

Recent Decisions: Must Doctors Disclose Their Own Personal Risk Factors? *Halkyard v. Mathew*

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The Alberta Court of Appeal recently held that a doctor does not have a duty to disclose his/her own medical condition, where there is no causal link between the medical condition and harm to the patient. In *Halkyard v. Mathew* 2001 ABCA 67, a unanimous panel (McClung, McFadyen and Hunt J.J.A.) dismissed the appeal from the trial judge's dismissal of the plaintiffs' action.

The plaintiff had died from a pulmonary thromboembolism following a hysterectomy performed by the defendant gynecologist and obstetrician, as well a subsequent repair procedure by another physician. The plaintiffs, her husband and the administrator of the patient's estate, sued the defendant doctor for negligence and battery, alleging that the doctor negligently performed the surgery and further, failed to obtain the patient's consent by not disclosing he was epileptic.

Trial Decision

Lewis J. accepted the standard of care evidence presented by the defendant's expert witness, and found the defendant had met the standard of care in performing the surgery: [1998] A.J. No. 986 (Q.B.). It was also found that the patient's death was not caused by the surgeries. The unanimous panel of the Court of Appeal affirmed these findings, refusing to interfere with the trial judge's assessment of the expert evidence.

The more interesting aspects of the trial and appeal decisions, however, are the allegations and findings relating to the doctor's failure to disclose to his patient that he suffered from epilepsy. The defendant's own doctors had cleared him to continue practicing, and his medication kept his epilepsy under control. There had been no epileptic

seizure in the operating room. The plaintiffs alleged that this non-disclosure amounted to battery, vitiating the consent given for the surgery; alternatively, that it was a negligent non-disclosure .

Lewis J. rejected the battery argument. The surgery performed on the patient was the one for which she had given her consent. Further, there was no evidence that the doctor had covered up his medical condition in order to obtain her consent to the surgery, so there was no question of misrepresentation or fraud.

Lewis J. addressed the extent and nature of the duty of disclosure on doctors, including an extensive review of American case law and periodical literature, much of which dealt with whether HIV-infected health professionals need disclose their health status. (These are discussed below.) He concluded that the defendant was not obliged to disclose his personal medical history to his patient. The defendant had made disclosure of all the material risks attending the surgery, the risks and potential complications of the procedure, and he thus had obtained the patient's informed consent. The Court considered the policy arguments and consequences of imposing such a duty on doctors, concluding that it was not a question of informing the patient. Rather, it was the duty of the defendant, the defendant's own personal doctor, and that of the hospital to determine whether he could continue performing surgery despite his medical condition.

Court of Appeal

On appeal, the plaintiffs argued that a failure to disclose a risk (such as the doctor's epilepsy) which could have led the patient to refuse consent was sufficient to vitiate the consent



and thus render the doctor liable in battery for any loss arising from surgery, regardless of whether the loss was unrelated to the risk. The plaintiffs also based their negligence argument on a similarly limited theory of causation. They submitted that the cause of the injury was not a relevant consideration when determining whether a failure to disclose was negligent. Rather, they reasoned that if the patient would not have consented to the surgery if she had been informed of the doctor's medical condition, causation was proven.

The Memorandum of Judgment issued by the panel (McClung, McFadyen and Hunt JJA) noted that on the evidence at trial, there was nothing to support the contention that the patient would not have consented to the surgery, even if disclosure had been made. The plaintiffs themselves suggested only that the patient would have consulted another surgeon. Nothing in the evidence suggested the consequences could have been avoided by another surgeon.

Referring to *Reibl v. Hughes*, [1980] 2 S.C.R. 880 and *Arndt v. Smith*, [1997] 2 S.C.R. 539, the Court affirmed that those cases required a causal link between the undisclosed risk and the injury actually suffered: (at para. 9):

Even assuming (without deciding) that a duty of care exists which requires disclosure of the personal medical condition of the physician, it is clear from both *Reibl* and *Arndt*, as well as the general law of negligence, that there is no liability unless the loss is caused by the failure to disclose or inform.

And further, at para 11:

Further, we do not accept that the law in Canada imposes any liability in negligence on a doctor who fails to disclose his personal medical problems in a case where those medical problems cause no harm to the patient. When harm is caused by the lack of disclosure, liability in negligence may arise.

Thus the Court of Appeal not only reaffirmed the need for the causal link between the non-disclosure and the actual harm suffered, but determined, for the first time, that doctors need not disclose their medical problems, at least not where those problems do not cause harm to their patients. Whether there is such a duty of care at all was not necessary to decide in the instant case, as the plaintiff's death was not caused by the doctor's epileptic condition.

The decision in *Halkyard v. Mathew* is significant in its articulation of the causal connection required between the undisclosed risk and the actual harm to the patient. Most informed consent cases have emphasized the other branch of causation; i.e. if the patient had been informed of the risk,

would he/she have consented to the procedure in any event? Further, both the trial and appellate decisions reflect a reluctance to require health professionals to disclose highly personal information about themselves to their patients, at least where it is unconnected to the care they are providing. It will, however, require another case with different facts to determine whether a physician's medical condition can become a "material risk" which must be disclosed in order to obtain the patient's informed consent.

Recent Caselaw

There appears to be no other Canadian case which has dealt with the issue of whether a physician's medical condition need be disclosed to the patient, when obtaining consent to a procedure. A few cases had considered and rejected a requirement to disclose one's experience with a procedure: *Hopp v. Lepp* (1980), 112 D.L.R. (3d) 67 (S.C.C.); *Turner v. Bederman*, [1996] O.J. No. 1712 (G.D.); and *Kita v. Braig* (1992), 17 B.C.A.C. 55. In one other case, a doctor's failure to wear prescribed eyeglasses during surgery was in issue, but was not decided on the basis of disclosure. Rather, the issue was whether the doctor's failure to wear his glasses resulted in negligent treatment: *Stefanyshyn v. Rubin* (1996), 34 C.C.L.R. (2d) 88 (Man. C.A.).

American law is presently unsettled as to the extent of disclosure required of physicians, including the need to disclose a physician's personal health. Much criticism surrounds the caselaw finding liability for a doctor's failure to disclose his/her own HIV status, particularly for the courts' willingness to accede to "HIV hysteria", and the error of basing materiality of risk on opinion polls, thus equating what the average person would want to know with what the "reasonable person" would want to know. The U.S. Supreme Court has yet to consider the issue and state Appellate Courts are not in agreement. American commentators have recently argued that requiring disclosure of a physician's HIV status to the patient invites irrational discrimination. Instead, employers and licensing authorities should monitor the individual's professional competency to determine whether risks are actually being posed to patients. In cases of actual risk, the physician should be required to limit, or terminate, his or her practice. (See for example, Larry Gostin, "The HIV-Infected Health Care Professional, Public Policy, Discrimination and Patient Safety" (1990) 18 L Med. & Health Care 303; Barry Furrow, "Must Physicians Reveal Their Wounds?" (1996) 5 Camb. Q. of Healthcare Ethics 204; K. deVile, "Nothing to Fear but Fear Itself: HIV-Infected Physicians and the Law of Informed Consent" (1994) 22 J. Law Med. & Ethics 6 at pp. 10, 11.).

An example of an American decision imposing liabilities on a physician's failure to disclose personal risk factors is *Hidding v. Williams*, 578 So2d 1192 (La.App. 5 Cir. 1991). The Court held that a physician's failure to disclose his chronic alcohol abuse was a failure to properly secure the plaintiff's informed consent to surgery. However, the opposite conclusion was reached by the Appellate Court in *Kaskie v. Wright*, 589 A2d 213 (Pa. Super. 1991), appeal denied 600 Ad. 854 (Pa. S.C., 1991). It was held in *Kaskie* that the failure to inform the parents that their child's surgeon was alcoholic and unlicensed was not a negligent failure to obtain informed consent, nor was there any causal connection between the failure to inform and the injury.

The Georgia Supreme Court has recently ruled that neither the state's common law nor informed consent statute required physicians to disclose negative personal life factors, such as illegal drug use, before treating patients. In *Albany Urology Clinics, P.C. v. Cleveland*, 528 SE2d 777 (Georgia S.C., 2000), the highest state court overruled the Court of Appeal, which had held that in such a confidential relationship as between doctor and patient, failure to disclose drug abuse was fraudulent and willful misrepresentation. In the absence of a specific inquiry by a patient, at least in Georgia, no doctor need disclose their own personal problems or disabilities.

The American cases must, however, be treated with caution as they often rely upon statutory consent laws; there is no equivalent consent law in Alberta. American cases and articles do confirm that, similar to Canadian law, they require both stages of causation as an essential element in an action against a physician for lack of informed consent. The Plaintiff must prove on a modified objective test that, if informed of the material risks, the Plaintiff would not have consented to the treatment. Further, there must be a causal connection between the non-disclosed risk and the injury suffered by the Plaintiff.

Conclusion

The imposition of a requirement on doctors to disclose personal life factors to his/her patients would raise serious policy questions. Holding doctors liable in tort for failing to share highly personal information based on a purely theoretical risk to the patient would violate traditional causation principles. The privacy rights of the physician about his or her own health must also be considered along with the potential for discrimination against persons with illnesses or disabilities that do not, in reality, pose a risk to the patients' health. As suggested by Lewis J. in *Halkyard v. Mathew*, a more appropriate way to deal with concerns over a physician's health may be through the current

licensing and regulatory authorities in place governing physicians and hospital privileges.

Further, the limits on disclosure of personal factors become difficult to draw. Which health condition should be disclosed? Should other personal factors be disclosed, such as a physician's mental or emotional status, marital problems, career concerns or financial problems?

The most satisfactory resolution is to continue to require disclosure of "material" and "special risks" that are referable to the treatment itself. A patient is entitled to assume his/her physician is competent and skilled and will perform to the standards of the profession. Only if a physician's personal factors actually intervene in the treatment and cause injury to the patient, is an action in negligence the appropriate avenue for addressing liability. This alternative will not force disclosure of highly personal and private information by our health care professionals, in circumstances where their health does not pose a risk to their patient's health, meeting the goal of protecting the important privacy rights of physicians while not endangering patient care.

Patients are not without a remedy where a physician's personal health actually causes harm to the patient, as physicians are still accountable through traditional negligence principles. If it can be proven that the patient suffered injury due to the treating physician's personal risk factors, such as illegal drug use or a disease, liability will be imposed.

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