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How Can Causation Be Established in a Labor and Delivery Malpractice Action?

A malpractice action requires the plaintiff to prove: (1) the defendant caregiver owed a duty of care to the plaintiff-patient, (2) the caregiver departed from that standard of care, and (3) that departure from the standard of care actually *caused* the injury claimed by the plaintiff.

"Causation" is often the critical component in a malpractice action because the presence of a duty is often obvious, except perhaps in "Good Samaritan" cases, but the statutorily-required expert witnesses will argue about whether the caregiver departed from *some* standard of care. Because defining "causation" is difficult, there are interesting distinctions in legal versus medical, sociological, or philosophical concepts of cause-and-effect. Applying this difficult concept of "causation" to the very complex world of labor and delivery (L&D) does indeed beg the question, just how *can* causation be established? [For this brief essay, I will address the more typical negligence action against a healthcare provider. For interesting aspects of causation when health care institutions are accused of negligence, including vicarious liability, the reader is referred to Furrow BR, et al. Health Law, 2nd Edition: Ch. 7, *The Liability of Health Care Institutions*, West Group, St. Paul, 2000, pp 372-93. Please note this hornbook has been updated very recently.]

In an alleged malpractice action, causation requires the caregiver to have actually caused the plaintiff's claimed loss, termed "factual causation." This is the mechanism underlying the "but-for" test: *but-for* the caregiver's action, or lack of action, the plaintiff would *not* have suffered injury. However, the "but-for" test fails in the complex world of health care, hosting potentially multiple defendants (e.g., ob/gyns, anesthesiology staff, nurses), multiple diagnoses, preexisting diseases, and negligence or lack of compliance by the plaintiff herself. One way to deal with these complexities regarding causation has been the development of the concept, "proximate cause". [See: Furrow et al., *Liability of Health Care Providers*, b. Basic Causation Tests, pp 302-3, citing **Stecker v. First Commercial Trust Company**, 962 S.W.2d 792 (Ark 1998).]

Proximate cause doctrines allow the trier of fact flexibility in imposing duties on defendant caregivers in complex situations. The court instructs the jury that the jury may find the defendant liable "...if the injury is the natural and probable consequence of the original negligent act or omission *and* as such might reasonably have been foreseen as probable." [See: Furrow et al., *Liability of Health Care Providers*, b. Basic Causation Tests, pp 302-3, citing **Stecker v. First Commercial Trust Company**, 962 S.W.2d 792 (Ark 1998).] Often, the defendant "proximately causing" the injury is that actor closest to, or most "proximate" to the alleged injury. But that is not necessarily true in all situations – perhaps especially in L&D.

Proximate cause is difficult to apply when there are multiple defendants. What if each alleged act of negligence, by itself, was not enough to cause the injury, i.e. there is a lack of independently sufficient causation? Is the admitting ob/gyn liable for a nonreassuring fetal electronic monitoring result if the labor nurse fails to alert the doctor as to the ominous new finding? The ob/gyn will be accused of failing to timely deliver, but isn't the nurse, at least, co-negligent as

well? And if so, to what degree, or even percentage attributable, of the total damages should the nurse be responsible?

Intervening causes can also complicate proving up proximate cause. For example, a doctor is accused of lack of timely delivery of a distressed baby. Yet the mother was known to be high risk due to hypertensive disease, thyroid disease, and advanced maternal age. Also, she called her ob/gyn's on-call partner complaining of decreased fetal movements, but failed to arrive at the hospital until 12 hours after she was initially instructed to go to an emergency room. The on-call ob/gyn called ahead, preparing for the worst; he even selected his favorite nurse working that day to evaluate the patient on arrival. Within an hour of hitting the front door of the hospital, the patient is welcomed; admitted; evaluated; labs are drawn; an intravenous line is started; she is electronically monitored, which demonstrates non-reassuring fetal tracing; an urgent cesarean section is called; anesthesia is consulted; and the baby is delivered by the on-call ob/gyn - with some not-unforeseeable subsequent neonatal respiratory problems due to meconium passage. The defendant-physician claimed during litigation that the patient's preexisting conditions were a contributory cause, possibly an intervening cause of the fetus's challenges, and the patient herself was more proximate in causing the alleged damages than the caregiver (i.e., "contributory negligence"). [This suit was dropped upon explaining this logic after the original petition was filed.]

Proximate cause includes an aspect of "foreseeability." The first prong of foreseeability is "subjective": did the caregiver actually know and foresee the potential harm from his or her actions, or lack thereof? However, a defendant cannot evade responsibility for his or her act via a form of willful blindness or ignorance. Because of this, the "objective" prong in testing for foreseeability is whether the vast majority of similar caregivers, in the same or similar circumstance, would be able to foresee the possible injury?

Whereas proximate cause instructions are given to juries in most states, alternative causation instructions do exist. Some years ago, California used a "substantial factor" test: the jury was asked whether the defendant's conduct was a "substantial factor" in bringing about harm, thus allowing the jury to find against the defendant even if the defendant's conduct was only a contributing factor, not necessarily the most direct, most important or sole factor, or the most proximate factor. Concepts of causation are likely to continue to evolve within American jurisprudence over time.

What are possible defenses in the typical L&D scenario where a caregiver, say an ob/gyn, is accused of failing to timely deliver a fetus that ends up having neurologic impairment sometime over the next 18+ years? [Statutes of limitation for impaired newborns vary, often tied to the statutorily defined age of majority, or adulthood. Of course, all statutes can be updated, concepts of causation updated, and venues can differ.]

- The ob/gyn did not owe an actual duty (the patient was delivering with a midwife; the ob/gyn was not 'on call'; or, a "Good Samaritan" situation occurs, when an ob/gyn is called in to deliver a complete stranger because the attending caregiver cannot be found).
- The ob/gyn actually fulfilled his or her *standard* duty; the plaintiff is erroneously asserting that she should have been provided exemplary or outstanding care.

The two defenses above deal with 'duty' and 'breach of duty.' Potential defenses regarding causation include:

- Preexisting cause(s), e.g. medical condition(s) of the patient that put her at high risk for an injury;
- Multiple caregivers, i.e., the ob/gyn's care was not the "most proximate" to the alleged damages, as a nurse-midwife and anesthesiologist also acted when delivering the fetus;
- Some other intervening cause actually resulted in the injury, not the ob/gyn's care, e.g., placental abruption caused by cocaine use, not the hypertension the doctor was managing;
- The injury was not foreseeable by the 'reasonable' ob/gyn, e.g., an unsuspected chromosomal anomaly causing sudden intrauterine fetal death during labor;
- The patient assumed the risk by her choice, e.g., refusing transfusion or cesarean delivery; or
- A lack of scientific plausibility that the ob/gyn's action actually caused the injury, i.e. the claim of negligence was based on 'junk science,' or an expert opinion was given without a scintilla of scientific proof.

A hospital's L&D service is part operating room, part waiting room, part trauma center, and part emergency room. In L&D, one can experience unimaginable joy, and deafening grief – many times in the same typical day. Caregivers need to be held accountable for their actions and lack thereof, of course, but also need to be given the support and mechanisms to provide standards of care – or even than standard care – to their patients and their babies. Accurate, transparent documentation, ongoing meaningful caregiver education, and fair review and analysis of cases will contribute to the greater good of women and their infants, their families, and society overall.

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"In honor of the outstanding ob/gyn Dr. Timothy B. Waterhouse, February 25, 1967 to December 13, 2013 – gone now one year."