

Structuring the Issues in Informed Consent

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Introduction

Canadian courts, at all levels, have recently been called upon to deal with the issues raised by consent to medical care. These decisions have clarified many issues but some problems remain, principally due to two factors. First, the courts have only been able to deal with the issues raised by the facts of the particular cases before them; thus, although a judgment such as the Supreme Court of Canada's decision in *Reibl v. Hughes*¹ laid down relatively clear guidelines, it did so only with respect to certain issues. Secondly, and with all respect, some judgments are confused and confusing. The cause of this confusion has been failure to structure adequately the doctrine of consent before applying it to the facts of a particular case. Such failure can result in inaccurate or vague decisions that are difficult for both the legal and medical professions to use as a guide to future conduct.

It is the aim of this enquiry to establish a decision-making structure which will organize and assist in determining the legal issues relating to the *consent of competent adults* in the medical relationship. One hopes that such a structure will prove useful in ascertaining the conduct required and in reaching decisions in subsequent cases. To establish this structure it is first necessary to trace the development of the law of informed consent in Canada. This will include consideration of recent cases on consent in the Supreme Court of Canada, how these cases have altered the law, and the issues left unsettled.

There are many other aspects of consent which could be explored, from the purposes served by requiring it, or the values and philosophical principles underlying it, to its role and function when the subject of a medical intervention is either incompetent or a minor.² One reason for limiting this discussion to the competent adult model is that close analysis of the issues raised by consent in that context is a prerequisite to dealing with the more complicated problems that arise with incompetents or minors.³

¹ (1980) 114 D.L.R. (3d) 1, *rev'd* (1978) 21 O.R. (2d) 14 (C.A.).

² For a general discussion of medical consent, see Somerville, *Consent to Medical Care* (1979).

³ See, e.g., *Re Eve* (1980, 1981) 115 D.L.R. (3d) 283 (P.E.I.S.C. *in banc*), *rev'd* (1979) 10 R.F.L. (2d) 317 (P.E.I.S.C.). This case is now on appeal before the Supreme Court of Canada.

I. Battery or negligence?

The proper cause of action when a defective consent is alleged may be either battery or negligence. The difference is significant because:

It will have important bearing on such matters as the incidence of the onus of proof, causation, the importance of expert medical evidence, the significance of medical judgment, proof of damage and, most important, of course, the substantive basis upon which liability may be found.⁴

While each of these factors will not be discussed in detail here, it is necessary to be aware of them.⁵

Common law courts in Canada have taken the traditional approach that the consent that is both necessary and sufficient for avoiding a cause of action in battery in medical cases is consent to "the basic nature and character of the operation or the procedure".⁶ The difficulty in applying this rule is determining which factors form part of the basic nature and character of an act and which do not.⁷ Such determinations have been made by judges on a case-by-case basis, with no more definite guidelines than the rule itself. But

⁴ *Kelly v. Hazlett* (1976) 15 O.R. (2d) 290, 310 (C.A.). The Supreme Court of Canada disapproved of *Kelly v. Hazlett* in part in *Reibl v. Hughes*, *supra*, note 1.

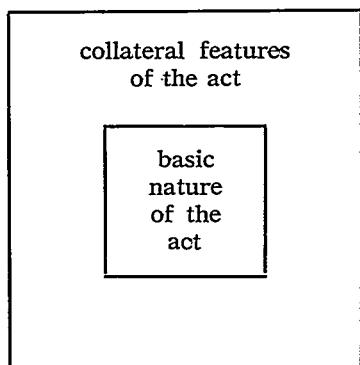
⁵ It should be noted that this problem of the proper cause of action and the differences between one cause of action and another does not present itself in the same way in the civil law of Quebec. Liability based on delict or quasi-delict is governed by Art. 1053 of the Civil Code, whether or not the offending conduct would found an action in battery or negligence at common law. Thus any differences in the way in which two claims, both falling under Art. 1053 C.C., are handled, does not depend on a difference in the basis of liability (cause of action), as it does at common law, but on the different facts or circumstances of the two cases. However, a claim based on a breach of duty in the physician-patient relationship is more likely to sound in contract in the civil law than it would at common law, and contrary to the civilian doctrine of *cumul*, which would allow a plaintiff to claim in both delict or quasi-delict and contract in relation to the same facts which it is alleged give rise to liability, there is a trend to exclude delictual or quasi-delictual liability to the extent that the obligation in issue has a contractual basis. Support for this trend depends on also excluding a doctrine of *option*, as argued by Professor P.A. Crépau (*La responsabilité médicale et hospitalière dans la jurisprudence québécoise récente* (1960) R. du B. 434, 470-2), but the doctrine of *option* was recently endorsed by a unanimous bench of the Supreme Court of Canada in *Wabasso Ltd. v. The National Drying Co.* (dated 22 June 1981).

⁶ *Kelly v. Hazlett*, *supra*, note 4, 313.

⁷ There may be liability in negligence even though there may be no liability in battery for failing to disclose consequences which are not part of the basic nature and consequences of an act: see *infra*.

some judges have tried to formulate a clearer, more objective rule, which would help determine when non-disclosure of information or failure to obtain consent should give rise to a cause of action in battery.⁸

The situation facing the judges can be represented diagrammatically:



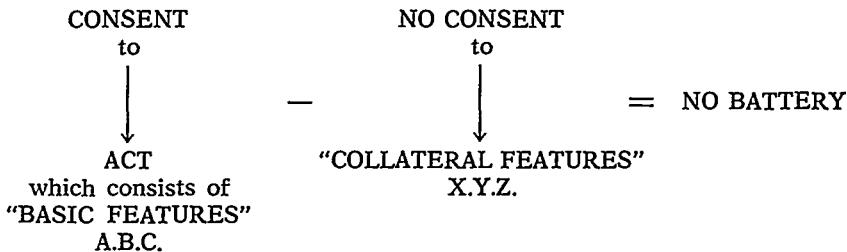
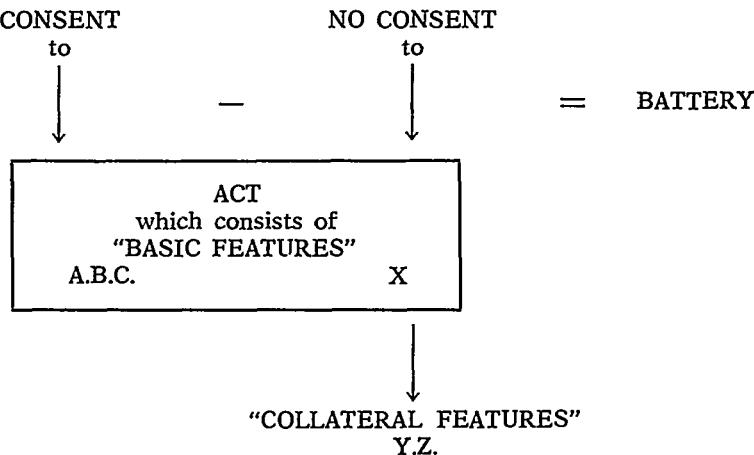
The outer square represents all the consequences or risks to which the patient must consent if liability in tort (battery or negligence) for failure to obtain consent is to be avoided. The inner square represents the factors that make up the basic nature and character of the act of touching. Failure to obtain consent to these factors will give rise to a cause of action in battery. Thus, whether or not battery lies depends on where the inner line is drawn.

That judges will vary in drawing this line, even with respect to the same facts, can be seen by comparing the decision of the majority of the Supreme Court of Canada in *R. v. Bolduc & Bird*⁹ with that of the dissent and that of the Court of Appeal of British Columbia in the same case. Likewise, the judgment of the majority of the Court of Appeal of Ontario in *R. v. Maurantonio*¹⁰ can be compared with that of the dissent. These are criminal assault (battery) cases, but the rules governing consent in criminal law and in the tort of battery not only have common origins but are directly comparable. Such cases demonstrate that because criminal assault (or battery) will not lie if there is consent as to the basic nature and character of the act, liability will depend on whether or not the feature to which consent has *not* been obtained forms part of the act's basic nature and character. Thus, to the extent that there is discretion involved in determining whether or not a particular feature forms part of the basic nature and character of the act ("basic features"), there is discretion as to the imposition of liability. The two possible alternative analyses of any given fact situation that gives rise to this discretion may be represented as follows:

⁸ See, e.g., *Kelly v. Hazlett*, *supra*, note 4.

⁹ [1967] S.C.R. 677, *rev'd* (1967) 61 D.L.R. (2d) 494 (B.C.C.A.).

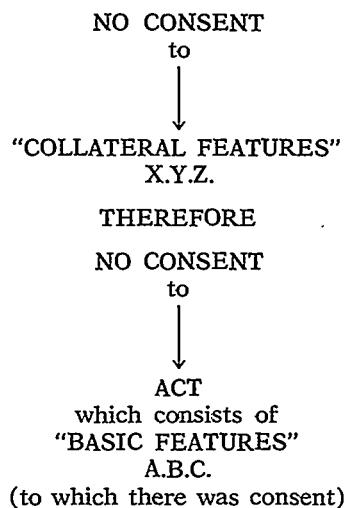
¹⁰ [1968] O.R. 145.

Analysis I:**Analysis II:**

From this diagram it can be seen that, depending on whether or not X¹¹ is held to be a "collateral feature" or a "basic feature" of the act alleged to constitute criminal assault or the tort of battery, the necessary consent will or will not be present, respectively, and liability will be determined accordingly.

There is another way in which a holding as to whether or not battery-avoiding consent is present can be varied. This does not require altering the characterization of a feature of the act from "basic" to "collateral" or *vice versa*, but rather makes consent to the act conditional upon the collateral features being as represented. Using the same model this can be represented as follows:

¹¹ In *R. v. Bolduc & Bird* (*supra*, note 9) and *R. v. Maurantonio* (*supra*, note 10), the feature which X would represent was as to the holding of professional medical qualifications by the person observing or conducting, respectively, a medical examination. The question in both cases was whether having such qualifications was part of the basic nature and character of a medical examination. If it were, a person without such qualifications could not conduct a true medical examination and, if he attempted to do so, the act consented to would not be the act carried out and assault would be



established. If, on the other hand, such qualifications are only a collateral feature, there may be consent to the act of examination and hence no assault, although fraud as to the qualifications of the person conducting it. In *R. v. Maurantonio* the majority of the Ontario Court of Appeal held that the patients seen by the accused had only consented to being examined by a medically qualified person, that such qualifications related to the basic nature and quality of the act of examination and, consequently, fraud as to the holding of medical qualifications vitiated consent to the examination. In contrast, the dissent held that the holding of professional qualifications did not relate to the nature and quality of the act of examination. In *R. v. Bolduc & Bird* the majority of the Supreme Court held that "[t]he fraud that was practised on [the patient] was not as to the nature and quality of what was to be done but as to Bird's identity as a medical intern" (*supra*, note 9, 680). In this case the person who actually examined and carried out a medical procedure on the woman patient was medically qualified, but his "voyeur" friend, Bird, who did not touch her, was not. The majority of the Court stated that if Bird had touched the woman there would have been an "unlawful assault", which indicates that they treated fraud as to qualifications as going to the basic nature and character of an act and as capable of vitiating assault-avoiding consent. But here there was no *actus reus* of an assault, no touching by the person without qualifications and hence the presence or absence of consent to such an act was irrelevant. In comparison, Mr Justice Lord of the British Columbia Court of Appeal held that the patient's consent was vitiated because she only consented to being examined in the presence of medically qualified persons and when this was not the case there had been "a drastic change in the nature and quality of the act and ... [therefore] the consent she gave cannot be considered as a consent to the thing done to her and cannot be relied upon by the appellants" (*supra*, note 9, 495). Lord J.A. thus characterized what constituted the act of assault more broadly than the Supreme Court and hence found that consent to the act had been vitiated by fraud as to one of the accused's qualifications.

Pursuant to this analysis, it is irrelevant whether X is characterized as a "basic" or "collateral" feature, as even if X is a "collateral" feature, if X is not as represented, the consent will fail to "flow through" as a valid consent to the act. *R. v. Williams*,¹² in which the accused, a choir-master, persuaded a young woman that sexual intercourse was therapy for her voice, is probably an example of a court taking such an approach. Depending on the circumstances, whether an act is therapeutic for the patient could be regarded as a "collateral" feature of the act or could relate to the basic nature of the act. However, accepting that in the particular circumstances characterization of an act as therapy is a collateral feature, battery could still lie when there is fraud or misrepresentation in this respect. For instance, if, as in the *Williams* case, a collateral feature of an act was not as represented (that is the act of sexual intercourse was not voice therapy), then despite the consent to the act itself (having sexual intercourse), that consent would be invalid, as the Court held, because consent to the act was conditional on the collateral feature (that the act was therapy) being as represented. Although this example may seem very far removed from a normal medical context, it may have important applications. For instance, if a patient were misled to the effect that a particular procedure was therapeutic when in fact it was performed for the purposes of non-therapeutic research, battery-avoiding consent could similarly be vitiated.

How has the law outlined above been applied in the medical relationship? The requirement that there be consent to the basic nature and character of the operation or procedure means that a physician must disclose all inevitable consequences of a proposed procedure in order to obtain battery-avoiding consent. Consequently, all courts faced with the issue have held that there will be a cause of action in battery when a physician does something to which the patient has not consented at all, or which the patient has expressly requested not be done¹³ or has refused. Battery could also be established where the physician's act was essentially different in nature from that to which the patient consented. For instance, if the patient was told that the purpose of the operation was to relieve pain, but not told that the consequences would include sterility, any consent given would be invalidated and a cause of action in battery would be available.

¹² [1923] 1 K.B. 340 (C.C.A.).

¹³ See *Allan v. New Mount Sinai Hospital* (1980) 28 O.R. 356 (H.C.); see also *Beausoleil v. La Communauté des Soeurs de la Charité de la Providence* [1965] B.R. 37 for a similar situation in Quebec law.

Some courts have also held that knowledge of certain risks could be so material to understanding of the basic nature and character of an operation that failure to disclose them would vitiate battery-avoiding consent.¹⁴ In other words, it has been held that not only non-disclosure of inevitable results of a procedure can vitiate battery-avoiding consent, but also non-disclosure of risks of which knowledge was "essential to an informed decision to undergo the operation".¹⁵ It is with respect to failures to disclose a risk, as compared with an inevitable consequence, that the Supreme Court of Canada has probably restricted the availability of an action in battery.

It is not easy to decide, from a policy point of view, whether or not a cause of action in battery should be allowed for non-disclosure of certain risks. The argument that it should be allowed is that some risks are so serious that they necessarily relate to the basic nature and character of an operation and, therefore, their non-disclosure should give rise to a battery action. The difficulty is that as only some risks have this effect, how is the line to be drawn between those that do and those that do not? The alternative solution, which may be the position adopted by the Supreme Court of Canada in *Reibl v. Hughes*, is that any liability for non-disclosure of a risk can only lie in negligence and not in battery.¹⁶

[A]ctions of battery in respect of surgical or other medical treatment should be confined to cases where surgery or treatment has been performed or given to which there has been no consent at all or where, emergency situations aside, surgery or treatment has been performed or given beyond that to which there was consent [U]nless there has been misrepresentation or fraud to secure consent to the treatment, a failure to disclose the attendant risks, however serious, should go to negligence rather than to battery. Although such a failure relates to an informed choice of submitting to or refusing recommended and appropriate treatment, it arises as the breach of an anterior duty of due care, comparable in legal obligation to the duty of due care in carrying out the particular treatment to which the patient has consented. It is not a test of the validity of the consent.¹⁷

That is, non-disclosure of a risk will not give rise to a cause of action in battery except when there has been a "misrepresentation or fraud to secure consent to ... treatment". But what can constitute misrepresentation within this rule, and why does such misrepresentation allow non-disclosure of a risk to give rise to an action in battery, whereas without such misrepresentation it does not?

¹⁴ *E.g., Kelly v. Hazlett, supra*, note 4, 313.

¹⁵ *Ibid.*

¹⁶ *Supra*, note 1, 7-10.

¹⁷ *Ibid.*, 10-1.

In exploring these issues it is necessary to determine the basis of the holding of the Supreme Court referred to above. Is it, first, that non-disclosure of a risk does not amount to misrepresentation (although that of an inevitable consequence can); or, second, that information about risks can never relate to the basic nature and character of an operation and thus cannot vitiate battery-avoiding consent; or both propositions; or neither? Presumably, the Court has established the second proposition rather than the first, as it is difficult to draw a distinction between one type of non-disclosure (non-disclosure of inevitable consequences) constituting misrepresentation, and the other (non-disclosure of risks) not doing so. It may be argued that because there is a pre-existing duty to disclose inevitable consequences, but not risks, non-disclosure of inevitable consequences constitutes a misrepresentation, while that of risks does not. But this pre-empts the question to which an answer is sought, that is, just what information is there a duty to disclose so as to avoid an action in battery? Moreover, reliance on a rule that total non-disclosure of a risk does not give rise to a cause of action in battery, because a total non-disclosure cannot constitute misrepresentation, would not exclude a *partial disclosure*. But an approach that recognizes partial but not total non-disclosure of risks as misrepresentation would be artificial and could give rise to fortuitous results. Further, the distinction between nonfeasance and misfeasance has no place when there is a pre-existing duty relationship, as there is between physician and patient.

If the Court has not relied on a rule that a non-disclosure is unable to constitute misrepresentation, has it held that the risks of a procedure cannot relate to its basic nature and character? This question can be explored by asking what the situation would be where a significant and serious risk was grossly misrepresented, rather than undisclosed. This could, arguably, give rise to a cause of action in battery within the Court's ruling. However, the fact that misrepresentation of a risk could give rise to a cause of action in battery means, by definition, that the misrepresentation must relate to the basic nature and character of the act. If this is true it shows that the action in battery is not excluded because of the nature of the misrepresentation, that is because the misrepresentation related to a risk and a risk cannot relate to the basic nature and character of a procedure, but that battery is excluded on some other basis.

If the above analysis is accepted the basis of the Supreme Court's holding is not that total non-disclosure of risks cannot constitute misrepresentation, nor that risks cannot relate to the

basic nature and character of a medical procedure. This leaves the question which reveals the key to the basis of the Supreme Court's ruling still unanswered. Why does "misrepresentation or fraud to secure consent to the treatment" cause non-disclosure of a risk to give rise to a cause of action in battery, where it would not do so if the elements of misrepresentation or fraud were not present?

The true test of whether or not a cause of action in battery will lie for non-disclosure of a risk, provided the risk is serious and sufficiently likely of occurrence to relate to the basic nature and character of the act carried out, depends on the *nature of the physician's conduct with respect to the non-disclosure*. Not only the nature of the undisclosed information is significant, but also the nature of the *failure* to disclose. It is proposed that, if the physician negligently (*i.e.*, unintentionally) fails to disclose or misrepresents a risk, he will be liable in negligence. If he intentionally does either of these things the action will also lie in battery, provided that the risk which is not disclosed or is misrepresented is fundamental enough to relate to the basic nature and character of the procedure.¹⁸ Thus the presence or absence of intention with respect to the non-disclosure of a risk which relates to the basic nature and character of an intervention will determine the causes of action available for failure to obtain consent to that risk. By contrast, when the non-disclosure relates to an inevitable consequence of an intervention, intention or lack of it in relation to the non-disclosure is irrelevant to establishing a cause of action in battery. This is true because the intention necessary to support a cause of action for battery arising from an intentional, non-consensual touching of the kind which occurs is present in carrying out the act which has those inevitable consequences, regardless of the presence or absence of intention with respect to the non-disclosure.

Hence, what is being suggested is that the intention necessary to support an intentional tort will be found in relation to a different element of the tortious act (that is, either the touching or the non-disclosure) depending on whether the failure in obtaining consent

¹⁸ It may be argued that it is inappropriate to have both battery and negligence available on the same set of facts. Historically, this was not unusual (see Prichard, *Trespass, Case and the Rule in Williams v. Holland* [1964] C.L.J. 234), and the reason for which this was true is equally applicable here. It occurs because the plaintiff pleads in a lesser cause of action in terms of the culpability of the defendant than he might have done; *i.e.*, he pleads in negligence (or, formerly, in an action on the case) when he could have pleaded in battery.

relates to failure to inform of risks or of inevitable consequences, but in both cases, the necessary intention may be present.

In relation to determining whether the touching itself was intentional, there is a key concept: the question which must be asked is not simply whether there was consent to a touching, which in most cases there will be, but whether there was consent to touching *of that kind or in that manner*. Likewise, it is relevant to ask not only whether there was intention to touch, but whether there was intention to touch *in that manner*. The concept of intention "to touch in that manner" is broader and more precise than the concept of just touching. It includes the inevitable consequences and purposes of an intervention, as well as the touching itself. Because risks, by definition, may not occur, it is not possible to find the required intention to touch in the manner which results from risks occurring simply by demonstrating their crystallization. Any proof of intention relates, rather, to the act of non-disclosure of these risks. By contrast, when what occurs is an inevitable consequence of an intervention it can be presumed that this was intended, as in tort a reasonable person is presumed to intend the inevitable consequences of his acts. Consequently, in the latter case, the necessary intention to support intentional touching in that manner and a *prima facie* tort of battery is established by proving the touching, and the only question is whether or not there was sufficient consent.

An objection could be raised here that two different entities are being compared: in one case the question asked is whether or not there is *intentional non-disclosure of information* to which the patient is entitled: that is, is there intentional failure to obtain consent? In the other case the question is whether there is *intentional touching* in a situation where the failure to obtain consent to that touching may have been intentional or unintentional. It is submitted that there is no contradiction between these two approaches. Battery is an intentional tort, which may be established through the intention "to touch in that manner" or the intentional failure to obtain the necessary consent. It is just that demonstrating the latter is superfluous when it can be shown that there was an intention to touch in a certain manner to which there was no consent.

There is one further problem with the Supreme Court's approach to actions in battery for failure to obtain adequate consent. Some risks are so important that most people would regard them as an essential part of any description of the basic nature and character of a procedure. For instance, the fact that an operation

carries a substantial risk of death would cause most persons to characterize that operation as being of a serious nature. Further, can any real distinction be drawn between failure to disclose, for instance, that as a result of an operation a person will certainly be rendered sterile, and failure to disclose that there is a substantial risk of this occurring? It is submitted that the law should not try to draw distinctions that do not accord with generally held views as to what factors constitute the basic nature and character of an act, no matter how conceptually pleasing and easy of application the resulting rule may be.

Thus, with all respect, it is submitted that to the extent that the Supreme Court has limited the availability of an action in battery by stating the law to be that risks do not relate to the basic nature and character of an act and, consequently, their non-disclosure cannot vitiate battery-avoiding consent, the ruling may not be desirable. However, as shown above, the effect of the Supreme Court's ruling on the availability of a battery action will vary, depending on how it is analyzed. The analysis suggested accepts the Supreme Court's ruling but minimizes its effect of making unavailable a battery action that otherwise would have been available under Canadian common law.

The approach suggested may be summarized as follows: in all cases where lack of consent is alleged, one is arguing either that there was no consent at all to the touching or to touching in that manner. The first question is whether the touching itself and in that manner was intentional. It is highly unlikely that the touching itself will be unintentional, but this is not true of the manner of the touching. The manner of the touching includes two types of consequences: inevitable consequences and risks which eventuate. When the feature of the touching to which it is alleged there was no consent is an inevitable consequence, then there will necessarily have been an *intention* to touch *in that manner*. When, on the other hand, the touching is of that manner because of the crystallization of a risk, touching *in that manner* is *unintentional* (unless, possibly, the risk which eventuates was of very high probability, but this case will not be considered here). In the second case, it may initially seem that battery should not lie for non-disclosure of a risk, as the act of which the plaintiff complains — that he was touched in a manner to which he did not consent — was unintentional. However, a second question is relevant: whether the failure to obtain consent was intentional. It is suggested that where it is intentional, and provided the non-disclosure is of a sufficiently serious and probable risk that the risk can be said to

form part of the basic nature and character of the intervention, the necessary intention for a cause of action in battery will exist. Such an approach would allow non-disclosure of certain risks because of "misrepresentation or fraud" to give rise to a cause of action in battery, as the Supreme Court suggests. It would include within the notion of misrepresentation some total non-disclosures; that is, intentional concealment of certain risks would suffice. Thus, only the unintentional non-disclosure of a risk that relates to the basic nature and character of an act would not be actionable in battery. The suggested approach and the correlation of the variables it includes can be demonstrated in the following way:

Non-disclosure:	of inevitable consequence	of "sufficiently serious and probable" risk
INTENTIONAL	Battery	Battery
UNINTENTIONAL	Battery	Negligence

Defects in consent which do not give rise to a cause of action in battery will be either actionable in negligence (or possibly in contract¹⁹) or will not be actionable at all. The dividing line between those that are actionable in negligence and those that are not actionable at all is determined by whether or not the physician has breached the standard of care required of him by the law relating to negligence with respect to obtaining the patient's consent. The substantive content of this duty is discussed below.

Finally, it is appropriate here to note that some confusion may be caused because two doctrines "consent" and "informed consent" are not distinguished. It is suggested that the word "consent" be reserved to refer to the substantive entity which must be present to avoid liability in battery and similarly for the term "informed consent" in relation to negligence. It is proposed that with respect to the substantive content of consent the traditional notion should be retained. This means that consent will be present when there is consent to the basic nature and character of the act. Informed consent is a more extensive concept that also comprehends consent to certain consequences or risks of consequences. But, as further discussion will show, there has not always been consensus as to its requirements. It necessarily includes all elements of the consent doctrine, but the reverse is not true. Thus a physician may have obtained sufficient consent to avoid liability in battery, but not in negligence.

¹⁹ See, e.g., the discussion in *Dendaas (Tylor) v. Yackel* (1980) 109 D.L.R. (3d) 455 (B.C.S.C.).

II. Scope of disclosure

What must physicians disclose in order to fulfill their legal duty to obtain informed consent?²⁰ This has been a vexed issue for the courts and some problems remain. However, the Supreme Court of Canada has now settled one matter on which there was uncertainty, that is, the standard for determining the scope of disclosure.

A discussion of the scope of disclosure of information required in any given circumstances in order to obtain informed consent, like any decision by a court concerning it, involves three determinations, which must be undertaken in a particular order. First, the scope of disclosure "normally" required by the law must be determined. Within this context, the effect of a proposed intervention being therapeutic or non-therapeutic and "practice" ("pure" therapy) or research,²¹ must be considered. Secondly, it must be asked whether this "normal" scope of disclosure may be restricted in some circumstances, which necessitates consideration of waiver and "therapeutic privilege". Thirdly, does the law recognize any mechanism for extending the "normal" scope of disclosure? Here one must consider the effect of the patient's questions.

A. Determining the scope of disclosure "normally" required by law

1. Therapeutic interventions

a. "Pure" therapy

The physician-patient relationship is a fiduciary one²² which means that unlike "arm's length" transactions (where the law only imposes a duty to be honest and, in certain circumstances, not to be negligent with respect to one's statements), there is a positive duty on the part of the physician to inform the patient. This type of duty is sometimes described as one of trust, confidence and conscience. It arises when the law recognizes an imbalance in power or status or position between the parties to a relationship, such that the person in the position of authority must prove that he did not abuse this authority. In the medical relationship the physician would abuse his authority if he failed to accord sufficient respect to the patient's rights to autonomy and inviolability.

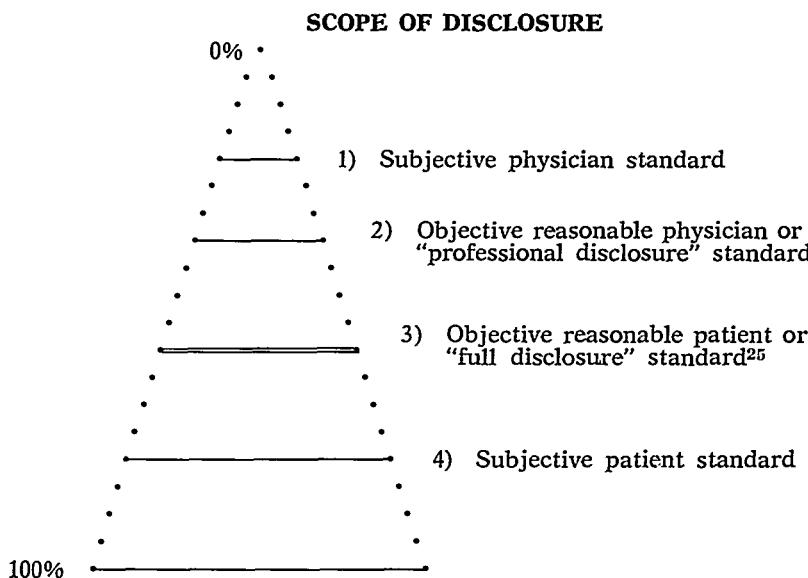
²⁰ Because the scope of disclosure necessary for informed consent is wider than that for consent, the more extensive concept is surveyed here except where the contrary is stated.

²¹ For definition of the terms "practice" and "research", see Somerville, *Clarifying the Concepts of Research Ethics: A Second Filtration* [1981] Clinical Research [forthcoming].

²² See *Kenny v. Lockwood* [1932] O.R. 141 (C.A.).

The rights of the patient require, if it is at all possible, that the patient be placed in a situation where he can make his *own* decisions regarding medical treatment. In order to make such decisions the patient needs information. In deciding what information must be supplied to the patient, two situations must be distinguished: where the patient asks questions and where he does not.

Where the patient has not asked any questions about a purely therapeutic (*i.e.*, non-research) treatment which he is to receive, what must the physician disclose to fulfill his legal duty to inform? The court could adopt several possible responses: what the physician thinks the patient ought to be told (the subjective-physician standard); what the reasonable physician of that specialty would tell the patient in the same circumstances (the reasonable physician or the "professional disclosure"²³ standard); what the reasonable patient would want to know in those circumstances (the reasonable patient or the "full disclosure"²⁴ standard); or what that patient wants to know (the subjective-patient standard). These four possible standards require progressively more information to be disclosed. This can be represented diagrammatically as follows:



²³ See Picard, "The Tempest of Informed Consent" in Klar, *Studies in Canadian Tort Law* (1977), 129.

²⁴ *Ibid.*

²⁵ It may be unfortunate that the term "full disclosure" has been adopted to describe the standard of disclosure based on informing the patient of all those consequences and risks which would be material to the reasonable

It is possible to find examples of acceptance of each of these standards in various Canadian and American cases. However, almost without exception, courts now reject the first standard as being too paternalistic and as not conforming to the usual legal standard of care exacted of physicians in relation to other duties apart from consent: that is, a physician may not, solely according to his own discretion, establish what is a legally acceptable standard of conduct in relation to a particular matter, but must, at least, conform to the norms of the profession in that respect. Likewise, the fourth standard is rejected as affording the patient too much the advantage of hindsight, as the patient can always claim that *he* wanted to know a certain fact that was undisclosed. Consequently, the choice is between the "reasonable physician" and the "reasonable patient" standards and, until very recently, most Canadian courts had adopted the "reasonable physician" standard as the norm.²⁶ In doing so it was not uncommon to find a court distinguishing those American judgments²⁷ which had accepted the "reasonable patient" standard.²⁸ However, the Supreme Court of Canada, in *Hopp v. Lepp*, and even more clearly in *Reibl v. Hughes*, changed the required legal standard of disclosure from standard 2 to standard 3. The latter standard requires a physician to disclose all those consequences and risks which would be material to a reasonable patient in the same circumstances. And "[a] risk is ... material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to undergo the proposed therapy."²⁹

This change in the law does not mean that medical evidence is irrelevant to setting the required scope of disclosure. As the Supreme Court explains,³⁰ it is just that such evidence is no longer

patient in the same circumstances. This would be true, if the term "full disclosure" were to cause confusion, as it might. The denotation of the term "full" tends to indicate that all possible information must be disclosed, but, as can be seen from the diagram this is not necessarily the case.

²⁶ See, e.g., *Kelly v. Hazlett*, *supra*, note 4; *Reibl v. Hughes*, *supra*, note 1 (C.A.); *Lepp v. Hopp* (1979) 98 D.L.R. (3d) 464 (Alta C.A.), *rev'd sub nom. Hopp v. Lepp* (1980) 112 D.L.R. (3d) 67 (S.C.C.).

²⁷ See, e.g., *Canterbury v. Spence* 464 F. 2d 772 (D.C. 1972).

²⁸ See, e.g., *Kelly v. Hazlett*, *supra*, note 4, 319.

²⁹ Waltz & Scheuneman, *Informed Consent to Therapy* (1970) 64 Nw. U. L. Rev. 628, 640, adopted by the Court in *Canterbury v. Spence*, *supra*, note 27 and quoted by Laskin C.J.C. in *Hopp v. Lepp*, *supra*, note 26, 80.

³⁰ *Reibl v. Hughes*, *supra*, note 1, 124.

sufficient to determine the full scope of disclosure that the law requires.³¹ In particular medical evidence is still necessary

to establish (1) *risks* inherent in a given procedure or treatment, (2) the *consequences* of leaving the ailment *untreated*, (3) *alternative* means of treatment and their risks, and (4) the *cause* of the injury suffered by the plaintiff-patient. Finally, if the defendant-physician claims a privilege, expert testimony is needed to show the existence of (1) an emergency which would eliminate the need for obtaining consent, and (2) the impact upon the patient of risk disclosure where a full disclosure appears medically unwarranted.³²

What would the reasonable physician disclose and how is this to be determined? The court will hear expert evidence on what physicians of that specialty tell their patients, but this evidence does not automatically become part of the accepted legal standard, even as far as disclosure of medical risks is concerned. It is taken into account when the court *determines* the legal standard.³³ These two standards (the standard of disclosure of the profession and the one determined by the court) will usually be identical, but need not necessarily be so. This allows the court a discretion to reject or alter the accepted professional standard if it considers it inadequate.³⁴

Factors that will invariably require disclosure because they will always be material to any reasonable patient include the nature of the procedure, its seriousness, its purpose and whether it is necessary or elective. With respect to other effects of a given medical intervention that must be disclosed, the distinction between inevitable consequences and risks is again relevant.

Inevitable consequences of the proposed treatment, and of its alternatives, including foregoing all treatment, must be disclosed. The only exception to this would be if the consequences in question were matters of such common knowledge that the physician could assume the patient knows of them and, consequently, that there is no need to make an express disclosure in order to inform the patient. Of course, if the physician had actual knowledge that the patient was not so informed any presumption that the

³¹ See Somerville, *Legal Investigation of a Medical Investigation* [1981] Alberta L. Rev. [forthcoming].

³² See *Reibl v. Hughes*, *supra*, note 1, 13-4: the passage quoted is from a discussion of *Canterbury v. Spence*, *supra*, note 27, in *New Trends in Informed Consent* (1975) 54 Neb. L. Rev. 66, 90 (emphasis added).

³³ See *Reibl v. Hughes*, *supra*, note 1; *Hopp v. Lepp*, *supra*, note 26, 80 (S.C.C.).

³⁴ For an example of a court exercising such a discretion, see *Helling v. Carey* 519 P. 2d 981 (Wash. 1974).

patient was informed arising from "common knowledge" would be rebutted, and the physician would have an obligation to inform the patient expressly of these consequences.

Risks include chances of benefit and chances of harm. A physician must describe the nature of the benefit hoped for and the likelihood of achieving it in relation to each possible alternative treatment, including no treatment.

The initial factors to be taken into account in deciding which risks of harm must be disclosed are the probability of the risk occurring and its seriousness. The more serious the consequences and the higher the probability, the more likely it is that the patient should be informed. Not only the "material risks"³⁵ of accepting treatment must be outlined, but also those of alternative treatments and of refusing any treatment, as a reasonable patient with a condition needing treatment would consider disclosure of the "material risks" of alternative treatments or refusing treatment necessary to his decision.³⁶ This latter duty may relate not only to the risks of refusal of treatment, but also to the risks of refusal of diagnostic tests, if a recent American case is to be followed. In that case a physician was held liable for failing to warn a woman patient of the dangers of not having a "Pap" smear test for cervical cancer, when the woman refused the test because she said she could not afford to pay the cost. The woman's children subsequently recovered damages from the physician when their mother died of this disease.³⁷

It is difficult to specify the degrees of probability or the types of risks of harm which necessitate disclosure, although some American statutes have attempted to delineate both of these factors, but it is suggested that any risk with greater than one *per cent* probability of causing irreversible morbidity should be disclosed. Risks of death with a lesser probability of occurring should also be disclosed, but for this most serious risk, it is difficult to state a minimum level.

In *Reibl v. Hughes* the majority of the Court of Appeal of Ontario seemed to suggest that a physician may "set-off" these risks against each other in determining whether a sufficient probability of risk was present to require disclosure.³⁸ The Supreme Court of Canada clearly rejected such an approach.³⁹ In fact, in *Hopp v. Lepp* the

³⁵ *Reibl v. Hughes*, *supra*, note 1, 5 (S.C.C.).

³⁶ *Ibid.*, 13.

³⁷ *Truman v. Thomas* 611 P. 2d 902 (Cal. 1980).

³⁸ *Reibl v. Hughes*, *supra*, note 1, 23 (C.A.).

³⁹ *Supra*, note 1, 12.

Supreme Court seemed to indicate that telling the patient the risks of not having treatment could reassure him about having it.⁴⁰ It may be argued that such a "set-off" approach is justified if the risks of having or foregoing a procedure are of the same kind, even if it cannot be accepted where the risks of having or foregoing the procedure are of different natures. But to accept such a "set-off" rule even when the risks are identical would mean, for example, that a ten *per cent* risk of death in having a procedure could be set off against a ten *per cent* risk of death in foregoing it, and likewise, a similar 0.01 *per cent* risk of death could be set-off, with the result that in neither case need the risks be disclosed. Clearly, this would be an unsatisfactory result as the two cases are not comparable in terms of whether disclosure should be required. The aim of requiring that the patient be informed is to allow *him* to measure the risks and benefits of various alternatives when making a decision as to which course of conduct he will pursue. Thus, it is not, and should not be, the overall "net" risk which is the probability determining whether or not disclosure is required, but rather the individual "gross" risks of the alternative courses of conduct which are open to the patient.

Another reason for not allowing such a "set-off" is that in riskier procedures the patient may want to be put on notice to seek a second opinion or, perhaps, the most expert operator or the most up-to-date facilities for undertaking the procedure. Moreover, in many cases the nature of the risks involved in having or foregoing a procedure may not be of the same kind, or even if they are, the times at which they are likely to occur may differ.⁴¹ It could be that the patient's value-preference in any of these respects will differ from the physician's. For instance, the patient may prefer a risk of death to a risk of a life as a quadriplegic, whereas the physician may not. Likewise, another person, who is the parent of a young family, may prefer a risk which is likely to eventuate in the future rather than one which is immediate. As it is the patient who must live with the results of the decision, the patient's preference must prevail.

The final point to be made about assessing the probability and seriousness of medical risks in order to determine whether they must be disclosed is that the assessment must be carried out in relation to the particular patient involved.⁴² This involves two en-

⁴⁰ *Hopp v. Lepp, supra*, note 26, 79-80 (S.C.C.).

⁴¹ *Reibl v. Hughes, supra*, note 1, 32-5 (S.C.C.).

⁴² See *Kelly v. Hazlett, supra*, note 4, 305-7; *Reibl v. Hughes, supra*, note 1; *Hopp v. Lepp, supra*, note 26, 80 (S.C.C.).

quiries: first, is the patient particularly susceptible to any given risk in terms of its probability of occurrence or seriousness? Secondly, do the patient's circumstances make an otherwise immaterial risk material to him.

Although a subjective or objective assessment with respect to the first enquiry will very often reach the same result, this is not necessarily the case. For instance, if the physician takes into account any special vulnerability of the patient to certain risks of which the physician is aware or, as a reasonable physician, should be aware, the assessment of the seriousness and probability of the risks in relation to the particular patient may vary from what it would be for the hypothetical, "reasonable" patient.

The second enquiry, which determines material risks according to those risks which would be material to a reasonable patient *in the same circumstances*, introduces a subjective factor, but one which is assessed objectively, as all tests which take into account the "same circumstances" invariably do. The circumstances which will be taken into account are wider than simply medical considerations and will be established by evidence from persons other than just physicians. They can include, for instance, the fact that a patient may wish to delay an operation for financial reasons.⁴³ The presence of such relevant extra-medical circumstances will be established by evidence of the patient and other witnesses.⁴⁴ Presumably such circumstances would be limited to those that were known to the physician, or those that ought to have been known, or would have been known to him if he had made the enquiries a reasonable physician ought to have made in the circumstances.

Courts also use classifications other than the probability and seriousness of any given risk in determining whether or not that risk must be disclosed. Some risks that are indicated as needing disclosure within these other classifications would also require disclosure under a probability/seriousness classification, and, therefore, the additional test may be regarded as superfluous. Alternatively, some risks needing disclosure under one of these tests may be exempted from disclosure on other grounds, because, for instance, they are matters of "common knowledge" and in such cases the additional test may be regarded as irrelevant. But despite such overlap or exemption from disclosure, these classifications are worth examining for the added information they give on how the courts are applying the scope of disclosure standard.

⁴³ *Reibl v. Hughes*, *supra*, note 1, 6 (S.C.C.).

⁴⁴ *Ibid.*, 13.

Risks have been classified as "definite", "special", and "usual".⁴⁵ "Definite risk" is assessed on the basis of the likely effect of the proposed procedure on the particular patient, taking into account his disabilities. "Special risk" consists of the risks of operations in general, such as the risk involved with general anaesthesia. Risks have also been divided into two groups, "definitive" and "collateral".⁴⁶ "Definitive risks" are those which are so important that their omission would give rise to a misdescription of the nature and character of the procedure. In consequence, a consent given in ignorance of these risks "is no consent at all".⁴⁷ In comparison, "collateral risks" are those risks that do not fit the description of "definitive risks" and do not fall within the category of risks not requiring disclosure. The current validity or usefulness of the distinction between "definitive" and "collateral" risks would need to be questioned, however, if it were accepted that the Supreme Court has held that the risks attached to an act cannot relate to its basic nature and character.⁴⁸

It has been held that the physician's duty of disclosure "does not require warning the patient of dangers incident to or possible in any surgical procedure, such as the dangers of anaesthesia or the risk of infection, matters which men of ordinary knowledge are presumed to appreciate".⁴⁹ This is the "common knowledge" exception to requiring disclosure, but there are other risks *so common* that expert evidence is not needed to assess them, but which *must be disclosed* in order to avoid liability in battery.⁵⁰

In summary, one can derive from the cases a classification of five possible classes of risks:

⁴⁵ *Kelly v. Hazlett*, *supra*, note 4, 319.

⁴⁶ *Reibl v. Hughes* (1977) 16 O.R. (2d) 306, 312 (H.C.).

⁴⁷ *Ibid.*

⁴⁸ See text between notes 14 and 19, *supra*.

⁴⁹ *Reibl v. Hughes*, *supra*, note 46, 312 (H.C.).

⁵⁰ In *Reibl v. Hughes* the trial judge, Haines J., states that when the cause of action is in battery "[t]here is no issue for which medical evidence is required" (*ibid.*, 311). (Presumably such evidence is not needed because the tribunal of fact can itself assess the required scope of disclosure, rather than the evidence not being needed because disclosure is not required due to the matter being one of "common knowledge".) But Mr Justice Haines also contemplates that non-disclosure of some risks could give rise to a cause of action in battery (*ibid.*, 312). In conjunction, these two statements envisage that there are risks which must be disclosed in order to obtain battery-avoiding consent, but which do not need medical evidence in order to establish this. It is this group of risks which is referred to here and in the second category listed in the paragraph next following.

1. those risks so common that disclosure is not necessary and consent to run them may be presumed;
2. those risks so common that expert evidence is not needed to assess them, but which must be disclosed and consent to which may not be presumed;
3. those risks which require expert evidence for their definition and which must be disclosed as it is competent medical practice to do so;
4. those risks which must be disclosed because they would be material to the reasonable patient in the same circumstances; and, finally,
5. risks falling within none of the previous four categories.

Thus at both ends of this classification there is a category of risks not requiring disclosure and, in the middle, three categories, where what has to be disclosed is determined by a different test according to the categorization of the risk.⁵¹

This scheme may seem cumbersome but it is necessary, because it is very unclear in some cases why the court has held that a particular risk need not be disclosed. It is important that the justification of any non-disclosure be clear because, while non-disclosure of a certain risk may be perfectly acceptable on one ground, it may be unacceptable (and set a bad precedent) on another. For instance, not to require express disclosure of a risk because it is "usual" (*i.e.*, a matter of "common knowledge") is a very different justification from not requiring its disclosure on the basis that the probability of the consequences occurring, and their seriousness should they do so, do not warrant requiring disclosure. Confusion as to exactly which justification is being relied upon leads, in turn, to confusion in interpreting the resulting judgments. It is submitted, with respect, that the Supreme Court of Canada's decision in *Hopp v. Lepp* displays some of this confusion.⁵² For instance, the Court holds that "[p]robable risks, which must be disclosed, have been contrasted with mere possibilities (as, for example, risks involved in any operation), but this dichotomy cannot be absolute because it ought to take note of whether a risk

⁵¹ It could be asked whether there are any risks in category 3 which would not be included in category 4 and therefore whether category 3 is superfluous. However, even if there are not any additional risks added by category 3, it may be important to assess which risks should be disclosed from the standpoints of both the reasonable physician and the reasonable patient, as this may give a more complete analysis. In other words, in determining which risks are material to a reasonable patient, it is relevant to ask which risks should be disclosed according to competent medical practice in the same circumstances. Moreover, such an approach reflects the historical development of standard-setting by the courts in relation to the physician's duty of disclosure.

⁵² *Supra*, note 26, 71-2, 75, 77, 79, 80-1.

is or is not quite remote, and here the gravity of the consequences, if a risk should materialize, must be brought into account".⁵³ Is the Court speaking here of justifying non-disclosure of a risk on the basis of a low frequency, taking into account the seriousness of the consequences if the risk eventuates, or is the justification one of common knowledge that the particular risk is involved in all operations? The two justifications are not of the same nature and content, although in this passage the Court could be interpreted as equating them.

b. *Therapeutic research*

There is one further therapeutic situation in which the scope of disclosure should be considered, that in which therapeutic research is undertaken. The definition of medical research is a difficult and controversial matter.⁵⁴ However, *therapeutic research* may be distinguished from "pure" *therapy*; although in both there is an intention to benefit therapeutically the particular patient on whom it is carried out (which is the feature distinguishing therapeutic research from non-therapeutic research), in therapeutic research the procedure has research aspects such as novelty, or it cannot be said in advance that it has a reasonable chance of success, or it is part of a formal research endeavour such as a controlled trial.

*Cryderman v. Ringrose*⁵⁵ and *Zimmer v. Ringrose*⁵⁶ are two of the few cases in which a court has considered therapeutic research. In both cases the procedure involved was sexual sterilization using an experimental method. With the exception of the trial judge in the *Zimmer* case, all the courts treated the procedure undertaken as therapeutic, and one query is whether they were correct in doing so, as purely contraceptive sterilization has usually been classified as non-therapeutic. Moreover, in the *Zimmer* case, the Court of Appeal of Alberta held that the procedure used "was experimental only in the sense that it represented an innovation in sterilization techniques which were relatively untried."⁵⁷ In other words, the Court seems to have held that the procedure *was* therapy and *was not* research, both of which findings, it is respectfully submitted, are open to question.

⁵³ *Ibid.*, 80.

⁵⁴ See Somerville, *supra*, note 21.

⁵⁵ (1978) 89 D.L.R. (3d) 32 (Alta C.A.). The decision affirms the judgment of Stevenson D.C.J. and the report includes the reasons of the trial judge.

⁵⁶ (1981) 28 A.R. 69 (C.A.), *rev'g* in part (1978) 13 A.R. 181 (S.C., T.D.); leave to appeal to the Supreme Court of Canada denied (1981) 28 A.R. 92 (S.C.C.).

⁵⁷ *Supra*, note 56, 77.

The above approach was consistent with that taken in *Cryderman v. Ringrose*, where the Court of Appeal of Alberta affirmed the trial judgment which rejected the application of *Halushka v. University of Saskatchewan*⁵⁸ as being "of very limited assistance because it involves a case of pure medical experimentation and different considerations must there apply."⁵⁹ It was held that "[w]hen an experimental procedure is employed the common law requires a high degree of ... disclosure to the patient of the fact that the treatment is new and risky."⁶⁰ The standard of care required, presumably in relation to performance of the procedure and disclosure of information, is "that of a reasonable medical man considering all the circumstances [However,] [t]he disclosure must be critically analysed when a new procedure is prescribed by its very inventor."⁶¹ These holdings must now be interpreted in conformity with the recent Supreme Court judgment on the standard of disclosure in the "pure" therapy context, as the Court of Appeal of Alberta does in the *Zimmer* case: it is clear that the appropriate standard of disclosure would not be that of a "reasonable medical man", but would be what the reasonable patient-subject would want to know in the circumstances. Further, it is suggested, "the circumstances" should be identified as being at least those of therapeutic research. But how full is "full disclosure" when therapeutic research rather than "pure" therapy is involved, and does the content of the disclosure differ depending on whether the research is therapeutic or non-therapeutic?

Clearly, full disclosure in the research context will require disclosure that research is being undertaken and, in this respect, even if no other factors differed, the disclosure required may be regarded as "fuller" than that required in relation to "pure" therapy. It is also likely that whatever the theoretical similarities of the required scopes of disclosure for therapeutic research and "pure" therapy, in practice courts would be more stringent with respect to what is required to be disclosed in the research context and less willing to allow justification of any non-disclosures. Further, a patient-subject *must* be advised whether any given research procedure is therapeutic or non-therapeutic. This is also a relevant circumstance which could alter what would be material information to a research subject in all the circumstances in which he finds

⁵⁸ (1965) 53 D.L.R. (2d) 436 (Sask. C.A.).

⁵⁹ *Cryderman v. Ringrose*, *supra*, note 55, 41 *per* Stevenson D.C.J.

⁶⁰ *Ibid.*

⁶¹ *Ibid.*, 41-2.

himself.⁶² Despite the holdings in *Cryderman v. Ringrose* and *Zimmer v. Ringrose*, it is suggested that the following approach should be adopted: any non-disclosure of information in the therapeutic research situation which would be required to be disclosed in the non-therapeutic context, must be justified, if any such justification exists,⁶³ on some basis other than simple reliance on the fact that in one case the research is therapeutic and in the other non-therapeutic.

Because, in the past, courts have varied the required scope of disclosure according to whether or not an intervention was therapeutic, and because this distinction may still be of some relevance in this respect, it is worth examining what courts have said about the scope of disclosure in cases of non-therapeutic interventions.

2. Non-therapeutic interventions

a. Non-therapeutic research

The scope of disclosure required for non-therapeutic research interventions is well stated in the judgment of Hall J.A., speaking for the Court of Appeal of Saskatchewan, in *Halushka v. University of Saskatchewan*:⁶⁴

[T]he duty imposed upon those engaged in medical research ... to those who offer themselves as subjects for experimentation ... is at least as great as, if not greater than, the duty owed by the ordinary physician or surgeon to his patient ... The subject of medical experimentation is entitled to a full and frank disclosure of all the facts, probabilities and opinions which a reasonable man might be expected to consider before giving his consent.⁶⁵

The standard of disclosure just cited applies to all non-therapeutic medical research interventions whether these are carried out on patients or on healthy volunteer subjects, as was the case in *Halushka*. In other words, it is important to distinguish between identifying the situation as being one in which therapy will be undertaken, and identifying whether or not a particular intervention carried out in that situation is intended to be therapeutic

⁶² To the contrary, the Medical Research Council of Canada, in *Ethics in Human Experimentation* [Report No. 6] (1978) rejected any distinction between therapeutic and non-therapeutic research with respect to ethical requirements, including the obtaining of consent. It would be open to a court to adopt these guidelines as expositive of generally accepted practice as to the appropriate standard of disclosure required in relation to all medical research.

⁶³ See the discussion of therapeutic privilege, *infra*.

⁶⁴ *Supra*, note 58.

⁶⁵ *Ibid.*, 4434.

for the patient on whom it is performed. One may have a healthy or a sick volunteer subject, but in either case, if the intervention is non-therapeutic, it is the most exacting standard of disclosure which applies. There may be an understandable tendency to classify a situation by its overriding characteristic, and when a sick person is involved this is almost invariably therapy. In such circumstances there is a danger that certain non-therapeutic interventions may not be identified as such and that therapeutic research may be regarded as "pure" therapy, resulting in failure to apply the more stringent standard or standards of disclosure that these require.⁶⁶

b. *Non-therapeutic non-research interventions*

One of the most common non-therapeutic interventions is aesthetic or cosmetic surgery. Although courts have characterized such interventions as therapeutic, on the basis that they are psychologically beneficial, the tendency to adopt this approach has lessened. In many cases the aesthetic surgery involved was clearly not within the usual meaning of "therapy", but courts felt compelled to identify it as such as it was thought that non-therapeutic surgical interventions were illegal.⁶⁷ Whether or not this belief was, or still is, correct, it is certainly not upheld in practice, as aesthetic surgery is manifestly commonplace. It is arguable that the law has changed to allow non-therapeutic interventions if certain conditions are fulfilled. The most important of these conditions are that the subject of the intervention give his fully informed consent, that the intervention not be contrary to public policy or "public order and good morals" and, possibly, that the subject is adult.⁶⁸

In a recent British Columbia case, *Petty v. MacKay*,⁶⁹ the patient, whose occupation was that of "an exotic dancer", alleged negligence on the part of the defendant doctor in failing to inform her of the risks of plastic surgery in the form of a "modified abdominoplasty". Although the judge paid very little direct attention to the required scope of disclosure in relation to such interventions, he referred to it in passing when speaking on the issue of causation. It was held that the plaintiff had not proved causation, as

a reasonable and prudent person, in the circumstances of the plaintiff, including the knowledge and experience of the plaintiff and her desire

⁶⁶ For a discussion of the disclosure standards required in therapeutic research see text at note 54 *et seq.*

⁶⁷ See Somerville, *Medical Interventions and the Criminal Law: Lawful or Excusable Wounding?* (1980) 26 McGill L.J. 82.

⁶⁸ *Ibid.*

⁶⁹ (1979) 14 B.C.L.R. 382 (S.C.) (emphasis added).

to attain a state of cosmetic perfection or near-perfection, would have gone ahead with this operation even if the risks involved had been *fully discussed* with that reasonable and prudent person prior to the operation.⁷⁰

There is no indication what the judge intended by "fully discussed" in this statement, but it has been suggested that, as the judge incorporated the report of a specialist in plastic surgery into his judgment, he may have been accepting the "professional disclosure standard".⁷¹ If this is true, the standard of disclosure now required would be the more exacting "reasonable patient" or "full disclosure" standard adopted by the Supreme Court. As this would take into account that undertaking the plastic surgery involved here was clearly a non-therapeutic intervention, it may be that a "fuller" or more demanding standard of disclosure would apply than for a therapeutic intervention.⁷²

One of the difficulties which used to exist when a "professional disclosure" standard applied to therapeutic interventions and a "full disclosure" standard to non-therapeutic ones, was that the patient would sometimes request that an aesthetic, non-therapeutic procedure be performed in the course of what was otherwise a therapeutic intervention. This tended to cause confusion in the standard to be applied, especially in determining whether risks of procedures, such as anaesthetics, which were necessary for both the therapeutic and non-therapeutic intervention, were then subject to a "professional" or a "full disclosure" standard. In *Kelly v. Hazlett* just this situation existed,⁷³ and the Court applied the "professional disclosure" standard to all aspects of the procedure which was undertaken.⁷⁴ This difficulty has now been solved with the uniform adoption of the "full disclosure" standard.

⁷⁰ *Ibid.*, 388.

⁷¹ Picard, [Comment: *Petty v. MacKay*] (1979) 10 C.C.L.T. 99.

⁷² See the recent case of *Hankins v. Papillon* [1980] C.S. 879, 881 *per* Rothman J.: "In cases of plastic surgery ... where the decision to be made by the patient is more subjective and personal than therapeutic, I believe the doctor has a duty to be especially careful to disclose completely all the risks and, certainly, any special risks, as well as the consequences for the patient should such risks materialize."

⁷³ Note that the Court in *Kelly v. Hazlett*, *supra*, note 4, 315, held that "cosmetic values have to be weighed carefully in the balance. There is more than mere improved appearance involved ... [a cosmetic procedure may be] done for the 'functioning of the individual in society'." The Court seems to accept that the latter purpose may be therapeutic, but it did not find that this was the surgeon's aim in undertaking the cosmetic procedure in this case.

⁷⁴ *Ibid.*, 319-20.

The discussion throughout Part A relates to the "normal" standard of disclosure required by the law in order to obtain "informed" consent from competent adults for medical interventions to be performed on themselves. It is now necessary to ask under what conditions this "normal" scope of disclosure may be validly restricted in relation to this same class of persons.

B. Restricting the scope of disclosure: waiver and "therapeutic privilege"

1. Therapeutic interventions

Risk that should be disclosed under the "normal" scope of disclosure requirements, as outlined above, may still be exempted from disclosure either because of a valid waiver by the patient of the right to be informed, or pursuant to the doctrine of therapeutic privilege.

Allowing a patient the right to waive his right to be informed is part of the full recognition of a patient's right to autonomy or self-determination. However, it should be clear that the patient has exercised his right of choice in deciding not to be informed and, consequently, waiver should usually be express rather than implied, and should occur in a situation where the physician has made it clear that he is willing to inform the patient.⁷⁵

The doctrine of therapeutic privilege has been described as having such a broad operation that it is thought to apply when informing the patient will cause him to "become anxious and apprehensive and so nervous that he might be reluctant ... to go forward with a procedure that is necessary."⁷⁶ It is submitted, however, that a preferable approach is that the physician may rely on therapeutic privilege to justify a non-disclosure of risks where the reasonable physician in the same circumstances would have believed that the disclosure, *in itself*, would physically or mentally harm the patient to some significant degree. The doctrine should not apply if the only reason for the non-disclosure is that it may cause the patient to refuse treatment that the physician regards as necessary.

As has been noted elsewhere, such an approach does not seem inconsistent with recent statements by the Supreme Court of

⁷⁵ See the discussion of the scope of consent, sections IV and V, *infra*, particularly in relation to *Kelly v. Hazlett* and the extension of the scope of consent, or waiver of information, clause, referred to at p. 309 of that case.

⁷⁶ *McLean v. Weir, Goff & Royal Inland Hospital* [1977] 5 W.W.R. 609, 621 (B.C.S.C.) (testimony of Dr Goff, accepted by the Court), *aff'd* [1980] 4 W.W.R. 330 (B.C.C.A.). See Picard, [Comment] (1977) 3 C.C.L.T. 87.

Canada.⁷⁷ In *Hopp v. Lepp*, the Court had the following to say about the scope of the doctrine of therapeutic privilege:

No doubt, a surgeon has some leeway in assessing the emotional condition of the patient and how the prospect of an operation weighs upon him; the apprehension, if any, of the patient, which may require placating; his reluctance, if any, to submit to an operation which, if the surgeon honestly believes that the operation is necessary for the preservation of the patient's life or health, may demand a detailed explanation of why it is necessary.⁷⁸

Further, Chief Justice Laskin, speaking for the Court, was

far from persuaded that the surgeon should decide on his own not to warn of the probable risk ... if the course of treatment contemplated is administered. A surgeon is better advised to give the warning, which may be coupled with a warning of the likely consequence if the treatment is rejected. The patient may wish for a second opinion, whatever be the eminence of his attending physician. It should not be for that physician to decide that the patient will be unable to make a choice and, in consequence, omit to warn him of risks.⁷⁹

In *Reibl v. Hughes*, the Supreme Court acknowledged that "it may be the case that a particular patient may, because of emotional factors, be unable to cope with facts relevant to recommended surgery or treatment and the doctor may, in such a case, be justified in withholding or generalizing information as to which he would otherwise be required to be more specific."⁸⁰ However, after considering the facts of the case, the Court held that the normal disclosure requirements had not been modified as "there was no evidence that the plaintiff was emotionally taut or unable to accept disclosure of the grave risk to which he would be exposed by submitting to surgery."⁸¹

Thus, while recognizing the existence of the doctrine of therapeutic privilege, the Supreme Court seems to have taken a rather restrictive approach to its application. The physician may be required to disclose to the patient and then placate and explain to avoid adverse effects of the disclosure, rather than avoid a dialogue that may cause anxiety to the patient, and possibly the physician. There is a suggestion that therapeutic privilege may only operate when someone else, presumably another physician, agrees that its application is warranted. Moreover, it would seem that before the privilege will apply, account must be taken of whether any adverse effects of disclosing the risks of the proposed procedure to the

⁷⁷ See Somerville, *supra*, note 31.

⁷⁸ *Hopp v. Lepp*, *supra*, note 26, 77.

⁷⁹ *Ibid.*, 79-80.

⁸⁰ *Reibl v. Hughes*, *supra*, note 1, 13.

⁸¹ *Ibid.*, 34.

patient can be off-set by disclosing to him the risks of not having the procedure. Despite the somewhat mandatory language used by the Supreme Court in this regard, if such a set-off did not seem likely to occur with respect to a particular patient, or if disclosing the risks of not having treatment could additionally harm the patient's physical or mental health, then, presumably, therapeutic privilege would apply. Finally, the Supreme Court indicates that the privilege is not always complete; that is, when the patient can cope with the information in a more generalized form this must be given, and in such cases total non-disclosure will not be justified.

Any reliance on the doctrine of therapeutic privilege should be clearly distinguished from other justifications for non-disclosure. For instance, in a British Columbia case, *McLean v. Weir*,⁸² an expert witness, a physician-radiologist, in giving evidence for the purpose of determining the required scope of disclosure of risks, stated that certain "complications are known to have occurred, but they are rare and we do not tell the patient that those things are possible because we do not expect them to happen."⁸³ This evidence was referred to in the judgment at first instance, but in such a way that the distinction between a non-disclosure justified by therapeutic privilege and that justified by low probability of the risk occurring, was not clearly drawn. Further, the Court of Appeal of British Columbia may have continued this confusion by approving the physician-radiologist's approach which "avoided rare and unexpected complications which would serve only to make the patient anxious and apprehensive".⁸⁴ Although it is most unlikely to have been intended, this statement of the Court of Appeal could be interpreted as formulating a justification for non-disclosure that requires the presence of both the criteria mentioned. That is, non-disclosure of certain risks would only be justified if they were both "rare and unexpected" and would "make the patient anxious and apprehensive".⁸⁵

It is submitted that what falls within therapeutic privilege and therefore constitutes an exception to the "normally" required scope of disclosure, should be determined according to both the "reasonable patient" and the "subjective patient" standards. More precisely, estimates of the effect of the disclosure must be made in relation to the reasonable patient and if non-disclosure is indicated it should

⁸² *Supra*, note 76.

⁸³ *Ibid.*, 622.

⁸⁴ *Supra*, note 76, 336.

⁸⁵ This section of the discussion is taken from Somerville, *supra*, note 31, where *McLean v. Weir, Goff & Royal Inland Hospital* is analyzed in detail.

then be considered whether this is also justified in relation to the particular patient, taking into account subjective factors of which the physician is aware or ought to be aware. Conversely, if disclosure is indicated according to an "effect of the disclosure on a reasonable patient" test, non-disclosure may still be justified by subjective considerations. The subjective test thus determines whether or not therapeutic privilege justifies a particular non-disclosure. But the suggested two-stage approach, because it also requires an objective assessment, is important in determining as precisely as possible whether any given non-disclosure falls within this doctrine.⁸⁶

The doctrine of therapeutic privilege is usually regarded as being a particular example of the defence of necessity. Even if this is correct, therapeutic privilege differs from most examples of the necessity defence in that it is the patient's interests that are both invaded and purportedly promoted by the otherwise legally actionable conduct, whereas, in general, a defence of necessity operates when one person's interests are invaded to promote those of another. However, the principle underlying the defence of necessity is that the conduct in question is justified as it is undertaken to avoid a greater harm, despite the fact that it is otherwise prohibited by the law and may cause harm. This is also true of a justification of therapeutic privilege and, consequently, even if the latter is not an example of the defence of necessity, it does have in common with it this underlying principle.⁸⁷

It is interesting to note that in *Kelly v. Hazlett* the doctrine of therapeutic privilege is stated as being relevant to a cause of action in negligence and not one in battery. The judge only refers to negligence when he says that there may be no cause of action if the non-disclosure was "justified by reasonable medical considerations".⁸⁸ It is therefore arguable that a doctor could not withhold all information, as compared with some information, under a justification of therapeutic privilege. If this line of reasoning were

⁸⁶ An alternative way of reaching the same result without using a two-stage approach is to hold that the information which may be withheld from the patient is to be judged according to the effect of the information on a reasonable patient in the same circumstances as the patient, and that such "circumstances" include subjective factors related to the patient of which the physician knew, or ought to have known.

⁸⁷ Although it may seem pedantic to be concerned about whether or not therapeutic privilege is an example of the defence of necessity, this could be important. For instance, if it is not of this nature, it will not be subject to the same criteria for application or of limitation as the defence of necessity.

⁸⁸ *Kelly v. Hazlett, supra*, note 4, 313.

followed it would mean that a physician must at least disclose the basic nature and character of the procedure and its inevitable consequences, even if there were a privilege, in the circumstances, with respect to non-disclosure of risks. If therapeutic privilege is excluded in the battery situation this demonstrates another way in which it differs from the defence of necessity, as the latter can apply to excuse battery. This is shown in the medical context by the way in which courts and legal commentators use the defence of necessity to justify emergency medical interventions where the patient is unable to consent.⁸⁹ This difference may be just another indication that the doctrines of necessity and therapeutic privilege are not of the same nature. But even if this is true, the possible reasons for excluding the application of the doctrine of therapeutic privilege in relation to a cause of action in battery merit further consideration.

One reason for adopting such an approach would be to prevent physicians from, in effect, imposing treatment on patients by withholding certain basic information. Courts and commentators in many jurisdictions have vacillated when facing the problem of what to do about the competent adult patient who refuses life-saving treatment. Some jurists⁹⁰ have proposed that when a patient refuses consent in such circumstances a physician may be able to override his will without incurring legal liability because a defence such as necessity applies. But if, as suggested above, the defence of therapeutic privilege is inapplicable, the physician may be liable for acting without giving the patient certain basic information, where this is possible. In other words, there could be circumstances in which, because the defence of necessity applies, a physician is justified in overriding a patient's decision, but the physician is not justified in failing to inform the patient about the intervention which constitutes that overriding, because "therapeutic privilege" does not apply. This distinction could be important in protecting rights of the patient, such as autonomy, because if he is informed

⁸⁹ Although it should be queried, in light of the previous discussion, whether or not the use of the defence of necessity is appropriate to justify emergency medical interventions as, similarly to the situation when the doctrine of therapeutic privilege applies, it is the patient's interests which are both invaded and promoted in intervening in an emergency. The use of necessity to justify emergency interventions may represent an extension by the modern law of the defence of necessity and may explain why traditionally the justification relied upon in relation to such interventions was implied consent.

⁹⁰ See, e.g., Mayrand, *L'inviolabilité de la personne humaine* (1975), Nos 38-40, pp. 47-9.

the patient may at least challenge the justification for overriding his wishes.

The previous discussion demonstrates the precision with which any justification for contravening a patient's rights must be identified, if those rights are to be protected to the full extent required by the law. In particular, even if therapeutic privilege is a species of necessity, it does not apply in the same conditions as other forms of the necessity defence. Hence, it is inadequate and could set dangerous precedents to allow blanket defences simply on the basis of a wide and undifferentiated doctrine of necessity. Rather, each situation must be examined to see whether the particular necessity claimed fulfills the conditions required to make it sufficient legal justification.

The approach taken above contemplates that in certain circumstances a patient's right to make a decision concerning himself may not be respected, but that failure to honour this right cannot take the form of obtaining the patient's compliance by withholding information from him or not telling him that his decision is not being respected.

Alternatively, excluding the application of therapeutic privilege in a battery action may be a recognition of a patient's right to exercise his right to refuse treatment. More explicitly, to the extent of the information required to be given to avoid a cause of action in battery, the law may be requiring that the patient's autonomy be respected as the predominant value and, to this degree at least, that the patient be informed in order to exercise his right to refuse treatment.

No matter which of these two possible explanations is accepted, they both demonstrate that there are limits beyond which the law will not allow the individual's right of self-determination to be ignored, at least by way of the justification of therapeutic privilege.

A further enquiry is whether a defence of "therapeutic privilege" can ever apply in a medical research situation. It is submitted that the answer is negative. If a physician is unable to obtain informed consent to a research intervention, because to inform the patient adequately may physically or mentally harm the patient, then the physician may not rely on the doctrine of therapeutic privilege and carry out the research. In such a situation, the patient must be given some form of accepted treatment, in which case the doctrine of therapeutic privilege is potentially available.

The only extremely rare and exceptional case in which the doctrine of therapeutic privilege may apply to therapeutic research

would be where the patient's life was in danger, or his health seriously threatened, and the research intervention was the only hope of helping the patient, and the conditions for the application of therapeutic privilege were otherwise fulfilled. However, consideration is needed before allowing such an exception: it could too easily make dying persons the subjects of research interventions without their fully informed consent.

Finally, it should be noted that as therapeutic privilege operates as a legal justification or defence, the burden of proof of its applicability will be borne by the person seeking to rely upon it — the physician.

2. Non-therapeutic interventions

Neither waiver nor therapeutic privilege ever apply to non-therapeutic medical interventions. In *Halushka v. University of Saskatchewan* the Court had the following to say in relation to a non-therapeutic medical research context:

There can be no exceptions to the ordinary requirements of disclosure in the case of research as there may well be in ordinary medical practice. The researcher does not have to balance the probable effect of lack of treatment against the risks involved in the treatment itself. The example of risks being properly hidden from a patient when it is important that he should not worry can have no application in the field of research.⁹¹

This rule will be applied most easily in non-therapeutic research and in relation to interventions such as cosmetic surgery. More difficulty may arise when, for instance, a cosmetic procedure is combined with a therapeutic one, as was the case in *Kelly v. Hazlett*. The Court in that case expressly stated that therapeutic privilege was inapplicable. The basis for this holding was not only that there was "no danger in alarming the patient",⁹² but, that "since the operation was for cosmetic purposes only, it would have been prudent to attempt to alarm the patient".⁹³ Thus the Court relied on a rule that the doctrine of "therapeutic privilege" did not apply to non-therapeutic interventions and "non-therapeutic" was defined in the traditional, strict sense of the term.

C. Extending the scope of disclosure: the patient's questions

The first case on informed consent to reach the Supreme Court of Canada, *Hopp v. Lepp*,⁹⁴ involved the effect of a patient's question on the required scope of disclosure. Unfortunately, the full content

⁹¹ *Supra*, note 58, 444.

⁹² *Supra*, note 4, 319.

⁹³ *Ibid.*

⁹⁴ *Supra*, note 26.

of the question that the plaintiff-patient alleged he had asked was not explicit, but needed to be implied from evidence of a conversation between the patient and the surgeon, which was open to more than one interpretation. The Supreme Court of Canada disagreed with the majority of the Court of Appeal of Alberta⁹⁵ as to what implications could be drawn from this. As a result, the Supreme Court reversed the Court of Appeal's holding that the normal scope of the duty of disclosure had been extended by the patient's enquiries. However, all judges agreed, and it has never been questioned, that a physician must answer any specific questions posed by the patient, even when they relate to matters that would otherwise not require disclosure. Consequently, the patient has the power to extend the scope of disclosure beyond the normal disclosure standard.

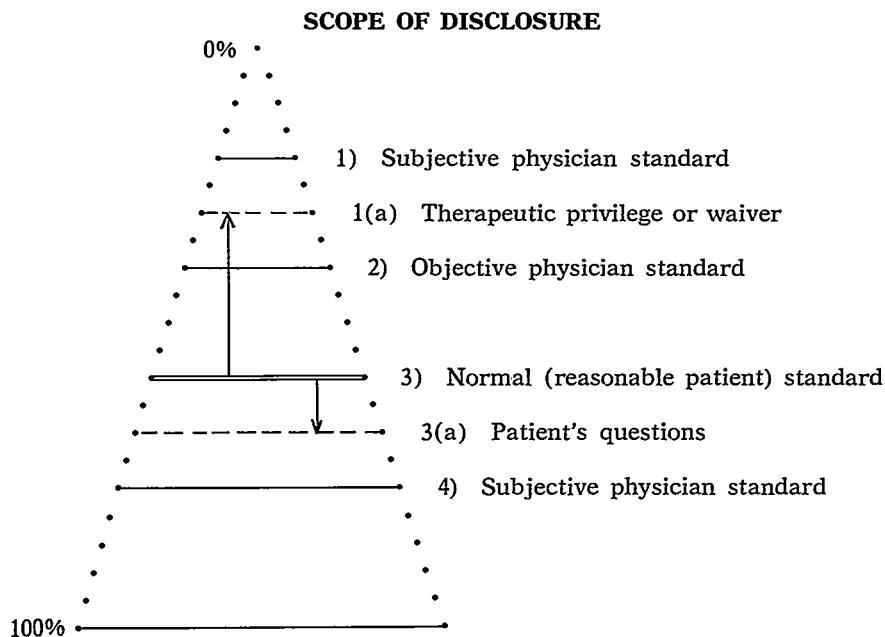
It is worth noting that the majority of the Court of Appeal of Alberta were relatively willing to find a specific question about the risks and seriousness of a proposed operation in the plaintiff's query as to whether or not he would be as well to have the proposed operation in Lethbridge as in Calgary. Despite the fact that the Supreme Court rejected this implication as an unwarranted extrapolation from the evidence, it does indicate an approach a court may take in another case. In other words, the question which must be answered by the physician may not always be explicit; it may be implied from a statement or question of the patient. Presumably, a question could also be inferred from the patient's conduct in that it either would have put the reasonable physician on notice, or did provide the physician with subjective knowledge, that the patient required additional information. Although it would be undesirable and unfair to physicians to take this extension of the normal scope of disclosure by implied questions too far, it is not unreasonable to expect a physician to give the patient the additional information that he knew, or a reasonable physician in those circumstances would have known, that the patient was seeking.

Finally, it must be asked what would be the effect of a patient's claiming that the scope of disclosure was extended, or even that the normal scope was maintained by his questions, and the physician's arguing that the scope was restricted, or that the specific question need not have been answered, on the basis of therapeutic privilege. As deception should, almost certainly, never be allowed in the physician-patient relationship and as, in these circumstances, even a failure to reply may be deceptive or give rise to misrepresentation, it is submitted that the doctrine of therapeutic

⁹⁵ *Ibid.*

privilege would not apply. In such circumstances the physician could tell the patient that he considers it better for the patient not to discuss the matter, and he could seek the patient's agreement to this. Such an approach would amount to waiver by the patient of his right to be informed, rather than reliance by the physician on the doctrine of therapeutic privilege as a defence to not informing. However, great care would have to be exercised to avoid coercing the patient in this situation, and it would seem that the patient could prevent the application of therapeutic privilege where it would otherwise apply by his express request for information. Therefore, to the extent that the patient by his questions extends or maintains the normal scope of disclosure, this would override any application of the doctrine of therapeutic privilege restricting that scope.

It is possible to modify the diagram used previously to represent the normally required scope of disclosure, to include extensions or restrictions of that scope:



It can be seen that the normal, reasonable patient standard for determining the scope of disclosure, Standard 3, can be restricted or enlarged, theoretically to requiring that anywhere between 0% and 100% information be given.⁹⁶

⁹⁶ Positions 1(a) and 3(a) are arbitrarily chosen here simply for purposes of exposition.

III. The patient's reception of the disclosure

Leaving aside questions of involuntariness or coercion, as Canadian courts have not yet been called upon to deal with these matters in relation to consent to medical care,⁹⁷ the issue now raised is whether the physician has fulfilled his legal duty to a competent adult patient with respect to obtaining that patient's consent simply by disclosing all the information that the law requires to be disclosed. Does the law require the patient to display certain characteristics upon receiving information before the consent based upon that information is considered valid? The two characteristics most often considered in this respect are understanding and rationality. The former relates to input criteria, the latter to outcome ones.

A. *Understanding*

Must the patient understand the information given by the physician in order to give consent or informed consent? This question was raised in *Kelly v. Hazlett* and was dealt with separately in relation to battery and negligence.

The plaintiff-patient, in that case, had been given 100 mg of pethidine just before she purportedly gave consent. In relation to battery-avoiding consent the judge did not believe

that it could be suggested otherwise than that the giving of the consent under such circumstances, at the very least, leaves the validity of the consent open to question ... and that it would be incumbent on the defendant to prove affirmatively that the effect of this sedation probably did not adversely affect the patient's *understanding* of the basic nature of the contemplated operation.⁹⁸

In other words, the surgeon must show

that the combination of sedation, and ... [the patient's] labile condition, had not blotted the information from her mind, respecting the basic nature and character of the operation when she made her demand. In such circumstances he has shown a sufficient consent to avoid liability on the basis of battery.⁹⁹

But, if the plaintiff

did not know the basic nature of the operation ... and ... all she was asking for was a *result* not a procedure, and she manifested this lack of knowledge to the defendant, then her apparent consent to the operation, notwithstanding her clear desire for the result, would be ineffective.¹⁰⁰

⁹⁷ For discussion of these questions, see Somerville, *supra*, note 2.

⁹⁸ *Supra*, note 4, 317 (emphasis added).

⁹⁹ *Ibid.*, 318.

¹⁰⁰ *Ibid.*, 317.

In other words, if the doctor *knows* or if he ought to know that the plaintiff does not understand the basic nature of the operation, the doctor is, in the absence of other justification, liable in battery if he performs the operation. Moreover, proof of battery-avoiding consent by the physician will require proof of the necessary degree of understanding of the information by the patient.¹⁰¹

With respect to the patient's understanding of any collateral risks that the physician must disclose in order to avoid liability in negligence, the defendant surgeon in *Kelly v. Hazlett* admitted that he "could sense that ... [the plaintiff] was *not understanding* what ... [he] was attempting to communicate with her by words."¹⁰² That is, in this particular case, the surgeon had subjective knowledge of the patient's lack of understanding. The Court held that it is the doctor's "duty to be satisfied that ... [the risk] had been brought home to the patient before he could reasonably regard her apparent consent as being valid."¹⁰³ The consent needed to avoid liability in negligence, that is the consent required in relation to collateral risks, "involves both *awareness* and *assent*".¹⁰⁴ However, "it would be quite unreasonable, and the law does not call for it, to expect the doctor to see into the mind of the patient to satisfy himself that the patient not only understands the risks but also puts the degree of emphasis on them which the doctor considers to be reasonable".¹⁰⁵

Although the remarks of the Court in *Kelly v. Hazlett* in both the battery and negligence contexts could be read as requiring actual subjective understanding by the patient of the disclosed information, it is clear that this is not the case, as the physician may rely on the patient's consent if he could reasonably have thought at that time that she was aware of the basic nature and character of the special risks of the operation.¹⁰⁶ Hence the physician may rely on

¹⁰¹ *Ibid.*

¹⁰² *Ibid.*, (emphasis added).

¹⁰³ *Ibid.*, 319. Note that "apparent consent" is to be contrasted with "apparent understanding" (see discussion of the latter term, *infra*). "Apparent consent" seems to mean that consent is only apparent unless there is apparent subjective understanding of the information on which it is based.

¹⁰⁴ *Ibid.*, 318 (emphasis added).

¹⁰⁵ *Ibid.*

¹⁰⁶ *Ibid.*, 317-8. There is a statement in the majority judgment of the Ontario Court of Appeal in *Reibl v. Hughes* (*supra*, note 1, 24) which can be compared with this approach. The Court held that although the trial judge "rejected the defendant's explanation that the plaintiff was aware of a risk of a stroke as a risk of the surgery", he made "no specific finding of credibility and indeed does not disbelieve the defendant's evidence that

the patient's consent if it is given pursuant to *apparent subjective understanding* by the patient of the information disclosed. It is submitted that this is the most satisfactory approach. A fully subjective standard requiring actual understanding by the patient is too onerous for physicians and may not be in the best interests of patients, as the patient may not want to understand the information, or to make the intellectual effort to understand it, or have the physician bothering him to ensure that he does understand. Thus a physician may rely on the consent of a patient as a defence to an action in battery if the physician shows that a reasonable physician in those circumstances would have thought that this patient apparently understood the basic nature and character of the operation, provided, always, that the particular physician had no subjective knowledge that this patient did not understand. When a patient sues in negligence for breach of a physician's duty to inform him and alleges that the breach consists in the physician's failure to ensure that he, the patient, understood the information, the plaintiff-patient must prove on the balance of probabilities that a reasonable patient in the same circumstances as those in which the plaintiff found himself would not have understood the information communicated to him, or that he did not understand the information, and the physician knew this.

This approach can be examined in view of *Reibl v. Hughes*. At the trial level the test of when the requirement of understanding of information by the patient will be fulfilled was formulated in different terms with respect to battery and negligence. It was held that "the law of battery in effect places on a physician a strict duty to explain to his patient, in language which the patient can *understand*, the essential nature and quality of the treatment he is to undergo."¹⁰⁷ To avoid negligence liability, on the other hand, the doctor must have "take[n] sufficient care to convey to the plaintiff and *assure* that the plaintiff *understood* the gravity, nature and extent of risks specifically attendant on the [procedure]".¹⁰⁸ It is

he thought the plaintiff understood the risk." There is no discussion of whether the physician's belief would be tested against an objective or subjective standard to determine whether it would be sufficient to enable him to rely on the consent of the patient as a legal defence, but it appears that the majority of the Court allowed a *subjective* standard in this regard. That is, if this physician thought that the patient understood the required disclosure (rather than the test being whether the reasonable physician would have thought this in the circumstances), the patient's consent will be valid as far as requiring the patient to understand the information is concerned.

¹⁰⁷ *Supra*, note 46, 311 (emphasis added).

¹⁰⁸ *Ibid.*, 314 (emphasis added).

not exactly clear what standard of care is being required of the physician here in order to avoid negligence liability for non-disclosure, but it seems to vacillate between one of taking all reasonable means that a reasonable physician would take to ensure understanding and one of actually requiring that this result be achieved. In comparison, it is much clearer that actual understanding by the patient of the information is necessary to obtain battery-avoiding consent.

This approach should be contrasted with that of the majority of the Court of Appeal in the same case. In discussing whether the patient understood the *purpose* for which the surgery was being undertaken, a matter which would relate to battery-avoiding consent, it was held that "[i]f as the patient said, the doctor did his best to tell him about the surgery, and the patient had some difficulty in understanding it, there was some obligation to have told the doctor what troubled him."¹⁰⁹ This approach is acceptable to the extent that it maintains that the test for validity of the patient's consent, as far as non-understanding of information is concerned, should be determined in the absence of subjective knowledge on the part of the physician that the patient does not understand, on the basis of whether the reasonable physician, taking all the circumstances into account, would have thought the patient understood. But, to the extent that it establishes only an obligation on the physician to ensure understanding by the patient if the patient expressly indicates that he does not understand, it should not be accepted. To make the content of the physician's duty depend on the patient fulfilling some obligation, such as asking questions,

may overlook the power and status differential in the doctor-patient relationship. From a practical point of view, such a power imbalance both makes the patient less likely to ask questions or to understand what he is told and makes him reluctant to disclose this to the doctor. Further, the patient may not even know enough to ask appropriate questions, or to know he does not understand the answers, or he may be too emotionally upset to realize this.¹¹⁰

The proposed test requiring "apparent understanding" of information by the patient avoids such difficulties, as it would require the physician to assess at least, as a reasonable doctor would, whether the patient apparently understands the information he has been given, and to act accordingly.

It should also be asked what the trial judge in *Reibl v. Hughes* meant by qualifying the doctor's duty as "strict" as far as the

¹⁰⁹ *Supra*, note 1, 21.

¹¹⁰ Somerville, *supra*, note 31.

patient's understanding of the information necessary to give battery-avoiding consent was concerned. This characterization can be compared with the way in which the Court described the requirement of understanding in relation to the negligence-avoiding disclosure, that the physician took "sufficient care" in giving information to the patient.

It is suggested that the word "strict" may have two connotations in this context. First, the physician may be said to have what, in civil law terminology, is referred to as an "obligation of result".¹¹¹ This would mean that the physician does not fulfill his legal duty merely by taking all steps that a reasonable physician would take in the circumstances to ensure that a patient understands the basic nature and character of the proposed procedure (which would amount to an obligation of "means") but, rather, the physician must ensure the result that the patient does understand. The Supreme Court of Canada reviewed the evidence given in this case by the plaintiff-patient as to his understanding of the information disclosed to him by the physician and held that "it must have been obvious to the defendant [physician] that the plaintiff had some difficulty with the English language and that he should, therefore, have *made certain* that he was understood".¹¹² The first point to note about this statement is that any duty of the physician to ensure actual understanding of information by the patient is not limited to issues of battery. In fact, the statement was made only in relation to a cause of action in negligence for non-disclosure, as the Court had already decided that no cause of action in battery lay on the facts. Read literally, the Supreme Court's statement means that the physician must ensure subjective understanding of the information by the patient. This is more stringent as regards the obligation placed on the physician than the test of "apparent understanding". With all respect, the Supreme Court's approach places too onerous an obligation upon the physician and may not be in the best interests of patients, if not in relation to the information which needs to be disclosed to obtain battery-avoiding consent, at least in relation to that required to avoid negligent non-disclosure. As explained above, it amounts to an obligation of result — that is, an obligation to ensure a particular eventuality, in this case understanding, rather than an obligation of means which is an obligation to take all the steps that a reasonable physi-

¹¹¹ See Crépeau, *Le contenu obligationnel d'un contrat* (1965) 43 Can. Bar Rev. 1.

¹¹² *Reibl v. Hughes*, *supra*, note 1, 34 (emphasis added).

cian in the circumstances would take in attempting to ensure understanding. For this reason, it is suggested that the Supreme Court statement should be read only in relation to the case then before it. Where a physician has subjective knowledge that a person is not completely familiar with the language in which he is being addressed, then the physician, as a reasonable physician, must take greater care than would otherwise be required in attempting to ensure understanding. Rather than requiring subjective understanding by the patient, this approach maintains the objective standard of requiring the physician to do what a reasonable physician would do in the circumstances, and modifies those circumstances to take into account the patient's difficulties with the language.

The second possible interpretation of the word "strict" in *Reibl v. Hughes*¹¹³ may be that the physician is strictly liable for all untoward results if he acts without the patient's informed and understanding consent as to the basic nature and character of the intervention. In other words, the physician will be subject to a risk of strict liability rather than fault liability with respect to such results. For recovery of damages, this would mean that even where the untoward results were not caused by any fault of the physician, but were simply the crystallization of one of the unavoidable risks of the procedure, the physician would be liable to compensate for these if he acted without consent. Although the battery can itself be regarded as constituting fault on the part of the physician, the point is that there is no need to establish the presence of fault in the sense of negligence in undertaking or carrying out the procedure or in failing to obtain the patient's consent to the running of risks, in order to recover compensation for risks which eventuate.¹¹⁴ Moreover, once liability in battery

¹¹³ See *Reibl v. Hughes*, *supra*, note 46, 311 (H.C.).

¹¹⁴ This situation is interesting from the point of view of legal analysis. Liability is often characterized as either fault, or strict or no-fault. The former usually refers just to negligence liability. Battery was originally a tort of strict liability (in that the necessary and sufficient criterion for liability was simply directness of the physical contact). Later, and possibly in connection with the element of wilfulness or intention becoming relevant to battery, a defence was recognized in that the defendant was not liable if he could prove that the tort occurred "utterly without his fault" (*Weaver v. Ward* (1616) Hob. 134, 80 E.R. 284 (K.B.)). The point is, therefore, that fault is relevant to whether a person will be held liable in battery, but it is not the same degree or nature of fault as in negligence. Thus, in a sense, battery may be described as a stricter liability than negligence, but it is not strict liability in the sense that presence or absence of fault is totally irrelevant.

is established, the damages recoverable will often be more extensive than those recoverable in negligence, as the test of causation is one of directness, rather than reasonable foreseeability, which may be more limiting. A recent case on point is *Allan v. New Mount Sinai Hospital*.¹¹⁵ This case did not involve a defect of understanding by the patient, but a direction by the patient that her left arm was not to be used for intravenous administration of an anaesthetic agent, which the anaesthetist ignored. The Court found that there was no negligence on the part of the anaesthetist and yet awarded damages to the plaintiff for all the untoward results of the procedure, whether they were reasonably foreseeable or not. The basis for this holding was that as the plaintiff had specifically requested that the procedure not be carried out in the way in which it was, to contravene her wishes constituted battery and, consequently, all directly resulting damages were recoverable.

Finally, the relationship between understanding of information by the patient and coercion or duress should be considered. Sometimes a patient fails to understand information that he must be given, because that information is given after the patient has received medication and the medication affects his ability to comprehend what he is being told. Alternatively, the patient may understand such information but the medication causes him to act upon it in a way in which he would not have acted, had he not received the medication. Some cases fail to distinguish these two types of defect and in either situation treat the patient's consent as defective because of the *coercive* effects of the medication.

Coercion or duress means that the patient has consented *against* his will, and his consent is voidable. Such consent is to be contrasted with decisions taken in the absence of will (e.g., in a state akin to automatism), in which case the purported consent is void *ab initio*. In a sense, lack of understanding is more akin to a partial absence of will than coercion, unless the lack of understanding was deliberately induced in order to coerce the person's decision. In law, this distinction could be important not only because the nature of the defect in the consent varies in the two cases, but also because conduct that is contrary to someone's will is often more reprehensible than that done in the absence of his will, and this could affect such matters as the award of punitive or aggravated damages. Thus, is the effect of the medication on the patient of such a nature and degree that a purported consent given after receiving it is really given in the absence of the patient's will and therefore the consent

¹¹⁵ *Supra*, note 13.

is void?¹¹⁶ Or has the effect of the medication been to limit the patient's ability to understand what he is being told to the extent that his consent is defective because of lack of understanding? Or has the medication made the patient unduly susceptible to being influenced in his decision? Showing that the patient reached a decision which he would not normally have taken may be evidence of any of the above and it may be important to identify exactly which situation occurred. The point is that the same circumstances may raise questions both of lack of understanding and of coercion or duress, and both should be considered when determining the adequacy of the patient's consent.

B. *Rationality*

Does the law require rationality¹¹⁷ of the patient's decision as a substantive element of a valid consent?

The first consideration is the relationship between understanding and rationality. If, as argued above, the law requires that the patient apparently understand the required disclosure of information in order to give a valid consent, does this mean that the law is seeking to promote rationality of the patient's decision and, further, if his decision is adjudged irrational, may it be ignored or overridden on this basis?

Even if it is accepted that understanding of the required disclosed information is being mandated in order to promote rationality, it must be asked whether this means rationality of the decision-making process or rationality of the decision itself or both. Although understanding may promote rationality in both of these respects, it is usually only the rationality of the decision outcome that is relevant to the law, and understanding may not be an essential

¹¹⁶ See *Kelly v. Hazlett*, *supra*, note 4; *Beausoleil v. La Communauté des Soeurs de la Charité de la Providence*, *supra*, note 13.

¹¹⁷ It is being presumed here that there are certain objective criteria according to which a decision can be classified as rational or irrational, but what these criteria are is open to debate. For instance, in *The Framing of Decisions and the Psychology of Choice* (1981) 211 Science 453, 458, Tversky and Kahneman state that "the modern theory of rational choice has adopted the coherence of specific preferences as the sole criterion of rationality. ... [B]ut [c]onsistency is only one aspect of the lay notion of rational behavior. ... [T]he common conception of rationality also requires that preferences or utilities for particular outcomes should be predictive of the experiences of satisfaction or displeasure associated with their occurrence. Thus, a man could be judged irrational either because his preferences are contradictory or because his desires and aversions do not reflect his pleasures and pains."

condition for this. It is quite possible for a decision to be judged rational by an objective bystander, when the reasons on which it was based were quite irrational. Moreover, the law's requirement of understanding of information by the patient may be seen as promoting autonomy rather than rationality. In this case, to require rationality either of the patient's decision-making process or its outcome would be to contradict directly the value of self-determination which is being promoted by requiring understanding, because self-determination requires recognition of the competent patient's right, for no matter what reason or on what basis, to determine what shall be done to himself.

It is submitted that the preferable approach is to view understanding as promoting autonomy, rather than rationality. Any legal limits to irrationality of a decision-making process or decision outcome should then be set by declaring the person factually or legally incompetent. Thus, the right to autonomy would mean that the competent patient could make irrational decisions concerning himself without the law overriding such decisions. Further, in order to give proper scope to such a rule, it is necessary to recognize that irrationality of the decision-making process or of decision outcomes does not of itself indicate incompetence, although in some circumstances it may be evidence of this.

The issue of irrationality of the patient's decision was considered in *Kelly v. Hazlett*. The defendant surgeon gave evidence that he considered the plaintiff "irrational", that is, "irrational from the point of view of not being able to think the way that [he, the doctor] was thinking, which [he] thought was more rational".¹¹⁸ The actual irrationality referred to was the patient's decision to undergo the operation only if the cosmetic procedure were included. In the result the Court held that the patient's "apparent consent" was insufficient to protect the surgeon from liability in negligence on the basis of failure to obtain informed consent. It is not exactly clear how much the irrationality of the patient's decision influenced his holding, but it seems that such irrationality should at least put the physician on notice that the patient's "decision was not based upon any knowledge or appreciation of the risk",¹¹⁹ in which case the physician may not rely on the consent as being valid. This case is probably a demonstration of a court looking to the rationality of the patient's decision to indicate both whether the patient had the required understanding of the risks that must

¹¹⁸ *Supra*, note 4, 316.

¹¹⁹ *Ibid.*, 318.

be understood in order to give informed consent, and whether the physician had, or ought to have had, knowledge of any lack of understanding on the part of the patient.

In summary, the question of rationality in matters of consent is difficult. To allow (or even more so, require) second-guessing of the patient's decision according to whether that decision is rational may seriously detract from autonomy (which it is the purpose of consent to protect). The more a person's decision deviates from what the person assessing that decision would decide in the same circumstances, and the more serious the consequences of that decision, the more likely it is that the person making the decision will be labelled incompetent and his decision irrational.¹²⁰ Rather than judging the rationality of a patient's decision and validating or invalidating consent on that basis, the better solution (which was probably the approach of the Court in *Kelly v. Hazlett*) is to adopt understanding by the patient of the information required to be disclosed as the necessary safeguard. Pursuant to such an approach, provided the patient is otherwise judged to be competent, if the physician has no subjective knowledge that the patient lacks understanding and the reasonable physician would have believed that the patient apparently understood the information disclosed, the resulting consent may be relied upon as valid whether or not the patient's decision is considered rational.

In a paternalistic physician-patient relationship, consent was often the *imprimatur* of the doctor's rational decision-making on the patient's behalf. Under a doctrine of informed consent the aim is to enable the patient to make a decision on his own behalf. A remaining question is how far the physician is justified in carrying out a patient's informed, irrational decisions. The physician is far less likely to be acting within legal or ethical limits when implementing such a decision requires a positive intervention on his part, than when it is a situation in which he must desist from violating the patient's physical or mental integrity against his will. More explicitly, a patient's irrational refusal of treatment should be accorded greater respect than his irrational demand for it.

IV. Who must disclose

There are two questions involved here. Does a referring doctor have an obligation to disclose to a patient any risks of a procedure to be carried out by the physician to whom the patient is referred?

¹²⁰ See Roth, Meisel & Lidz, *Tests of Competency to Consent to Treatment* (1977) 134 Am. J. of Psychiatry 279.

To what extent may a physician rely on the consent obtained on his behalf by someone else?

It has been held in two British Columbia cases¹²¹ that the referring physician does not have any duty to disclose the risks of a procedure to be carried out by another physician to whom he has referred the patient. In both cases the referral was to a more specialized medical practitioner who, presumably, would be more familiar than the referring doctor with the risks to be disclosed to the patient. It has been argued elsewhere¹²² that such an approach may be justified in these circumstances, but that there could, in some instances, be a danger in extending this reasoning to situations where a more junior colleague carries out the procedure, which is commonly the case in instances of medical treatment by an alternative doctor.

It has also been suggested that referral to a specialist can be regarded as part of the treatment undertaken by the first physician and that he has some general duty of disclosure in this situation, such as to warn the patient to ask about risks of the other procedure.¹²³ However, a statement by the Court in *Strachan v. Simpson* rejects such an approach. It was held that there was "no claim against [the referring doctor] ... for failure to warn, because it was not his duty to warn [the plaintiff-patient] ... about a procedure to be carried out by [the surgeon to whom he was referred]."¹²⁴ In this case the referral was to a specialist surgeon and not to a junior colleague, and the ruling can therefore be restricted to such a situation. Moreover, a distinction can be drawn between a duty to warn about risks of a procedure and a duty to warn the patient to ask about such risks.

The appropriateness of delegating the duty to obtain informed consent, which is a common practice in Canada, does not appear to have been in issue as yet in any Canadian case. Except in circumstances where one physician has referred the patient to another and, on this basis, has argued that he did not have a duty either of disclosure or to obtain informed consent, no physician has pleaded that his duty was fulfilled by someone else, or that liability for failure to obtain the required consent did not lie with him because he had non-negligently delegated the task of obtaining it. Such an argument would be rejected because it is clearly the duty

¹²¹ *McLean v. Weir, Goff & Royal Inland Hospital, supra*, note 76; *Strachan v. Simpson* (1980) 10 C.C.L.T. 145 (B.C.S.C.).

¹²² Somerville, *supra*, note 31; Picard, *supra*, note 76, 90.

¹²³ See note 122, *supra*.

¹²⁴ *Strachan v. Simpson, supra*, note 121, 173.

of the intervenor either to obtain consent himself or to ensure that adequate consent has been obtained. Consequently, to the extent that a delegee failed to obtain consent, the intervenor would be liable for an intervention performed without adequate consent.

One legal analysis of the approach outlined above would be that, even if performance of the physician's duty to inform the patient is delegable, liability for non-performance of that duty is non-delegable. In other words, the physician has a duty to ensure that the patient has been adequately informed, even if in law he need not carry out the informing process himself. Expressed in another way, the physician is directly liable for breach of his own duty of ensuring that consent is obtained, rather than vicariously liable for his delegee's failure to obtain informed consent. Consequently, for the physician to be liable, it is not necessary to establish a bond of authority, such as a master-servant relationship, between the physician and his delegee. Under such an analysis the breach of duty by the delegee quantifies the damage caused by the physician's breach of duty, and does not establish the liability of the physician by the mechanism of vicarious liability.

It is also worth noting that disclosure by a physician other than the one carrying out the procedure may protect the latter from liability even though he did not know of the disclosure. This will be true if the court holds, as it did in *Davidson v. Connaught Laboratories*¹²⁵ that despite the physician's non-disclosure of the risks of undergoing rabies vaccination, the patient knew of them because he had been so informed by another physician. Hence, even if the non-disclosure were a breach of duty by the physician, it had not caused the plaintiff's damage, as the disclosure would not have altered the decision which the patient made.¹²⁶

V. The consent form

Canadian courts have taken the view that a patient's signature to a consent form does not of itself mean that the required consent has been obtained:¹²⁷ as one judge has described it, such a procedure may be just "the ritual of the signing of the consent form".¹²⁸ Although written consent may not be sufficient, it may still be necessary because, for instance, there is a legal requirement that

¹²⁵ (1980) 14 C.C.L.T. 251 (Ont. H.C.).

¹²⁶ See text following note 138, *infra*.

¹²⁷ See, e.g., *Kelly v. Hazlett*, *supra*, note 4; *Lepp v. Hopp*, *supra*, note 26 (C.A.).

¹²⁸ *Kelly v. Hazlett*, *supra*, note 4, 318.

consent to surgical operations or general anaesthesia be in writing.¹²⁰

Whether or not a written consent is sufficient depends on the substance of the information, the communication of information and the reality of the agreement that is symbolized by the patient's written consent, and not just on the form or formal expression of that consent in writing. This distinction is sometimes made in the law by saying that the written document does not constitute the consent, but is evidence which must be taken together with all other evidence in deciding whether or not legally sufficient consent was present. Consequently, a signed consent form is not, as some physicians have tended to believe, an effective shield against liability. Moreover, when a health professional undertakes an intervention on a person from whom he has not personally obtained consent, he cannot simply rely on a signed consent form as demonstrating that the required consent has been obtained. Assuming that the intervenor may validly delegate the obtaining of the necessary consent, he must at least ascertain its adequacy or take the risk of legal liability if it is inadequate.

What are the responsibilities of a witness to a consent form? The possible purposes of such a signature could be either to witness that the legally required consent was obtained, or to witness that the signature on the form is that of the patient. In the absence of indications to the contrary (such as a statement included in the form itself, or legislation requiring that the witness certifies as to the substantive presence of legally valid consent), the witness will normally only attest that the signature is the patient's.

VI. Scope of the consent

It is clear that when a patient expressly consents to a certain medical procedure he does not consent to any other procedure unless this can be implied from the express consent, his conduct, or the surrounding circumstances. Any intervention not covered by express or implied consent would be unlawful unless justified on some other basis, such as necessity.

Difficult problems can arise in relation to whether or not there was consent to particular aspects of an intervention, rather than to the intervention in general. The most common of these problems occurs when the patient alleges that he consented to a

¹²⁰ See, e.g., O.-in-C. 3322-72 (8 November 1972), made pursuant to *Loi sur les services de santé et les services sociaux*, L.Q. 1971, c. 48 [now L.R.Q., c. S-5].

procedure but only if it were carried out in a particular manner,¹³⁰ or by a particular person. In each case it will be a question of fact as to what the consent covered. It is suggested that, like the proposed test of apparent understanding of information by the patient, the extent of the patient's consent should be determined according to an apparent scope of consent test: that is, what would the reasonable physician in these circumstances have thought, or what did this physician subjectively know, were the limits to the scope of the patient's consent? The alternative approach would be to determine the scope of the patient's consent by asking what the reasonable patient in these circumstances would have thought he was consenting to? Whether the reasonable physician or the reasonable patient standard is used, the final determination of the apparent scope of consent must be reasonable. In other words, the apparent scope of consent must not be unduly restricted so as to cause uneasiness among physicians as to what they are entitled to do pursuant to the patient's consent; but neither should it be extended in such a way that it is the patient's implied, rather than express, consent that is being relied upon in circumstances where this was not necessary. Certain matters need express consent. In normal circumstances a surgeon could not argue, for example, that allowing another surgeon to carry out a procedure on the patient, when the patient had not expressly consented to this, was justified, as it fell within the apparent scope of the patient's consent. Rather, the patient must be clearly aware of such substitution, and consent to it. In the latter situation, the scope of the patient's consent, with respect to substitution of the surgeon, is explicit, and there is apparent consent present. That is, the distinction between the suggested apparent scope of consent rule and apparent consent should be kept in mind as they are not the same entity.

It should also be kept in mind that this apparent scope of consent test cannot be viewed in isolation but must be seen as operating in conjunction with other requirements such as the required scope of disclosure of information to the patient and his apparent understanding of this information. Hence, before a procedure can fall within the apparent scope of the patient's consent, the physician must have met all disclosure requirements and there must be apparent understanding of this information by the patient.

Does the fact that the patient has acknowledged something in writing extend the apparent scope of consent where this would not otherwise be the case? It was noted in *Kelly v. Hazlett*

¹³⁰ See *Allan v. New Mount Sinai Hospital, supra*, note 13.

that the defendant raises no argument based on the language of the consent form. Specifically, he places no reliance on "such additional operations or procedures as are considered necessary or desirable in the judgment of the surgeon" or on the patient certifying that she is "aware of the contents and significance of this statement".¹³¹

Thus the fact of signing a consent form does not, of itself, extend the apparent scope of consent any more than it constitutes apparent understanding. It may be that, as a matter of public policy, the apparent scope of the patient's consent cannot be extended by having him agree to clauses as vague and general as the one referred to in *Kelly v. Hazlett*. That is, the patient must give reasonably specific consent and any justification of an intervention to which this has not been obtained must be on some basis other than consent.¹³²

The above discussion may be thought to indicate that clauses such as that in the consent form signed by the patient in *Kelly v. Hazlett* are of no legal effect. But this may not be correct as such a clause may constitute valid waiver of the right to be informed and thus an alternative justification to informed consent for carrying out the intervention.¹³³ For such a clause to constitute a waiver, the patient must understand that that is its nature and freely and voluntarily consent to it in circumstances where he knows the physician is willing to inform him. In this case the apparent scope of the patient's consent would be extended by such a clause to include all procedures which fell within its terms although the

¹³¹ *Supra*, note 4, 309.

¹³² Such a basis would be necessity. For instance, if during a surgical procedure a surgeon discovers a condition which is immediately dangerous to the patient's life or health, or a condition which could be dealt with in a separate and later operation but a second operation would "unduly" endanger the patient's life or health, the surgeon may act without consent under a doctrine of necessity: see, e.g., *Tabor v. Scobee* 254 S.W. 2d 474 (Ky 1952). However, if the necessity should have been anticipated before the operation being commenced, at which time the patient's consent could have been obtained, the surgeon may be liable for failing to obtain consent: see *Marshall v. Curry* [1933] 3 D.L.R. 260 (N.S.S.C.). It should be noted that if a clause such as that in the consent form discussed in *Kelly v. Hazlett* were only meant to include situations such as necessity, it would be superfluous as a defence exists in such circumstances regardless of consent. In fact the clause cited in *Kelly v. Hazlett* is much wider than this as it covers "procedures ... considered ... desirable in the judgment of the surgeon" (*supra*, note 4, 309).

¹³³ Waiver involves consent to the extent that there must be consent to the waiver of the right to be informed. But such consent is to be distinguished from consent to run the risks (or, even, consent to the consequences) of the intervention itself, which is the usual justification for undertaking an intervention.

patient had not been informed of the risks of these procedures, or even consented to the procedures themselves. Thus valid waiver by a patient of the right to be informed can affect the apparent scope of his consent.

VII. Proof

The fault alleged in cases involving failure to obtain consent or informed consent is an omission. This omission either consists of a non-disclosure of information, or, less frequently, a failure to obtain consent itself, that is, failure to obtain a legally adequate expression of the patient's will indicating that he agrees with the proposed course of conduct.

In battery the burden of proof of consent is on the physician,¹³⁴ which means that the physician must prove positively the presence of the necessary and sufficient consent on the balance of probabilities. When the cause of action is negligence the plaintiff patient must prove absence of the necessary and sufficient consent, also on the balance of probabilities. In practice the patient may not be able to do much more with respect to proof than to allege that the omission said to constitute the fault took place. It is then a matter of whether or not the court believes the plaintiff. This means that the physician facing such an allegation will usually have an evidentiary burden of proving the omission to disclose required information or obtain consent did not take place. The evidence brought in such circumstances will include the physician's own denial of the alleged omission. Not infrequently courts must decide this issue simply according to which of the two parties, plaintiff or defendant, they believe. In negligence actions where the evidence leaves the court in equal doubt as to whom to believe, the plaintiff will lose, as he carries the legal burden of proof of the *absence* of the necessary and sufficient consent: he necessarily loses his claim in negligence if he cannot establish failure to disclose the required information or lack of the necessary consent on the balance of probabilities. Conversely, when the cause of action is in battery, the defendant physician will lose in cases of equal doubt, as he has the legal burden of proving the presence of the necessary disclosure of information and consent.

It has been claimed that "[t]he greatest problem facing a physician is to prove what he did disclose".¹³⁵ Almost without exception

¹³⁴ See, e.g., *Kelly v. Hazlett*, *supra*, note 4, 318.

¹³⁵ Ferguson, *Informed Consent: What the Law Requires* (1980) 1 Health Law in Canada 56, 57.

a trial takes place years after the event and, as one author has commented, this may result in the courts' relying on a formula such as the following:

[the patient] recalled with precision the exact words she spoke, as well as the exact words used by the doctor. I accept her evidence. This operation was a very important event for her, and, consequently, it is one that she remembers distinctly.

Doctor _____ did not expressly deny [the patient's] version of the conversation with him. For the doctor, of course, it was only one instance of many thousands of such procedures. Thus, it is understandably very difficult for him to recollect exactly what was said. His evidence, since he did not, in fact, recall anything that was actually said, was largely speculative; he merely surmises what he may have said and what she may have said.¹³⁶

Clearly, combinations of circumstances such as those raised here could be a cause of injustice to physicians. The best course may be for physicians to keep full and careful records regarding their disclosures of information to patients.

A signed or written consent form is *prima facie* evidence of consent. Likewise, if a patient had been given reading material, or audio-visual aids had been used to inform him about a medical procedure, these could be produced in evidence as proof that the required disclosure of information was made. It would, of course, be a further question whether there was apparent understanding of this information by the patient and, consequently, a legally valid consent. Where such evidence is produced, one of the factors that will be assessed in order to determine whether the patient understood what he was being told will be the complexity of the information material, including the nature and structure of the language used. It is worth noting in this respect that a recent analysis of consent forms found that they gave information in language too complex to be readily understood by the average person.¹³⁷

It may be thought that a physician could prove that he made the necessary disclosure to a particular patient by bringing other patients as witnesses to give evidence that in similar circumstances the physician made the required disclosure to them. However, the problem with such an approach is that in all likelihood it is barred by the rules on similar fact evidence. These prohibit proving a fact by proving other similar facts and then drawing an

¹³⁶ *Ibid.*, citing *Allan v. New Mount Sinai Hospital*, *supra*, note 13.

¹³⁷ Grundner, *On the Readability of Surgical Consent Forms* (1980) 302 New England J. Medicine 900.

inference that the fact to be proved is established because in other similar cases the like fact has been proven to be present.¹³⁸

VIII. Causation

Canadian courts have faced many of the same problems in developing a test for determining when damage will be deemed in law to have been caused by failure to disclose required information to a patient as they have establishing a test for the required scope of that disclosure. The two problems are related.

Causation is the necessary link in law between the fault or breach of duty and the damage which occurs. The usual test of causation-in-fact, when a single cause is alleged, is the "but for" test: but for the alleged wrongdoing, would the damage have occurred? If the answer to this question is no, causation-in-fact is present. The test of causation-in-law (except where the only damage suffered is "pure" economic loss) is, whether damage of that kind occurring in that way was reasonably foreseeable as a result of the breach of duty? If it was, and the damage is not too remote,¹³⁹ it will be recoverable.¹⁴⁰

Proof of damage is not necessary to establish a cause of action in battery and, consequently, neither is proof of causation. But when damage results from an intentional tort, the test of its recoverability is the directness of the damage.¹⁴¹ This test can be regarded simply as requiring that causation-in-fact be shown. It should be noted that this means showing only that the touching to which no consent

¹³⁸ See Cross, *Evidence*, 5th ed. (1979), 355 *et seq.* It should be noted here that such evidence would be admissible if it fell outside the limitations on introducing similar fact evidence, for instance, if it constituted proof of custom by habitual conduct on the part of that physician.

¹³⁹ Damage is not too remote if recovery is not barred by any of the legal rules on the remoteness of damage. Such a rule is that certain damage is not of a nature that the law regards as non-compensable.

¹⁴⁰ See generally Somerville, *A Diagrammatic Approach to Causation* (1978) 24 McGill L.J. 442, 442-3. Causation-in-law may be relevant in two ways: an essential to establishing a cause of action and to identify which items of damage will be compensated. These two aspects of causation-in-law may be separated conceptually, for purposes of analysis, by referring to rules relating to the former as rules on causation of damage, and those relating to the latter as rules on remoteness of damage, although it should be noted that these terms, causation and remoteness, are often used interchangeably to refer to either or both those aspects of the causation-in-law doctrine.

¹⁴¹ See *Turner v. Thorne & Thorne* (1959) 21 D.L.R. (2d) 29 (Ont. H.C.); see also Somerville, *supra*, note 140.

was given directly caused the damage, and but for the touching the damage would not have occurred. It is not required to show also, as in negligence, that but for the failure to obtain consent the damage would have been avoided.¹⁴² By contrast, proof of damage, and hence proof of causation-in-fact and causation-in-law, is essential to establishing a cause of action in negligence. Thus the amount of damages recoverable may differ depending on whether a cause of action lies in battery or negligence, because direct but unforeseeable damages, or non-negligently inflicted ones, are recoverable in battery but not in negligence.¹⁴³ The recent Ontario case of *Allan v. New Mount Sinai Hospital*¹⁴⁴ demonstrates such a situation. The Court held that all direct damages were recoverable in battery, which lay because a procedure had been conducted without consent, despite the fact that there was no negligence involved in undertaking or carrying out the procedure which gave rise to those damages. The result is that if the plaintiff patient can prove battery, as in the *Allan* case, she can recover compensation for damages resulting from the crystallization of an unavoidable or unforeseeable risk of the procedure. Moreover, establishing battery may alter the amount of compensation payable even where the patient also has a cause of action in negligence for breach of duty in undertaking or carrying out a procedure, as pursuant to the latter claim some damages may not be recoverable on the basis that they were not reasonably foreseeable.¹⁴⁵

Assuming that the tribunal of fact is convinced that a potentially actionable non-disclosure of information has occurred in a medical context, how does it judge for the purposes of the law of negligence whether or not the non-disclosure is the cause-in-fact and the cause-in-law of the damage?

In non-disclosure of information cases, most discussion of causation problems by the courts has related to establishing causation-in-fact. Causation-in-law has not usually raised difficulties because in all cases the patient has alleged that the occurrence of the non-disclosed risk that should have been disclosed constitutes his damage. In such cases it is not necessary to be more precise as to

¹⁴² It should be queried, however, whether the same test of causation of damage applies as in negligence, if battery lies because of an intentional non-disclosure of information relating to the basic nature and character of an act.

¹⁴³ Note that some unforeseeable damages are recoverable in negligence under rules such as the "take your victim as you find him" or "egg-shell skull plaintiff" rule.

¹⁴⁴ *Supra*, note 13.

¹⁴⁵ See generally Somerville, *supra*, note 140.

whether the patient's damage consists of having made a different decision from the one that would have been made if the required disclosure had been made, or whether it consists of the ill-effects suffered as a result of the undisclosed risk eventuating. In either case once it is shown that the non-disclosure is the cause-in-fact of the patient's damage, that damage is *ipso facto* reasonably foreseeable and hence proof of causation-in-fact also establishes causation-in-law.¹⁴⁶

The test of whether the causation-in-fact is present is as follows: if the physician had made the required disclosure, would the patient have made a different decision about having or foregoing the treatment, and thus have avoided the damage? If the patient's decision would have been different, and that different decision would have avoided the damage, then the non-disclosure is the cause-in-fact of the damage for the purposes of the law. If proper disclosure would not have given rise to a different decision, or if a different decision would not have avoided the damage (provided, in the latter case, if multiple causes are present that the decision taken was not a contributing cause to the damage and provided that if no other sufficient causes had been present the decision taken would not have been sufficient to cause the damage), then causation-in-fact is not established. But this seemingly simple formula hides many difficulties.

The first difficulty has been in deciding whether the test of causation-in-fact should be subjective or objective. Canadian courts have vacillated between the two¹⁴⁷ and have even suggested a combination.¹⁴⁸ The difference between the two tests is captured in the different formulations of the basic question for determining whether or not causation-in-fact is present. Under a subjective approach the test is: if the required disclosure of information had been made to *this patient* would *he*, on the balance of probabilities, have made a different decision regarding treatment? Under an objective approach the question is: if the *reasonable patient* in the patient's circumstances had been given the required information would *that reasonable patient*, on the balance of probabilities, have made a different decision?

¹⁴⁶ For discussion of the difficulties which may arise in relation to establishing causation-in-law, see text following note 156, *infra*.

¹⁴⁷ For instance, a subjective test was adopted in *Kelly v. Hazlett*, *supra*, note 4, 320, *Strachan v. Simpson*, *supra*, note 121, 179, and an objective test in *Petty v. MacKay*, *supra*, note 69, 392. See also *Picard*, *supra*, note 71.

¹⁴⁸ *Reibl v. Hughes*, *supra*, note 1 (C.A.). For critical comment on this approach, see *Petty v. MacKay*, *supra*, note 69.

The decision as to which test of causation will be adopted is probably related to the test that the law will use to set the required scope of disclosure of information to the patient. When that scope was determined according to what the reasonable doctor would tell a patient in those circumstances, a subjective patient test of causation was generally adopted. This was understandable because a subjective test, in favouring the patient, balanced any prejudice that was caused to the patient by the reasonable physician standard having been applied to determine what he should have been told. Thus, although the subjective test of causation gave the patient the benefit of hindsight (and quite clearly the patient would be relying on such hindsight, as he would not be suing unless he felt that he would have decided differently if he had been given the information that he thought he should have been given), the court could limit liability of the physician, and in fact the medical profession could limit its own liability to some extent¹⁴⁹ by not requiring that the particular matter be disclosed.¹⁵⁰ In such a case the patient would have no cause of action because there was no breach of the duty of disclosure, rather than his action in negligence failing because the defendant's breach of duty was not the cause-in-fact of the patient's damage. But the Supreme Court of Canada has now adopted a more patient-favouring standard for scope of disclosure of information, which is what the reasonable patient in those circumstances would want to know. This change may alter the decision as to which test of causation it is more appropriate to employ.

In *Reibl v. Hughes*¹⁵¹ the Supreme Court rejected the subjective test of causation as being too favourable to plaintiff patients as they would always have the benefit of hindsight and would claim that their decision would have been different if the proper disclosure had been made. In fact the Court had before it the plaintiff's evidence that he would not have accepted the operation if he had known that the particular undisclosed risk which eventuated could occur.¹⁵² On the other hand, the Court recognized that the problem

¹⁴⁹ This is true because when a reasonable-physician standard of disclosure is used custom in the medical profession and expert medical evidence are influential in determining that standard.

¹⁵⁰ Although a court can still limit liability of a physician by finding that there was no duty to disclose a certain matter, there is more opportunity to do this under the narrower reasonable-physician scope of disclosure standard than under the wider reasonable-patient one.

¹⁵¹ *Supra*, note 1.

¹⁵² *Ibid.*, 17 *et seq.*

with adopting a purely objective test of causation is that one would assume that the reasonable person would not refuse an operation which had been recommended by a physician.¹⁵³ Thus, under a purely objective approach, the fact that a physician recommended treatment would automatically establish causation-in-fact. The Court rejected this. It held that the risks of having surgery and foregoing surgery must be taken into account to see what the reasonable patient would decide. Where the benefits of having a procedure clearly outweigh any risks of doing so and the risks of foregoing it are serious, then a reasonable patient would be likely to follow his physician's recommendation to undergo a certain procedure. In other words, in reaching a decision, the reasonable patient would take into account the risks and benefits of the alternatives available to him and set them off against each other. But the results of this assessment do not yield a final answer as to whether causation-in-fact is present. The Supreme Court held that special considerations affecting the particular plaintiff-patient must also be taken into account in determining what the reasonable patient would decide. This is achieved by characterizing such considerations as "circumstances" and placing the "reasonable patient" in the same circumstances as the plaintiff. Such circumstances include matters that the plaintiff-patient thought important, provided the defendant physician knew, or ought to have known, of them. The proviso suggested here is necessary to introduce some measure of objectivity into what may be taken into account as material circumstances.

As can be seen, the process of developing a rule to test for the presence or absence of causation-in-fact in medical non-disclosure cases is one of continuous adjustment between purely subjective and purely objective criteria. This can be demonstrated by a more particular example: disclosure that there was an immediate risk of paralysis from an operation, as compared with a more delayed risk of the same nature from postponing the operation, as was the case in *Reibl v. Hughes*, would be material to the reasonable patient in reaching a decision whether or not to undergo the operation immediately rather than later in circumstances where the patient had approximately a year and a half before being eligible for a full disability pension from his employer. The physician ought to know that he should enquire about the patient's position in such respects, or should make a disclosure of risks which takes such possibilities into account, and, if the physician fails to do so, it appears that he does so at the risk of being held liable to com-

¹⁵³ *Ibid.*, 16.

pensate. Consequently, if, as the Supreme Court held, a reasonable patient in the position of the plaintiff in *Reibl v. Hughes* would, on the balance of probabilities, refuse surgery which is recommended treatment from the purely medical point of view, damage, such as the plaintiff's loss of his pension, arising from having the surgery will have been caused in fact (and, as it was reasonably foreseeable, caused in law) by the non-disclosure of information.

In summary, the test of causation-in-fact can be formulated as what the reasonable patient in the patient's particular position would, on the balance of probabilities, have done if "all material and special risks of going ahead with the surgery or foregoing it were made known to him".¹⁵⁴ And, it bears repeating, "[a] risk is ... material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to undergo the proposed therapy".¹⁵⁵

There are some other points to be emphasized here. First, it has already been seen that the patient's questions will affect the scope of disclosure requirements. They will also affect the determination of the presence or absence of causation. The patient's questions can show factors important to the patient in reaching his decision about treatment, which may not be important to the reasonable patient. These factors can be taken into account in testing causation by making them part of the circumstances in which the reasonable patient finds himself and which will influence the latter's hypothetical decision. Thus to the extent that the patient informs the physician of subjective factors which would not be material to the reasonable man, but which are important to him, the latter can enter into and, therefore, affect the outcome of the test of causation.

Second, the Supreme Court's test of causation will tend to mean that if the medical risks of having or foregoing a procedure are equally balanced it is for the patient to make up his mind, as in this case it is not obvious what a reasonable patient would decide, and the defendant physician has deprived the patient of the chance of making a decision on the basis of adequate information. In this respect, however, it must be remembered that as the patient has the burden of proving causation on the balance of

¹⁵⁴ *Reibl v. Hughes*, *supra*, note 1, 16 (S.C.C.).

¹⁵⁵ *Hopp v. Lepp*, *supra*, note 26, 80 (S.C.C.), quoting Waltz & Scheuneman, *supra*, note 29, 640. This passage was adopted by the Court in *Canterbury v. Spence*, *supra*, note 27.

probabilities, he will be unsuccessful in his claim if the court finds the evidence to be equally in favour of a reasonable patient, to whom the required disclosure of information had been made, making or not making the same decision as the plaintiff. By comparison, if, for instance, the risks are strongly in favour of having surgery, it will be more difficult for the patient to prove causation — that is, to prove that he would have refused the operation if the full disclosure had been made — unless he can show some circumstances apart from the medical risks which would affect the decision of a reasonable patient, and which, one assumes, in fact affected him, such as was the case in *Reibl v. Hughes* with respect to the disability pension. Consequently, as the Supreme Court takes care to note, the objective test of causation does not mean that the issue of causation is completely in the physician's hands. This correlates with the approach which has been taken to setting the standard for scope of disclosure of information.

Thus, although the Supreme Court adopts an objective test of causation, they mean to include within it certain subjective factors by placing the reasonable patient in the same circumstances as the particular plaintiff patient. This can be compared with the alternative objective-subjective approach of the Court of Appeal of Ontario in *Reibl v. Hughes*, where it was suggested that first a purely objective test of causation be applied, followed by a subjective test of what that particular patient would have decided if the proper disclosure had been made.¹⁵⁶ The subjective test was meant to test the validity of the decision outcome reached under the objective test, but, as was pointed out in *Petty v. MacKay*, if such an approach is adopted, “[w]hat is the court to do where the plaintiff's evidence [as to what his decision would have been if the required disclosure had been made] is in conflict with the objective test (the standard employed by a reasonable and prudent person)? The judgment of Brooke J.A. [speaking for the majority of the Court of Appeal of Ontario in *Reibl v. Hughes*] does not, with respect, provide an answer to this question.”¹⁵⁷ The answer, it is respectfully submitted, depends on the way in which the patient's subjective decision varies from what a reasonable patient would have decided. If the reasonable patient would have decided in the same way as the patient decided, then it is irrelevant that the particular patient would have decided differently if the required disclosure had been made. A more interesting question is what a court would find with

¹⁵⁶ *Supra*, note 1.

¹⁵⁷ *Supra*, note 69, 392.

respect to causation where it could be proved that, although the undisclosed information would have affected the decision of a reasonable patient, it would not have affected the decision of this patient. It would seem unjust to find causation present and yet, in general, in tort liability subjective considerations are only allowed to override objective ones to the extent that this imposes greater and not lesser liability on the defendant. However, the latter statement may need to be restricted to cases where the defendant seeks to avoid liability imposed according to an objective standard by arguing subjective factors. It may not apply where the plaintiff has no claim on a subjective basis but does on an objective one. In such circumstances the defendant is not avoiding liability by relying on subjective factors relating to his own conduct; rather, the plaintiff, in a sense, does not have "clean hands". To the extent that this discussion represents a real issue there may be merit in having a dual objective-subjective test of causation in which subjective factors may sometimes bar a recovery which would have been allowed under a purely objective standard.

The approach of the Supreme Court in introducing subjective factors within an objective test of causation is more unitary in concept than the dualized objective-subjective test outlined above and is probably more limited as to which subjective factors may be introduced. The Chief Justice said:

the patient's particular concerns must ... be reasonably based; otherwise, there would be *more subjectivity* than would be warranted under an objective test. Thus, for example, fears which are not related to the material risks which should have been but were not disclosed would not be causative factors. However, economic considerations could reasonably go to causation where, for example, the loss of an eye as a result of non-disclosure of a material risk brings about the loss of a job for which good eyesight is required. In short, although account must be taken of a patient's particular position, a position which will vary with the patient, it must be objectively assessed in terms of reasonableness.¹⁵⁸

The passage just cited raises some difficulties. What is meant by "fears which are not related to the material risks which should have been but were not disclosed"? Does the Court mean to exclude as causative factors just fears related to risks which did not require disclosure, or fears related to disclosed material risks, or both? The former interpretation presents no difficulty. But if the Court is saying that fears related to *disclosed* risks can play no role as causal factors in relation to the patient's decision, there is a problem. The reasonable patient could, and almost certainly

¹⁵⁸ *Reibl v. Hughes*, *supra*, note 1, 17 (emphasis added).

would, take such fears into account as part of the "cluster of risks"¹⁵⁰ relevant to his reaching a decision about treatment. Consequently, such fears do play a rôle in assessing causation with respect to an undisclosed risk. It may be that the Court is saying that disclosed risks can never give rise to a cause of action even when there has been a non-disclosure. This is a complex causation problem which will be discussed presently.

The second question raised in relation to the Supreme Court's statement is what is meant by saying that the "patient's particular concerns must . . . be reasonably based". This should only apply to concerns of the patient of which the physician was *not* subjectively aware and of which it would be unreasonable to deem the physician to have knowledge because such concerns would not be concerns of a reasonable patient. It is submitted that, no matter how unreasonable a particular patient's concerns, if the physician knows of them and if there is a risk relating to these concerns, then if that risk is not disclosed and the patient undergoes treatment which he would have refused had that particular risk been disclosed, non-disclosure of that risk will be the cause-in-fact of its realization.

The discussion so far may be summarized: non-disclosure of information which there was a duty to disclose will be the cause-in-fact of damage resulting from a patient's decision to accept or forego treatment if, on the balance of probabilities, disclosure would have caused a reasonable patient in the plaintiff's position to alter his decision concerning treatment. The circumstances that will be taken into account in assessing the plaintiff's position include all those relevant circumstances in which the plaintiff patient finds himself and of which the physician knew or ought to have known, and will also include any additional subjective factors which the plaintiff patient made known to the physician as being important to him in reaching his decision. Referring to the facts in *Reibl v. Hughes*, the Supreme Court sums it up this way:

Relevant in this case to the issue whether a reasonable person in the plaintiff's position would have declined surgery at the particular time is the fact that he was within about one and one-half years of earning pension benefits if he continued at his job; that there was no neurological deficit then apparent; that there was no immediate emergency making the surgery imperative; that there was a grave risk of a stroke or worse during or as a result of the operation, while the risk of a stroke without it was in the future, with no precise time fixed or which could be fixed except as a guess of three or more years ahead. Since, on the trial Judge's finding, the plaintiff was under the mistaken impression, as

¹⁵⁰ See Waltz & Scheuneman, *supra*, note 27, 640, quoted by Laskin C.J.C. in *Hopp v. Lepp*, *supra*, note 26, 80.

a result of the defendant's breach of the duty of disclosure, that the surgery would relieve his continuing headaches, this would in the opinion of a reasonable person in the plaintiff's position, also weigh against submitting to the surgery at the particular time.

... [A] reasonable person in the plaintiff's position would, on a balance of probabilities, have opted against the surgery rather than undergoing it at the particular time.¹⁶⁰

Thus the plaintiff had proved causation-in-fact for the purposes of a cause of action in negligence by showing, on the balance of probabilities, not that he would never have undertaken this surgery and, consequently, never have run the risk which eventuated, but that he would not have undertaken the procedure at the time at which he did if it were not for the defendant's negligent non-disclosure. Further, the plaintiff proved that this variation in the time of the performance of the procedure and, consequently, of the crystallization of the risk which occurred, constituted a damage to him.¹⁶¹

This last point is important because it demonstrates that simply showing that at some time in the future the same treatment may be needed, or the same situation could result without treatment, will not necessarily operate as a defence against a claim for damages for negligent non-disclosure of information. This is true because proof of such facts does not destroy the causal link between the defendant's breach of duty, the non-disclosure, and the plaintiff's damage, when the nature of the damage alleged is acceleration of the condition of which the plaintiff complains rather than a claim that the condition would never have occurred at all except for the defendant's breach of duty. Obviously, there are limits with respect

¹⁶⁰ *Supra*, note 1, 35.

¹⁶¹ In *Reibl v. Hughes* the acceleration of the running of the risk, and hence of its crystallization, amounted to damage in two ways: first, it should be regarded as causing economic loss of an *aggravated* kind as far as the damage represented by loss of the pension is concerned (as all persons unable to work usually suffer some economic loss and, consequently, unless aggravated loss were required, any acceleration of damage could be regarded as causing economic loss). Secondly, the patient has the damage of suffering the disability sooner rather than later. This second loss could be present in many cases and there is no reason why it should not be compensable when standing alone. This is demonstrated in *Strachan v. Simpson*, *supra*, note 121. Exploratory spinal surgery was performed on the patient. It involved a risk of paraplegia which was not disclosed and which resulted, but without the operation it was likely that the plaintiff-patient would have become totally paraplegic within a year. The Court held that the plaintiff would not have consented to the surgery had the risk been explained and awarded general damages of \$22,000.00 because of *acceleration* of the condition of paraplegia, which acceleration (not the condition of paraplegia itself) would have been avoided by not having the operation.

to defining acceleration of a condition as a head of damage. For instance, if an operation were in the nature of an emergency, the plaintiff could not prove causation by characterizing the damage as acceleration of a certain condition, because to delay the procedure would not be an option open to the reasonable plaintiff. Further, there may be situations of *de minimis* acceleration, or difficulty in proving that any acceleration of a condition resulted from the intervention and not other causes. In these circumstances the plaintiff has not proven causation, or even, in some instances, has not proven damage itself. The latter is true because when the nature of the alleged damage is acceleration of the occurrence of a condition, it is necessary to prove damage, that is acceleration, before looking for a causal link. If the condition would have occurred naturally at the same time, there is no acceleration, and hence no damage, rather than no causation.¹⁶²

Depending on the nature of the alleged damage, its actual pathogenesis may be irrelevant to causation as no matter what this was the physician will be liable. For instance, in *Hankins v. Papillon*¹⁶³ the plaintiff-patient underwent a dermabrasion procedure to remove brown marks from her face, which had been caused by taking oral contraceptives. These marks reappeared after the treatment. The Court held that the plaintiff had failed to prove that the physician had not made an adequate disclosure of the risks. It noted, however, that even had this been achieved "the causal link is not free from doubt".¹⁶⁴ The Court did not elaborate on this statement, but it raises an important point. Depending on whether the plaintiff alleges her damage consists of undergoing the procedure or suffering the reappearance of the brown marks, there may or may not be causation-in-fact. In the former case it would be irrelevant to proving causation arising from a non-disclosure whether the reappearance of the marks was caused by the procedure which was performed to remove them, or was simply a continued effect of having taken the oral contraceptives, as in either situation the physician's fault would lie in failing

¹⁶² If the cause of the condition occurring when it did was something other than natural causes, and if this constitutes an acceleration of the occurrence, it is a further question whether any breach of duty by the physician contributed to such acceleration. If the physician's breach of duty did so it may be a cause, for the purposes of the law, of the damage constituted by acceleration of the condition, despite the fact that other sufficient causes were also present.

¹⁶³ *Supra*, note 72.

¹⁶⁴ *Ibid.*, 883.

to warn of the possibility of such reappearance, and this omission could cause the plaintiff to agree to a procedure which she would not otherwise have undergone. In other words, whatever the source of the reappearance of the marks, the necessary causal link between the physician's fault (the failure to inform) and the patient's damage (deciding to undergo and undergoing the procedure) will be present. If, by comparison, the damage consists of the reappearance of the brown marks, then the plaintiff must prove that this was caused by having the procedure as only then will the physician's breach be the cause-in-fact of this damage. A finding as to causation-in-law can also depend on exactly what is identified as constituting the plaintiff's damage. This will be discussed presently.

A further matter relating to causation also merits discussion here, although it has been canvassed elsewhere.¹⁶⁵ This is the question of whether it must be the undisclosed risk which eventuates in order to give rise to a positive finding of causation. More precisely, suppose that a procedure carries two risks which require disclosure, risk A and risk B. The physician discloses risk A but not risk B. Risk A eventuates. But if risk B had been disclosed the reasonable patient in the patient's circumstances would have refused the procedure and avoided risk A. Has causation-in-fact been proven for the purposes of an action in negligence for non-disclosure? Two approaches are possible: one can argue that each risk is to be treated separately, that risk A was disclosed to the patient, that he agreed to run risk A, that risk A eventuated as the plaintiff knew it could when he consented to run it, and therefore, no cause of action based on non-disclosure arises. This may be designated a *separatist approach*.¹⁶⁶ Alternatively, one can argue that the patient agrees to run a bundle of risks and that he would have avoided running risk A if risk B had been disclosed to him. Therefore, the failure to disclose risk B caused him to run risk A and, consequently, he may recover in a cause of action based on negligent non-disclosure when risk A eventuates. This can be regarded as a *cumulative approach*. The Canadian courts have not been called upon to decide which approach to adopt. However, it is worth noting that the Supreme Court of Canada in *Hopp v. Lepp*, at least without disapproval and possibly with approval, cites *Halushka v. University of Saskatchewan* to the following effect: "[i]n the view of the Court

¹⁶⁵ Somerville, *supra*, note 31.

¹⁶⁶ In *Scott v. Bradford* 606 P. 2d 554, 559 (Okla 1979) the Court held that "[a]bsent any occurrence of the undisclosed risk, a physician's failure to reveal its possibility is not actionable."

of Appeal [of Saskatchewan], there were undisclosed or misrepresented facts and, it added '[they] need not concern matters which directly cause the ultimate damage if they are of a nature which might influence the judgment upon which the consent is based'.¹⁶⁷ This statement could support the view that causation can be established in some circumstances when a disclosed risk eventuates, provided that there was an undisclosed risk present which should have been disclosed and which would have affected the decision of the reasonable patient whether or not to undergo the procedure. On the other hand, the statement of the Supreme Court already discussed,¹⁶⁸ that "fears which are not related to the material risks which should have been but were not disclosed would not be causative factors",¹⁶⁹ may indicate the contrary.

However, if the cumulative test for establishing causation-in-fact is accepted, there is a further problem involving causation-in-law. Assume that there has been a non-disclosure of risk A that was required to be disclosed, and if it had been disclosed the reasonable patient in the same circumstances would have refused the procedure, and risk X, which did not require disclosure, eventuates. Under the cumulative approach to causation-in-fact, non-disclosure of risk A is the cause-in-fact of risk X eventuating. But is it the cause-in-law? As stated previously, the test of causation-in-law is whether that type of damage occurring in that way was reasonably foreseeable. Hence, the answer to this question in any given circumstances depends first on what a risk being reasonably foreseeable means and, second, on how the damage and the damaging event is described.

The concept of reasonable foreseeability is wide. A reasonably foreseeable risk is one which "would occur to the mind of a reasonable man in the position of the [defendant] and which he would not brush aside as far-fetched".¹⁷⁰ A risk may be reasonably foreseeable although it is extremely unlikely and may be described as only a remote possibility.¹⁷¹ "A risk of injury which is quite unlikely to occur ... may nevertheless be plainly foreseeable."¹⁷²

¹⁶⁷ *Supra*, note 29, 78, quoting Hall J.A. in *Halushka v. University of Saskatchewan*, *supra*, note 58, 445.

¹⁶⁸ See text at note 151, *supra*.

¹⁶⁹ *Reibl v. Hughes*, *supra*, note 1, 17.

¹⁷⁰ *Overseas Tankship (U.K.) Ltd v. The Miller Steamship Co. Pty [The Wagon Mound (No. 2)]* [1967] 1 A.C. 617, 643-4 (P.C.) per Lord Reid.

¹⁷¹ *Wyong Shire Council v. Shirt* (1980) 29 A.L.R. 217 (Aust. H.C.).

¹⁷² *Ibid.*, 221.

The problem of describing the damage and the damaging event in order to ask whether the nature of X and the way in which it occurred were reasonably foreseeable results of the defendant's conduct must now be considered. In this respect the more general the terms in which a court, in the exercise of its discretion, frames the description of what needs to have been reasonably foreseen, the more likely it is that reasonable foreseeability of the damage, and causation-in-law, will be found.

Reasonable foreseeability of the way in which the damage occurred will not usually be in issue in cases concerning non-disclosure of medical information, because if the damage itself is foreseeable, in general, the way in which it occurred will also be foreseeable. The exception will be when a known type of risk occurs, but arises from an unknown source.¹⁷³ In such cases, depending on how generally or precisely the court describes the damaging event, for example, either as paralysis arising in the course of an angiogram or as paralysis arising from an unknown source of the risk of paralysis during an angiogram, the way in which the damage occurred will or will not be foreseeable, respectively.¹⁷⁴

The fact that there may be an issue as to what constitutes the patient's damage in relation to non-disclosure of information has already been considered. Does the damage consist of the patient's decision to run and then running known or unknown risks (including X), which he would not have run if the required disclosure had been made? Or is the patient's damage constituted by occurrence of X? If the damage is of the former nature, then proof of causation-in-fact will automatically establish causation-in-law, because the damage is necessarily foreseeable as a result of the non-disclosure. Under this approach, proof of X will simply quantify the amount of damages the patient can recover. It may be that the reason why there is no discussion of causation-in-law, as distinct from causation-in-fact, in any of the Canadian cases on informed consent, is that the courts are adopting such an approach. It is impossible to be categorical about this, however, because the fact situations so far presented have not made the distinction critical.

By contrast, if the damage is constituted by the occurrence of X, the question for establishing causation-in-law is whether or not X was a reasonably foreseeable risk of the procedure which the plaintiff underwent as a result of the defendant's breach of duty.

¹⁷³ *McLean v. Weir, Goff & Royal Inland Hospital*, *supra*, note 76.

¹⁷⁴ See Somerville, *supra*, note 31.

The answer may not always be clear, though in this respect it is important to note that a distinction must be made between risks which require disclosure and risks which are reasonably foreseeable: the latter is a much broader class.

Consequently, under either approach to characterizing the patient's damage, causation-in-law may be present respecting the occurrence of a risk that did not require disclosure when there has been a breach of duty in failing to disclose another risk. It bears repeating that this argument depends on accepting that the presence of causation-in-fact does not depend on the undisclosed risk eventuating. If this approach is not adopted, then a discussion of causation-in-law is irrelevant except with respect to undisclosed risks which eventuate and form the basis of a claim for negligent non-disclosure, as only in such cases will causation-in-fact be present.

Finally, one approach to avoiding some of the more complicated causation problems arising from non-disclosure of information would be to adopt a concept similar to the civil law doctrine of "loss of a chance" ("la perte d'une chance").¹⁷⁵ This approach means that the damage complained of would not be the eventual injury (which merely quantifies the amount of damage caused), but the loss of the chance of acting with full knowledge of the options and alternatives available.¹⁷⁶ In effect this theory makes the same event — the non-disclosure — both the wrongful act or breach of duty and the damage itself. Consequently, the necessity to find the causal link between the breach of duty and the resulting damage is eliminated. The doctrine, as developed in French law, postulates that the physician owes a duty to the patient to give him all chances of being cured and the physician will be liable if he deprives the patient of such chances. The extension suggested here is that liability could also lie for failing to give the patient a chance to choose, when he was entitled in law to have a choice. To some extent, this approach introduces a discretion that allows a court to award damages in cases where it feels that it is just to do so but where there are difficulties in finding proof of causation of damage, as traditionally required. Whether it is a good idea to introduce such notions into the law will remain a matter of debate.

¹⁷⁵ See Boyer Chammard & Monzein, *La responsabilité médicale* (1974), 92-105.

¹⁷⁶ This doctrine could be regarded as an overt expression and formalization of the decision which must be taken as to what constitutes the patient's damage. The doctrine is equivalent to holding that the patient's damage consists in having made and followed a decision to have or forego treatment in the absence of a proper disclosure of information, rather than in the occurrence of a risk of that procedure.

Conclusion

There has recently been much development in the law relating to informed consent in the medical relationship. But many unresolved issues remain, even in the fact situations that have so far been presented before Canadian courts, and the full range of potential fact situations involving informed consent and the issues which they can present are very extensive.

It is most important, at this early stage, to ensure that decisions involving informed consent are not made on an *ad hoc* basis. Rather, fundamental principles must be carefully worked out and their necessary and intricate variations studied. This can be done best by structuring a framework of questions and subquestions that must be considered in a certain order. The approach outlined in this paper represents one such framework.

The question of informed consent has raised complex and interesting legal, ethical and policy issues. This development is far from finished. The Supreme Court has now firmly established the foundations of the house that Canadian law will build in this area and, possibly, has completed the external structure. But there is still much left to be done. We should strive for a structure that is unified, harmonious and livable in the view of patients, the community in general, physicians and lawyers. We must also keep in mind that the structure itself needs a certain amount of built-in flexibility to accommodate changes or new additions that will inevitably be needed in this rapidly changing area. Unless such flexibility is incorporated damage to the structure can result from changes both in technology and in the mores of a given society. The aim must be to develop a basic structure which can accommodate and incorporate such changes without itself being destroyed.
