AN OVERVIEW OF THE LAW REGARDING INFORMED CONSENT

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The Doctrine of Informed Consent in Canada

In 1980, the Supreme Court of Canada rendered two landmark decisions pertaining to the related matters of the duty of a physician to make disclosure to the patient and the requirement of informed consent of the patient to a surgical procedure.

In *Hopp v. Lepp*[2] Chief Justice Laskin considered whether a patient who suffered permanent damages after the performance of a hemilaminectomy had given informed consent to the procedure. After suggesting that the patient had a right to decide what, if anything, should be done with his body, Laskin C.J. went on to hold that there was a duty of disclosure – that is, the surgeon or physician was bound by a duty to provide information to his or her patient.

Laskin C.J., speaking for the court, reviewed a number of the leading authorities and stated the following conclusion[3]:

> "In summary, the decided cases appear to indicate that, in obtaining the consent of a patient for the performance upon him of a surgical operation, a surgeon, generally, should answer any specific questions posed by the patient as to the risks involved and should, without being questioned, disclose to him the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation. However, having said that, it should be added that the scope of the duty of disclosure and whether or not it has been breached are matters which must be decided in relation to the circumstances of each particular case."

Shortly thereafter, the Supreme Court of Canada again had reason to address the issue of informed consent, among other issues, in the leading case of *Reibl v. Hughes*[4]. In this judgment *Hopp v. Lepp* was considered in the context of the plaintiff's claim that he had not given

informed consent to an endarterectomy procedure that had left him a hemiplegic.

Broadly speaking, it was the *Reibl* judgment that introduced the doctrine of informed consent into Canadian law. Building on his reasons in *Hopp v. Lepp*, Laskin C.J., writing for a unanimous court, confirmed that the relationship between a doctor and a patient undoubtedly gives rise to a duty of the doctor to disclose material risks associated with a procedure, without having to be questioned by the patient. Thus, the traditional standard of disclosure – that is, what a reasonable physician would disclose – was replaced with the standard of what a reasonable patient would want to know.

While the judgment of Laskin C.J. also restricted the tort of battery to those cases where surgery or treatment was performed or given without any consent or where it went beyond the consent given, his most important conclusion was that relating to the proper test for causation. Chief Justice Laskin held that the subjective test for causation – that is, what a particular patient would have done if properly informed – should be replaced with a modified objective test that sought to determine what a reasonable person in the plaintiff's position would have done if properly informed. He opined[5]:

> "In saying that the test is based on the decision that a reasonable person in the patient's position would have made, I should make it clear that the patient's particular concerns must also 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."

Therefore, even if a physician fails to obtain an informed consent, liability will only attach where it can be established that a reasonable person in the patient's position would have decided

to forego the surgical procedure had he or she been properly informed.

The foregoing judgments established that doctors have a duty to provide material information that a reasonable patient would want to know. It is for the Court to determine whether there has been material non-disclosure of facts or risks, having regard to the expert evidence, and the evidence as a whole.

The question of disclosure, however, is qualitatively different from an expert opinion as to whether a doctor has been negligent in the performance of a medical procedure. This distinction was highlighted by Chief Justice Laskin in *Reibl v. Hughes*[6]:

> "... To allow expert medical evidence to determine what risks are material and, hence, should be disclosed and correlatively, what risks are not material is to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that duty. Expert medical evidence is, of course, relevant to findings as to the risks that reside in or are a result of recommended surgery or other treatment. It will also have a bearing on their materiality but this is not a question that is to be concluded on the basis of the expert medical evidence alone. The issue under consideration is a different issue from that involved where the question is whether the doctor carried out his professional activities by applicable professional standards. What is under consideration here is the patient's right to know what risks are involved in undergoing or foregoing certain surgery or other treatment."

As summarized by Picard and Robertson in their text, *Legal Liability of Doctors and Hospitals in Canada*, 3rd Edit., (Scarborough, Ont.: Carswell, 1996)[7]:

> "The language in both *Reibl v. Hughes* and *Hopp v. Lepp* is couched in terms of disclosure of *risks*. The doctor must inform the patient of those risks which a reasonable person in the patient's position would want to know. However, it is now well established that the duty of disclosure is not confined to risks, but extends to other material information which a reasonable patient would want to have. In particular, the patient must be informed of any available alternatives to the treatment being proposed, as well as the material risks associated with those alternatives. The duty to disclose available alternatives is especially important

> where these are more conservative, and involve fewer risks, than the treatment which is being proposed."

In *Videto v. Kennedy* [8], the Ontario Court of Appeal summarized the duty of disclosure as established in *Hopp v. Lepp* and *Reibl v. Hughes* in accordance with the following principles:

1. The questions of whether a risk is material and whether there has been a breach of the duty of disclosure are not to be determined solely by the professional standards of the medical profession at the time. The professional standards are a factor to be considered.

2. The duty of disclosure also embraces what the surgeon knows or should know that the patient deems relevant to the patient's decision whether or not to undergo the operation. If the patient asks specific questions about the operation, then the patient is entitled to be given reasonable answers to such questions. In *Reibl v. Hughes*, Laskin C.J.C. stated:

> "The patient may have expressed certain concerns to the doctor and the latter is obliged to meet them in a reasonable way. What the doctor knows or should know that the particular patient deems relevant to a decision whether to undergo prescribed treatment goes equally to his duty of disclosure as do the material risks recognized as a matter of required medical knowledge."[9]

3. A risk which is a mere possibility ordinarily does not have to be disclosed, but if its occurrence may result in serious consequences, such as paralysis or even death, then it should be treated as a material risk and should be disclosed.

4. The patient is entitled to be given an explanation as to the nature of the operation and its gravity.

5. Subject to the above requirements, the dangers inherent in any operation such as the dangers of the anaesthetic, or the risks of infection, do not have to be disclosed.

6. The scope of the duty of disclosure and whether it has been breached must be decided in relation to the circumstances of each case.

7. The emotional condition of the patient and the patient's apprehension and reluctance to undergo the operation may in certain cases justify the surgeon in withholding or generalizing information as to which he or she would otherwise be required to be more specific.

8. The question of whether a particular risk is a material risk is a matter for the trier of fact. It is also for the trier of fact to determine whether there has been a breach of the duty of disclosure.[10]

Since *Reibl v. Hughes* was decided, however, a number of Canadian judicial decisions have cast doubt upon the validity of Justice Laskin's "modified objective" test, suggesting that there is a possibility that more than one reasonable choice may exist in an elective or risk-avoidance situation. Accordingly, these judgments have sought to ascertain how far the courts can and should go in considering the personal, subjective characteristics and circumstances of a particular plaintiff in determining what a fully informed reasonable patient would have done.[11]

A thorough review of the relevant authorities suggests that the doctrine of informed consent remained relatively unchanged in Canadian law, however, until the 1995 Supreme Court of Canada decision in *Hollis v. Dow Corning*[12]. In that case, the Supreme Court of Canada replaced the modified objective standard with a subjective standard for medical negligence cases involving product liability.[13]

In its 1997 judgment in *Arndt v. Smith*[14] the Supreme Court of Canada again had occasion to address the issue of informed consent to medical treatment. However, notwithstanding calls from jurists and commentators alike for a critical reassessment of the continued applicability of

Justice Laskin's modified objective standard, the majority simply reaffirmed the modified objective test enunciated in *Reibl v. Hughes* in relation to the issue of causation.

In particular, for the majority in *Arndt*, Cory J. explained that the Canadian test to determine whether there was a lack of disclosure, which could be said to be the cause of the patient's injury, involved a mixture of objective and subjective factors. According to Cory J., the test, initially articulated in *Reibl v. Hughes,* involved the court objectively considering the balance between the risks of the treatment compared with those of forgoing the treatment. The *Reibl* test also required the court to assess the balance of risks and benefits of the treatment. *Prima facie*, where the benefits outweigh the risks, the treatment will be reasonable.

Justice Cory reasoned[15]:

> "...The test enunciated relies on a combination of objective and subjective factors in order to determine whether the failure to disclose *actually* caused the harm of which the plaintiff complains. It requires that the court consider what the reasonable patient *in the circumstances of the plaintiff* would have done if faced with the same situation. The trier of fact must take into consideration any "particular concerns" of the patient and any "special considerations affecting the particular patient" in determining whether the patient would have refused treatment if given all the information about the possible risks."

Later, he concluded[16]:

> "*Reibl* is a very significant and leading authority. It marks the rejection of the paternalistic approach to determining how much information should be given to patients. It emphasizes the patient's right to know and ensures that patients will have the benefit of a high standard of disclosure. At the same time, its modified objective test for causation ensures that our medical system will have some protection in the face of liability claims from patients influenced by unreasonable fears and beliefs, while still accommodating all the reasonable individual concerns and circumstances of plaintiffs. The test is flexible enough to enable a court to take into account a wide range of the personal circumstances of the plaintiff, and at the same time to recognize that physicians should not be held responsible when the idiosyncratic beliefs of their patients might have prompted

> unpredictable and unreasonable treatment decisions.
>
> ... In short, I see no reason to abandon the modified objective test to causation set down in *Reibl v. Hughes*, a test which asks whether a reasonable person in the circumstances of the plaintiff would have consented to the proposed treatment if all the risks had been disclosed."

While Cory J.'s majority opinion may be said to have entrenched the modified objective test for the foreseeable future, Mitchell McInnes makes the following observations in his article entitled "Causation in Tort Law: A Decade in the Supreme Court of Canada" (2000), 63 *Sask. L. Rev*. 445[17]:

> "Conceivably, when compared to the decision in *Reibl*, the length and general tone of the majority's comments in *Arndt* might be interpreted as endorsing a more expansive attitude toward importing subjective factors into the objective test. Although Cory J. did not expressly state that courts should adopt a relatively relaxed approach to the construction of the reasonable person, he did indicate a willingness to consider a broad range of "reasonable" idiosyncrasies. Ultimately, however, it seems likely that lower courts will approach *Arndt* in much the same manner as they approached *Reibl*: flexibly and perhaps instrumentally. Indeed, the very nature of the test may preclude any other possibility. As in other areas of tort law, the reasonable person standard requires a judge to exercise discretion and may allow a judge (consciously or subconsciously) to tailor reasons to support a just result. And as the case law emerging from *Reibl* indicates, the resulting test has been applied both broadly and narrowly, depending upon the circumstances of a case.
>
> The practical lesson, then, seems clear. For both parties, persuasive advocacy is at a premium under the reasonable person test. In difficult cases, defendant's counsel should argue that *Arndt* merely reaffirmed *Reibl*, build upon the many instances in which liability was denied under the objective test prior to 1997 and characterize the plaintiff's circumstances as involving irrational idiosyncrasies. In contrast, plaintiff's counsel should, in similar circumstances, stress the range of factors that Cory J. endorsed in *Arndt*, appeal to the court's sense of compassion, and portray any peculiarities pertaining to the claimant's situation as being reasonable."

In this regard, it is further noteworthy that, in dissent, Sopinka and Iacobucci J.J. argued that *Reibl* should be overruled and replaced with a subjective test of causation. While McLachlin J.

concurred with the majority's result, she too agreed with Sopinka and Iacobucci J.J. that the applicable test should be subjective.

The Law of Informed Consent – Selected Post-*Arndt* Jurisprudence

As alluded to above, the law of informed consent in Canada has remained largely unchanged since the Supreme Court's decision in *Reibl v. Hughes.* Judges interpreting and applying the present doctrine have continued to do so in variant ways and the causation component of the doctrine of informed consent, which employs the modified-objective standard, often appears to be applied to favour defendants.[18] The following decisions are briefly reviewed as they have either confirmed the principles discussed above or sought to introduce subtle modifications to those general principles of law.

In the fairly recent Alberta case of *Rhine v. Millan*[19] Ritter J., in the context of a medical malpractice action involving an allegedly inappropriate prescription of corticosteroids, reviewed the law in relation to informed consent. Justice Ritter first confirmed that[20]:

> "The doctor/patient relationship requires the doctor to disclose to a patient all material risks of procedures or treatments being recommended. In determining whether this has been accomplished, the Court should adopt a patient-centered approach to defining those material risks. The test includes consideration of what the patient would have found relevant, as well as what the medical profession deems material. ...
>
> In determining whether facts are material necessitating disclosure, the test is what the patient would have wanted to know. ..."

Then, relying on Lomas J.'s earlier judgment in *Mangalji (Next Friend of) v. Graham et al.*[21], Ritter J. endorsed the following series of well-established principles to apply in dealing with the question of informed consent[22]:

(a) It is understood that the relationship of physician and patient gives rise to a duty to make

disclosure to the patient of all material risk attending the procedure or treatment that is being recommended;

(b) The materiality of non-disclosure of certain risks is a matter for the trier of fact and the question of whether a risk is material and whether there has been a breach of duty of disclosure are not to be determined solely by professional standards of physicians. The professional standards are a factor to be considered, but so is other evidence including evidence from the patient and his or her family;

(c) In obtaining the consent of a patient to a particular treatment or procedure, the physician should answer any specific questions posed by the patient, as well as disclosing the nature of all material risks, without relying on the patient to ask questions to elicit this information;

(d) The scope of disclosure is determined in relation to the circumstances of each particular case;

(e) The emotional condition of the patient and his apprehension and reluctance to undergo treatment may, in certain cases, justify the surgeon withholding or generalizing information about which he or she would otherwise be required to be more specific;

(f) Even if a certain risk is a mere possibility, which ordinarily need not be disclosed, where occurrence brings with it serious consequences, it should be regarded as a material risk requiring disclosure; and

(g) Material risks encompass those risks which the doctor knew or ought to have known a reasonable person in the patient's position would consider in deciding whether to undergo a procedure or treatment.

In short, therefore, Justice Ritter's judgment confirmed the prevailing view of informed consent outlined in *Reibl v. Hughes* and echoed in *Arndt v. Smith*.

In *Seney v. Crooks*[23], the Alberta Court of Appeal confirmed that the duty of disclosure is not confined to risks, but extends to other material information – such as any alternatives to the treatment being proposed and the risks associated therewith – which a reasonable patient would want to have.

The *Seney* decision involved a plaintiff who, after having broken her wrist, alleged that the orthopaedic surgeon who assessed and treated her had done so negligently and had, thereby, caused permanent disability. In considering the defendants' appeal, the Alberta Court of Appeal observed that the duty to inform required that a physician inform the patient not only of the treatment he proposed but of the existence of an alternative mode of treatment preferred by some specialists and the risks associated with proceeding with each option. Lack of negligence in proceeding with the treatment he did use did not excuse him from informing his patient of the risks of proceeding in that manner rather than with the alternative treatment.

Conrad J.A. reasoned[24]:

> "... Dr. Crooks owed more than one duty of care to his patient. In addition to the duty to provide treatment, Dr. Crooks owed the duty to proceed with any treatment on the basis of informed consent. The duty to inform, in this case, required informing the patient of the status of her condition, the treatment being proposed, an alternative mode of treatment preferred by some specialists, and the risks associated with proceeding with mere casting rather than the alternative treatment. The essence of the trial judgment is that Ms. Seney had a right to make a fully informed decision about the treatment received.
>
> Lack of negligence in the choice of treatment or the manner in which that treatment is performed does not negate a physician's additional duty to inform his patient of the risks of proceeding in one way as opposed to another. That a physician can owe more than one duty, and the distinction between such duties, was made clear in **Reibl v. Hughes**, supra, ...

Conrad J. continued[25]:

> "The duty to inform a patient includes the duty to inform of alternative treatments as well as the risks of treatments. ...
>
> This Court in **Zimmer v. Ringrose** (1981), 28 A.R. 69 ... (C.A.), held at p. 222 that "the physician or surgeon should also discuss the benefits to be gained from the recommended treatment or operation, the advantages and disadvantages associated with alternative procedures and the consequences of foregoing treatment.""

In another recent Alberta decision, *Keane v. Adams et al.*[26], Lutz J. had this to say in regard to the state of the law pertaining to informed consent[27]:

> "In **Reibl v. Hughes** ..., Laskin, C.J. noted that a relationship between a doctor and a patient undoubtedly gives rise to a duty of the doctor to disclose material risks associated with a procedure, without having to be questioned by the patient. ..."

Lutz J. then made the following observations regarding the application of Laskin C.J.'s modified objective standard[28]:

> "In **Reibl**, supra, Laskin, C.J., noted that the test is what would a reasonable person in the plaintiff's position have done, provided that the patient's concerns are reasonable. In **Arndt v. Smith** ..., Cory, J., for the majority noted that in assessing the plaintiff's circumstances one could consider his age, income, and marital status as well as special circumstances. Cory, J., also noted that a reasonable person would also possess the patient's "reasonable beliefs, fears, desires and expectations"... "

And finally, in the recent Ontario case of *Ross v. Welsh*[29] the plaintiff had arthroscopy and debridement surgery on her right knee. She was warned about the rare but serious complications resulting from all lower extremity surgery which include complications from anaesthetic, thrombophlebitis and infection. However, prior to the surgery, she was not told, given her

condition, that with the surgery the likelihood of improvement was 50%, the likelihood of staying the same was 35% and the likelihood of her condition being worse following the surgery was 15%. Neither was non-invasive treatment such as medication, bracing, injections or physiotherapy discussed. Not surprisingly, the plaintiff asserted that, had she been aware of these predictions and the possibility of pursuing non-surgical treatment, she would never have had the surgery.

Wilson J. concluded that the statistical information should have been provided, stating[30]:

> "Dr. Welsh knew or ought to have known in August 1995, based upon the history and the x-ray, that Mrs. Ross had a 50% chance of improving following the surgery, and a 15% chance of being worse. His file note appears to confirm his awareness as he indicates it "is always problematic to get benefit for these individuals."
>
> In this case the statistics were generally known, and had been published in the literature as a result of studies. There was no dispute amongst the experts with respect to the applicable statistics. The issue is whether they ought to have been disclosed.
>
> I conclude in these circumstances that Mrs. Ross should have been given the material information about potential benefits of the proposed surgery, including the percentage chance of being worse after the surgery to provide an informed consent. I conclude that to fail to do so falls below an acceptable standard for an orthopedic surgeon with a specialty in knee arthroscopic surgery..."

The reasons for judgment of Wilson J. also confirmed that there exists a general obligation on doctors to advise patients of alternatives and available options such as no treatment or conservative management. As he pointed out, "[t]his is recognized in both the common law and the legislation" and is enhanced when the procedure is an elective one.[31]

Codification of the Law of Informed Consent – Selected Legislation

Several Canadian provinces have seen fit to enact legislation that specifically addresses the issue of informed consent in the health care context. Generally speaking, these statutes were intended as a codification of the common law rules regarding informed consent as those were enunciated in the leading case of *Reibl v. Hughes*. These statutes also seek to strike a balance between the person's right to be informed and the need for the health practitioner not to be sued once he fully complies with his or her duty of disclosure.

By way of example, section 11 of Ontario's *Health Care Consent Act, 1996*[32] states that the following are the elements required for consent to treatment: (a) consent must relate to the treatment; (b) consent must be informed; (c) consent must be given voluntarily; and, (d) consent must not have been obtained through misrepresentation or fraud.

Section 11 also confirms that a consent is informed if, before giving it: (a) the person received the information about the nature of the treatment, the expected benefits of the treatment, the material risks and side effects of the treatment, and the likely consequences of not having the treatment that a reasonable person in the same circumstances would require in order to make a decision; and (b) the person received responses to his or her requests for additional information about those matters.

Summary

The issue of informed consent in a medical negligence action was addressed by the Supreme Court of Canada in the landmark cases of *Hopp v. Lepp* and *Reibl v. Hughes*.

In *Hopp v. Lepp*, Laskin C.J., giving judgment for the Court, set out the duty upon a surgeon to make disclosure to a patient when obtaining consent to a surgical procedure[33]:

> "... [I]n obtaining the consent of a patient for the performance upon him of a surgical operation, a surgeon, generally, should answer any specific questions posed by the patient as to the risk involved and should, without being questioned, disclose to him the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation. ..."

In *Reibl v. Hughes*, Laskin C.J., writing for a unanimous court and building on his reasons in *Hopp v. Lepp*, confirmed that the relationship between a doctor and a patient undoubtedly gives rise to a duty of the doctor to disclose material risks associated with a procedure, without having to be questioned by the patient.

Stated briefly, therefore, a doctor's obligation to his patient extends beyond a duty to treat with a reasonable degree of care, skill and knowledge to include an obligation to provide sufficient information to allow a patient to make an intelligent, informed and rational decision in respect of proposed medical treatment.

In determining whether a doctor's negligent failure to advise of the material risks has, in fact, caused the plaintiff's loss, the court must assess the probability that the plaintiff would have undergone the surgery even if he or she had been aware of the risks. In making that assessment, the court applies the "modified objective test" established by Laskin C.J. in *Reibl v. Hughes*.

In *Arndt v. Smith* Cory J. endorsed this test, describing it this way[34]:

> "... It requires that the court consider what the reasonable patient in the circumstances of the plaintiff would have done if faced with the same situation. The trier of fact must take into consideration any "particular concerns" of the patient and any "special considerations affecting the particular patient" in determining whether the patient would have refused treatment if given all the information about the possible risks."

In addition, the "reasonable person" is taken to possess the patient's reasonable beliefs, fears,

desires and expectations and, while the evidence of reasonable fears and concerns can be taken into account, purely subjective fears which are not related to material risks are not to be considered[35].

ENDNOTES

1. This article is authored by Bill McNally and Andrea Manning-Kroon and Barb Cotton of Bottom Line Research and Communications.
2. [1980] 2 S.C.R. 192
3. at p. 210
4. [1980] 2 S.C.R. 880
5. at pp. 899-900
6. at pp. 894-895
7. at pp. 129-130
8. (1981), 33 O.R. (2d) 497 (C.A.)
9. at p. 894
10. at pp. 502-503. Also reference: *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119 (S.C.C.).
11. See Professor Philip H. Osborne, "Causation and the Emerging Canadian Doctrine of Informed Consent to Medical Treatment" (1985), 33 C.C.L.T. 131 at pp. 133-136
12. [1995] 4 S.C.R. 634 (S.C.C.)
13. See Mark Crow, "Confusion Over Causation: A Journey Through Arndt v. Smith" (1998), 7 *Health L. Rev.* (No. 1) 3-13
14. [1997] 2 S.C.R. 539 (S.C.C.)
15. at p. 547
16. at pp. 553-554
17. at p. 475
18. Reference: Mitchell McInnes, "Causation in Tort Law: A Decade in the Supreme Court of Canada" (2000), 63 *Sask. L. Rev.* 445 at pp. 473-476; Ellen Picard and Gerald Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3rd Edit., (Scarborough, Ont.:Carswell, 1996) at p. 159.
19. (2000), 78 Alta. L.R. (3d) 352 (Q.B.)
20. at p. 360
21. (1997), 194 A.R. 116 (Q.B.)
22. at pp. 360-361
23. (1998), 223 A.R. 145 (Alta. C.A.)
24. at pp. 157-158
25. at p. 158
26. (2002), 309 A.R. 237 (Q.B.)

27. at p. 247
28. at p. 249
29. (2003), 18 C.C.L.T. (3d) 107 (Ont. H.C.J.)
30. at pp. 130-131
31. at p. 131
32. S.O. 1996, [being Schedule A to the *Advocacy, Consent and Substitute Decisions Statute Law Amendment Act*, S.O. 1996, c.2]
33. at p. 210
34. at p. 547
35. Also reference: *Videto v. Kennedy* (1981), 33 O.R. (2d) 497 (C.A.) and *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119 (S.C.C.).