aware of her obligation and failed to obtain consent from" Ms. Noel. I do not think this reflects Dr. Okun's evidence. She repeatedly testified that she was "an assistant" and did not have a primary treating relationship with Ms. Noel. She correctly acknowledged that Ms. Noel needed to provide her informed consent for the application of the forceps, but never admitted that she had any role to play in obtaining that consent, given that her role was limited to providing a second opinion to Dr. Hawrylyshyn.

[312] I find that in these circumstances Dr. Okun had no obligation to obtain Ms. Noel's informed consent. That responsibility fell solely upon Dr. Hawrylyshyn.

E. The causation element of informed consent

[313] I have found that Dr. Hawrylyshyn provided sufficient information to Ms. Noel and that Ms. Noel actually provided informed consent to the treatment.

[314] I do not accept Ms. Noel's evidence that she would not have consented to the procedure if the risks of sequential procedures had been disclosed to her. Her evidence in this regard is too infused with hindsight to be accepted.[51] I do not accept her evidence that she did not actually consent and, similarly, I do not accept her evidence that she would not have consented if additional information had been provided to her.

[315] Even if Dr. Shone is correct about all of the risks that needed to be disclosed to Ms. Noel, a reasonable person in Ms. Noel's circumstances would still have consented to the treatment plan suggested by Dr. Hawrylyshyn.

[316] While it is no doubt a difficult decision for any patient to make, in my view a reasonable patient would accept the advice of her doctor that a vacuum-assisted delivery provided the

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[51] *Bollmon v. Soenen*, 2014 ONCA 36, at paras. 21 to 23.

highest likelihood of the fastest delivery of the fetus that was experiencing distress. A reasonable patient would accept the advice of her doctor regarding the relative risks of vacuum-assisted delivery, a forceps-assisted delivery, and delivery by Caesarean section to her own body and to the fetus. Choosing the recommended option is logical and reasonable in an urgent situation where the health of the fetus is at risk and deferring the treatment was not an option. All procedures carry risk. The risks posed by Dr. Hawrylyshyn's management plan were reasonable given the urgent circumstances and the need to deliver the fetus as soon as possible. A reasonable person would have consented to the recommended treatment even if a broader range of information had been provided.

F. Conclusion

[317] I dismiss Ms. Noel's claim that Dr. Hawrylyshyn and Dr. Okun breached the standard of care by failing to obtain Ms. Noel's informed consent to the treatment plan Dr. Hawrylyshyn proposed to her between 1900h and 1910h.

5. Standard of Care

[318] In addition to the plaintiffs' claims in battery and failure to obtain informed consent, the plaintiffs also assert that the defendant doctors were negligent. To succeed in this aspect of their claim, the plaintiffs must prove that:

a. the defendant owed a duty of care to the plaintiffs;

b. the defendant breached the standard of care;

c. the defendant's breach of the standard of care caused the plaintiff to suffer a bodily injury; and

d. the injury resulting from the defendant's conduct was not too remote.[52]

[319] The parties agree that the defendants owed a duty of care to the plaintiffs. The plaintiffs assert that the defendants breached the standard of care in the following ways:

a. Dr. Allen failed to document and communicate Ms. Noel's expressed preference that she did not want to have a delivery assisted by vacuum or forceps;

b. Dr. Hawrylyshyn failed to recommend that Ms. Noel undergo a Caesarean section at 1700h;

c. Dr. Hawrylyshyn, as assisted by Dr. Okun, applied a vacuum and then the forceps when it was inappropriate to do so.

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[52] *Hasan v. Trillium Health Centre (Mississauga)*, 2024 ONCA 586, at para. 12; *Willick v. Willard*, 2023 ONCA 792; *Mustapha v. Culligan of Canada Ltd*., 2008 SCC 27, [2008] 2 S.C.R. 114, at para. 3.

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[320] For the reasons that follow, I find that the plaintiffs did not prove that the defendants breached the standard of care.

A. Legal principles

[321] The parties agree that every medical practitioner must exercise a reasonable degree of care, skill, and knowledge which could reasonably be expected of a careful, prudent practitioner of the same experience and training.[53] The standard of reasonableness is not a standard of excellence or a standard of perfection.[54] The standard of care must be responsive to the recognized risks presented by the medical situation.[55]

[322] A specialist will be held to a higher degree of skill than a general practitioner, and the physician's conduct will be assessed against the conduct of other similarly situated specialists, not the best and not the worst, but an average physician in that specialty.[56]

[323] Diagnosis is an exercise of judgment based on the doctor's training and experience.[57] Physicians must exercise their judgment in the provision of care and treatment to their patient. If that judgment was exercised reasonably at the time, in light of the circumstances that existed at the time and the facts that were known, an error in judgment does not equate with a breach of the standard of care, as long as it was an "honest and intelligent exercise of judgment."[58] A doctor will breach the standard of care when the doctor embarks on a course of action that would not have been taken by any similarly situated, reasonably competent physician in similar circumstances. The Court of Appeal described the error of judgment principle this way:

> The error of judgment principle is rooted in the reality that a great deal of medical treatment depends on the exercise of medical judgment. Although that judgment may be wrong, the fact that it is wrong does not mean that it is necessarily negligent. What the law requires is that reasonable care be taken in the exercise of medical judgment.[59]

[324] An unfortunate or unanticipated outcome does not constitute proof of negligence. The question to be determined is whether the act or omission is acceptable conduct for a reasonably prudent and diligent physician in the same circumstances.[60]

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[53] *Crits v. Sylvester et al*., [1956] O.R. 132 (C.A.).
[54] *Armstrong v. Royal Victoria Hospital*, 2019 ONCA 963, 452 D.L.R. (4th) 555, at para. 86 (per van Rensburg J.A., dissenting), rev'd *Armstrong v. Ward*, 2021 SCC 1.
[55] *Ediger v. Johnston*, 2013 SCC 18, [2013] 2 S.C.R. 98, at paras. 44-49.
[56] *ter Neuzen v. Korn*, 81 B.C.L.R. (2d) 39 (C.A.), at para. 102, aff'd [1995] 3 S.C.R. 674.
[57] *Dean v. York County Hospital et al*., [1979] O.J. No. 348 (High Ct.), at para. 42.
[58] *Wilson v. Swanson*, [1956] S.C.R. 804, at p. 812; *Samms v. Moolla*, 2019 ONCA 220, at paras. 73 and 79.
[59] *Samms v. Moolla*, 2019 ONCA 220, at para. 73.
[60] *St.-Jean v. Mercier*, 2002 SCC 15, [2002] 1 S.C.R. 491, at para. 53.

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[325] The actions of a physician are assessed in light of the medical knowledge and the facts and background history that they ought to have known at the time of the alleged negligence. The conduct of a doctor must not be assessed with the benefit of hindsight, knowing the outcome. The Supreme Court of Canada put it this way:

> [C]ourts should be careful not to rely upon the perfect vision afforded by hindsight. In order to evaluate a particular exercise of judgment fairly, the doctor's limited ability to foresee future events when determining a course of conduct must be kept in mind. Otherwise, the doctor will not be assessed according to the norms of the average doctor of reasonable ability in the same circumstances, but rather will be held accountable for mistakes that are apparent only after the fact.[61]

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[326] As I will explain below, I find that the defendant doctors took reasonable care in the exercise of their judgment. There is no doubt that the delivery produced an unfortunate outcome, but that is not proof of negligence. It is only with the benefit of hindsight, knowing of the outcome, that one would question the exercise of judgment by the defendants. For the reasons set out below, I find that the plaintiffs did not prove that the defendants breached the standard of care.

B. Evaluating the expert evidence

[327] The parties led a significant amount of opinion evidence on the topics of the standard of care and causation. In assessing the expert opinions, the parties agree that I am to follow the approach set out by Trimble J. in the *Sit* case.[62] This includes a consideration of the expert's qualifications and impartiality, an assessment of the evidentiary basis for the opinion, and an examination of the whole opinion. In addition, while I may accept or reject some or all of an expert's evidence, I am not to substitute my own medical opinion or theory:

> It is true that the court may accept in whole or in part or reject in whole or in part the evidence of any witness on the respective grounds of credibility or plausibility, or a combination of both. But in technical matters, unlike in lay matters within the traditional intellectual competence of the court, it cannot substitute its own medical opinion for that of qualified experts. The court has no status whatsoever to come to a medical conclusion contrary to unanimous medical evidence before it even if it wanted to, which is not the situation in this case. If the medical evidence is equivocal, the court

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[61] *Lapointe v. Hopital Le Gardeur*, [1992] 1 S.C.R. 351, at para. 28.
[62] *Sit v. Trillium Health Centre*, 2020 ONSC 2458, at paras. 120-125; *Johnson v. Lakeridge Health Corporation*, 2023 ONSC 2575, at para. 16; *Hasan v. Trillium Health Care Mississauga*, 2022 ONSC 3988 aff'd 2024 ONCA 586.

> may elect which of the theories advanced it accepts. If only two medical theories are advanced, the court may elect between the two or reject them both; it cannot adopt a third theory of its own, no matter how plausible such might be to the court. There is an evidentiary bar to opinion evidence on technical subjects from non-qualified witnesses, and an equally rigid bar against judges coming to conclusions on technical matters (other than domestic and constitutional law) founded on their own opinions rather than on evidence from qualified witnesses.[63]

[328] To be admissible, an expert opinion must comply with rule 53.03(2.1), which requires the expert to provide not only the reasons for their opinion but also the assumptions, documents, and research that informed that opinion.[64] The rule requires that the report shall contain:

> 6. The expert's reasons for his or her opinion, including,
>
> > i. a description of the factual assumptions on which the opinion is based,
> >
> > ii. a description of any research conducted by the expert that led him or her to form the opinion, and
> >
> > iii. a list of every document, if any, relied on by the expert in forming the opinion.

[329] This information is necessary, but not sufficient for an expert report to be admissible at a hearing.

[330] Expert opinion evidence is presumptively inadmissible unless it meets the two-stage test for admissibility set out in *White Burgess*.[65] The first stage focuses on threshold requirements of admissibility. If the proposed expert evidence does not meet the threshold requirements, it is excluded. If the proposed evidence meets the threshold requirements, the evidence must still pass the second stage, which focuses on the judge's discretionary gatekeeper role. The judge must be satisfied that the benefits of admitting the evidence outweigh the costs of its admission.[66]

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[63] *Hajgato v. London Health Association et al.* (1982), 36 O.R. (2d) 669 at 683 (H.C.J.), aff'd (1983), 44 O.R. (2d) 264 (C.A.).
[64] Rule 53(2.1)6(iii) of the *Rules of Civil Procedure*, R.R.O. 1990, Reg. 194.
[65] *White Burgess Langille Inman v. Abbott and Haliburton C*o., [2015] 2 S.C.R. 182; see also *R. v. Abbey*, 2017 ONCA 640, 140 O.R. (3d) 40 (*Abbey #2*); *R. v. Mohan*, [1994] 2 S.C.R. 9; *R. v. Abbey*, 2009 ONCA 624, 97 O.R. (3d) 330.
[66] *Abbey #2*, at para. 48- 49. Lisa Dufraimont, "Case Comment on White Burgess Langille Inman v. Abbott and Haliburton Co." (2015) 18 C.R. (7th) 312-313.

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[331] I admitted all of the expert evidence. However, in assessing the weight to be given to that evidence, one of the factors to be considered is its reliability. I am to take an evidence-based approach to the evaluation of the reliability of expert evidence. The court is not simply to trust the expert. The court asks the expert to show and then persuade the court that the expert's opinion is reliable. Justice Laskin adopted the academic work of Paciocco J.A. and explained that:

> courts now take what he called, and what the Goudge Report called, an evidence-based approach to the evaluation of the reliability of expert evidence. [Prof. David Paciocco] wrote at p. 146: "In effect, the 'trust me' approach, once typical in Canadian courts, has been replaced by a 'persuade me' standard". And near the end of his article, at p. 155,…he wrote: "…the essence of an evidence-based approach is that the tribunal be given all of the data it needs to assess the opinion it is being asked to accept. Anything less and a 'trust me' approach is used."[67]

[332] Opinions that are clearly rooted in the authoritative guidelines, practices, and literature are frequently more persuasive than those that are not anchored in the canonical texts. Where there are no citations to the authoritative academic literature, it can be more difficult for the court to assess which opinions represent a scientific consensus and which opinions are based on anecdotal observations or personal practice.[68] Experts who cite to the authoritative literature are showing their work and not asking the court simply to trust them.

[333] Similarly, where an expert offers an opinion that is not supported or is contradicted by the authoritative guidelines, practices, and literature, the court becomes extremely concerned that the opinion may reflect only the idiosyncratic preferences or beliefs of the expert. Such opinions are rarely of assistance to the court and do not assist in establishing the standard of care.[69] At a minimum, the expert must offer a cogent and compelling explanation for why their opinion is not supported by or is contradicted by the literature. Otherwise, the expert is simply asking the court to "trust me."

[334] I will address each expert's evidence below as I consider whether the plaintiffs have proved a breach of the standard of care.

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[67] *Abbey (#2),* at para. 119.
[68] *Johnson v. Lakeridge Health Corporation*, 2023 ONSC 2575, at para. 278; *Bauer v. Kilmurry*, 2016 ONSC 7749, at para. 83.
[69] *Fortune-Ozoike v. Wal-Mart Canada Corp.*, 2023 ONSC 421, at 82; *Bafaro v. Dowd*, 2008 CanLII 45000 (ONSC), aff'd 2010 ONCA 188; *The Estate of Carlo DeMarco v. Dr. Martin*, 2019 ONSC 2788, at para 66.

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B. Dr. Allen's antenatal record keeping

[335] The plaintiffs allege that Dr. Allen breached the standard of care "when she failed to document [Ms. Noel's] birth plan." I disagree.

[336] I set out some of the evidence related to the interactions between Ms. Noel and Dr. Allen in paragraphs [60] to [90], which are found in my discussion of Ms. Noel's claim of medical battery. I will repeat some of that evidence below but I rely on all of the evidence in reaching my conclusion.

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Evidence from Ms. Noel and Dr. Allen

[337] Dr. Allen admitted that she did not have any independent recollection of assessing or treating Ms. Noel and relied on her medical records and standard practices in 2004-2005 to inform her evidence. At their first appointment Dr. Allen took Ms. Noel's medical history and recorded her notes on a standard form called "Antenatal Record 1."

[338] Ms. Noel testified that she met with Dr. Allen 13 times during her pregnancy, which was confirmed by the medical records.[70] Dr. Allen testified that she did not have any concerns about the health or progress of the fetus and Ms. Noel did not recall Dr. Allen ever expressing any such concerns.

[339] On March 15, 2005, Dr. Allen referred Ms. Noel to a dietician and discussed strategies for dealing with weight gain that was a little bit higher than expected. On March 29, 2005, Dr. Allen referred Ms. Noel to a social worker and a psychiatrist based on the depressed mood symptoms that she expressed during that visit. The note from that meeting recorded "Anhedonia / sad / teary / anxious / not suicidal / increased sleep / relationship not abusive." Ms. Noel testified that she had no recollection of that referral. Ms. Noel's failure to recall this referral causes me to doubt the reliability of her recollection of her discussions with Dr. Allen. A referral for to a social worker and a psychiatrist during pregnancy would seem to be an important event that a patient would recall, even many years later.

[340] Dr. Allen testified that her usual practice was to discuss labour and delivery management with her patients at 36 weeks of gestational age but acknowledged that there is no record of such a discussion in Ms. Noel's chart. Ms. Noel reached 36 weeks on or about the appointment on May 11, 2005. Although she did not have a specific recollection of a conversation with Ms. Noel, Dr. Allen testified that she would typically discuss a range of topics including when to arrive at the hospital after labour started, labour support, pain management options, and outcomes of labour, which would include a spontaneous vaginal birth, a vaginal birth assisted with the use of vacuum and or forceps, or a Caesarean section. Dr. Allen testified that it was her usual practice to discuss in general the risks and benefits

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[70] Antenatal visits took place on November 23 and December 21, 2004, and January 18, February 15, March 15 and 29, April 12 and 26, May 11, 18, and 25, and June 1 and 8, 2005.

of these approaches but that it was unlikely that such a conversation would get into the details of the exact risks posed to the fetus from each of these modes of delivery.

[341] Dr. Allen testified that if her patient brought a written birth plan, Dr. Allen would discuss that plan with the patient. Dr. Allen confirmed that she could also have discussed a birth plan even if the patient did not bring a written plan. Dr. Allen testified that she would usually document this conversation in her chart, but that Ms. Noel's chart did not contain such a note. Dr. Allen testified that this could mean that the conversation took place and was unremarkable or it could mean that the conversation did not take place. Dr. Allen testified that she would document conversation if there were "pertinent positives or negatives" from that conversation, which she understood to be the standard of care expected in 2004-2005.

[342] Ms. Noel testified that she spoke with Dr. Allen a few times about her birth plan. She recalled one particular conversation that was took place fairly close to her delivery date. Ms. Noel placed this conversation at the time she was seeing Dr. Allen on a weekly basis. According to the antenatal records, Ms. Noel started seeing Dr. Allen on a weekly basis starting May 11, 2005. Ms. Noel testified that she reiterated her "wishes not to have a vacuum or forceps in my birth. And I would have a [Caesarean] section if that was what the alternative was to not using those instruments." She described this as a conversation about she "did not want" to happen during her birth. She explained that she told Dr. Allen that she did not want to have a forceps or vacuum delivery and would "take the cut," meaning a Caesarean section.

[343] Ms. Noel recalls that Dr. Allen responded by saying that she understood Ms. Noel's views, but that her pregnancy was progressing well and that it would not be necessary to speak about vacuum or forceps assisted birth at that time. Ms. Noel confirmed on cross-examination that Dr. Allen told her that she did not need to make any decisions about the use of vacuum or forceps at that time because she was not at that stage of her pregnancy.

[344] Dr. Allen testified that she had no independent recollection of Ms. Noel saying anything about the possibility of the use of vacuum or forceps. Dr. Allen explained that if a patient stated that she never wanted the vacuum or forceps applied during delivery, she would explore the individual's fears and concerns and explain that it is hard to make a decision before labour because it is a dynamic process and there could be a situation where using vacuum or forceps is the safest option. Dr. Allen testified that she would explain the importance of listening to the obstetrician at the time of delivery to try and understand the reasons for the recommendations for care that were being provided at that time. In addition, if a patient then said she was adamant that under no circumstances would she agree to a vacuum or forceps, Dr. Allen would treat that as a very unusual situation that would be documented in the chart and explored further.

[345] Dr. Allen emphasized that it would be very unusual in her practice for someone to make an absolute decision in the antenatal period not to have a delivery involving the use of vacuum or forceps. Dr. Allen testified that she would probably have taken other steps,

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including talking to colleagues about how to transmit that information to those who might be on call for the birth. Dr. Allen confirmed that there were no such notes in Ms. Noel's chart. Dr. Allen agreed that if a patient was particularly adamant about any issue in her pregnancy, it would have been her usual practice to write that down in the medical record. On cross-examination, Dr. Allen stated that if Ms. Noel had "told [Dr. Allen] of her decision not to have vacuum or forceps for her delivery," she would have documented that "decision." Dr. Allen allowed that it was possible that Ms. Noel expressed a preference not to have the vacuum or forceps used during delivery, but that it was unlikely that Ms. Noel expressed an adamant decision to never have those instruments used under any circumstances. Dr. Allen noted that while it was common for her patients to express a preference for avoiding operative delivery it would be very uncommon for a patient to express a refusal to ever consider an operative delivery.

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[346] Ms. Noel confirmed that she never prepared a written birth plan setting out her wishes for her labour and delivery. She stated that she did not know that was an option and did not "feel like writing [her birth plan] down," because she felt she had communicated it to Dr. Allen and she hoped that Dr. Allen would have written it down. There is no dispute that Dr. Allen recorded in the antenatal record neither that she discussed a birth plan with Ms. Noel nor any components of a birth plan.

Expert evidence on the standard of care

[347] Dr. Davies, an expert obstetrician called by the defendants, testified that if a patient expressed a preference not to have a vacuum or forceps-assisted delivery, as opposed to an outright refusal to ever have those instruments used, a doctor would not breach of the standard of care if she did not record that preference in the medical chart. Dr. Davies testified that patients frequently express those preferences early in their pregnancies and that many patients do not understand the many different scenarios that might play out during labour. Dr. Davies testified that even where patients have an initial stated preference to avoid an operative vaginal delivery, many patients will agree that an operative vaginal delivery is a good idea depending on the clinical circumstances present during labour. Dr. Davies testified that unless the patient expressed an adamant refusal to ever have an operative delivery, the standard of care did not require a doctor to record that conversation.

[348] Dr. Shone, an expert obstetrician called the plaintiffs, testified that Dr. Allen breached the standard of care by not making a notation of Ms. Noel's birth plan. I have concerns about Dr. Shone's opinion on this point. First, in his written report Dr. Shone stated that "Ms. Noel attended regular prenatal appointments and management of prenatal care appears to have been appropriate." Regarding Dr. Allen's care at the hospital, Dr. Shone wrote, "Dr. Allen's involvement early on was appropriate and care was handed over to Dr. Hawrylyshyn." I find it difficult to reconcile these clear opinions with Dr. Shone's testimony that Dr. Allen's antenatal record keeping breached the standard of care.

[349] In his written report, Dr. Shone elaborated on Dr. Allen's discussions with Ms. Noel and her notetaking as follows:

> Although the decision whether an assisted delivery is appropriate, is best made at the time of delivery, an office visit is a good time to review knowledge and correct misconceptions in an unbiased way about the methods of assisting delivery. If a full discussion did occur than [*sic*] I would have expected a notation of it in the chart from Dr. Allen's office and also on the prenatal sheet.

[350] Under the heading “if Janelle Noel’s recollections are correct,” Dr. Shone wrote

> It is clear that Janelle had strong feelings about an assisted vaginal delivery and which she says were raised with Dr. Allen in the antepartum period. This is the ideal opportunity to discuss the issue and address any misconceptions as there are no constraints to limit the discussion.

[351] Dr. Shone described the purpose of his report as being to offer an opinion on whether the obstetrical care provided to Ms. Noel met the standard of care:

> The purpose of my report is to revie the records provided to me related to the labour of Janelle Noel, and subsequent delivery of Milo [*sic*] Noel, and to provide my opinion as to the obstetrical care provided, and whether or not it met the standard of care at that time.

[352] Nowhere in his written report did Dr. Shone express the opinion that Dr. Allen failed to meet the standard of care. From reading his report, I had no idea that Dr. Shone had formed the opinion that Dr. Allen breached the standard of care by failing to record Ms. Noel’s preferences. When Dr. Shone intended to express an opinion that an obstetrician fell below the standard of care, he did so explicitly and using that precise phrase. For example, in three places he offered the explicit opinion that Dr. Hawrylyshyn did not meet the standard of care.[71]

[353] At trial, however, Dr. Shone testified that the failure of Dr. Allen to make a notation of Ms. Noel’s preferences regarding an operative delivery breached the standard of care:

> Q. Let me see if I can shorten that down, Dr. Shone. Again, if I ask you to assume that Ms. Noel did express to her treating obstetrician, Dr. Allen, that she did not want a vacuum or forceps used during her delivery, and to the extent that no such discussion

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[71] See: “After reviewing the records and Dr. Hawrylyshyn’s Discovery, if what he states was normal practice, with regards to using a vacuum followed by 4 steps followed by Caesarean Delivery, then that falls below the standard care as it was not normal practice in 2005.” See also, “If that is what occurred then Dr. Hawrylyshyn performed a procedure without consent and that is below the standard of care as expected in the circumstances”. See also, “after reviewing the chart and the information available from discovery, it is my opinion that Dr. Hawrylyshyn[‘s]… decision to perform a vacuum delivery followed by a forceps and subsequent Caesarean Delivery for a midpelvic transverse arrest also not meet the standard of care expected at that time.”

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> was charted in the antenatal records anywhere, can you advise how that accords with the standard of care to be expected?
>
> A. I would expect that if the patient brought up her birth plan and expressed concerns about an instrumental vaginal delivery, then I would expect the care provider to discuss the risks and benefits of those instrumentations, and whether there was any exceptions to her birth plan. And I would expect that to be documented on the antenatal sheet.
>
> Q. And when you say "I would expect that", in your opinion, is that what the standard of care would require?
>
> A. That would be my opinion is that the standard of care would require documentation of that discussion.

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[354] It is difficult for me to reconcile Dr. Shone's conclusion in his written report that Dr. Allen's management of prenatal care "appears to have been appropriate" with his testimony at trial that she breached the standard of care. This discrepancy causes me to place less weight on Dr. Shone's opinion.

Conclusion

[355] I find the plaintiffs have not proved on a balance of probabilities that Dr. Allen breached the standard of care in her antenatal record keeping.

[356] The plaintiffs submit that Ms. Noel "developed a strong birth plan to avoid the use of vacuum or forceps." I disagree. Ms. Noel neither wrote her plan down nor expressed the view that she would never under any circumstance consent to the use of the vacuum or forceps. I find that Ms. Noel expressed only her preference. I accept that she wanted to have a spontaneous vaginal delivery and that she did not want either the vacuum or the forceps to be used. Moreover, Ms. Noel expressed this preference to Dr. Allen at approximately week 36, before there were any circumstances of her labour that could cause her reconsider her preferences with the benefit of medical advice.

[357] I do not accept the plaintiffs' submission that Dr. Allen attempted "to explain away" the failure to record the conversation or Ms. Noel's preference in the chart. Dr. Allen's explanation was internally coherent and reasonable. There are undoubtedly many unremarkable conversations between a doctor and her patient during the antenatal period that are not recorded in the chart.

[358] I prefer Dr. Davies opinion that Dr. Allen met the standard of care to Dr. Shone's testimony that she did not. As noted above, it is difficult for me to reconcile Dr. Shone's written opinion that Dr. Allen's care and management during the antenatal period was appropriate with his testimony that Dr. Allen breached the standard of care by failing to record Ms. Noel's preferences.

[359] Moreover, Dr. Shone referred to no literature, professional guidelines, or standards that state that a patient's preferences must be recorded in the medical record. It makes sense that if a patient expressed a categorical and inflexible opposition to the use of the vacuum or forceps that the doctor would engage in further conversations with the patient and record the patient's refusal. The failure to record such a categorical refusal should be recorded in the medical record and the failure to do so might well breach the standard of care.

[360] In this case, however, I do not find that Dr. Allen breached the standard of care by failing to record the preference expressed by Ms. Noel.

C. Dr. Hawrylyshyn's decision not to recommend a Caesarean section at 1700h

[361] The plaintiffs submit that Dr. Hawrylyshyn breached the standard of care at 1700h when he did not recommend that Ms. Noel deliver by Caesarean section at that time. The plaintiffs rely on the opinion of Dr. Shone and submit that at 1700h, Ms. Noel was not fully dilated and was presenting with abnormal progression in labour and a Caesarean section should have been recommended. I disagree.

[362] Ms. Noel was continuing to make progress at 1700h, she did not meet the definition of a patient with abnormal progression in labour, and the fetus showed no signs of distress. Dr. Shone's opinion is untethered from the facts of this case and the applicable guidelines and literature. I do not accept it. The plaintiffs have not proved that Dr. Hawrylyshyn breached the standard of care at 1700h when he did not recommend that Ms. Noel deliver by Caesarean section.

Dystocia and the use of synthetic oxytocin

[363] Abnormal progression in labour is called dystocia. In 1995, the SOGC observed that Canada had the second highest rate of deliveries by Caesarean section in the Western developed world. This caused the SOGC to develop plans to assist physicians to reduce the rate of delivery by Caesarean section. In the 2004 ALARM course syllabus, the SOGC noted the connection between the appropriate management of dystocia and reducing the number of Caesarean sections:

> Over the past few decades, there has been a dramatic increase in the number of Caesarean sections being performed. Caesarean section is associated with increased maternal morbidity and mortality, increased neonatal morbidity, and increased healthcare costs. Dystocia and elective repeat Caesarean sections account for the majority of sections. Clearly, the optimal progress of labour and appropriate management of dystocia if it occurs, could potentially lead to a significant reduction in the number Caesarean section rate.

[364] For the purposes of this case, there are two relevant stages of labour. The 'first stage (active phase)' is understood to be the presence of regular painful contractions leading to cervical dilation after 3-4 cm in women who have not previously given birth. The second stage of

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labour is runs from the full dilation of the cervix to delivery. Ms. Noel was in the first stage (active phase) of labour by 0940h and remained in that phase until 1840h. Ms. Noel was in the second stage of labour from 1840h until she delivered at 1953h.

[365] The SOGC ALARM course syllabus state that dystocia is:

a. more than 4 hours of less than 0.5 cm/hr dilatation in the first stage (active phase); or

b. more than 1 hour with no descent during active pushing in the second stage.

[366] Ms. Noel never experienced dystocia in the second stage of labour because she was only actively pushing for about 15 minutes before the nurses identified the decelerations in fetal heart rate.

[367] According to the SOGC ALARM course syllabus, oxytocin is indicated where a patient does not make satisfactory progress in the active phase of labour. The SOGC policy statement on Dystocia states that women who experience “arrest of dilatation over a two-hour period” may required an oxytocin infusion. The SOGC ALARM course syllabus notes that protocols for the administration of oxytocin vary but suggest starting with a low dose and small increments at intervals of 30 minutes and states that “it is important to allow adequate time for oxytocin to work.” The SOGC Dystocia Policy states that it may take two to three hours to achieve a therapeutic concentration followed by a further period of observation:

> Once the decision has been made to intervene medically for dystocia, adequate time must be allowed to observe a response to treatment. Depending on the starting dose and rate of increase of oxytocin, two to three hours may be needed to achieve therapeutic concentrations in maternal serum and a further period of observation is required to observe a response.

<u>Facts</u>

[368] Many of the facts related to Ms. Noel’s care are set out above in paragraphs [94] to [115] and paragraphs [232] to [239] For the purposes of the plaintiffs’ submissions regarding Dr. Hawrylyshyn’s failure at 1700h to recommend a Caesarean section, I have set out the key facts in the following chart:

Time	Dilation of cervix (cm)	Notes
0940	6.0	Dr. Hawrylyshyn visits Ms. Noel for the first time
1100	7.0	
1200	9.0	Fetus at station -1
1330	9.0	Scalp pH 7.36

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Time	Dilation of cervix (cm)	Notes
1400	9.0	Oxytocin started at 1mU/min
1515	9.0	Oxytocin continued at 2mU/min
1515	9.0	Ultrasound completed
1540	9.0	Hypertonic uterine contractions; oxytocin shut off
1615	9.0	Oxytocin restarted at 2mU/min
1700	9.5	Oxytocin infusion at 2mU/min; Fetus at station 0;
1710	9.5	Scalp pH 7.32
1715	9.5	Dr. Hawrylyshyn notes labour is progressing
1730	9.5	Oxytocin increased to 4 mU/min
1840	10.0	Pushing begins

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Expert evidence

[369] Dr. Shone, the expert obstetrician called by the plaintiffs, testified that Ms. Noel presented with an arrested labour by 1700h and Dr. Hawrylyshyn should have recommended a Caesarean section to Ms. Noel at this time. Dr. Shone testified that Ms. Noel was in arrested labour because at 1700h there had been five hours with “no change.” Dr. Shone was incorrect. Ms. Noel’s cervix had dilated 0.5 cm and the fetus had descended 1 cm over those five hours.

[370] Moreover, Dr. Shone’s reference to a five-hour window was also not correct Dr. Hawrylyshyn started a treatment of synthetic oxytocin for Ms. Noel at 1400h. This treatment was to address the fact that Ms. Noel’s cervix had not dilated further than 9.0 cm since 1200h. As set out in the SOGC Dystocia policy, since Ms. Noel was experiencing an arrest of dilation over a two-hour period, commencing oxytocin was an appropriate treatment.

[371] Dr. Shone agreed on cross-examination that the clock started again once the synthetic oxytocin was started at 1400h. Nevertheless, he opined that Ms. Noel had not made adequate progress over the two hours between 1500h and 1700h and that a Caesarean section should have been recommended at 1700h.

[372] However, because Ms. Noel experienced hypertonic uterine contractions, Dr. Hawrylyshyn stopped the synthetic oxytocin treatment at 1540h. There is no dispute that this was the appropriate response to hypertonic uterine contractions. The medical team restarted the synthetic oxytocin 35 minutes later, at 1615h. Therefore, the three-hour window described in the SOGC Dystocia policy would be reached at approximately 1730h, after which there would need to be a further opportunity to observe the progress of labour.

[373] Dr. Davies, the expert obstetrician called by the defendants, testified that in 2005 the standard of care required doctors to follow the SOGC Dystocia Policy and the ALARM course syllabus. In Dr. Davies’ opinion, Ms. Noel was not in arrested labour at 1700h applying the standards articulated by the SOGC. In Dr. Davies’ opinion, the three-hour

window for measuring the progress of Ms. Noel's labour opened at 1400h, when the synthetic oxytocin treatment started, and it needed to be extended to recognize that the medical team stopped the synthetic oxytocin treatment for the 35 minutes.

[374] In Dr. Davies' opinion, Ms. Noel was making real progress in her labour at 1700h. Her cervix had dilated a further 0.5 cm to 9.5 cm and the fetus had descended to station 0. In Dr. Davies' opinion, Ms. Noel's cervix continued to dilate, the fetal head was descending, and the reassuring pH test at 1710h showed that the fetus was tolerating labour very well and could do so for several more hours. Given these three factors, Dr. Davies concluded that there was no clinical basis to recommend a Caesarean section at 1700h.

[375] I prefer the evidence of Dr. Davies to that of Dr. Shone on this issue. I do not accept Dr. Shone's conclusion that Ms. Noel demonstrated an arrested labour at 1700h. The SOGC Dystocia policy states that it takes "two to three hours" to achieve a therapeutic dose of oxytocin in maternal serum, plus an additional time for observation. Therefore, it would be premature to conclude, as Dr. Shone did, that Ms. Noel's labour was arrested at 1700h. Dr. Shone's conclusion inconsistent with the SOGC Dystocia policy the SOGC ALARM course syllabus. Dr. Shone's opinion is personal to him, idiosyncratic, and does not reflect the standard of care in Ontario in 2005.[72] I can find no support for Dr. Shone's opinion in any of the authoritative literature discussed by the experts. Moreover, it appears that Dr. Shone's approach would lead to an increased number of deliveries by Caesarean section, which seems to be at odds with the goals of the SOGC.

[376] I find that Dr. Hawrylyshyn did not breach the standard of care at 1700h when he did not recommend a Caesarean section. I find that the clinical circumstances did not require such a recommendation. Dr. Hawrylyshyn exercised reasonable professional judgment in not making such a recommendation. In my view, it is only with hindsight that one could suggest that Dr. Hawrylyshyn ought to have recommended to Ms. Noel that she undergo a Caesarean section at 1700h. Such a recommendation would have been inconsistent with the SOGC Dystocia Policy and the ALARM Course syllabus. Recommending a Caesarean section at 1700h would not have reflected the significant risks delivery by Caesarean section poses for the patient and the fetus.

[377] Dr. Shone also testified that he believed that Dr. Hawrylyshyn should have discussed the possibility of a Caesarean section with Ms. Noel at 1700h to obtain her informed consent to continue to labour or for her to choose a Caesarean section.

[378] I will not repeat, but rely on the facts described above in paragraphs [110] to [114], and [238]. I accept the evidence of Dr. Hawrylyshyn that he did discuss the possibility of a Caesarean section with Ms. Noel at 1700h and that after the discussion, Ms. Noel decided that she wanted to continue to labour toward a vaginal birth. Ms. Noel had no recollection

[72] *Fortune-Ozoike*, at para. 82; *Bafaro* at para. 36.

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of this conversation, but she denied that Dr. Hawrylyshyn provided her with the option of a Caesarean section.

[379] I prefer the specific recollection of Dr. Hawrylyshyn to the evidence of Ms. Noel. I recognize that there is no note in either the doctor's handwritten notes or the nursing notes to indicate that there was a discussion of the possibility of a Caesarean section. The absence of such a note caused me to consider carefully whether there was any evidence consistent with Dr. Hawrylyshyn's recollection. In my view, there are two types of evidence that are more consistent with Dr. Hawrylyshyn's evidence than Ms. Noel's evidence.

[380] First, Dr. Hawrylyshyn's operative note addresses the conversation he had with Ms. Noel at 1700h. It reads as follows:

> [Ms. Noel] was seen by myself and Dr. Ko at about 1500 hours and then reassessed again about 1700 hours. At this time, she was now anterior lip. The presenting part had descended to station 0. A second scalp pH was taken, which was reported as 7.32. In discussion with the patient, again it was emphasized to her that she had progressed on the [synthetic oxytocin]. It was hoped that within an hour or two she would be fully dilated and be able to start pushing.

[381] This note is strong support for Dr. Hawrylyshyn's evidence that he had a conversation with Ms. Noel at 1700h. Ms. Noel had no recollection of this conversation at all. I have no doubt that such a conversation took place. Accordingly, I think that Ms. Noel is incorrect (if she was submitting that no such conversation took place) or, at a minimum, that an important conversation took place of which she has absolutely no memory. I am not persuaded by Ms. Noel's testimony about what Dr. Hawrylyshyn did or did not say during a conversation that she does not recall.

[382] In addition, the operative note demonstrates that the conversation was about Ms. Noel's progress in labour as it referenced continued dilation of Ms. Noel's cervix, the descent of fetal head, and the reassuring scalp pH. Indeed, the note indicates that that Dr. Hawrylyshyn "emphasized" to Ms. Noel that she was making progress toward full dilatation and that she would hopefully be able to begin pushing in an hour or two. In my view, this note supports Dr. Hawrylyshyn's testimony that he discussed the option of a Caesarean section with Ms. Noel. The note would have been firmer support, of course, if it mentioned the option of a Caesarean section. However, this discussion took place after the earlier discussions about the range of delivery options, including the Caesarean section that took place at 1230h and 1330h. Because Ms. Noel's cervix was not yet fully dilated, the only delivery options available were to continue to labour towards a spontaneous vaginal delivery or to deliver by Caesarean section. In my view, the emphasis on Ms. Noel's progress toward a vaginal delivery (which was her preference) is best understood as part of a discussion that included the only other option available at that time, which was a Caesarean section.

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[383] This note must also be read alongside Dr. Ko's earlier note at 1515h, which recorded the observation that there could be a "possible Caesarean section if no descent." Dr. Ko's operative note records his advice at 1700h to Ms. Noel that the fetal head was descending and his own note in the medical record at 1715h that that the fetal head had descended and that he would reassess in one hour. This reassessment would necessarily be among the only two delivery options available: continued labour and Caesarean section. All of these records are consistent with Dr. Hawrylyshyn's evidence.

[384] In conclusion, I accept Dr. Hawrylyshyn's testimony that he did discuss the possibility of a Caesarean section delivery with Ms. Noel at 1700h.

[385] The plaintiffs have not proved that Dr. Hawrylyshyn breached the standard of care at 1700h when he did not recommend that Ms. Noel deliver by Caesarean section at that time.

D. Dr. Hawrylyshyn's decision to attempt a vacuum-assisted delivery

Introduction

[386] The plaintiffs submit that Dr. Hawrylyshyn breached the standard of care by recommending a vacuum-assisted delivery to Ms. Noel and then applying the vacuum at 1910h. In their written submissions, the plaintiffs put it this way: "Dr. Hawrylyshyn's use of a vacuum was inappropriate and should never have been offered or used at that stage at all."[73]

[387] The plaintiffs agree that there was an urgent need to ensure a prompt delivery of the fetus due to the risk of hypoxia. However, they submit that because the fetal head was in the pelvis, and the head was rotated in the left occipital transverse position, attempting a vacuum-assisted delivery breached the standard of care.

[388] Dr. Shone, the expert obstetrician called by the plaintiffs, testified that the SOGC guidelines for operative vaginal birth identified two relative contraindications for vacuum delivery on these facts: rotation greater than 45 degrees from either occiput anterior position; and that the fetus was +1 cm (in a mid-pelvic station). Dr. Shone testified that the vacuum is not used for rotation (forceps are used for rotation) and that the vacuum is used to bring the baby down the birth canal. Dr. Shone testified that Dr. Hawrylyshyn breached the standard of care by recommending and attempting a vacuum-assisted delivery that carried a low probability of success because the fetus was in mid-pelvic station and the vacuum was not designed to rotate the baby and thus carried increased risk of failure.

[389] The plaintiffs submit that because of the relative contraindications, and the need to ensure a prompt delivery, Dr. Hawrylyshyn breached the standard of care by using the vacuum.

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[73] Plaintiffs's submissions at p. 79, para. 207 [emphasis in original removed].

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They submit that Dr. Hawrylyshyn cannot meet the standard of care simply by relying on his experience as the reason he made that treatment decision.

[390] For the reasons that follow, I do not accept the plaintiffs' submission. I prefer the evidence of Dr. Davies, who opined that applying the vacuum in these circumstances was within the standard of care, consistent with the applicable guidelines, and a widely accepted practice in Canada.

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The 2004 SOGC operative vaginal birth guidelines: absolute and relative contraindications

[391] All parties agree that the 2004 SOGC operative vaginal birth guidelines provided authoritative guidance to Dr. Hawrylyshyn at the time of Ms. Noel's labour and delivery. The SOGC guidelines list "non-reassuring fetal status" as one of the indications for an operative vaginal birth (defined to include both vacuum and forceps-assisted vaginal births). As Dr. Davies testified, all of the prerequisites for operative vaginal birth were present in this case, including that Ms. Noel's cervix was fully dilated, the head was fully engaged in the pelvis (here, the fetal head was at station +1).

[392] The SOGC guidelines do not prohibit the use of a vacuum in the circumstances of this case. The SOGC guidelines list five absolute contraindications to operative vaginal birth:

a. Non-vertex or brow;

b. Unengaged head;

c. Incomplete cervix dilation;

d. Clinical evidence of cephalopelvic disproportion; and

e. Fetal coagulopathy.

[393] The experts agreed that an obstetrician was not permitted to attempt an operative vaginal birth in the presence of even a single absolute contraindication. Any such attempt would not meet the standard of care. In this case, however, no absolute contraindications were present.

[394] Ms. Noel's case did present two relative contraindications. There was nothing in the guidelines, or in any of the other authoritative literature presented at trial, that suggested that the presence of two relative contraindications prohibited an attempted operative vaginal birth. Instead, the presence of one or more relative contraindications simply meant, in the words of Dr. Shone, that there was a condition present that required extra caution and consideration to be taken.

[395] The first relative contraindication was that the fetal head was at the mid-pelvic station (station +1).

[396] Dr. Shone testified that the vacuum was not an appropriate delivery option because at 1900h, Ms. Noel was experiencing a "mid-pelvic transverse arrest." She was not. At 1900h, Ms. Noel had only been pushing for 20 minutes. The SOGC Dystocia policy states that two hours has traditionally been considered the upper limit for the duration of the second stage of labour. Arrest in the second stage is determined if the presenting part of the fetus's skull fails to descend. In the part of the SOGC ALARM course syllabus dealing with management of labour, dystocia is defined to mean more than one hour with no descent during active pushing in the second stage.

[397] Dr. Shone's error is significant. This mischaracterization of the clinical setting that faced Dr. Hawrylyshyn and Ms. Noel causes me to have grave concerns about whether I can rely on his opinion. A clinician facing a situation where a patient has been pushing for over an hour or two with no descent and a fetus in the left occipital transverse position might well make a very different clinical judgment than Dr. Hawrylyshyn made in the situation he actually faced. In any event, Dr. Shone's opinion is predicated on a different clinical situation than the one presented by Ms. Noel.

[398] As Dr. Davies testified, there is nothing in the SOGC guidelines, or any of the other authoritative literature, to suggest that an obstetrician should not attempt a vacuum-assisted delivery for a fetus at station +1.

[399] The second relative contraindication was that the fetus's head was in the occiput transverse position. The guidelines list "rotation >45º from occiput anterior or occiput posterior (vacuum)" as a relative, not an absolute contraindication for both vacuum and forceps-assisted operative vaginal deliveries. Dr. Shone, however, testified that he believed it to be an absolute contradiction. On cross-examination, Dr. Shone conceded that his opinion was not consistent with the SOGC guidelines:

> Q. Your opinion is outside the guideline, because what you're essentially saying is that to use a vacuum on an occiput transverse head is an absolute contraindication, that's your opinion?
>
> A. Yes.
>
> Q. And that's not what the SOGC guideline says, it says it's a relative contraindication, right?
>
> A. Yes.
>
> …
>
> Q. Okay…. . The literature that you referenced in your second report, I've read it all and there's nothing -- there's no statement in any of those articles or guidelines that states that a vacuum should not be used on an occiput transverse head. Do you agree?

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A. Agree.

[400] Dr. Shone's admissions are troubling. He concedes that his opinion is inconsistent with the authoritative guideline. Dr. Shone admits that there is no support for his opinion in any of the articles or guidelines that he cited in his report. In addition, Dr. Shone's opinion is difficult to reconcile with the clinical practices described in the academic literature in the record. The Baskett study considered 1,000 vacuum assisted deliveries between 2002 and 2005 at a Canadian tertiary care hospital.[74] Of the total, 700 deliveries involved women (like Ms. Noel) who had not delivered previously. In 27 of those deliveries, the fetal head was in the occiput transverse position when the vacuum was first applied. There is nothing in the article to suggest that the authors were surprised by the application of the vacuum to a fetal head in the occiput transverse position or that the use of that technique was contrary to the standard of practice.

[401] In addition, while there is no dispute that physicians should not rotate the fetus's head with the vacuum, Dr. Shone's opinion did not reflect the reality that shape of the pelvis and the musculature of the patient may well cause the fetal head to rotate naturally as it descends the birth canal. This is reflected in the SOGC ALARM course syllabus that states that while "no rotational force is applied [with the vacuum] but the fetal head may rotate on its own with descent." The Baskett study concluded that the fetal head rotated from the occiput transverse to the preferred occiput anterior position in 97.3% of vacuum-assisted deliveries.

[402] Dr. Davies testified that it is within the standard of care to use a vacuum on a head in the occiput transverse position and that a practitioner would expect the head to rotate naturally through passive rotation. This opinion was well-supported by the authoritative guidelines and literature before the court. I prefer the evidence of Dr. Davies on this point.

[403] I find that Dr. Shone's opinion that the vacuum may never be used when the fetus would need to rotate by more than 45º is an idiosyncratic preference that finds no support in the literature before the court. Such a preference cannot define the standard of care.

Dr. Hawrylyshyn did not breach the standard of care

[404] I accept the opinion of Dr. Davies that Dr. Hawrylyshyn's recommendation of a vacuum-assisted delivery was a reasonable exercise of professional judgment.

[405] First, Dr. Hawrylyshyn testified that, in his opinion, a successful vacuum delivery would be the fastest way to deliver the fetus. Dr. Davies testified that that an experienced obstetrician is well positioned to make that assessment in light of the clinical circumstances. On the facts, Dr. Hawrylyshyn appears to have been correct. The vacuum was applied at 1910h. If it had been successful, the delivery would have been completed in about ten minutes, at 1920h. In contrast, it took 22 minutes from the time of the decision

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[74] Thomas F. Baskett, Cora A. Fanning & David C. Yount, "A Prospective Observational Study of 1000 Vacuum Assisted Deliveries with the OmniCup Device," 30:7 J Obstetric Gynaecology Can (2008) 573-580.

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to proceed with a Caesarean section to delivery. I do not accept the plaintiffs' submission, therefore, that there were no indicators that favoured the use of the vacuum.

[406] Second, the ACOG guidelines indicate that "operator experience should determine which instrument should be used in a particular situation." Dr. Hawrylyshyn had a great deal of confidence in his ability to achieve a successful delivery with the vacuum. He testified that he had successfully delivered many babies in similar clinical circumstances, and he believed there was an 80 to 90% chance of a successful vacuum-assisted delivery in Ms. Noel's case.

[407] I do not accept the plaintiffs' submission that the vacuum carried the lowest probability of success in these circumstances. There was no data presented to demonstrate that Dr. Hawrylyshyn's assessment of the expected outcome was unreasonable. The Beckett study indicated that 84.7% of the attempts at vacuum-assisted delivery resulted in a successful delivery. As noted above, there was a very high success rate (97.3%) in having the fetal head rotate naturally from the occiput transverse to the occiput anterior position. I do not accept the plaintiffs' submission that a forceps-assisted delivery or delivery by Caesarean section were the only, or even the most appropriate options to achieve as fast a delivery as possible. The risks associated with a forceps-assisted delivery are canvassed above and the evidence confirmed that there was no guarantee that the forceps would be successful. I do not accept the plaintiffs' submission that the likelihood of success with an attempted vacuum-assisted delivery was low. That submission is not grounded in the evidence before the court and, in my view, impermissibly relies on hindsight now that we know the outcome of that attempt.

[408] This is not a case, like *MacGregor v. Potts*.[75] In that case, the court rejected the submission that the defendant doctor exercised clinical judgment because the defendant did not inform himself of the facts that he needed to know in order to exercise his judgment to apply the forceps during a delivery. The plaintiffs have not identified any facts that Dr. Hawrylyshyn should have known, but did not know, before he exercised his judgment. I find that Dr. Hawrylyshyn was fully informed of all material and relevant facts before he exercised his clinical judgment to recommend the use of the vacuum. I do not accept that Dr. Hawrylyshyn's exercise of clinical judgment was, in the words of *MacGregor*, "guesswork based on limited facts." That submission does not reflect the careful and attentive care that Dr. Hawrylyshyn provided to Ms. Noel over the course of her labour.

[409] I will address Dr. Hawrylyshyn's actual application of the vacuum below at paragraphs [431] to [435].

[410] I conclude that the plaintiffs did not prove that Dr. Hawrylyshyn breached the standard of care in recommending and using the vacuum. I find that he complied with the applicable guidelines and exercised sound judgment when he recommended to Ms. Noel that he

[75] 2009 CarswellOnt 5077, aff'd 2012 ONCA 226.

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attempt to deliver the fetus with the assistance of the vacuum. In these clinical circumstances and balancing the need for a speedy delivery with the relative risks to the fetus and Ms. Noel, Dr. Hawrylyshyn's decision met the standard of care.

E. Dr. Hawrylyshyn's decision to attempt to use forceps after the vacuum

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[411] The plaintiffs submit that Dr. Hawrylyshyn breached the standard of care by attempting a forceps-assisted delivery after an unsuccessful attempted vacuum-assisted delivery. The plaintiffs rely on the opinion of Dr. Shone, the expert obstetrician called by the plaintiffs, who testified that, by 2005, the profession knew about the increased risks to the fetus associated with a combination or sequential use of instruments and the standard of care prohibited their use. I do not accept the opinion of Dr. Shone because it contradicted by and inconsistent with the authoritative guidelines and practices in place at that time.

[412] The SOGC guidelines for operative birth contemplate that there will be clinical circumstances where it is appropriate to use the vacuum and the forceps in sequence. For example, the SOGC guidelines on recommendations contains the following:

> 5. Failure of the chosen method, vacuum and/or forceps, to achieve delivery of the fetus in a reasonable time should be considered an indication for abandonment of the method.

[413] The guidelines, therefore, explicitly address situations where both the vacuum and the forceps might be used in sequence. The guidelines state that doctors must anticipate and plan for the potential failure:

> Most operative deliveries, including the application of a vacuum, should be considered a trial. Unless the practitioner is certain that an operative vaginal delivery is going to be successful, the possibility of failure needs to be anticipated. In these circumstances, an alternative plan that will result in a safe and expeditious birth must be in place and implemented promptly if the planned operative birth is unsuccessful.

[414] Similarly, the ACOG practice bulletin on operative vaginal delivery acknowledges the increased risks associated with using different instruments in an operative vaginal delivery, but allows that it may be appropriate in certain clinical circumstances:

> Although studies are limited, the weight of available evidence appears to be against attempting multiple efforts at operative vaginal delivery with different instruments, unless there is a compelling and justifiable reason. The [Towner] study reported that the incidence of intracranial hemorrhage was highest in infants delivered by combined vacuum and forceps compared with other reported

> methods of delivery. The incidences of other injuries also were increased with combined methods of operative vaginal delivery.[76]

[415] The Baskett article also suggests that between 2002 and 2005, obstetricians at a tertiary care centre in Halifax continued to use forceps following a failed attempt to use a vacuum. In the 700 cases involving a woman who had not previously given birth and where a vacuum was applied, the forceps were then applied 11.8% of the time.[77] There is nothing in the Baskett article to suggest that this practice fell below the standard of care. Dr. Hawrylyshyn also testified that this was an accepted practice at the hospital when it was clinically indicated.

[416] The SOGC ALARM course syllabus also recognized that obstetricians should "pause for thought" before applying forceps following an unsuccessful attempt at a vacuum-assisted operative delivery. Referencing the Towner study, the SOGC ALARM course syllabus stated:

> PAUSE FOR THOUGHT:
>
> In light of the data presented above, the widely accepted practice of using the vacuum extractor to move the fetal vertex from the mid pelvis to the low pelvis and then applying forceps to complete the delivery if the vacuum is unsuccessful must be re-evaluated. A recent committee opinion supports the above statement.

[417] Even Dr. Shone admitted on cross-examination that none of the academic and authoritative sources he cited in his opinion, even those that referenced the Towner study, states that sequential instruments should not be used. The Towner study itself did not conclude that sequential use of vacuum and forceps should be banned.

[418] Dr. Davies, the expert obstetrician called by the defendants, testified that the standard of care in 2005 did not prohibit the sequential use of the vacuum and forceps. He testified that after the Towner study, the standard of care required doctors to consider carefully whether to proceed to use a second instrument, but that neither the Towner study nor any guideline post-dating the Towner study categorically prohibited a trial of forceps after an unsuccessful attempt to deliver with the assistance of a vacuum.

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[76] Internal citations omitted.

[77] Another article stated that "after a failed vacuum extraction, delivery is usually by forceps." See Richard Johanson & Vijay Menon, "Vacuum extraction versus forceps for assisted vaginal delivery" 2 *Cochrane Database of Systematic Reviews* (2000) CD000224. This article was withdrawn in 2010 (after the events in this case) and replaced by an updated article: Fidelma O'Mahony, G. Justus Hofmeyr & Vijay Menon, "Choice of instruments for assisted vaginal delivery" 11 *Cochrane Database of Systematic Reviews* (2010 November) CD005455.

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[419] It was certainly open to ACOG or SOGC, with the benefit of the Towner study, to prohibit the use of forceps after an unsuccessful attempt at a vacuum-assisted delivery. They did not do so. Dr. Shone agreed on cross-examination that such a rule would be imprudent:

> Q. Dr. Shone, just to finish off that discussion about the sequential instrument, use of sequential instruments. I'm going to suggest to you that it wouldn't be prudent, and the reason we don't see in the literature any statement prohibiting the use of sequential instruments, is because you wouldn't want to tie the hands of the obstetrician who might themselves in the clinical situation in which a vacuum fails and in their judgment the best, safest method to complete the delivery is to use forceps?
>
> A. Correct.
>
> Q. And there would be circumstances in which that would occur where that would present itself as the -- probably the safest and fastest route to delivery?
>
> A. Correct.
>
> Q. And in that situation when – if a vacuum delivery is attempted and fails, at that point the operator has to balance the risks of using the second instrument as against the risks of doing a Caesarean section following a failed vacuum, right?
>
> A. Correct.

[420] I find that this exchange significantly undermines Dr. Shone's opinion that the increased risks to the fetus associated with "a combination or sequential use of instruments, is such that it reaffirmed the change in practice to not have sequential use of instruments for delivery."

[421] I prefer the evidence of Dr. Davies, which was consistent the authoritative literature and guidelines. He testified that given the incremental risk of intracranial hemorrhage if more than one of the vacuum and forceps were utilized in a delivery, a doctor should carefully consider whether the clinical circumstances indicate that it is appropriate to attempt a trial of forceps after the vacuum failed.

[422] I accept the evidence of Dr. Davies that the incremental risks of intracranial bleeding arising from using both a vacuum and forceps were not so significant as to outweigh in every case the benefits that could flow from a successful sequential application of those instruments.

[423] The plaintiffs submit that Dr. Hawrylyshyn breached the standard of care by deciding to proceed with a trial of forceps after the failed vacuum. I disagree. Dr. Hawrylyshyn testified

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that if the vacuum failed, it was his standard practice to reassess the situation and determine whether it would be appropriate to proceed to a trial of forceps. He stated that it was not automatic to move to the forceps and if that treatment was not appropriate, he would move to a delivery by Caesarean section.

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[424] In this case, Dr. Hawrylyshyn did not automatically or unthinkingly move to the forceps without considering carefully the clinical situation and the incremental risks, which might well have breached the standard of care. Instead, he requested that Dr. Okun attend the delivery room to give him the benefit of a second opinion. Recall that Dr. Okun was the lead obstetrician on Team B, which was the high-risk obstetrical team. Dr. Okun testified that in her opinion a trial of forceps was appropriate and would offer the most expedited method of delivering the fetus as quickly and as safely as possible given the clinical circumstances.

[425] Two experienced obstetrical colleagues at a renowned tertiary care hospital assessed the clinical circumstances and concluded independently, and in the exercise of their best clinical judgment, cognizant of all the risks and benefits, that proceeding with a trial of forceps was the approach that gave the best chance of a speedy and safe delivery. I do not accept the plaintiffs' submission that proceeding directly to a Caesarean section at this time was necessary to meet the standard of care. I find that Dr. Hawrylyshyn did not breach the standard of care when he recommended or attempted to apply the forceps following the unsuccessful attempt at a vacuum-assisted delivery.

[426] Finally, Dr. Shone testified that Dr. Hawrylyshyn fell below the standard of care by not moving Ms. Noel to the operating room before attempting to apply the vacuum and forceps. The plaintiffs did not press this point in their closing submissions. For completeness, I do not accept Dr. Shone's opinion.

[427] Dr. Hawrylyshyn had direct access to a fully staffed operating room that was only steps away from the delivery room. Unlike many hospitals, Dr. Hawrylyshyn and Dr. Okun had the benefit of dedicated anesthesiologists and trained nurses standing by in the event there was the need for a Caesarean section. Dr. Shone appeared to set the bar much higher than the SOGC guidelines, which only required that the ability to do a Caesarean section be immediately available. This may reflect Dr. Shone's personal practice experience. He had only two months of experience at a tertiary hospital like Mount Sinai. His evidence may have been informed by his experience at a regional hospital that lacked the extensive and on-demand surgical facilities available at Mount Sinai.

[428] I prefer the evidence of Dr. Davies who testified that it was within the standard of care to apply the vacuum and forceps in the labour room. His opinion is supported by SOGC guidelines as well as the standard practice both at his tertiary care hospital as well as Mount Sinai.

[429] I find that the plaintiffs did not prove on a balance of probabilities that Dr. Hawrylyshyn breached the standard of care by attempting a forceps-assisted delivery after an unsuccessful attempted vacuum-assisted delivery.

F. Dr. Hawrylyshyn's application of vacuum and forceps

[430] The plaintiffs' challenge to Dr. Hawrylyshyn's use of the vacuum and the forceps is focussed on his decision to use those instruments and to use them sequentially. I have addressed the plaintiffs' submissions on those points in the sections above. For completeness, I also find that the plaintiffs have not proved that Dr. Hawrylyshyn breached the standard of care in his application of the vacuum and forceps.

<u>The application of the vacuum</u>

[431] Dr. Hawrylyshyn testified that he applied the vacuum to the fetal skull over a period of no more than 10 minutes. He testified that he used the vacuum to pull three times over three consecutive contractions and observed descent with each pull. He testified that he stopped using the vacuum despite the fetal descent because the head was not rotating naturally, and he was concerned the delivery might not be completed in time. His testimony was consistent with his operative note, which read as follows:

> The vacuum was carefully applied at 1910. Its position was rechecked. It was clear of any cervix or vaginal tissue. The presenting part was in the LOT position, again at spines +1. The pressures were checked and kept at under 500 mmHg. During the next three contractions, traction was applied. There was descent of the presenting part such that it appeared to be crowning or at +2. Despite encouraging the patient to push, it was not possible to get the presenting part to come any lower. At this part the vacuum was removed (at 1920) after 10 minutes, and a second opinion was obtained from Dr. Okun.

[432] Dr. Davies, the obstetrical expert called by the defendants, testified that Dr. Hawrylyshyn performed the attempted vacuum-assisted vaginal delivery within the parameters laid out within the SOGC guideline. Dr. Davies noted that the SOGC identified that a doctor should not pull more than four times over four contractions and that it should not be used for more than 10 minutes. Dr. Davies testified that Dr. Hawrylyshyn's application of the vacuum met the standard of care.

[433] Dr. Shone, the obstetrical expert called by the plaintiffs, acknowledged that applying the vacuum for 10 minutes was within the recommended time limits. Although Dr. Shone initially took the position that more than three pulls would be outside the standard of practice, he conceded on cross-examination that the SOGC guideline on vacuum assisted delivery did not express such a standard. Ultimately, Dr. Shone agreed that Dr. Hawrylyshyn applied and used the vacuum within standard recommendations. Although

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Dr. Shone's initial testimony appeared to be critical of how Dr. Hawrylyshyn applied the vacuum, by the end of his cross-examination he appeared to accept that Dr. Hawrylyshyn used the vacuum within the standard recommendations.

[434] To the extent there was any difference left between the opinion of Dr. Shone and Dr. Davies, I accept the opinion of Dr. Davies, which was rooted in and consistent with the SOGC guidelines. I find that Dr. Hawrylyshyn applied the vacuum correctly and within the SOGC guidelines. Dr. Hawrylyshyn applied the vacuum over three contractions for a total of 10 minutes. There is no evidence to suggest that Dr. Hawrylyshyn used an improper or unsafe technique with the vacuum or that it would likely lead to harm.

[435] I find that the plaintiffs did not prove on a balance of probabilities that Dr. Hawrylyshyn's application of the vacuum fell below the standard care.

<u>The application of the forceps</u>

[436] None of the plaintiffs' experts testified that Dr. Hawrylyshyn failed to meet the standard of care in his application of the forceps to the fetal head. As I will explain below, Dr. Hawrylyshyn was unable to wander the anterior forceps blade into place and could not lock the blades together. I find that Dr. Hawrylyshyn did not apply any torsion or traction with the forceps.

[437] I find that the plaintiffs have not proved that Dr. Hawrylyshyn breached the standard of care in his application of the forceps.

G. Conclusion

[438] In conclusion, I find that the plaintiffs did not prove on a balance of probabilities that:

a. Dr. Allen's antenatal record keeping breached the standard of care;

b. Dr. Hawrylyshyn's decision at 1700h not to recommend a Caesarean section breached the standard of care;

c. Dr. Hawrylyshyn's recommendation to attempt a vacuum-assisted vaginal delivery breached the standard of care;

d. Dr. Hawrylyshyn's recommendation to attempt a forceps-assisted vaginal delivery, if the vacuum failed and it was clinically recommended breached the standard of care; and

e. Dr. Hawrylyshyn's application of the vacuum and forceps breached the standard of care.

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6. Causation: the skull and brain trauma suffered during delivery

[439] I have already found that none of Dr. Allen, Dr. Hawrylyshyn, or Dr. Okun breached the standard of care. In case I am wrong, in this section I will assume that their conduct breached the standard of care and determine if the plaintiffs have proved that but for the breach of the standard of care, Mr. Noel would not have suffered the neonatal injuries he suffered.

A. Legal principles

[440] The causation analysis involves two distinct inquiries: whether the defendant's breach of the standard of care was the factual cause of the plaintiffs' loss and, in addition, the legal cause of the loss.[78]

Factual causation: the "but for" test

[441] The Supreme Court of Canada's decision in *Clements* remains the binding authority on causation in negligence cases.[79] In general, to establish factual causation, the plaintiff must prove on a balance of probabilities that without a breach of the standard of care by one or more defendants, the injury would not have occurred.[80] This is the "but for" test.

[442] Causation must be assessed in the context of a breach of the standard of care. It is necessary to identify the act or omission that breached the standard of care and determine what, if any, connection it has to the harm at issue.[81] The plaintiff must prove, therefore, that the defendant's conduct was necessary to bring about the injury.[82] The plaintiff need not prove the defendant's conduct was the only cause of the injury, but the plaintiff must prove on a balance of probabilities that the defendant's breach of the standard of care was part of the cause of her loss.[83] Chief Justice McLachlan's statement on the law of causation remains authoritative:

> The plaintiff must show on a balance of probabilities that "but for" the defendant's negligent act, the injury would not have occurred. Inherent in the phrase "but for" is the requirement that the defendant's negligence was *necessary* to bring about the injury — in other words that the injury would not have occurred without the defendant's negligence. This is a factual inquiry. If the plaintiff does

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[78] *Nelson (City) v. Marchi*, 2021 SCC 41, 463 D.L.R. (4th) 1, at paras. 96-97.
[79] *Clements v. Clements*, 2012 SCC 32, [2012] 2 S.C.R. 181; *Hasan*, at para. 14.
[80] *Clements*, at para. 8 and 37; *Donleavy v. Ultramar*, 2019 ONCA 687, at para. 62.
[81] *Chasczewski v. 528089 Ontario Inc.*, 2012 ONCA 97, at para. 15.
[82] *Clements*, at para. 8.
[83] *Athey v. Leonati*, [1996] 3 S.C.R. 458, at para. 17

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> not establish this on a balance of probabilities, having regard to all the evidence, her action against the defendant fails.[84]

[443] Causation requires a substantial connection between the injury and the defendant's conduct.[85] Causation is made out under the "but for" test if a defendant's breach of the standard of care caused the whole of the plaintiff's injury, "or contributed, in some not insubstantial or immaterial way to the injury that the plaintiff sustained."[86] Put differently, a defendant that is found to have been a cause of some harm to the plaintiff will be liable in tort. A defendant will be liable for all injuries caused or contributed to by his or her breach of the standard of care, even if other non-tortious causes are present.[87] A court that concludes that one or more defendants "materially contributed" to a plaintiff's loss is simply recognizing that the defendant's breach of the standard of care was a "but for" cause of the loss, but was not the only cause of loss.[88]

[444] The alternative, and exceptional basis on which legal causation may be established is where the defendant's act or omission "materially contributed to the plaintiff's risk of injury."[89] In *Clements*, the Supreme Court of Canada explained that the material contribution test is exceptional because it eliminates the plaintiff's need to prove factual causation:

> Exceptionally, a plaintiff may succeed by showing that the defendant's conduct materially contributed to risk of the plaintiff's injury, where (a) the plaintiff has established that her loss would not have occurred "but for" the negligence of two or more tortfeasors, each possibly in fact responsible for the loss; and (b) the plaintiff, through no fault of her own, is unable to show that any one of the possible tortfeasors in fact was the necessary or "but for" cause of her injury, because each can point to one another as the possible "but for" cause of the injury, defeating a finding of causation on a balance of probabilities against anyone.[90]

[445] In this case, I see no reason to depart from the "but for" test of causation. The mere fact that there are three defendant doctors involved in the care of Ms. Noel during the relevant times is not a reason to depart from the "but for" test of causation.[91] The "but for" test for causation remains the default test in case where there are multiple alleged tortfeasors.[92]

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[84] *Clements*, at para. 8 [emphasis in original].
[85] *Resurfice Corp. v. Hank*e, 2007 SCC 7, [2007] 1 SCR 333, at para 23.
[86] *Donleavy* at para. 72.
[87] *Donleavy*, at para. 63, citing *Athey,* at paras. 12 and 17.
[88] *Donleavy*, at para 72; *Farej* ONCA at para. 67; *Athey* at paras. 13 to 16.
[89] *Clements*, at para. 46; *Donleavy*, at para. 64.
[90] *Clements*, at para. 46.
[91] *Resurfice Corp. v. Hanke*, 2007 SCC 7, [2007] 1 S.C.R. 333, at para. 19.
[92] *Donleavy*, at para. 68.

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This is not a case where it is impossible for the plaintiffs to prove which of two or more possible tortious causes is in fact the cause of the injury.[93]

[446] I am to assess the evidence relevant to factual causation in a robust and common-sense way. Scientific proof of causation is not required, common sense inferences from the facts may suffice.[94] This approach must be applied to the evidence, and it is not a substitute for evidence to show that the breach of the standard of care caused the injury. The Court of Appeal has outlined the three-step process used to determine causation.[95] To determine causation, the court must:

a. determine what likely happened in actuality;

b. consider what would likely have happened had the defendant not breached the standard of care:

   i. if the court draws the inference from the evidence that the plaintiff would likely have been injured in any event, regardless of what the defendant did in breach of the standard of care, then the defendant did not cause the injury; or

   ii. if the court infers that the plaintiff would not have been injured without the defendant's breach of the standard of care, then the "but for" test for causation is satisfied; and

c. allocate fault among the defendants who breached the standard of care.[96]

[447] At the second stage, the court engages in a counterfactual exercise where the court attempts to isolate the defendant's actions to determine if the injury would have occurred in the absence of that conduct.[97] The authors of a leading text describe the counterfactual exercise as where the court holds:

> fixed relevant background facts, together with the fact that the plaintiff suffered the injury complained of, and then hypothetically subtract the defendant's allegedly negligent conduct from that factual matrix. If, in the counterfactual situation, the plaintiff would still have suffered the same injury, then the defendant is not a "but for" cause of the plaintiff's injury: since the injury would have happened anyway, the defendant's conduct made no difference. If,

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[93] *Donleavy*, at para. 69; *Clements* at para 43.
[94] *Clements*, at para. 38.
[95] *Sacks v. Ross*, 2017 ONCA 773, 417 D.L.R. (4th) 387, at para. 47.
[96] *Sacks*, at para. 47-48.
[97] *Hemmings v. Peng*, 2024 ONCA 318, at para. 64.

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> on the other hand, the plaintiff's injury would not have occurred in the absence of the defendant's conduct, then the defendant is said to be a "but for" cause of the plaintiff's injury. The "but for" test therefore establishes a necessary connection between the defendant's conduct and the plaintiff's injury. It shows, in other words, that what the defendant did made a difference.[98]

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Legal causation

[448] The plaintiffs must also prove that the defendants were a legal cause, or proximate cause, of their injury.[99] If the harm suffered by the plaintiff is too unrelated to the defendant's wrongful conduct to hold the defendant fairly liable, then the defendant's conduct was not the legal cause of the injury.[100]

[449] This inquiry turns on whether it was reasonably foreseeable that the defendant's conduct could cause injury to the plaintiff. There must be a real risk, not a mere possibility of harm. The Court of Appeal recently described the inquiry this way:

> In general terms, foreseeability lies at the heart of this inquiry: "it is the foresight of the reasonable man which alone can determine responsibility"… Mere possibility that the harm would occur is not sufficient: "possibility alone does not provide a meaningful standard for the application of reasonable foreseeability": *Mustapha*, at para. 13. Instead, in *Mustapha*, the Supreme Court stated the degree of probability or likelihood that would satisfy the reasonable foreseeability requirement is a "real risk", that is "one which would occur to the mind of a reasonable man in the position of the defendan[t]…and which he would not brush aside as far-fetched"….[101]

[450] Foreseeability is to be assessed in the circumstances of the particular defendant and asks if the risk of harm would occur to the mind of a reasonable person in the position of the defendant or if such a person would brush the risk aside as far-fetched.[102] What must be

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[98] Erika Chamberlain and Stephen G.A. Pitel, eds., *Fridman's The Law of Torts in Canada*, 4th ed. (Toronto: Thomson Reuters, 2020), at p. 506.
[99] *Saadati v. Moorhead*, 2017 SCC 28, [2017] 1 S.C.R. 543, at para. 20.
[100] *Mustapha*, at para. 12.
[101] *Hemmings*, at para. 67, citing *Overseas Tankship (U.K.) Ltd. v. Morts Dock & Engineering Co.*, [1961] A.C. 388 (P.C.) ("The Wagon Mound No. 1"), at p. 424, and *Overseas Tankship (U.K.) Ltd. v. Miller Steamship Co. Pty.*, [1967] A.C. 617 (P.C.) ("The Wagon Mound No. 2"), at p. 643.
[102] *Mustapha*, at para. 13; *Brenenstuhl v. Caldwell*, 2020 ABQB 315, at para. 94.

reasonably foreseeable is the type of harm, not the particular manner in which the harm occurred.[103]

[451] In medical malpractice cases, if a doctor's negligence results in the patient requiring further treatment, and this additional treatment causes injury to the patient, the first doctor will be liable for the injury if it is a reasonably foreseeable consequence of the negligence.[104]

B. The injuries suffered by Mr. Noel from birth to October 2005

[452] At 1953h on June 11, 2005, Mr. Noel was born pale, limp, with no tone, and no spontaneous movements. He was not breathing on his own and was intubated at three minutes of life. His cord blood gas results for pH were 7.17 (umbilical artery) and 7.20 (umbilical vein). He first had spontaneous respiration around ten minutes of life. His APGAR scores were 1 at one minute, 4 at five minutes, and 8 at ten minutes.

[453] Mr. Noel was not discharged from the Hospital for Sick Children until July 8, 2005.

<u>Skull and brain injuries</u>

[454] At birth, Mr. Noel was noted to have a boggy collection of blood over the right parietal-occipital area that crossed the midline. On June 12, 2005, Mr. Noel had a CT scan of his head, which was interpreted to reveal the following:

a. diffuse, bilateral cerebral edema (swelling);

b. a large subgaleal hematoma;

c. moderate subdural hematoma tracking along the tentorum (right greater than left), mild posterior fossa subdural hematoma, and mild subdural hematoma posteriorly along the falx;

d. mild subarachnoid hemorrhage in the right temporal lobe and small, partially hemorrhagic contusions in the right temporal/parietal region near the site of the parietal bone buckling.

[455] The unchallenged evidence of Dr. Levin, the expert pediatric neurologist called by the defendants, is that Mr. Noel experienced interstitial edema, which means excess fluid between the cells. This type of edema occurs when damaged blood vessels leak fluid into the space around the blood vessels and brain cells. Dr. Levin explained that Mr. Noel had widespread, interstitial edema.

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[103] *R. v. Côté et al.*, [1976] 1 S.C.R. 595, at p. 604; *Frazer v. Haukioja*, 2010 ONCA 249, 101 O.R. (3d) 528, at para. 51.

[104] *Hemmings*, at para. 68; Gerald B. Robertson and Ellen I. Picard, *Legal Liability of Doctors and Hospitals in Canada*, 5th ed. (Toronto: Thomson Reuters, 2017) at p. 363; *Jones v. Shafer*, [1948] S.C.R. 166 at pp. 170-71.

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[456] Fifty-six minutes after birth, Mr. Noel's haemoglobin was 104 g/L. Medical staff gave him a blood transfusion, which returned his haemoglobin to normal range.

[457] On June 14, 2005, the neurosurgery service noted that on examination, Mr. Noel's fontanelle was "okay."

[458] On June 17, 2005, Mr. Noel had an MRI performed on his brain. The radiology report stated:

> Impression: MRI of the brain reveals a few foci of abnormal diffusion in the right temporal lobe which represents foci of ischemia with hemorrhagic conversion or petechial hemorrhages. There is interval reduction in the size of the hemorrhage over the tentorium and posterior aspect of falx. No new focus of hemorrhage or ischemia seen. MR angiography and venography sequences are within normal limits. The hematoma seen over the right parietal scalp has decreased. Image findings were discussed with Dr. Azis from Mt. Sinai Hospital

[459] On June 18, 2005, Mr. Noel had a second CT scan of his head, which revealed the following:

> FINDINGS:
>
> Small foci of hemorrhage are once again noted in the right temporal lobe with associated perifocal edema. There is no new focus of intra or extraaxial hemorrhage. The subdural hematomas seen over the tentorium cerebelli and posterior aspect of falx cerebri has decreased compared to the last CT scan study. The scalp hematomas seen over the right frontoparietal convexity has also decreased. There is no hydrocephalus or shift of midline structures. The ventricles however seem to be more open than the last CT scan study. On the contrast enhanced images for the dural venous sinuses normal enhancement is seen in the major dural venous sinuses as well as the veins of the deep venous system. There is minimal extrinsic compression upon the sagittal sinus and the transverse sinuses by the presence of blood as mentioned above.
>
> COMMENTS:
>
> The follow up CT scan study shows no new focus of hemorrhage. Previously noted hemorrhagic foci in the right temporal lobe with minimal perifocal edema once again noted. There are no imaging findings to suggest venous thrombosis.

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[460] The neonatal follow-up program at The Hospital for Sick Children monitored Mr. Noel until December 15, 2008, when he was 3.5 years old. The program observed that he was developing at an age-appropriate level. The psychological report completed at the end of the program concluded that Mr. Noel's cognitive functioning and language skills were in the average range for his age.

Seizures

[461] Thirteen minutes after birth, Mr. Noel had seizure-like activity, which was treated with phenobarbital. He also had clinically evident seizures on June 18 and 19, 2005. The seizures were treated with phenytoin, phenobarbitone, and Lorazepam.

[462] On June 21, 2005, during an electroencephalogram, Mr. Noel was noted to be having clinical seizures but no seizure activity was observed. This was his last neonatal seizure. On June 29, 2005, phenobarbital was discontinued. Mr. Noel has not taken seizure medication since that time.

[463] In 2011, Ms. Noel observed Mr. Noel have a seizure and thought she might have seen another seizure about a year earlier. Mr. Noel was referred to a pediatric neurologist, Dr. Langburt, who saw Mr. Noel four times.[105] Although Dr. Langburt gave opinion evidence at trial, this was a clinical referral. In his consultation report dated April 18, 2011, Dr. Langburt reported the following impression:

> Impression: Seizures, unprovoked, x 2 . These were separated in time by 1 1/4 years. Given the remote history of damage to the right frontal or temporal region, this is likely the cause. Despite the neonatal history, this development is excellent although he has 'emotional immaturity'.

[464] Dr. Langburt ordered an electroencephalogram for Mr. Noel, which took place on June 20, 2011. During the electroencephalogram, Mr. Noel was observed to have a 15-minutee electroclinical seizure. This was the last time Mr. Noel had a known or reported seizure.

[465] Dr. Langburt interpreted the results to indicate focal epilepsy, likely secondary to remote damage sustained perinatally. Ms. Noel declined the antiepileptic treatment for Mr. Noel recommended by Dr. Langburt.

[466] Dr. Langburt ordered an MRI, which took place on January 18, 2012. The report made the following findings:

> FINDINGS: There is bilateral symmetrical patchy increased signal intensity in the posterior periventricular white matter of a non-

[105] Dr. Langburt prepared consultation reports dated April 18, 2011, July 25, 2011, December 5, 2011, and February 13, 2012.

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> specific appearance. There is no evidence of a posterior fossa or supratentorial mass lesion or evidence of mass effect noted, There are no areas of restricted diffusion. No susceptibility artifact on the MPGR sequence to suggest hemosiderin. The hippocampi are symmetric in size and signal intensity. The ventricles, sulei and cisternal spaces are within normal limits.
>
> IMPRESSION: Non-specific peritrigonal white matter hyperintensities as described above. Otherwise normal study.

[467] In his final consulting report, dated February 13, 2012, Dr. Langburt confirmed that the results of the 2012 MRI were "normal – except some peritrigonal changes increase signal." Under the heading, impression, Dr. Langburt wrote:

> 1. Focal Epilepsy, left hemispheric likely secondary to remote damage sustained perinatally. Mom did not initiate medications, but no recurrent seizures. MRI shows no new changes.
>
> 2. Academic issues- I did briefly discuss pros/cons of stimulants; will defer to you.

Respiratory difficulties

[468] On June 26, 2005, Mr. Noel was extubated, suffered respiratory distress, and was reintubated. One of his intubations appears to have caused significant damage and his breathing difficulty continued over time. The plaintiffs did not assert that any of the intubations or extubations were themselves negligently performed.

[469] On June 29, 2005, Mr. Noel underwent a micro laryngoscopy with nasal excision of laryngeal granuloma and rigid bronchoscopy.

[470] Mr. Noel was hospitalized with stridor and respiratory distress on July 13, 2005. On July 19, he underwent a rigid bronchoscopy and dilation of the subglottis for subglottic stenosis, which is an airway disease that is common among intubated babies. He was discharged on July 22, 2005, but was admitted to hospital from July 29 to July 31, 2005, for breathing difficulties. On August 15, 2005, Mr. Noel underwent a second rigid bronchoscopy procedure for subglottic stenosis. Mr. Noel was hospitalized again from October 27 to October 30, 2005, during which time he underwent a right bronchoscopy and direct laryngoscopy.

[471] Mr. Noel spent about a month in hospital between February 2 and March 5, 2007, with croup and subglottic stenosis. On February 12, 2007, he underwent laryngotracheal reconstruction surgery. That surgery required Mr. Noel to be placed into an induced coma for four weeks. When he came out of the coma, he was unable to hold his head up, walk, talk, or eat. Mr. Noel had to relearn all of his motor skills, which he gradually achieved by his third birthday. This was the last respiratory procedure for Mr. Noel.

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C. What actually happened?

[472] As a first step in the causation analysis, I must make findings of fact about what actually happened to cause the injuries that Mr. Noel experienced before and at the time of his birth. I will address each injury or group of injuries in turn.

[473] As. Dr. Davies testified, spontaneous vaginal delivery has been associated with the types of skull and brain injuries experienced by Mr. Noel. There is, as he put it, a baseline rate for these types of injuries.

<u>The subgaleal hemorrhage was caused by the use of the vacuum</u>

[474] The June 12, 2005, CT scan of Mr. Noel's head revealed a large subgaleal hematoma.

[475] Dr. Marin, an expert neonatologist called the plaintiffs, testified that the subgaleal hemorrhage was likely caused by the vacuum. He testified that several studies have associated subgaleal bleeds with application of the vacuum. Because of this association, he noted that it is now routine that any child who has a vacuum-assisted birth is monitored specifically for subgaleal hemorrhages. Dr. Marrin's opinion was informed by and consistent with the article by Dr. Michael Colditz, which noted that "Subgaleal haemorrhage occurs most frequently after a difficult vacuum extraction and is an underdiagnosed, potentially fatal condition."

[476] As far back as June 15, 2005, Dr. Tanswell, a neonatologist, concluded that the vacuum caused Mr. Noel's subgaleal hemorrhage.[106] His report stated that the "sub-galeal haematoma [was] likely related to use of vacuum during attempts at delivery."

[477] Dr. Davies, the expert obstetrician called by the defendants, acknowledged that this type of bleed can occur with the vacuum and agreed that the vacuum could have caused to the subgaleal bleeding. Dr. Davies acknowledged that subgaleal hemorrhage has a higher rate of occurrence with vacuum than with other modes of delivery. The defendants acknowledged in their written submissions that "except for the subgaleal hemorrhage," I should find that the impaction and disimpaction of the head was the cause of Mr. Noel's birth complications.

[478] I find that the plaintiffs have proved on a balance of probabilities that Mr. Noel's subgaleal hemorrhage was caused by Dr. Hawrylyshyn's use of the vacuum during the attempted delivery.

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[106] Although Dr. Tanswell did not testify at trial, the defendants tendered his report at trial and I admitted it into evidence pursuant to s. 52 of the *Evidence Act*, R.S.O. 1990, c. E.23.

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The intracranial bleeding and buckle fracture

[479] The plaintiffs submit that the the use of the vacuum and the forceps caused the balance of the skull and brain trauma suffered by Mr. Noel. The defendants submit that the injuries were caused by the impaction and disimpaction of the fetal head in the maternal pelvis. For the reasons that follow, I accept the evidence of the defendants' experts.

[480] Dr. Shone, the expert obstetrician called by the plaintiffs, was qualified to give opinion evidence on the standard of care and "the mechanics of causation and how the physical injuries might have occurred" to Mr. Noel. In his testimony, however, most of his evidence was devoted to the standard of care issue and he gave very little evidence on the mechanics of causation for Mr. Noel's birth complications. In addition, Dr. Shone testified that applying the vacuum to a baby in the transverse position may increase the impaction of the fetus into the maternal pelvis:

> A. So what I mean by that is you have the vacuum applied onto the baby's head, you are now pulling down in one direction hoping that the baby is going to rotate into a proper direction using mom's pelvic floor.
>
> And if that rotation does not take place then all what you are doing is bringing the baby further down into a transverse position, deeper into the pelvis, and thereby increasing impaction.

[481] Dr. Shone's evidence about elevation and intracranial hemorrhage was as follows:

> Q. And that, if I can put it that way, the increased force that's necessary to elevate the head out of the pelvis due to increased impaction, how does that relate, or does that relate to the potential injuries that Mylo suffered?
>
> A. If you put an increased pressure onto a localized area of the skull, then you can cause indentation of the skull, like a ping pong ball indents, and then that can come out again afterwards. But that ping ponging in and out can cause intracranial hemorrhage.

[482] I pause here to note that Dr. Shone testified that the Dr. Hawrylyshyn breached the standard of care by the "sequential use of instruments." I have dealt with that issue under standard of care, but I also wish to address that issue under causation. If Dr. Shone's evidence was to the effect that this delivery involved the sequential use of the vacuum and forceps, I do not accept that evidence. Instead, I accept the opinion of Dr. Davies that the delivery at issue in this case is not fairly described as involving the sequential use of vacuum and forceps.

[483] As Dr. Davies explained, any of the increased risks associated with a delivery involving the sequential use of the vacuum and forceps only arise if both of those instruments are

actually used. Here, I have found that Dr. Hawrylyshyn was not able to lock the forceps and never applied traction or torsion with the forceps. On these facts, the delivery did not involve the sequential use of the vacuum and forceps. Dr. Hawrylyshyn used the vacuum but not the forceps. I find that there was no sequential use of instruments and, consequently, the sequential use of instruments did not cause any of the injuries suffered by Mr. Noel.

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[484] Dr. Marrin, the expert neonatologist called by the plaintiffs, testified that the findings on the CT scan "would be consistent with significant compressive forces either generally or locally on the brain." Dr. Marrin testified that Mr. Noel suffered a traumatic brain injury that was caused by the vacuum extraction, an attempt at forceps extraction, and the elevation of the fetal head prior to the delivery by Caesarean section:

> Q. And based on your review of the records, did you form an opinion as to the mechanism by which the traumatic brain injury was caused in Mylo Noel's case?
>
> A. Well, Mylo experienced the attempt of a vacuum extraction; an attempt at a forceps extraction. Now, the risk of a brain injury with those is not high, but nevertheless it exists.
>
> And my reading of the issue, for example, with the application of the forceps and the difficulty extracting the forcep blade, made sense to me in light of the position of the baby and where the right temporal bone buckling was seen, with the associated injury to the brain underneath that seen on the CT and the MRI that was done in the first days of life.
>
> He also, and I believe Dr. Davies referred to this, there was obviously an attempt to get him delivered vaginally with these devices. The decision was made to go to a Caesarean section, which means his head would have to have been pushed up from the vagina back into the uterus to access for the C-section. So there's the potential for additional compression, torsion injury to the brain, occurring in reversing the original attempt. So probably three things – three aspects of the delivery likely contributed to that traumatic injury.

[485] I have difficulty accepting Dr. Marrin's opinion on causation. He noted that the risk of a brain injury with vacuum and forceps is not high, but he did not offer any explanation for why the application of the vacuum, for example, in this case would have caused these injuries. In addition, I do not accept his opinion regarding the use of forceps. Dr. Marrin did not offer a plausible explanation of how the forceps could cause any of the bleeding or trauma if the blades were never locked in place and torsion and traction were never applied. The fact that he includes the forceps, which never applied any force to the head of the fetus,

among the aspects of the delivery that likely caused to the traumatic brain injury causes me to doubt the validity of his opinion.

[486] Dr. Langburt is the pediatric neurologist called by the plaintiffs. Dr. Langburt's opinion regarding the cause of the injuries revealed on the CT scan was imprecise. Dr. Langburt testified the injuries identified on the CT scan were "related to the traumatic birth" and "excessive mechanical forces" applied to the head:

> Q. Thank you. And I appreciate there is sort of multiple injuries, or a long list. Are you able to tell us what on a balance of probabilities caused those injuries?
>
> A. Well, the hemorrhages were fresh and were clearly related to the traumatic birth, and this was repeatedly noted in the perinatal notes of all the physicians. And this is due to excessive mechanical forces applied to head directly.

[487] Dr. Langburt did not elaborate on which of the "mechanical forces" caused which injury. Dr. Langburt did not offer a specific opinion on the mechanism of injury. I note that Dr. Langburt is not an obstetrical expert and may not have felt comfortable giving a more precise opinion on the mechanism of injury, which may have been outside his area of expertise. That is, of course, perfectly appropriate and commendable. Scientific proof of causation is not required but his evidence was vague and not of significant assistance to me in determining causation.

[488] Dr. Davies is an expert obstetrician called by the defendants. Dr. Davies testified and confirmed on cross-examination that in his opinion the most likely cause of the bleeds and the injuries to Mr. Noel's head were the forces of delivery and the impaction / disimpaction of the fetal head:

> Q. And what's your opinion as to whether the elevation of the fetal head and/or the disimpaction of the fetal head from the maternal pelvis may have caused or contributed to the parietal buckling, bone buckling and the bleeding complications?
>
> A. Yeah, I think that definitely that scenario more than any of others is the more likely time when the injuries occurred. And they may -- those injuries -- let's just talk -- let's separate them out.
>
> The parietal bone buckling I think is most likely caused at that time from pressure from the hand pushing the head up.
>
> The bleeding I think, you know, again, most likely happened either from the forces used to push the head up, or the bleeding may have already been there just because of the pushing forces from the mother; or as you've disengaged or disimpacted the head, as the head

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> goes back to its normal shape, or more normal shape, that they happened at that time.
>
> So regardless of the mechanism, I think that's the part of the delivery where the injuries occurred.

[489] I accept Dr. Davies' opinion. It is consistent with the evidence that the molding and caput observed were evidence of the significant forces of labour and delivery at work on his skull. It also consistent with Dr. Hawrylyshyn's evidence that he had to apply significant force to the fetal skull to disimpact it from the pelvis and to elevate the head for delivery by Caesarean section. The disimpaction would have placed direct force on the fetal skull and there would have been further forces arising as the skull corrected to its natural shape.

[490] The experts agreed, and the plaintiffs have proved on a balance of probabilities, that the intracranial bleeding caused the seizures that Mr. Noel experienced shortly after his birth.

<u>The buckle fracture was caused by Dr. Hawrylyshyn using his hand to disimpact the fetal head</u>

[491] The June 12, 2005, CT scan of Mr. Noel's head revealed an inward buckle fracture in his right parietal bone (the back of the right side of his skull). A buckle fracture, as the name implies, occurs when the bone buckles but does not completely break. Dr. Marrin described a buckle fracture as analogous to the inward dimpling of a ping pong ball placed under external pressure.

[492] The plaintiffs raised three possible causes of the buckle fracture: the use of the vacuum; the use of the forceps; or Dr. Hawrylyshyn using his hand to disimpact the fetal head from the pelvis and to elevate up the birth canal to permit the fetus to be delivered by Caesarean section.

[493] First, I find that the use of the vacuum did not cause the buckle fracture. Although Dr. Shone testified that he could not exclude the use of the vacuum as the cause of the buckle fracture, I do not accept his evidence on this point. I agree with the evidence of Dr. Davies that it is "really unlikely" that the vacuum caused the buckle fracture. A buckle fracture is a depression in the skull caused by external pressure on the soft bones of the infant skull that press the skull inward, toward the brain. The vacuum is pulling on the skull, not pushing on it. None of the experts offered a satisfactory explanation for how the vacuum could have place sufficient inward pressure on the skull to cause it to buckle. The plaintiffs have not proven on a balance of probabilities that the use of the vacuum caused the buckle fracture.

[494] Second, I find the attempted use of the forceps did not cause the buckle fracture. I find as a fact that Dr. Hawrylyshyn never locked the forceps into place on the fetal head and never used the forceps to apply traction or torsion to the fetal head. Dr. Hawrylyshyn testified that the forceps blades never even got to the position where he could have locked them together and he did not lock them together. Locking the blades together is a precondition

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of applying any traction or torsion to the fetal head. Both Dr. Hawrylyshyn and Dr. Okun testified that no traction was applied to the fetal head. The contemporaneous notes of Dr. Hawrylyshyn, Dr. Okun, and Dr. Ko attest that no traction was applied to the fetal skull. I accept that if forceps are locked on the fetal skull and used to apply torsion and traction, the forceps could have caused the buckle fracture, but that never happened.

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[495] Dr. Marrin testified that it was likely that the forceps caused the buckle fracture because the buckle was located "exactly where one would place the [anterior] blade." Dr. Shone testified that "depending on where [the anterior] blade was located, it could have contributed to the skull fracture." While that might be where one would want to place the anterior blade, the uncontradicted evidence of Dr. Hawrylyshyn is that he could not position the anterior blade in that area. Dr. Hawrylyshyn testified that he was unable to "wander" the blade into position and the blade was never over the right parietal bone. Dr. Okun's unchallenged and unimpeached evidence confirmed Dr. Hawrylyshyn's evidence. I find that the anterior forceps blade never made it into the correct position and was never over the area of the right parietal bone that suffered the buckle fracture.

[496] Although Dr. Shone testified that it was likely that the forceps "contributed to" the buckle skull fracture, none of the plaintiffs' experts explained how the forceps blade could cause the buckle fracture if the anterior blade was never positioned over the right anterior parietal bone. I accept the opinion of Dr. Davies that if the anterior blade never got into the correct position, it was impossible for the forceps to cause the buckle fracture.

[497] I also find that the blades were never locked, torsion was never applied, and traction was never applied. I find that the plaintiffs have not proven on a balance of probabilities that the attempted use of the forceps caused the buckle fracture, intracranial, or extracranial hemorrhage.

[498] Third, I find that Dr. Hawrylyshyn's attempt to elevate the head to permit the fetus to be delivered by Caesarean section caused the buckle fracture. In his evidence, Dr. Hawrylyshyn allowed that "the elevation of the head might have contributed to the buckle fracture." He testified that obstetricians try to use the palm of their hand when elevating the fetal head to spread the pressure out evenly across the skull. He stated, however that "your hand has to go around the head" and that "at some point your fingers may come in contact with the head" and you have to keep pushing up because you "have to apply whatever pressure is required to get the baby out." He acknowledged that there is a known association between trying to elevate the fetal head and buckle fractures.

[499] Dr. Davies testified that the buckle fracture was "most likely caused at that time from pressure from the hand pushing the head up." I agree.

[500] The force exerted by Dr. Hawrylyshyn to elevate the fetal head is the most likely cause of the buckle fracture. Dr. Hawrylyshyn and Dr. Davies acknowledged a known association between elevating the fetal head and buckle fractures. Dr. Hawrylyshyn's description of where he had to put his hand and how he would have to cradle the fetal head even as he

tried to apply pressure with the palm of the hand is evidence that supports this theory of causation. As the defendants candidly concede in their written submissions, “Dr. Hawrylyshyn had to apply significant force to the top of [the fetus’s] head to disimpact it from the maternal pelvis during delivery.” The reason was simple. As Dr. Davies testified, “you can’t not use force…stopping or doing nothing…is just not an option because of concerns the baby will die.”

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[501] I find that the plaintiffs have proved on a balance of probabilities that Dr. Hawrylyshyn caused the buckle fracture to Mr. Noel’s head when he placed pressure on the fetus’s head to elevate the head to permit the delivery of the fetus by Caesarean section.

[502] In closing submissions, counsel for the plaintiffs conceded that if I found that the buckle fracture was caused by Dr. Hawrylyshyn’s elevation of the fetal head as part of the Caesarean section, then that was not a caused by a breach of the standard of care unless I found that the use of the vacuum caused further impaction of the head. As I explain below, I do not make that finding.

Conclusions

[503] As explained above, I make the following findings about what actually happened:

a. The application of the vacuum caused the subgaleal hemorrhage.

b. The balance of the bleeding was caused by the impaction and disimpaction of the fetal head in the pelvis. In particular, the buckle fracture was caused when Dr. Hawrylyshyn elevated the fetal head up the birth canal to permit delivery by Caesarean section.

c. The seizures immediately after birth were caused by the intracranial bleeding,

d. The respiratory issues were caused by the intubation which was caused by the intracranial bleeding.

D. Dr. Allen’s record keeping was not a “but for” cause of Mr. Noel’s injuries

[504] The evidence and my findings related to the antenatal conversations between Ms. Noel and Dr. Allen are set out at above at paragraphs [60] to [73] and [335] to [346].

[505] I found as a fact that Ms. Noel did not tell Dr. Allen that she would not under any circumstance consent to the use of the vacuum or forceps. I found as a fact that, around week 36 of her pregnancy, Ms. Noel told Dr. Allen of her preference for a spontaneous vaginal delivery and did not want either the vacuum or forceps to be applied. It is common ground that Dr. Allen did not record this conversation in her medical chart, and I concluded that this did not breach the standard of care. Assuming that I am incorrect, and that the failure to record Ms. Noel’s preferences breached the standard of care, I will now consider

whether the plaintiffs have proved that but for Dr. Allen's breach of the standard of care, Mr. Noel would not have suffered his injuries during the delivery.

[506] The plaintiffs frame their argument this way:

> The Plaintiffs further submit that Dr. Allen's breach of the standard of care started the Mylo's trajectory and set the stage of the lack of understanding and clarity of Janelle's longstanding birth plan of a non-instrumental birth. Had Dr. Allen followed the standard of care required of her, Dr. Hawrylyshyn would have been aware of her Janelle's long-standing views and presumably would have taken her decision more seriously.

[507] I disagree. Ms. Noel testified that she told Dr. Hawrylyshyn directly of her preferences no later than 0940h. The evidence related to this conversation is set out above at paragraphs [95] to [101]. To summarize, Ms. Noel testified that she told Dr. Hawrylyshyn the very first time she met him that she would take a Caesarean section because "I'd rather no forceps no vacuum." Ms. Noel also testified that she delivered the same message to Dr. Hawrylyshyn between 1230h and 1330h.

[508] Assuming Dr. Allen wrote the conversation down in the medical record, Dr. Hawrylyshyn could have seen it no earlier than 0900h when he started his shift. I accept that Dr. Hawrylyshyn was fully aware of Ms. Noel's preferences by 0940h and had that message reinforced in the early afternoon. Every time Dr. Hawrylyshyn had a conversation with Ms. Noel, made a judgment call, offered a treatment recommendation, or made a decision, he did so with full and complete knowledge of Ms. Noel's views.

[509] Given these facts, Dr. Allen's failure to record her conversation with Ms. Noel in the medical records has no connection to the harm at issue. Dr. Allen's conduct was not necessary to bring about the injury and was not a part of the cause of any of Mr. Noel's injuries. The failure of Dr. Allen to record her conversation with Ms. Noel is irrelevant where Ms. Noel directly delivered that same information to Dr. Hawrylyshyn at least twice before any of the harm was caused.

[510] Considering the facts that I have found and accepting that Mr. Noel suffered injuries during the labour and delivery, if I subtract Dr. Allen's alleged breach of the standard of care from the factual matrix, Mr. Noel would have suffered exactly the same injuries. Dr. Allen's record keeping did not cause or make a material contribution to the injuries suffered by Mr. Noel.

[511] In addition, Dr. Allen was not a legal or proximate cause of the harm suffered by Mr. Noel. It was not reasonably foreseeable that the failure to record Ms. Noel's preference could cause harm to Ms. Noel. Ms. Noel's preference was expressed long before anyone knew of the circumstances of her delivery. Because she did not express a categorical position, Ms. Noel's preferences would need to be considered and folded into a treatment plan based

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on the clinical circumstances present during her labour. The risk of harm would not occur to the mind of a reasonable person in the position of Dr. Allen. If there was any risk of harm at all, it was far fetched.

[512] I find that the plaintiffs have not proved that Dr. Allen's failure to record her conversation with Ms. Noel caused or made a material contribution to the injuries suffered by Ms. Noel or Mr. Noel.

E. Dr. Hawrylyshyn failure at 1700h to recommend a Caesarean section was a "but for" cause of Mr. Noel's injuries

[513] The evidence and my findings related to Dr. Hawrylyshyn's failure to recommend a Caesarean section at 1700h are set out above at paragraphs [361] to [384].

[514] I found as facts that Ms. Noel was continuing to make progress at 1700h, she did not meet the definition of a patient with abnormal progression in labour, and the fetus showed no signs of distress. I found that Dr. Hawrylyshyn met the standard of care when he did not recommend at 1700h that Ms. Noel deliver by Caesarean section. Assuming that I am incorrect, and that the failure to recommend a Caesarean section at 1700h breached the standard of care, I will now consider whether the plaintiffs have proved that but for Dr. Hawrylyshyn's breach of the standard of care, Mr. Noel would not have suffered his injuries during the delivery.

[515] The plaintiffs submit that had Mr. Noel been delivered by a Caesarean section at 1700h, "he would have avoided a brain injury in its entirety."

[516] If Dr. Hawrylyshyn had recommended a Caesarean section to Ms. Noel at 1700h, I find that she would have accepted that recommendation and delivered by Caesarean section. Throughout the day, Ms. Noel consistently accepted the advice of her medical practitioners regarding the recommended course of treatment. Among other treatments, she accepted the advice of her treating physicians and consented to an ultrasound, the administration of two fetal scalp pH test, the application of a synthetic oxytocin, the application of the vacuum, and the application of forceps.

[517] Most importantly, Ms. Noel accepted Dr. Hawrylyshyn's advice when he recommended a Caesarean section delivery at 1930h. Although Ms. Noel wanted to have a vaginal delivery, she did not have a firm opposition to a delivery by Caesarean section. Ms. Noel testified that she was always willing to delivery by Caesarean section. I accept that evidence and find on balance of probabilities that if Dr. Hawrylyshyn had recommended to Ms. Noel that she undergo a Caesarean section at 1700h, she would have accepted that recommendation and Mr. Noel would have been delivered by Caesarean section at that time.

[518] According to Dr. Ko's handwritten note, at 1700h the fetal head was at spines and some caput was forming. Ischal spines are an anatomical location on the female pelvis that can be felt transvaginally. Dr. Hawrylyshyn confirmed Dr. Ko's observation at 1715h. Dr.

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Hawrylyshyn recorded that the vertex of the fetal head "has descended to spines." When the fetal head is at spines, which is sometimes called station zero, the fetus is at mid-pelvis and it is the first time that the fetal head can be described as engaged with the maternal pelvis.

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[519] If the fetus was delivered by Caesarean section at 1700h, the vacuum would never have been used.

[520] 1700h was also before Ms. Noel started pushing. She did not start pushing until 1840h. Dr. Davies testified that the impaction of the fetal head was likely caused, in part, by Ms. Noel pushing. I accept his evidence and find that at 1700h, before Ms. Noel started pushing, the fetal head would not have been impacted and would not have required as much force to disimpact.

[521] I also find that Dr. Hawrylyshyn would not have been required to elevate the fetal head very much, if at all, for a Caesarean section delivery. Dr. Davies testified that if the fetus was at spines +2 (or two centimetres further than the fetal head had descended at 1700h), the fetal head would have to be elevated "several centimetres up higher to be able to come out the abdominal incision." This is consistent with elevation of the fetal head being unnecessary if it was at spines at the time of the Caesarean section. No witness testified that fetal elevation would have been necessary if the fetal head was at spines at the time of the Caesarean section.

[522] I find that if the fetus had been delivered at 1700h by Caesarean section it is more likely than not that:

a. the vacuum would not have been applied and the subgaleal hemorrhage would have been avoided;

b. the fetal head would not have been as deeply impacted and the forces of impaction and disimpaction would not have caused the intracranial bleeding and other injuries Mr. Noel suffered; and

c. Dr. Hawrylyshyn would not have had to elevate the fetal head at all, or would have been able use significantly less force, and the buckle fracture would not have occurred.

[523] If I am wrong, and Dr. Hawrylyshyn's failure to recommend a Caesarean section at 1700h breached the standard of care, then that omission was a "but for" cause of the injuries suffered by Mr. Noel at the time of delivery.

[524] If the standard of care required Dr. Hawrylyshyn to recommend a delivery by Caesarean section at 1700h, I would also find that Dr. Hawrylyshyn was the legal or proximate cause of the injuries. It would have been reasonably foreseeable to Dr. Hawrylyshyn that if he did not perform a Caesarean section when required by the standard of care, that there was a real risk that the fetus would suffer this type of harm. It would occur to the mind of a

reasonable obstetrician in the situation of Dr. Hawrylyshyn that there was a real risk of this type of harm occurring to the fetus.

F. Dr. Hawrylyshyn decision to use a vacuum and to attempt to use forceps

[525] The evidence and my findings related to Dr. Hawrylyshyn's decision to use the vacuum and attempt to use the forceps are set out above at paragraphs [411] to [428].

[526] I found that Dr. Hawrylyshyn met the standard of care in recommending and using the vacuum in an attempt for an operative assisted delivery at 1910h. I found that he complied with the applicable guidelines and exercised sound judgment in recommending to Ms. Noel that he attempt to deliver the fetus with the assistance of the vacuum. In these clinical circumstances and balancing the need for a speedy delivery and the relative risks to the fetus and Ms. Noel, Dr. Hawrylyshyn's decision met the standard of care. I also found that he met the standard of care by attempting to use the forceps when the vacuum-assisted delivery did not succeed.

[527] Assuming that I am incorrect, and that Dr. Hawrylyshyn breached the standard of care by using the vacuum and attempting to use the forceps, I will consider whether the plaintiffs have proved that but for Dr. Hawrylyshyn's breach of the standard of care, Mr. Noel would not have suffered his injuries during the delivery.

[528] The plaintiffs submit that Mr. Noel suffered skull and brain trauma because of the instrumentation. In their written submissions, the plaintiffs put it this way:

> it is critical to observe that Mylo was only deep in the pelvis (at +2 Station) because of the use of the vacuum. Additionally, due to the multiple attempts at instrumented delivery over a significant amount of time, Mylo was exposed to further and continued contractions that further impacted him into the pelvis. The additional twenty minutes with exposure to two further instruments and further descent of the fetal head would not have occurred had a c-section been conducted before the vacuum and the attempt at forceps. The pressure and torsional forces required to push Mylo's head back up through the birth canal were only present because the use of the vacuum had impacted his head deep into the pelvis. Absent the instrumentation, the further descent, and the additional time exposed to maternal forces, this level of force or torsion would not have been required to remove Mylo from the pelvis.

[529] I disagree. I find that the plaintiffs have not proved that the instrumentation was the "but for" cause of the injuries Mr. Noel suffered at the time of delivery.

[530] The clinical situation had changed significantly from 1700h to 1900h:

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a. The presenting part of the fetal head had descended from spines to spines +1 and, according to Dr. Hawrylyshyn's operative note had been at that position since 1840h;

b. Ms. Noel had been pushing for 20 minutes from 1840h to 1900h;

c. Caput (the swelling of the scalp) with molding (the temporary reshaping of the fetus's skull bones to allow for delivery) was now visible at the introitus (the entrance of the vagina); and

d. The fetus had been subject to strong contractions for an additional two hours.

[531] I find that the descent of the fetal head from spines (at 1700h) to spines +1 caused the most significant impaction of the head. Dr. Okun testified that the ischal spines are the narrowest transverse part of the pelvis and that the widest part of the fetal head is closer to the shoulders of the fetus than the presenting part. As the presenting part of the fetal head moved from being at the ischal spines to being one centimeter below the ischal spines, that is the point when the head likely became fully engaged with and impacted into the maternal pelvis.

[532] The plaintiffs have not proved that the descent of the head from station +1 to station +2, which was undeniably caused by the vacuum, made the head more difficult to elevate for the Caesarean section.

[533] I accept the defendants' submission that the plaintiffs' experts did not testify that it was likely that the descent of the head from station +1 to station +2 increased the impaction so significantly as to cause the impaction of the head that in turn caused the delivery related complications. Dr. Shone testified that one of the risks of using the vacuum was the possibility that it could cause further impaction of the fetal head. Dr. Marrin testified that there is a risk that the attempt at disimpaction of the fetal head might have played a role in the injuries suffered by Mr. Noel during the delivery.

[534] Dr. Davies testified that while this was possible, it was by no means certain or even likely to be the case that the head would be more difficult to elevate after the head descended from station +1 to station + 2 while the vacuum was applied. In his opinion, it would not be appropriate to assume that moving from station +1 to station +2 would likely make it more difficult to elevate the fetal head. I accept Dr. Davies' evidence on this point.

[535] This evidence does not satisfy me, on a balance of probabilities, that the use of the vacuum was a "but for" cause of the impaction of the fetal head. The fact that caput with molding was visible at the introitus is strong evidence that the fetal head was under significant pressure, sufficient pressure to reshape the skull bones, before the vacuum was applied. This pressure would have further increased after Ms. Noel began to push at 1840h.

[536] I also accept the submissions of the defendants that the Towner study does not assist the plaintiffs to prove that, in this case, the vacuum caused the impaction of the fetal head or

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the neonatal injuries to Mr. Noel (except for the subgaleal bleed, which was caused by the vacuum). I have described the Towner study above at paragraphs [285] to [299] above and will not repeat those points.

[537] Most importantly, after considering all of the data, the Towner study observed that its findings "suggest that the method of delivery is not necessarily the primary factor associated with intracranial hemorrhage" and that "a substantial proportion of the morbidity associated with operative vaginal delivery may be due to an underlying abnormality of labour rather than to the procedure." The Towner study explained as follows:

> We found that the rates of intracranial hemorrhage were low with all modes of delivery but were higher with vacuum extraction, forceps delivery, and cesarean delivery during labor than with spontaneous vaginal delivery. The rates for the three types of operative delivery were similar. There was an incremental increase in the rate of intracranial hemorrhage if more than one method of delivery was used. The frequency of intracranial hemorrhage in infants born by cesarean delivery during labor with no attempt at operative vaginal delivery did not differ significantly from the frequency in infants born by operative vaginal delivery, and the frequency of hemorrhage was similar in infants born by cesarean delivery with no labor and those delivered spontaneously. These findings suggest that the method of delivery is not necessarily the primary factor associated with intracranial hemorrhage.

[538] None of the experts challenged this conclusion. Dr. Shone and Dr. Langburt agreed with these conclusions.[107] These authoritative conclusions do not help the plaintiffs prove causation in this case.

[539] While I accept that it is possible that the use of the vacuum to move the fetal head from station +1 to station +2 over three contractions increased the impaction of the head so much that it caused injuries that otherwise would not have occurred, I find that the plaintiffs have not proven that to be the case on a balance of probabilities. Except for the subgaleal bleed, I do not find that "but for" the application of the vacuum Mr. Noel would have avoided his neonatal injuries. The application of the vacuum did not cause or make a material contribution to Mr. Noel's injuries, other than the subgaleal hemorrhage.

[540] As I stated above, I find that the forceps were not a cause of any of the injuries suffered by Mr. Noel. Dr. Hawrylyshyn did not lock the forceps, did not apply traction, and did not apply torsion.

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[107] Dr. Langburt pointed out that the study used the term "intracranial hemorrhage" to include subdural and subarachnoid hemorrhages and did not deal separately with intraparenchymal hemorrhages

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6. Causation: Mr. Noel's neurodevelopmental problems

[541] At paragraphs [474] to [503], I describe the birth complications suffered by Mr. Noel. To summarize, shortly after his birth, Mr. Noel was diagnosed as suffering from:

a. a large subgaleal hemorrhage;

b. a buckle fracture in the right parietal bone;

c. severe diffuse bilateral cerebral edema (swelling);

d. subdural hemorrhages;

e. subarachnoid hemorrhages in the right temporal parietal lobe

f. hemorrhagic contusions in the right temporal lobe; and

g. seizures, for which he was administered anti-seizure medication.

[542] In addition, Mr. Noel was placed under general anaesthesia. Dr. Marrin opined that this had negative long-term consequences for his development.

A. Mr. Noel's current neurodevelopmental limitations

[543] The plaintiffs, however, do not only seek damages for those immediate birth complications. They also submit that Mr. Noel has continued to suffer the consequences of these injuries and treatments to this very day.

[544] The plaintiffs submit that Mr. Noel has experienced "consistent, significant, and identified needs" during his educational career including that:

a. he studied under an individualized education plan from 2010 until his graduation in 2023;

b. in the 2011-2012 school year, Mr. Noel's individualized education plan identified him as having a learning disability that affected his literacy and numeracy skills, receptive language with reading and listening, expressive language with writing, long term memory, listening comprehension with inattention and hyperactivity, behaviour management with self-regulation and impulsivity, managing transitions, social/emotional skills and fine motor skills;

c. Mr. Noel was placed in a special education class on a full-time basis;

d. Mr. Noel demonstrated academic issues including hyperactivity and making self-deprecating remarks in 2012;

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e. In the 2012-2013 and 2014-2015 academic years, Mr. Noel was placed in a special education class with partial integration, but he was in a full-time special education class in 2013-2014;

f. Mr. Noel received an exemption from studying French;

g. In grade 4, the 2014-2015 school year, Mr. Noel's numerical operation and spelling abilities were at a grade 2.6 level;

h. In grade 5, the 2015-2016 school year, Mr. Noel's spelling was at a grade 3/4 level and his math numeration skills were at a mid-to-late grade 2 level, and all his subjects were modified, except for language, media literacy, and music in which he received accommodations.

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[545] The defendants agree that Mr. Noel has certain intellectual limitations and executive functioning deficits but note that Mr. Noel was not followed by any medical or para-medical specialists after he was discharged from the neonatology clinic. They point out that Mylo was never again placed on any medications for epilepsy and did not have ongoing speech language pathology consultations or treatments.

[546] Dr. Lemsky, an expert clinical neuropsychologist called by the plaintiffs, testified that Mr. Noel meets the criteria for a moderate intellectual disability disorder, attention deficit disorder and has indications of an adjustment disorder with mixed features, mild to moderate. Dr. Lemsky testified that Mr. Noel's social cognition, reasoning and judgment will develop at a much slower pace, causing him to continue to fall further behind his peers.

[547] In 2023, Mr. Noel graduated from high school and had been coaching youth soccer for 8 hours a day, three days a week at the MLSE Launch Pad. From December 2023 to the time of trial, Mr. Noel was living in Spain as a student of the FC Malaga City Academy. He was living alone, but under a regimented schedule. Mr. Noel would like to become a professional soccer player.

[548] Dr. Levin, the expert pediatric neurologist called by the defendants, testified that he did not believe that any of Mr. Noel's neurodevelopmental problems were attributable to the birth-related complications. Dr. Levin testified that he could not identify a cause for Mr. Noel's neurodevelopmental limitations and suggested that it would be worth reassessing Mr. Noel for other causes, including through genetic testing. There was no evidence introduced at trial that there was a genetic cause for Mr. Noel's neurodevelopmental limitations, and I do not accept that theory.[108]

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[108] The plaintiffs point out, correctly, that the defendants could have requested that Mr. Noel be sent for genetic testing pursuant to s. 105 of the *Courts of Justice Act*, R.S.O. 1990, c. C.43 and rule 33.01 of the *Rules of Civil Procedure*, R.R.O. 1990, Reg 194. The defendants did not make such a request.

[549] As I will explain below, I find that the plaintiffs have not proved on a balance of probabilities that any of the neonatal injuries suffered by Mr. Noel caused any of his neurodevelopmental delay. Dr. Marrin, the plaintiffs' expert neonatologist, testified of Mr. Noel's brain trauma and other injuries, "None of these things are good for brain development." Dr. Langburt and Dr. Lemsky agreed. While this may be true, it is insufficient to prove that those injuries caused Mr. Noel's neurodevelopmental limitations. The burden is not on the defendants to prove what caused Mr. Noel's neurodevelopmental limitations. The burden remains on the plaintiffs to prove causation on a balance of probabilities. The plaintiffs cannot do so simply by relying on Dr. Langburt's testimony that there is nothing in Ms. Noel's antepartum or personal history to suggest a cause for Mr. Noel's neurodevelopmental limitations. While scientific proof of causation is not required, the evidence of causation presented by the plaintiffs is not sufficient to permit me to draw common sense inferences of causation.

[550] Dr. Langburt testified that Mr. Noel's moderate intellectual disabilities, executive function disabilities, and ADHD could be traced back to his birth injuries. However, he did not provide a convincing or even a plausible explanation of the mechanism that might give rise to the linkage he posited. While there is no doubt that the birth complications predated Mr. Noel's current neurodevelopmental profile, that is not sufficient to prove on a balance of probabilities that the former caused the latter. As I will explain, the plaintiffs did not prove on a balance of probabilities that the neonatal injuries suffered by Mr Noel caused his current neurodevelopmental limitations.

B. The subgaleal hemorrhage

[551] As described above, I have found that Dr. Hawrylyshyn caused the subgaleal hemorrhage with the vacuum. For the reasons that follow, I find that the subgaleal hemorrhage did not cause or make a material contribution to any of Mr. Noel's ongoing neurodevelopmental challenges.

[552] All of the experts agreed that subgaleal hemorrhages are extremely dangerous and can be life-threatening. Dr. Davies testified that of the bleeds that Mr. Noel suffered, "the subgaleal one would be the most concerning."

[553] Bleeding in the subgaleal space can be both very rapid and very severe. The rapid loss of blood into the subgaleal space can lead to falling blood pressure, anemia, and low haemoglobin levels. If these symptoms remain untreated, the brain may not receive enough oxygen, which could result in a hypoxic ischemic insult. Fifty-six minutes after birth, Mr. Noel's haemoglobin was 104 g/L. Medical staff gave him a blood transfusion, which returned his haemoglobin to normal range. Mr. Noel did not have any further issues with his haemoglobin levels and there was no evidence of brain damage caused by a hypoxic ischemic insult on Mr. Noel's MRI, which was performed on June 18, 2005.

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[554] It is important to recall that a subgaleal hemorrhage is a collection of blood outside the skull.[109] The blood from the subgaleal hemorrhage never came in contact with the brain tissue itself.

[555] There was broad consensus among the experts that the subgaleal hemorrhage did not cause any neurological impairments.

[556] The first person to offer an opinion on the likely effects of the subgaleal hemorrhage was Dr. Tanswell, a neonatologist. On June 15, 2005, he concluded that the subgaleal hemorrhage was unlikely to contribute to neurological findings:

> Subgaleal haematoma likely related to use of vacuum during attempt at delivery. However subgaleal haematoma may result in jaundice and could result in need for blood transfusion but unlikely to contribute to neurological findings.

[557] Dr. Marrin, the expert neonatologist called by the plaintiffs, agreed that Dr. Tanswell's conclusion was "a fair statement." Dr. Langburt, the expert neurologist called by the plaintiffs, initially agreed with Dr. Tanswell's opinion but then qualified his opinion to say that where (as here) there is a transfusion, "although it's not the primary cause of the eventual damage, it is a factor that may, in a small way, contribute to it." Dr. Langburt did not explain the mechanism by which this could possibly occur and I reject this theory.

[558] Dr. Levin, the expert neurologist called by the defendants, testified that the subgaleal hemorrhage did not cause any long-term consequences to Mr. Noel because there was no evidence that he was ever hypotensive, let alone sufficiently hypotensive to cause deprivation of oxygen and glucose to the brain. In addition, the MRI taken of Mr. Noel's brain on June 18, 2005, showed no evidence of brain damage ("watershed ischemia") from a hypoxic ischemic insult. In the absence of that evidence, Dr. Levin was confident that Mr. Noel suffered no long-term injury arising from the subgaleal hemorrhage.

[559] While Dr. Marrin testified that a subgaleal bleed that causes hypotensive shock could cause damage to the brain, there is no evidence that Mr. Noel suffered from hypotensive shock. Dr. Marrin agreed with Dr. Levin that the 2005 MRI showed no evidence of a prenatal or postnatal brain injury due to a hypoxic ischemic insult. In my view, Dr. Marrin essentially

[109] According to an article by Colditz that was entered as a trial exhibit, "the scalp consists of five layers: skin; dense connective tissue; the tough fibrous layer of the galea aponeurotica, also known as the epicranial aponeurosis; loose connective tissue permitting the movement of the galea; and the dense periosteum tightly encasing each cranial bone and their diploic veins. The subgaleal space exists immediately superior to the periosteum, and inferior to the tough fibrous sheath of the galea as it extends uninterrupted across the cranial vault from the frontalis muscle to the posterior nuchal lines and laterally to the temporalis muscle": Michael J. Colditz et al., "Subgaleal haemorrhage in the newborn: A call for early diagnosis and aggressive management" 51 *J of Paediatrics and Child Health* (2015) 140 at 141.

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agreed with Dr. Levin that the subgaleal hemorrhage caused no long-term harm to Mr. Noel.

[560] In conclusion, I find there was a remarkably strong consensus on this issue. I agree with the opinion provided most clearly by Dr. Levin: neither the subgaleal hemorrhage nor its sequalae caused or made a material contribution to any of Mr. Noel's neurodevelopmental limitations.

C. The subdural and subarachnoid hemorrhages

[561] The plaintiffs submit that the subdural and subarachnoid hemorrhages caused or made a material contribution to Mr. Noel's neurodevelopmental deficits. I disagree.

[562] Beneath the skull bone, there are three layers of tissue that cover the brain matter: the dura, the arachnoid and the pia. A subdural hemorrhage fills the space below the dura and above the arachnoid. A subarachnoid hemorrhage fills the space between the arachnoid and the pia. The pia membrane is closely applied to the brain substance. Neither a subdural hemorrhage nor a subarachnoid hemorrhage is in the brain matter itself.

[563] Dr. Levin testified that there was no evidence that these bleeds caused any permanent damage to Mr. Noel. In his opinion, they did not affect the brain tissue and did not cause severe intracranial pressure. Although they might have initially caused Mr. Noel's seizures, once the blood dissipated, there was no ongoing or permanent damage. Although the plaintiffs cross-examined Dr. Levin on the literature he cited, I am satisfied that the literature supported his conclusions.

[564] I find that the plaintiffs have not proved that the subdural and subarachnoid hemorrhages caused any damage to Mr. Noel's brain. The plaintiffs' experts did not explain by what mechanism these bleeds could have caused any damage to the brain tissue. The evidence strongly suggests that the subdural and subarachnoid hemorrhages did not cause any damage to Mr. Noel's brain:

a. the blood in these bleeds did not permeate the pia and never interacted with the brain matter;

b. for the reasons set out below in paragraphs [573] to [578], there is no evidence that these bleeds caused increased intercranial pressure sufficient to cause a hypoxic ischemic insult that could damage the brain; and

c. the MRI scans completed in January 2012 do not show any evidence of injury in or near the area of the brain near subdural or subarachnoid hemorrhages.

[565] In addition, Dr. Langburt and Dr. Lemsky testified that Mr. Noel's functional limitations are related to functions controlled by the frontal lobe of the brain, not the posterior or temporal areas where the subdural and subarachnoid hemorrhages were located.

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[566] The burden is on the plaintiffs to prove causation and I find that they have not done so. I accept the defendants' submission that the plaintiffs have not proved "how the bleeds caused harm, where they caused harm, or how that harm" is currently affecting Mr. Noel.

[567] In conclusion, I find that the plaintiffs have not proved that the subdural or subarachnoid hemorrhages caused or made a material contribution to any of Mr. Noel's long-term injury or neurodevelopmental deficits.

D. The hemorrhagic contusion and conversion in the right temporal lobe

[568] Mr. Noel's 2005 CT scan revealed that he suffered a hemorrhagic contusion in the right temporal lobe. Mr. Noel's 2005 MRI scan revealed a hemorrhagic conversion on in the right temporal lobe. The January 2012 MRI, however, revealed no permanent scarring in this area.

[569] Dr. Levin testified that although these injuries directly affected Mr. Noel's brain, they were too small and localized, and resolved too quickly to have caused any of Mr. Noel's current neurodevelopmental limitations. Dr. Levin testified that it was "extremely unlikely that there would be any neurodevelopmental consequence from damage to that area."

[570] Dr. Langburt, the expert pediatric neurologist called by the plaintiffs, did not dispute Dr. Levin's opinion. Dr. Langburt conceded on cross-examination that Mr. Noel's neurodevelopmental limitations involve functions controlled by the brain's frontal lobe, not the right temporal lobe, where the hemorrhagic contusion and conversion were observed.

[571] I accept the evidence of Dr. Levin that the hemorrhagic contusion and conversion did not cause Mr. Noel's neurodevelopmental limitations. While the plaintiffs did not press this point in their written submissions, I find that they have not proved that the hemorrhagic contusion and conversion caused or made a material contribution to any of Mr. Noel's neurodevelopmental limitations.

E. The cerebral edema

[572] The plaintiffs submit that the cerebral edema caused Mr. Noel's neurodevelopmental deficits. I disagree.

[573] The unchallenged evidence of Dr. Levin, the expert pediatric neurologist called by the defendants, is that Mr. Noel experienced widespread interstitial edema, which means excess fluid between the cells. This type of edema occurs when damaged blood vessels leak fluid into the space around the blood vessels and brain cells.

[574] It is important to understand how interstitial edema causes brain injury. Dr. Marrin, the expert neonatologist called by the plaintiffs, testified that the brain may swell to the point where the raised intracranial pressure means that the patient's blood pressure is not strong enough to push blood into the brain. This compromised blood flow causes a hypoxic

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ischemic injury to the brain. Dr. Levin, the defendants' expert, agreed with Dr. Marrin's explanation of the mechanism by which cerebral edema harms the brain.

[575] Dr. Levin, the expert pediatric neurologist called by the defendants, gave two reasons why Mr. Noel's cerebral edema did not cause brain damage. First, although Mr. Noel's interstitial edema was widespread, it was not severe because there was no evidence of intracranial pressure as his anterior fontanelle was described as normal. Second, the MRI scans completed in 2005 and 2012 did not show any evidence of a hypoxic ischemic injury sufficient to cause any brain damage.

[576] The plaintiffs correctly point out that while the physicians who examined Mr. Noel on June 13 and 14 described the anterior fontanelle as soft and flat or normal, the nursing notes describe the fontanelle as bulging. I prefer the notes made by the physicians who examined Mr. Noel, including for the specific purpose of assessing whether he was dealing with intracranial pressure that would require brain surgery. The doctors concluded that surgery to relieve intracranial pressure was not required. Moreover, the MRI scans do not show any evidence of the type of hypoxic ischemic injury caused by severe brain edema. There is, therefore, neither clinical nor artefactual evidence of severe brain edema that could cause brain damage. I do not accept Dr. Marrin's opinion that the cerebral edema experienced by Mr. Noel caused brain damage or any other long-term consequence.

[577] Dr. Langburt, the expert pediatric neurologist called by the plaintiffs, testified that cerebral edema could cause brain damage without raised intracranial pressures. I accept the defendants' submission that Dr. Langburt did not explain the mechanism by which this damage could occur, cited no literature in support of his opinion, and that his opinion was contradicted by authoritative literature. I do not find Dr. Langburt's opinion on this point reliable.

[578] In conclusion, I find that Mr. Noel's widespread, interstitial cerebral edema did not cause or make a material contribution to any of Mr. Noel's neurodevelopmental deficits.

F. Hypoxic ischemia

[579] The plaintiffs submit that hypoxic ischemia caused Mr. Noel's neurodevelopmental deficits. I disagree.

[580] Dr. Langburt, the expert pediatric neurologist called by the plaintiffs, testified that the fetus suffered a hypoxic ischemic injury near the time of birth that contributed to the brain injury and Mr. Noel's neurodevelopmental deficits.

[581] There is some evidence that the fetus experienced a mild hypoxic insult prior to birth. Most notably, the early cerebral edema described above. However, as I will explain, the evidence suggests that this event took place before 1700h and was minor and unlikely to have any neurological significance.

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[582] First, on June 15, 2004, Dr. Tanswell, the neonatologist, reviewed the CT scan and medical and records and concluded that the fetus was not hypoxic during labour but may have had a hypoxic episode before that:

> 2. The normal scalp pH suggested that the infant was not hypoxic in labour. However, initial elevated lactate and early edema on CT consistent with hypoxic episode prior to birth.
>
> Likely sequence, therefore, episode of intrauterine hypoxia leading to brain ischemia, followed by recovery of circulation and normalization of pH. Therefore, delivery process *per se* unlikely to have contributed to brain injury.

[583] Second, the CT scan was completed on June 12, 2005, at 1617h, which was approximately 20 hours after Mr. Noel's birth at 1953h on June 11, 2005. Dr. Langburt interpreted the CT scan to indicate that there was a hypoxic ischemic "injury to the brain within the 24 to 36 hours" prior to the completion of the CT scan. On Dr. Langburt's theory, the hypoxic ischemic event took place between 0417h and 1617h on June 11, 2005. If Dr. Langburt is correct, the hypoxic ischemic event took place no later than 43 minutes before 1700h, which is when the plaintiffs suggest that Dr. Hawrylyshyn first breached the standard of care by not recommending a Caesarean section.

[584] On cross-examination, Dr. Langburt conceded that it was difficult to pinpoint the time of the hypoxic ischemic insult, but felt confident that it was between two and 12 hours prior to delivery:

> Q. So you're not really able to time the timing of the hypoxic ischemic insult that you say contributed to Mylo's brain injury, is that fair?
>
> A. No, I think you can time it. I just don't think you can time it to the exact minute or half hour, but you can time it within the timeframe I mentioned, within hours prior to delivery. Whether that's two hour or 12 hours I'm not sure.

[585] Ultimately, I do not accept Dr. Langburt's opinion because it is inconsistent with the facts in this case. The evidence is overwhelming that the fetus was not hypoxic in the period immediately leading up to birth. Dr. Hawrylyshyn took scalp pH samples at 1330h and 1715h. Both samples demonstrated that the fetus was not hypoxic and was tolerating labour

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well. Dr. Marrin testified that the cord gas readings taken at birth and the blood gas readings taken less than one hour later showed no evidence of hypoxia.[110]

[586] Mr. Noel underwent MRI scans on June 17, 2005, and in January 2012. Dr. Levin testified that neither MRI scan contained evidence of a hypoxic insult before or immediately after birth. When Dr. Langburt contemporaneously reviewed the January 2012 MRI results in a clinical setting, he did not identify any findings consistent with a hypoxic injury. In fact, there were no findings on the MRIs that met the ACOG criteria for assessing a hypoxic ischemic injury.

[587] Both expert neonatologists Dr. Marrin and Dr. Levin reviewed this clinical evidence and concluded that it was not likely that the fetus suffered a hypoxic ischemic insult prior to birth or in the day after birth sufficient to cause any brain damage or a neurodevelopmental deficit. I accept their opinions as they are consistent with the clinical evidence in the case. Moreover, their assessment of issues arising during the neonatal period is closer to the heart of their expertise than it is to the core expertise of Dr. Langburt, an expert pediatric neurologist.

[588] I prefer the evidence Dr. Tanswell, Dr. Marrin, and Dr. Levin to that of Dr. Langburt. It seems likely that there was a mild hypoxic event many hours before delivery that caused the cerebral edema (as described above). The literature discussed at trial strongly supports the notion that mild hypoxic insults do not cause brain damage and could not have caused Mr. Noel’s neurodevelopmental deficits.

[589] I find that the plaintiffs have not proved on a balance of probabilities that hypoxic ischemia caused or made a material contribution to any of Mr. Noel’s neurodevelopmental limitations.

G. The seizures

[590] The plaintiffs submit that the seizures Mr. Noel suffered at 13 minutes after his birth, at 6 days of life, or at age 5 caused his neurodevelopmental deficits. I disagree. I find that the plaintiffs have not proved on a balance of probabilities that the seizures caused or made a material contribution to any of Mr. Noel’s developmental deficits.

[591] Mr. Noel experienced his last seizure more than ten years ago. He has not taken any anti-seizure medication since he departed the hospital as a neonate. After his discharge from the hospital, Mr. Noel was not followed by a pediatric neurologist.

[592] Dr. Levin testified that Mr. Noel’s seizures in the neonatal period were likely caused by subdural and subarachnoid hemorrhages. He observed that some of the medical notes

[110] In his evidence, Dr. Langburt suggested that the “acidosis paradox” may mean that there was hypoxic injury even with normal pH readings. This opinion was not disclosed in his written report and the plaintiffs did not advance this theory in their closing argument. I do not accept his opinion regarding the acidosis paradox.

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describe Mr. Noel as engaging in "bicycling movements." In response to a question from me during his examination in chief, Dr. Levin testified that "bicycling movements" are not seizures, evidence that was not challenged during cross-examination.

[593] Dr. Levin was not able to identify a cause for the seizures in 2011. Relying on an authoritative paper by Dr. Trinka, Dr. Levin testified that brain cell damage starts to occur after continuous seizure activity of 30 minutes or longer.[111] He testified that the clinical term applied to a seizure that lasts for more than 30 minutes is status epilepticus.

[594] Dr. Levin testified that Mr. Noel's seizures during the neonatal period were unlikely to have caused any long-term consequences because there were not many of them and they were brief. He testified that the 2011 electroencephalogram results (diagnostic for a focal onset epilepsy arising from the left hemisphere) were not caused by Mr. Noel's birth related complications because the neonatal damage was on the right side of the brain.

[595] Dr. Langburt testified that seizures, even repeated seizures, do not usually cause long-term intellectual disability on their own. Dr. Langburt agreed with Dr. Levin that status epilepticus referred to seizures lasting more than 30 minutes and was a neurological emergency that required immediate intervention or response. He agreed that neither the treating doctors nor the nurses ever described Mr. Noel as having status epilepticus.

[596] Dr. Langburt did not accept Dr. Levin's opinion that brain cell damage was caused only after continuous seizure activity of more than 30 minutes because Dr. Trinka's paper did not discuss neonates or children. This is not correct.

[597] The Trinka paper defined a seizure to mean a "transient occurrence of signs and/or symptoms due to abnormal excessive or synchronous neuronal activity in the brain. The term transient is used as demarcated in time, with a clear start and finish." Status epilepticus is considered the most extreme form of a seizure. In the Trinka paper, the authors proposed the following definition of status epilepticus (SE):

> SE is a condition resulting either from the failure of the mechanisms responsible for seizure termination or from the initiation of mechanisms which lead to abnormally prolonged seizures (after time point t1). It is a condition that can have long-term consequences (after time point t2), including neuronal death, neuronal injury, and alteration of neuronal networks, depending on the type and duration of seizures.

[598] The Trinka paper concluded that t2, the point after which seizures can have long term consequences, should be set at 30 minutes:

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[111] Eugen Trinka et al., "A definition and classification of status epilepticus – Report of the ILAE task force on classification of status epilepticus" 56:10 *Epilepsia* (2015) 1515.

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> Given the experimental evidence indicating irreversible brain damage after prolonged seizures and the potential threat of brain damage in humans, we suggest the time of t2 at 30 min in convulsive SE, in line with previous definitions of SE. As in the animal experimentation, considerable variation in the duration of prolonged seizures that result in damage has been found, but this time point is chosen on the basis of providing a practical safe guideline for clinical purposes.

[599] The authors of the Trinka paper noted that the likelihood of damage is dependent on several features, including the age of the patient. The authors observed that further research would be required to "define those aspects further."

[600] The Trinka paper also proposed a new diagnostic classification system for status epilepticus, which would have four axes: semiology; etiology; electroencephalography correlates; and age. The purpose of the diagnostic axes is to provide a framework for clinical diagnosis. For the fourth axis of age, the paper broke persons down into five age groups: neonatal (0 to 30 days); infancy (1 month to 2 years); childhood (>2 to 12 years); adolescence and adulthood (>12 to 59 years); and elderly (>60 years).

[601] In my view, Dr. Langburt's criticism of Dr. Levin's reliance on the Trinka paper is misplaced. The Trinka paper's definition of and classification system for status epilepticus considered and addressed the situation faced by neonates and infants. The Trinka paper acknowledged that the likelihood of irreversible brain damage is dependent on a range of factors including the location of epileptic focus, the intensity of the status, the age of the patient, and other factors. The authors recommended further study of these factors. The authors acknowledged that the timing of the onset of cerebral damage will vary considerably in different clinical circumstances. However, the authors nevertheless set 30 minutes as the duration for all ages when a seizure may cause long term consequences including neuronal injury, neuronal death, alteration of neuronal networks and functional deficits.

[602] Dr. Langburt did not identify or rely on any academic literature to dispute the conclusions of the Trinka paper. For that reason, I do not accept Dr. Langburt's opinion that "Any duration of seizures can be harmful." Dr. Langburt's opinion appears to be idiosyncratic and unmoored from the literature placed before the court. I do not accept his opinion on this point.

[603] Dr. Marrin testified that "seizures have been shown to alter the development of the brain." Dr. Marrin did not cite any literature for this opinion. To the extent that Dr. Marrin is referring to seizures lasting 30 minutes or more, I accept his opinion. To the extent that he disagrees with Dr. Levin and the Trinka paper, I prefer the evidence of Dr. Levin, which finds more support in the literature presented to the court.

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[604] Based on the medical records filed at trial, I find that Mr. Noel did not suffer seizures lasting more than 30 minutes. The seizures he suffered 13 minutes after his birth were brief. I accept the defendants' submission that the seizures on June 17, 2005, are best described as intermittent episodes of seizures lasting no more than a few minutes, which continued over several hours. Seizures of this type do not meet the definition of status epilepticus. I do not place any weight on the notation "status epilepticus" that was written on the referral form for Mr. Noel's second CT scan. The notation is inconsistent with the balance of the clinical notations, none of which diagnose Mr. Noel as meeting the guidelines for status epilepticus. In addition, there is no evidence that his treating physicians responded in a manner that suggests Mr. Noel had a neurological emergency, which would have been the case had Mr. Noel actually presented with status epilepticus. Moreover, some of the medical notes describe Mr. Noel as engaging in "bicycling movements." As noted above, Dr. Levin's unchallenged evidence was that bicycling movements observed in neonates were not themselves seizures.

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[605] In addition, there is no evidence that the seizure or seizures that Mr. Noel suffered at age five lasted for more than 30 minutes. The plaintiffs have not proved that that these seizures caused any of Mr. Noel's ongoing neurodevelopmental issues. Moreover, it is not clear that these focal seizures, which originated on the left side of his brain, could be connected to the intracranial bleeding at the time of delivery, which was located on the right side of Mr. Noel's brain.

[606] Mr. Noel has not been on medication to control seizures and there is no evidence that he has had a seizure since he was five years old. I accept the evidence of Dr. Levin that the seizures during the neonatal period were unlikely to have caused any long-term consequences because there were not many of them and they were brief. I am not satisfied that there is any authoritative literature suggesting that seizures of a duration of less than 30 minutes are likely to cause long-term neurodevelopmental consequences.

[607] I find that the plaintiffs have not proved on a balance of probabilities that the seizures caused or made a material contribution to any of Mr. Noel's neurodevelopmental deficits.

H. The anti-seizure medication and anesthetic

[608] The plaintiffs submit that the anti-seizure medication or the general anaesthetic medicines given to Mr. Noel caused Mr. Noel's neurodevelopmental deficits. I disagree.

[609] Dr. Marrin, the plaintiffs' expert neonatologist, testified that in his opinion, the antiseizure medication and the general anaesthetic caused long-term developmental damage to Mr. Noel. There are two reasons why I do not accept his evidence.

[610] First, Dr. Langburt, the plaintiffs' pediatric neurologist, expressly rejected this theory of causation. He testified as follows:

> Q. In your reports you did not say that you believed that Mylo's anti-seizure medication contributed to his brain injury, correct?

A. Correct. I did not say that.

Q. And that's because you don't hold that opinion, correct?

A. Correct.

Q. And similarly in your reports, you do not say that you believe that the general anesthetic drugs that Mylo received during his first two years of a life contributed to his brain injury, correct?

A. Correct.

Q. And that’s because you do not hold that opinion, correct?

A. I would say that they did not in any significant manner contribute, correct.

Q. It wasn't a factor that was even worth mentioning in your reports because the contribution, if any, was so de minimis it wasn't worth writing down?

A. Yeah, that's fair.

[611] In my view, a pediatric neurologist is better positioned to provide an opinion on the effect of treatments outside the first hours of life on the brain development of toddlers, adolescents, and teenagers. The fact that an expert pediatric neurologist called by the plaintiffs completely rejected this theory of causation causes me to have doubts about the reliability of Dr. Marrin’s opinion.

[612] Second, Dr. Marrin did not cite any authoritative literature that supported his theory of causation. The paper he did cite addressed the impact of anti-seizure medication on rats. Dr. Marrin candidly agreed that an authoritative text, *Neurology of the Newborn*, concluded that “the relation of these data to the human infant is unclear.” Dr. Marrin could not identify any “hard science” that linked phenobarbital to any particular neurodevelopmental outcome. Dr. Marrin also admitted that there are studies that demonstrate that there is no link between anaesthetics and neurodevelopmental problems:

Q. And you would be keeping track of good, big, longitudinal studies that are trying to assess the question of whether general anesthetic drugs cause poor neurodevelopmental outcome?

A. Yes.

Q. Would you agree with me there [are] studies that say that they do not have an effect on things such as general cognitive ability, attention, working memory, reading and academic achievement?

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A. Yes.

Q. Yeah, so there [are] studies that say no effect on those sorts of outcomes?

A. That is true.

[613] Dr. Marrin's failure to cite those studies in his written report, and his failure to explain how those studies could be incorporated into, or reconciled with, his opinion, causes me to doubt his theory of causation.[112]

[614] In conclusion, I am left with grave doubts about the reliability of Dr. Marrin's opinion. It appears to be untethered to the academic literature. The fact that Dr. Langburt completely rejected this theory of causation causes me further concerns. If Dr. Marrin's opinion was firmly rooted in the academic literature and leading texts, that might have been sufficient to overcome my concerns about reliability. Instead, I am left with the view that Dr. Marrin's evidence on this point amounts to little more than him asking me to trust him.[113]

[615] I find that the plaintiff has not proved on the balance of probabilities that the anti-seizure medication or the general anaesthetic medicines given to Mr. Noel caused or made a material contribution to any of his neurodevelopmental deficits.

I. Cumulative effect of the neonatal injuries

[616] The plaintiffs submit that it is necessary to step back and consider the cumulative effects of all of Mr. Noel's injuries. This position is well summarized in the evidence of Dr. Marrin:

Q. Before we delve into the substance of everything, maybe I'll just start and ask, having reviewed all the materials you were able to review, Dr. Marrin, were you able to reach an opinion as to the cause of Mylo Noel's developmental challenges?

A. My conclusion was that the root cause was the traumatic brain injury that he sustained at the time of his birth, which led to a series of events which, in my opinion, had a cumulative -- negative effect on his brain development. So there was the initial trauma, followed by seizures. Followed by, as result of the seizures or the treatment of the seizures, the need to be intubated and ventilated which resulted in trauma injury to his trachea, ultimately a

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[112] *Johnson v. Lakeridge Health Corporation*, 2023 ONSC 2575, at para. 278; *Bauer v. Kilmurry*, 2016 ONSC 7749, at para. 83.
[113] *Abbey (#2)*, at para. 119.

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> narrowing of his trachea which required surgery and an extensive period of hospitalization.
>
> And cumulatively, it was my opinion that all of these things had a negative effect at a time when his brain would have been developing most actively, particularly in the first two years of his life.

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[617] Dr. Lemsky reached a similar conclusion. She testified that Mr. Noel's injuries at birth caused Mr. Noel's neurodevelopmental deficits. I give no weight to her evidence on this point.

[618] As described above, Dr. Lemsky is not a medical doctor. She is neuropsychiatrist who typically treats patients over the age of 18. As she acknowledged, she would defer to neonatologists or neurologists for any medical diagnosis. She would also defer to the opinion of a neurologist and neuroradiologists when interpreting MRIs.

[619] In my view, her opinion on causation is unreliable as I do not believe her expertise or training allowed her to reach the conclusions that non-specific white matter findings from a 2012 MRI scan were evidence of injury caused by a hypoxic ischemic insult. On cross-examination, Dr. Lemsky was forced to concede that no physician ever expressed the view that the MRI showed any evidence of injury caused by hypoxic ischemic insult. Moreover, she agreed that Dr. Langburt (Mr. Noel's treating neurologist at the time) did not identify any changes consistent with hypoxic ischemic insult and that she would defer to the opinion of a neurologist when interpreting the 2012 MRI. I believe the causation opinion offered by Dr. Lemsky fell far from her core expertise and she cited no authoritative literature to support her unique opinion. She did not offer a compelling explanation for the mechanism of causation and the three papers she cited in her opinion did not, on closer inspection, support her conclusions.

[620] Dr. Lemsky offered the following opinion:

> Research has provided evidence that perinatal factors including hypoxic-ischemic brain injury and intraventricular hemorrhage is associated with developmental disability and attention deficit disorder. [114]

[621] The facts of this case, however, are quite different. First, Dr. Lemsky conceded that Mr. Noel did not have an intraventricular hemorrhage. Second, Dr. Lemsky agreed that she would defer to the opinions of the neonatologist and neurologists regarding whether Mr. Noel had a hypoxic-ischemic brain injury. I have previously found that Mr. Noel did not

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[114] In support of this opinion, Dr. Lemsky cited K.M. Kim et al "Neurodevelopmental Prognostic Factors in 73 Neonates with the Birth Head Injury" Korean J. Neurotrauma (2008) 14:2, 80-85.

have a hypoxic-ischemic brain injury that caused any long-term issues. Therefore, neither of the factors identified in Dr. Lemsky's opinion were present in this case.

[622] Dr. Lemsky cited a paper by Dr. Handel titled "Long-term Cognitive and Behavioural Consequences of Neonatal Encephalopathy Following Perinatal Asphyxia." However, that paper concluded that "in all areas reviewed, the outcome of children with mild [neonatal encephalopathy] is consistently positive…."[115] The study used a child's Sarnat score to grade the severity of the neonatal encephalopathy, with mild being given a value of 1. On day 4 of his life, Mr. Noel's had a Sarnat score of 1. When confronted with this uncomfortable fact, Dr. Lemsky stated that one would need to consider many other factors including Mr. Noel's Sarnat scores at various times in order to rely on the paper. It was, however, Dr. Lemsky herself who relied on this paper without having assessed Mr. Noel's Sarnat scores over time.

[623] Dr. Lemsky also offered the following opinion:

> Jhawar, and colleagues, found that the greatest risk factors for poorer outcome were those that had evidence of frontal and intracranial hemorrhage in multiple compartments, had forceps deliveries and had thrombocytopenia.[116]

[624] In cross-examination Dr. Lemsky admitted that Mr. Noel did not have thrombocytopenia, which the paper defined as a platelet count of less than 70. The article concluded that "the factor that was most likely to contribute to poor outcome was thrombocytopenia." Mr. Noel also did not have a hemorrhage in the frontal lobe. Dr. Lemsky admitted that she misread Dr. Jhawar's paper and that it concluded that there was a higher risk with spontaneous vaginal deliveries than with forceps-assisted deliveries. The paper concluded that "Although forceps assisted delivery may contribute to [intra-cranial hemorrhage] occurrence, our study found better outcomes among these infants than those who had [intra-cranial hemorrhage] following a spontaneous vaginal delivery." Dr. Lemsky's opinion did not fairly reflect the conclusions in Dr. Jhwar's study.

[625] The plaintiffs submit that Dr. Lemsky's opinion was uncontested because the defendants did not call a neuropsychologist to provide an opinion. I disagree. The reliability of her opinion was significantly undermined on cross-examination. Even assuming that a neuropsychologist is capable of providing an opinion on causation, for the reasons set out above, I do not find Dr. Lemsky's causation opinion reliable. I do not accept her opinion on causation.

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[115] Marielle van Handel et al. "Long-term cognitive and behavioural consequences of neonatal encephalopathy following perinatal asphyxia: a review" Eur J. Pediatr (2007) 166:645-654.
[116] Balraj S. Jhawar et al. "A follow-up study of infants with intracranial hemorrhage at full-term" Can J. Neurol. Sci. 2005; 32: 332-339.

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[626] I do not accept the plaintiffs' submissions on this point. The plaintiffs' "cumulative causation" theory cannot succeed because it does not provide a coherent theory of how these injuries worked together to cause any of Mr. Noel's long-term neurodevelopmental limitations. For example, Mr. Noel's current focal deficits are located in his frontal lobe, which was not affected by the neonatal injuries. The plaintiffs' experts infer causation but do not explain how they reached that conclusion or what mechanism could have been responsible. The plaintiffs' experts did not identify any scientific literature that supported their theory of causation.

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[627] I accept the evidence of Dr. Levin that none of the neonatal injuries suffered by Mr. Noel caused his neurodevelopmental limitations. I find that the plaintiffs have not proved that the cumulative effect of those injuries caused or made a material contribution to any of Mr. Noel's neurodevelopmental limitations.

7. Conclusions

[628] For the reasons set out above, the action is dismissed against each of Dr. Allen, Dr. Hawrylyshyn, and Dr. Okun.

[629] If the parties are not able to resolve costs of this action, the defendants may email their costs submission of no more than three double-spaced pages to my judicial assistant on or before August 29, 2024. The plaintiffs may deliver their responding submission of no more than three double-spaced pages on or before September 12, 2024. No reply submissions are to be delivered without leave.

[630] In conclusion, I want to thank all counsel for their excellent advocacy in this difficult trial.

Robert Centa J.

Released: August 15, 2024

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2024 ONSC 4525 (CanLII)

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

Janelle Noel and Mylo Noel, by his Litigation Guardian Janelle Noel

Plaintiffs

– and –

Dr. Peter Hawrylyshyn, Dr. Samuel Ko, Dr. Lisa Allen, Dr. Nanette Okun, Dr. Romy Nitsch, Dr. Ivor Fleming, Dr. John Doe, Nurse Marie Dennis, Nurse Guinard, Nurse Ostapenko, Nurse Hue, Nurse Jane Doe, Nurse Linda Doe, and Mount Sinai Hospital

Defendants

REASONS FOR JUDGMENT

Robert Centa J.

Released: August 15, 2024