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Résumé de l'article

Cet article résume plusieurs décisions rendues par des tribunaux canadiens depuis 2015 dans le cadre de litiges portant sur des naissances et des vies injustifiées. Le succès du demandeur dépend souvent de la question de savoir si le lien de causalité est établi, selon la prépondérance des probabilités, entre le manquement d'un médecin à la norme de diligence et le préjudice subi par les parents ou l'enfant né ultérieurement. Le fait que les médecins ne proposent pas ou ne prescrivent pas de tests de dépistage ou de diagnostic a été une source de responsabilité en cas de naissance injustifiée, et le fait de ne pas s'assurer que les patients comprennent les résultats peut l'être également. Les médecins doivent veiller à recommander des tests de diagnostic lorsqu'ils sont en présence d'indications cliniques préoccupantes, conformément aux lignes directrices de la pratique professionnelle. Compte tenu des avantages du dépistage prénatal non invasif (DPNI) et de la menace d'une responsabilité pour naissance injustifiée en cas d'omission d'en parler, il est probable qu'il soit propulsé dans une position de plus en plus importante en tant qu'offre de premier choix pour le dépistage des aneuploïdies. Le comportement prudent des médecins consiste à discuter et à proposer un DPNI et à s'assurer que les résultats sont compris. Cela peut réduire la responsabilité du médecin, améliorer l'autonomie reproductive de la patiente et parfois être bénéfique pour la santé de la patiente en prévenant ou en atténuant le traumatisme que des femmes bien informées peuvent choisir d'atténuer lorsqu'elles en ont l'occasion.

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COMMENTAIRE CRITIQUE / CRITICAL COMMENTARY (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

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Résumé
Cet article résume plusieurs décisions rendues par des tribunaux canadiens depuis 2015 dans le cadre de litiges portant sur des naissances et des vies injustifiées. Le succès du demandeur dépend souvent de la question de savoir si le lien de causalité est établi, selon la prépondérance des probabilités, entre le manquement d'un médecin à la norme de diligence et le préjudice subi par les parents ou l'enfant né ultérieurement. Le fait que les médecins ne proposent pas ou ne prescrivent pas de tests de dépistage ou de diagnostic a été une source de responsabilité en cas de naissance injustifiée, et le fait de ne pas s'assurer que les patients comprennent les résultats peut l'être également. Les médecins doivent veiller à recommander des tests de diagnostic lorsqu'ils sont en présence d'indications cliniques préoccupantes, conformément aux lignes directrices de la pratique professionnelle. Compte tenu des avantages du dépistage prénatal non invasif (DPNI) et de la menace d'une responsabilité pour naissance injustifiée en cas d'omission d'en parler, il est probable qu'il soit propulsé dans une position de plus en plus importante en tant qu'offre de premier choix pour le dépistage des aneuploïdies. Le comportement prudent des médecins consiste à discuter et à proposer un DPNI et à s'assurer que les résultats sont compris. Cela peut réduire la responsabilité du médecin, améliorer l'autonomie reproductive de la patiente et parfois être bénéfique pour la santé de la patiente en prévenant ou en atténuant le traumatisme que des femmes bien informées peuvent choisir d'atténuer lorsqu'elles en ont l'occasion.

Mots-clés
droit, bioéthique, soins prénataux, obstétrique, dépistage prénatal non invasif

Abstract
This article summarizes several Canadian court decisions from 2015 onward stemming from wrongful birth and wrongful life litigation. Plaintiff success often turns on whether causation is established, on a balance of probabilities, between a physician's breach of standard of care and the harm to the parents and/or the child later born. Physicians' failure to offer or order screening or diagnostic tests has been a source of wrongful birth liability, as too can be failure to ensure patient understanding of results. Physicians should ensure that they recommend diagnostic testing when presented with concerning clinical indications in accordance with professional practice guidance. Given non-invasive prenatal screening's (NIPS) advantages and the threat of wrongful birth liability for failure to discuss this procedure, it is likely to be propelled into an ever more prominent position as a first-choice offering for aneuploidy screening. Appropriately cautious physician behaviour involves discussing and offering NIPS, and also involves ensuring that results are understood. This can reduce physician liability, improve patient reproductive autonomy, and sometimes benefit patient health by preventing or lessening trauma that informed women may opt to mitigate when granted the opportunity.

Keywords
law, bioethics, prenatal care, obstetrics, non-invasive prenatal screening

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INTRODUCTION

Medical negligence litigation relating to pregnancy and prenatal care exists in several forms. Wrongful life claims, where a (disabled) child sues a healthcare provider for prenatal negligence but for which the child would never have been born, are not prohibited in Canada but are usually rejected on public policy grounds due to concerns about valuing life vs non-existence (1). Wrongful birth claims are more commonly successful. They consist of one or more parents suing a health care provider for negligence, such as for a failure to disclose material risks but for which the pregnancy would have been terminated. Wrongful birth claims are predicated on a failure to provide material information or appropriate care that results in "being deprived of the opportunity to make an informed choice, post conception to terminate." (2,3)

Several forms of prenatal screening exist in Canada. Ultrasound is commonly used, as is related nuchal translucency analysis, and invasive measures such as amniocentesis are generally reserved for secondary diagnostic confirmation. For clarity, fetal ultrasound can be either a screening or a diagnostic test, but for aneuploidy it is only used for screening. Notably, maternal blood-based non-invasive prenatal screening (NIPS) is an evolving technology that is becoming an established mainstream screening option in Canada, though funding varies by province. Current practice guidance from the Society of Obstetricians and Gynaecologists of Canada (SOGC) recommends that the various aneuploidy screening options be discussed with patients, as well as the option of foregoing screening, including the risks, benefits and alternatives (4). A 2020 SOGC statement, which was reaffirmed in 2021, says that during the COVID-19 pandemic, NIPS, where funded and available, can be offered as a first-choice screen (5).

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It is important for physicians involved in prenatal care to understand the common law landscape, and particularly recent court decisions on negligence torts relating to prenatal screening, diagnostic testing and decision-making. Below are summaries of several Canadian decisions from 2015 onward stemming from prenatal negligence litigation. Following these summaries, I present concluding thoughts on the law's impacts on physicians' practices surrounding prenatal testing. *Nota bene*, our institute summarized and discussed earlier key Canadian decisions in 2014 (1).

CASE SUMMARIES

***KS v. Willox,* Alberta Court of Queen's Bench in 2016 (6), affirmed by Alberta Court of Appeal in 2018 (7)**
A child born prematurely with resulting severe disabilities sued two doctors for negligence for failure to recommend either ultrasound-indicated or emergency cervical cerclage for the mother's incompetent cervix that caused premature labour. The trial judge found that the general practitioner breached standard of care for not consulting specialists and failing to schedule ultrasounds after findings including unusual discharge and spotting. Despite these breaches, the claim was dismissed as the plaintiff was found not to have established causation. Ultrasound-indicated cerclage was not recommended for first pregnancies during the time period in which the pregnancy occurred. In addition, it was not established that the mother would have undergone emergency cerclage in the narrow, approximately two-day window of time in which it would have been available. Also, the mother had contracted chorioamnionitis prior to delivery, which could have quickly necessitated removal of the cerclage stitch and would have resulted in a similar premature birth. The appeal court held that the trial judge was correct in concluding causation was not established. The Supreme Court of Canada dismissed leave to appeal.

***TS v Adey*, Ontario Supreme Court in 2017 (8)**
The parents of a child born disabled due to SALL4 gene mutation sued a radiologist and an obstetrician for negligence. They claimed the radiologist did not communicate ultrasound findings in an appropriate way and the obstetrician did not review its results or advise the parents of the concerns raised in a timely manner, to allow them the opportunity to act via further testing and elective termination. The judge found that but for the negligent actions of the doctors, the parents would have been referred to a fetal development clinic or at least a follow-up ultrasound would have been ordered. Causation was established as the court held that but for this negligence, a reasonable person in the mother's circumstances would have terminated the pregnancy.

***Beauchamp v. Gervais,* Ontario Supreme Court in 2015 (2)**
A child born with spina bifida and her parents sued a radiologist, and others who were later dismissed from the claim, for failing to read obstetrical ultrasounds and diagnose the condition. The case history does not include a trial decision, and the published court decision rejected the defendant's motion for dismissal on the basis of time limitations. The judge also struck the child off as a plaintiff, leaving only the parents. It is likely the claim was settled.

***Florence v. Benzaquen,* Ontario Supreme Court in 2020 (9), affirmed by Ontario Court of Appeal in 2021(10)**
A mother and her triplets born premature with resulting disability sued the mother's gynaecologist for prescribing the fertility medication Clomiphene without advising of the associated risks including multiple pregnancy, and despite it allegedly being contraindicated in the circumstances. The motion judge struck the claim as it is not recognized by law that doctors owe a duty of care to a future child for negligence that occurred pre-conception. The appeal court upheld this conclusion in a split decision. The application for leave to appeal to the Supreme Court of Canada was dismissed with costs.

DISCUSSION

As the above summaries elucidate, court determinations relating to prenatal care and wrongful birth/life can often turn on whether causation was established, on a balance of probabilities, between a physician's breach of standard of care and the harm to the parents and/or the child later born. A significant portion of the jurisprudence concerns failure to order or interpret and appropriately communicate ultrasound results, some of which were screening and others more diagnostic in nature. This relates in part to the fact that complex or rare ultrasound results can require a significant degree of interpretation by specialists.

Regarding failure to order ultrasounds, physicians should ensure that they order testing when presented with concerning indications in accordance with professional practice guidance. The interests of patients and the desire for a defensive medical practice may contribute to greater use of ultrasound and other screening resources, but Canadian law generally does not allow physicians to prioritize health system concerns over the interests of individual patients to whom they are fiduciaries (11).

NIPS will likely play a large role in the future of prenatal screening for aneuploidy, so it is forward-looking to consider it in relation to this jurisprudence. NIPS and related forms of prenatal genetic sequencing exist to identify very specific genetic conditions and provide clear, "Yes or No" results that are bounded with high confidence and little to no specialist interpretation. Physicians can be responsible not only for discussing and offering NIPS, but also for ensuring that patients understand the various probabilities of false positive or negative results, as well as for upholding the practice standard of recommending a positive NIPS result indicating aneuploidy be confirmed with a secondary invasive diagnostic test (4). Genetic counsellors can be helpful but do not necessarily negate physicians' fiduciary obligations in relation to patient comprehension.

NIPS is advantageous as, though it may still pose psychological and/or social risks like all prenatal screening does, it does not present a significant medical risk to pregnant women or fetuses. As such, the law covered here and previously (1) suggest that

a finding of causation is likely, and liability to physicians is therefore likely to result, in cases where they are held to have breached standard of care for failing to raise and discuss NIPS as an effective aneuploidy screening option and harm from a detectable genetic anomaly results. Liability could also derive from failing to recommend NIPS over an invasive equivalent test once a patient shows interest in undertaking aneuploidy screening, if the latter subsequently causes harm. Finally, if NIPS reveals any anomalies, a physician could face liability for failing to ensure that the results are confirmed using invasive diagnostic testing and understood by the patient. While these topics are not entirely settled in the law, the threat of wrongful birth and other liability is likely to propel NIPS into an ever more prominent position as a first-choice screening test.

Overly defensive medicine can harm patients and by extension public trust in the medical system, so it should be avoided. However, appropriately cautious physician behaviour involves discussing and offering prenatal screening, as well as diagnostic testing when indicated. It also involves ensuring results are interpreted completely and patients understand them. These behaviours can reduce physician liability and benefit patient reproductive autonomy, and in some cases can also benefit patient health by preventing or lessening serious psychological and/or physical trauma that informed patients choose to mitigate when granted the opportunity.

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