

The Temporal Element of Informed Consent

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1. Introduction

The rules and standards of tort liability are typically stated at a high level of generality, one which makes no mention of specific activities or given groups of plaintiffs or defendants. The task of bringing those abstract rules to bear on the diverse behaviour to which tort law applies thus involves courts applying broad propositions to a wide range of particular occurrences. From time to time, however, legislatures have been persuaded to pass statutes singling out certain activities or persons for special treatment in tort actions. For instance, in Canada we have statutes which give beneficial treatment in some tort actions to certain favoured classes of defendants. These include farmers,¹ nuclear facilities,² anglers,³ and government itself.⁴ In addition, we have statutes which treat some defendants — tobacco manufacturers⁵ and dog owners,⁶ for example — more harshly than the general rules of tort would otherwise treat them.

The articulation of special tort rules for particular classes of defendants is not limited to statutes. From time to time courts have been prepared to depart from the generality that typically characterizes the standards of private law. They have promulgated special liability rules for particular groups of defendants. In Canada, two such groups have most frequently come in for such treatment: the government and doctors. It is not difficult to understand why there might be distinctive tort rules for government defendants. The state's mission, obligations, structure and limitations set it apart from private actors. However, it is less easy to understand why the general rules of tort law — rules which apply to the other professions and to other private actors of a non-professional nature — should require modification before they can be applied to doctors. Nevertheless those

rules have been modified for physician defendants. Moreover they have been altered in a manner that benefits defendant doctors. In *ter Neuzen v. Korn*⁷ the Supreme Court of Canada held that, in the context of medical negligence, a defendant medical doctor who complied with standard practice could not, except in exceptional circumstances, be held to have fallen below the applicable standard of care. In *Reibl v. Hughes*⁸ the Supreme Court articulated the distinction between negligence and battery so as to ensure that physicians who failed to gain informed consent to a procedure might be liable for the former cause of action, but not normally for the latter, more morally invidious one. *Reibl* also gave doctors, but no one else, the benefit of a special causation test. This distinctive rule for doctors was upheld by the Supreme Court in the 1997 case of *Arndt v. Smith*.⁹ In *Laferrière v. Lawson*¹⁰ the Supreme Court rejected a claim that the doctrine of loss of chance, which applies to certain actions in negligence, should apply to that claim for medical malpractice. And in its recent decision in *Cottrelle v. Gerrard*¹¹ the Ontario Court of Appeal confirmed the rule that loss of chance should not apply to medical malpractice claims.

Recently, in *Afshar v. Chester*,¹² the House of Lords decided a case which articulated yet another special tort rule for doctors. The question considered in *Afshar* has been before the High Court of Australia¹³ but has not yet been subjected to much consideration by Canadian courts. It easily could, however, and the goal of this note is to explain and critique *Afshar* with an eye to that decision's potential implications for Canadian law. Addressing that last matter may not be easy because, in contrast to the practice of the Supreme Court of Canada, which has viewed doctors as a "peculiarly vulnerable" class of defendants¹⁴ deserving of special pro-



tection, the House of Lords decision in *Afshar* sets out an exceptional rule that treats defendant doctors *less* favourably than other, non-medical defendants would be treated. The ruling of the majority of the House of Lords in *Afshar* holds the defendant doctor liable in circumstances where an analogous non-medical doctor defendant would have been exonerated.

2. The Facts and Holding in *Afshar*

The facts were straightforward. Ms Chester was referred to a neurosurgeon, Dr. Afshar, due to recurring back pain. Dr. Afshar recommended surgery to remove three intervertebral disks. The surgery was performed three days later. Although Dr. Afshar was not negligent in his conduct of the operation, one of the risks of lumbar surgery, disturbance to the cauda equina nerve root, unfortunately materialized in a major fashion. Ms Chester suffered motor and sensory impairment transiently in her right leg and on a more permanent basis on her left side. The trial was adjourned prior to an exploration of the extent of disability to enable resolution of the issue of liability.

Ms Chester claimed that Dr. Afshar had failed to warn her of the risk of nerve damage and the sequelae of paralysis. In response to her query regarding risks of surgery, she testified, Dr. Afshar responded that “he had not crippled anybody yet.”¹⁵ Her evidence was that she was reluctant to undergo surgery (confirmed in the note from her referring physician) but that Dr. Afshar had made it all sound so simple that she had agreed to the operation. Further, she testified that, had she been advised of the risks, she would have sought at least two additional opinions, and would have made a number of further enquiries.

Note that Ms Chester did not testify that she would have refused to undergo the surgery. Had she done so, the action would have proceeded as a simple question of uninformed consent, and the issue of factual causation would have been a matter of assessing the credibility of her claim. Rather, her claim was that she would not have submitted to the surgery a mere three days after her initial consultation with Dr. Afshar. This rendered the action questionable on the issue of causation in that she may well have consented to similar surgery performed by the same surgeon at a later date, presumably with the identical small risk that manifested in her case.

The parties agreed that failure to warn of the possibility of nerve damage would amount to a breach of the duty to

inform. Dr. Afshar testified that he had given that warning. However, the trial judge accepted Ms Chester’s testimony as to the failure of Dr. Afshar to identify the risks of surgery, in particular the possibility of paralysis. He also found that, had she known, Ms Chester would have sought a second and possibly a third opinion prior to consenting to surgery rather than proceeding when she did. In his view that was sufficient to establish the causal link.

Dr. Afshar appealed on the issue of causation. In dismissing the appeal¹⁶ the Court of Appeal noted the interesting problem posed by the case. If the plaintiff would have had the same operation even if warned, then the failure to warn did not cause the harm and the plaintiff’s case should fail. If the plaintiff would *not* have had the operation at all had she been warned, then the failure to make proper disclosure did cause the harm and the plaintiff should win. But how should the matter be approached in a case like this, where the plaintiff had failed to show that, had she been properly warned, she would not at some later date have undergone a comparable operation with roughly similar risks?

In the unanimous view of the Court of Appeal, the purpose of requiring doctors to give appropriate disclosure was “to enable the patient to exercise her right to choose whether or not to have *the particular operation* to which she is asked to give her consent.”¹⁷ Thus it followed that causation would be made out even if the patient would have agreed to the same operation at a later time. This followed since the risk of the nerve damage the plaintiff suffered was peculiar to the operation, not to the patient. Thus, even though she would have run the same risk of nerve damage on the hypothetical later operation that she ran on the operation she in fact had, on the balance of probabilities that harm would not have eventuated on that later operation. So causation was established on the basis of the traditional but-for standard.¹⁸

In a three to two split, the majority of the House of Lords ruled in favour of Ms Chester. The two dissenters, Lords Hoffmann and Bingham, took the view that the duty to warn did not relate to a particular operation on a given date, even if such an operation was contemplated by the parties. The date was regarded as “an irrelevant detail”¹⁹ and the duty was held to exist with respect to the decision whether to undergo the operation at all. Accordingly, the timing of the operation [was] irrelevant to the injury she suffered, for which she claims to be compensated. That injury would have been as liable to occur whenever the surgery was performed and whoever performed it.²⁰



In the dissenters' view that meant the plaintiff had failed to establish causation and the appeal should be allowed.

Lords Steyn, Hope and Walker thought otherwise. They dismissed the appeal and held for the plaintiff, but on grounds different than those offered by the trial judge and the Court of Appeal. The majority did not differ from Lords Hoffmann and Bingham in thinking that orthodox principles, properly applied, would not assist the plaintiff. In the words of Lord Hope, "a solution to this problem which is in Miss Chester's favour cannot be based on traditional causation principles."²¹ Rather, the majority based its decision in favour of the plaintiff on a newly created exception to those traditional principles, one based on the special nature of a physician's duty to warn.

The core of their reasoning was that Dr. Afshar had failed in his duty to advise of the risk of paralysis, the injury sustained was that of this very risk, and liability should follow. The majority, therefore, was prepared to assess the question of factual causation — whether the failure of Dr. Afshar to advise of the risk in question led to the injury caused — in what may generously be described as expansive fashion. In other words, despite the fact that Ms Chester may have agreed eventually to the surgical procedure that resulted in partial paralysis, she was entitled to recover damages due to the carelessness of Dr. Afshar in failing to advise of the material risks. We have described this outcome as "generous". Some may argue that it is a perversion of the concept of factual causation. On what grounds did a majority of the House of Lords arrive at this conclusion?

To answer this question, one must refer to the speeches that combined to make up the majority. Lord Steyn placed the right of a patient to proper warning of risk as superior to a number of other rights (without identifying the inferior rights).²² He also referred favourably to an excerpt by Tony Honoré which advocates strict liability where there is a failure to advise of risk followed by a realization of the risk.²³ In the view of Lord Steyn, modification of causation principles was warranted in order to give full validation to the right of the patient to not undergo surgery in the absence of informed consent. Thus, he found in favour of the plaintiff.

Lord Hope interpreted the facts to suggest that Dr. Afshar's breach of the duty to obtain informed consent had not, on a traditional analysis, caused the patient's injury. He viewed the risk to Ms Chester as being the same "irrespective of when or at whose hands she had the operation."²⁴ Nevertheless, he was willing on policy grounds to find liability where

"the harm was foreseeable as within the risk, or was within the scope of the rule violated by the defendant."²⁵ Like Lord Steyn, he argued that the doctor's duty to warn and inform was an especially significant duty.²⁶ Lord Hope was anxious not to leave the plaintiff without a remedy when she had been honest enough not to testify that she would have declined to undergo the surgery. Remarkably, he stated as follows:

The function of the law is to *enable rights to be vindicated and to provide remedies when duties have been breached*. Unless this is done the duty is a hollow one, stripped of all practical force and devoid of all content. It will have lost its ability to protect the patient and thus to fulfill the only purpose which brought it into existence. On policy grounds therefore I would hold that the test of causation is satisfied in this case.²⁷

Lord Walker likewise supported the extension of the law of causation in the circumstances at hand, and he also did so based on his perception that a doctor's duty to advise was an especially important obligation. He noted that he derived little assistance from analogies to the failure to warn in non-medical cases.²⁸ He was willing to find causation in order not to leave the honest patient without a remedy where the duty to obtain informed consent had been breached. The sole limit he appeared to place on this extension was that the injury incurred should be "directly within the scope and focus of that duty."²⁹

Thus, each of the judges constituting the majority was prepared to deviate from the standard approach to causation on policy grounds. Placing high priority on the principle of informed consent in the medical context, where the defendant has failed in his duty to warn of risk and such risk materializes, liability is deemed to follow. Factual causation, as it has traditionally been understood, is rendered irrelevant.

3. Critique: The Time Element of the Duty to Warn

The law pertaining to informed consent to surgical procedures is slightly different in common law Canada than the U.K., so the leading Canadian decision, *Reibl v. Hughes*, received no mention in *Afshar*. In Canada the scope of a physician's duty to warn is stated slightly differently than in the U.K., and, as noted above,³⁰ the test for assessing what the patient would have done if warned is also articulated differently.



Nevertheless, the problem in *Afshar* could easily arise in Canada. Stripped to its essentials, that problem was how to assess causation when (1) the plaintiff was not adequately informed of the risks inherent in a given medical procedure; (2) she assented to that procedure and, despite the fact it was competently performed, the unwarned-of risk manifested; (3) the plaintiff can show that had she³¹ been warned she would not have had the operation on the date she originally contemplated having it; but (4) the plaintiff *cannot* show that had she been properly warned she would not eventually, after some delay for further consultation or reflection, have consented to the same procedure (or a comparable course of action with similar risks).

Each of the three solutions to the problem that found favour at some stage in *Afshar* is potentially available in Canadian law. Like the trial judge and the Court of Appeal, it would be open a Canadian court to find that the duty to warn was with respect to a particular operation *on a given date*. Under this view, causation is made out because, on the counterfactual required by the but-for test, the plaintiff would have delayed the procedure to a later occasion on which, on the balance of probabilities, the harm would not have happened. Secondly, a Canadian judge might take the route followed by the dissent in the House of Lords and hold that the duty to warn is not with respect to an operation on a given date but rather to that operation³² generally. Under this approach, because the failure to warn cannot be shown to have made a difference to the patient's decision whether to undergo the procedure *at some time*, it did not increase the risk to which she was subjected and causation is not made out. The plaintiff loses. Finally, a Canadian court might adopt the view of the majority in the House of Lords and craft some new exception to the but-for test in order to find liability.

The first option — *i.e.*, that causation has been established on a balance of probabilities if it can be proven that the plaintiff would not have agreed to that particular operation, including its temporal aspects — may prove to be most attractive to courts in Canada. After all, it leads to a straightforward application of the but-for standard while affirming the plaintiff's autonomous right to choose whether or not to submit to the surgical procedure having been informed of

the material risks. The fact that a risk of low probability materialized in a given case is treated as not likely to happen on another occasion — *i.e.*, the same probability can be applied to the subsequent procedure, in this case 1% - 2%, and the plaintiff would have been unlikely to have been the unlucky one the next time around. This approach only becomes problematic on a but-for basis when the risk exceeds 50% probability. That is rare and generally involves consequences that are trifling, at least relative to those harms that give rise to law suits.

Further, this approach, endorsed by the trial and court of appeal judgments, appears to have some degree of precedence in the Canadian context. In one of the very early cases on informed consent, *Kinney v. Lockwood Clinic Ltd.*, the trial judge found liability on the part of the surgeon and his associate in that they had not properly advised the plaintiff of the possibility of permanent damage to her hand resulting from the proposed surgery. He indicated that the surgeons were not entitled to operate upon her hand until they put that matter with perfect frankness and plainness before her and then had her decision that she would or would not submit to the operation *at that time*.³³

This finding is further reinforced in the landmark Canadian case on informed consent, *Reibl v. Hughes*.³⁴ There, the Supreme Court of Canada ruled that in the absence of informed consent, the defendant surgeon was liable in negligence for proceeding with a competently performed surgery. One of the facts found to be material was that the plaintiff had undergone elective surgery when he was 1.6 years away from acquiring a vested pension from his place of employment. Thus, the judgment of a unanimous Supreme Court of Canada authored by Laskin C.J. concluded with this statement:

In my opinion, 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*.³⁵

Thus, although the plaintiff had testified that he might well have forgone the surgery completely, the Supreme Court was content to rest on the fact that, had he been properly

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informed, he would have refused the surgery at the time it was offered and performed. This provides some support for the possibility that Canadian courts will accept the temporal dimensions of an uninformed consent claim. In other words, if a plaintiff can establish that had she been properly advised of the risks, she would have forgone surgery at that time, the test of causation has been met. This would be in accordance with both the trial and appeal court judgments in *Afshar*.

However, despite these judicial references to an operation on a particular date, it is not clear that the courts in either *Kinney* or *Reibl* truly grappled with the full causal implications of the articulation of the temporal aspect of the duty. The arguments that were so central to the House of Lords approach in *Afshar* were not canvassed in either of those two decisions. As noted in our introduction, those arguments have not yet been weighed in on specifically by Canadian courts.

It seems to us that there will be many cases where it will be unrealistic or artificial to state the physician's duty to warn as relating to a particular operation *at a particular time*. That is, in the present Canadian climate of systemic delay, there will be instances where no prospective operation date has been set, even tentatively, and where the patient's decision is simply whether or not to have her name placed on a waiting list. An *Afshar*-type problem could certainly arise there, in that an unwarned patient who suffered the manifestation of some risk might still say that, had she been properly warned, she would at least have waited and thought about it before eventually entering her name on a waiting list. Such a patient could assert that, had she waited she would obviously not have placed her name on the waiting list until some later time and thus not had the operation until a later time, and the risk would, on the odds, not likely have manifested on the hypothetical later operation. Such a patient might accordingly still claim that the failure to warn caused the harm.

Of course, even there it would not be impossible to resolve that problem by judicially articulating the duty in terms of an operation *on a particular date*. Even though no *specific* date had been mentioned, a court dealing with the case set out in the previous paragraph might still articulate the duty as relating to only such operation as would eventually take place if the patient's name was entered on the waiting list immediately following the consultation in question — even though no precise date for the procedure could be ascertained at that time. Such a response is admittedly coherent. Yet there is some doubt that it reflects a realistic articulation

of the obligation as either the doctor or the patient might perceive it at the time of the consultation. In a great many cases the temporal aspect of the decision-making process will be considerably attenuated, and the overwhelming focus will be on whether or not to undertake the procedure. It is overwhelmingly with that decision that the core obligation of the duty to provide informed consent is concerned. Resolving the causation problem by some *ex post facto* magnification of the time element of the physician's duty to warn is certainly one way out of the *Afshar* dilemma, but, as all of the law lords in *Afshar* recognized, that resolution of the problem seems like a legal fiction.

What, then, about the third option — that of crafting some new, physician-specific exception to the but-for test? The majority of the House of Lords in *Afshar* justified their plaintiff-favouring departure from the longstanding but-for test on the grounds that the duty breached — the duty of physicians to provide adequate information to patients — was an especially important one. The significance of this departure from the traditional but-for test for factual causation is considerable. It is true that the House of Lords had authorized another exception to the but-for test the previous year in *Fairchild v. Glenhaven Funeral Services Ltd.*³⁶ However, *Afshar* seems a more significant exception. The exception in *Fairchild* was based on the finding that, given the state of knowledge about the etiology of the harm in question in that case, the but-for test was simply unworkable. In *Afshar*, however, the but-for test was eminently workable, as the reasoning of the dissenting judges demonstrated. It simply led to a conclusion that the majority did not like.

The Supreme Court of Canada has previously shown itself to be receptive to the argument that the causal standard can vary depending on the nature and importance of the duty breached. In *Hollis v. Dow Corning Corp.*,³⁷ a case which considered a manufacturer's duty to warn, the court held that the "imbalance of resources and information"³⁸ between manufacturers and patients justified a special, pro-plaintiff departure from but-for causation in the circumstances of that case. More generally, the Supreme Court of Canada has shown itself willing to depart from but-for causation in other circumstances, though the precise range of those departures is not easily defined.³⁹

Of course one problem with such rules lies in defining their scope. The justification for the special standard in *Afshar* rested on the particular need to promote autonomy and fight physician paternalism in the context of a doctor's breach of



his duty to provide certain information. That special standard would thus not be available in the circumstances of, say, a property evaluator's obligation to give accurate information.⁴⁰ But obviously borderline cases could arise, for instance those arising from the disclosure obligations of groups such as nurses, pharmacists, psychologists, physiotherapists, chiropractors, midwives, dentists and veterinarians. Which of those groups has a track record of paternalism that justifies the invocation against it of a special causation standard? While not opposing the view of the majority of the law lords in *Afshar*, it is our view adopting an *Afshar*-like exception should require such questions to be answered.

The additional problem here is that, as noted in our introduction, the Supreme Court of Canada has not shown itself open to causal (or other) standards that treat doctors more harshly than other defendants; in fact the opposite. If the Supreme Court of Canada were to follow the route of all five law lords in *Afshar* and articulate the duty to provide informed consent as a general one — one which did not relate to an operation on a particular date — then it seems far from likely that they would pursue the option taken by the *Afshar* majority and craft some novel, doctor-specific exception to the but-for test. Based on its record the Supreme Court of Canada seems more likely to side with Lords Hoffmann and Bingham and find that causation is not made out.

There are other routes available to Canadian courts faced with an *Afshar*-like situation. One that might be viewed as either alternative or complementary to the previously discussed options is to adjudge the absence of informed consent as a breach of a fiduciary duty owed by a physician to advise the patient of material risks. As far back as 1931, the Ontario Court of Appeal analysed the surgeon/patient relationship as fiduciary in nature, requiring honesty on the part of the surgeon.⁴¹ Where such duty is breached in not supplying sufficient information, harm that flows from such breach is worthy of compensation. Moreover, from the point of view of causation, when the duty breached is a fiduciary one, other contributing factors can be ignored; the plaintiff can receive compensation for her full losses, despite the presence of other contributing factors or the materialization of harms that seem outside the scope of the duty.⁴²

In recent years this approach has been endorsed in the context of the physician/patient relationship in both *McInerney v. MacDonald*⁴³ and *Norberg v. Wynrib*.⁴⁴ An advantage of this approach is that it waylays difficult aspects of causation of injury in the context of absence of informed consent by instead focussing the issue of causation as turning on the

point in time of the breach itself and not of the subsequent procedure. The fiduciary approach was followed by Lambert J.A. in his dissent in *Arndt v. Smith*. There he found that

the duty of disclosure of material risks or of special or unusual risks is not like an ordinary duty of care in negligence, because it is not set by the standard of a reasonable medical practitioner, but *is more similar to a fiduciary duty of disclosure*, where the standard is set by utmost good faith in the discharge of an obligation by a person in the position of power and control to a person who is vulnerable, in a position of dependency, and is known by the doctor to be in a position of reliance.⁴⁵

In arriving at this standard for assessing the duty of disclosure in informed consent, Lambert J.A. relied upon the judgment of Lord Thankerton in a Privy Council judgment analysing causation issues following a breach of fiduciary obligation in the commercial context:

When a party, holding a fiduciary relationship, commits a breach of his duty by non-disclosure of material facts, which his constituent is entitled to know in connection with the transaction, *he cannot be heard to maintain that disclosure would not have altered the decision to proceed with the transaction . . .* Once the Court has determined that the non-disclosed facts were material, *speculation as to what course the constituent, on disclosure, would have taken is not relevant.*⁴⁶

This would appear to simplify the temporal causal aspects of the claim, and to locate the analysis at the point of breach of duty to warn. The sole limitation is that the non-disclosed facts would need to be material in nature. This is entirely appropriate. Should an additional qualifier be that the breach of duty must have led to injury? It is unlikely that a claim for breach of fiduciary duty would proceed in the absence of injury, in that damages would be low. Nevertheless, it is not impossible, and should not be precluded.⁴⁷

The fiduciary approach was not canvassed by the House of Lords in *Afshar*, but there is an explanation for that. English courts have not been willing to expand the categories of fiduciaries in the way that the Supreme Court of Canada has authorized. Still, the *Afshar* majority's identification of the duty to warn as a duty of superior importance (justifying a special causation test) is in some ways analogous to the identification of a fiduciary relationship. A Canadian court, rather than taking the novel (at least in this country) route of articulating a hierarchy of duties *within* tort law, might pre-



fer the more familiar option of stepping outside tort law into the fiduciary realm. That would result in a solution to the *Afshar* problem that was nominally different from that adopted by the House of Lords, but in functional terms that difference would be minimal.

4. Conclusion

The good news is that when confronted with this issue Canadian courts will have a range of options from which to choose, some more clearly articulated than others in the judgments discussed here. The bad is that, while generally receptive to modifying the traditional approach to causation in light of the perceived imperatives of policy, Canadian courts have been less than clear and consistent about the scope of those modifications. Moreover, they have not demonstrated a willingness to bring these new, plaintiff-favouring causal standards to bear on defendant doctors.

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1. All ten provinces have passed farm protection legislation, starting with New Brunswick's *Agricultural Operations Protection Act*, S.N.B. 1986, c. A-5-2 and concluding with Newfoundland and Labrador's *Farm Practices Protection Act*, S.N.L. 2001, c. F-4.1.
2. *Nuclear Liability Act*, R.S.C. 1985, c. N-2.
3. *Angling Act*, R.S.N.S. 1989, c. 14, s. 3.
4. Special defendant-favouring rules for governments are legion. Government defendants benefit from special notice provisions, shorter limitation periods, relief from the application of the rule in *Rylands v. Fletcher* and excuse from the normal responsibilities that tort law imposes on the owners of animals.
5. See for instance British Columbia's *Tobacco Damages and Health Care Costs Recovery Act*, S.B.C. 2000, c. 30.
6. *Dog Owners' Liability Act*, R.S.O. 1990, c. D.16, s. 2.
7. [1995] 3 S.C.R. 674.
8. [1980] 2 S.C.R. 880. It is sometimes claimed that *Reibl's* holding on another point — *viz.* the applicable Ostandard for assessing what information a doctor should give to a patient who is contemplating a given

medical course of action — was an anti-doctor holding. In our view, *Reibl's* holding on this point should be seen only as subjecting doctors to the standard applicable to other defendants. In other words, *Reibl* overturned an existing pro-doctor rule and substituted a neutral, general one.

9. [1997] 2 S.C.R. 539. This special test for doctors required that the question of whether a plaintiff-patient who was not adequately informed of the risks of a given contemplated procedure should be assessed by asking whether a reasonable person, properly informed, would have submitted to the procedure. The test for other plaintiffs would not ask what a reasonable person would have done, but rather what the plaintiff would have done.
10. [1991] 1 S.C.R. 541.
11. (2003), 67 O.R. (3d) 737 (C.A.). At para. 36 Sharpe J.A., speaking for the court, wrote, "Unfortunately for the respondent, under the current state of the law, loss of chance is non-compensable in medical malpractice cases . . ." Interestingly, the Ontario Court of Appeal's antipodean counterpart recently decided otherwise. In its November 2004 decision in *Rufo v. Hosking*, 2004 NSWCA 391 in New South Wales Court of Appeal held that loss of chance causation was available in a medical malpractice claim.
12. [2004] UKHL 41.
13. In *Chappel v. Hart* (1998), 195 C.L.R. 232.
14. In *ter Neuzen v. Korn* (*supra* note 7 at 696). Sopinka J. quoted with approval a passage from *Fleming on Torts* which referred to doctors as "a peculiarly vulnerable profession".
15. *Afshar*, *supra* note 12 at para. 44.
16. [2003] Q.B. 356, [2002] EWCA Civ 724 (C.A.).
17. *Ibid.*, at 359 (Q.B.) (emphasis added).
18. Note that this is only true where the chance of the risk manifesting following any given procedure is 50% or less. If the chance is, say, 60%, then on the balance of probabilities it would have manifested on the counterfactual later operation, and but-for causation would not be established. In *Afshar* the odds of the risk manifested were 1% to 2%, so on the balance of probabilities they would not have manifested on a later operation.
19. *Afshar*, *supra* note 12, at para. 31, *per* Lord Hoffmann.
20. *Ibid.* para. 8, *per* Lord Bingham. Lord Hoffmann's speech was to similar effect.
21. *Ibid.* para. 81. Lords Steyn, Hope and Walker wrote separate speeches justifying their dismissal of the appeal. While there are some differences of emphasis in



those three speeches, at the core their reasoning is the same and we feel justified in saying that those three took the same approach.

22. *Ibid.*, para. 17.
23. *Ibid.*, para. 22. The Honoré article was “Medical Non-Disclosure: Causation and Risk: *Chappel v. Hart*” (1999) 7 Torts L.J. 1.
24. *Ibid.*, para. 84.
25. *Ibid.*, para. 85.
26. At para. 54 he noted that in *Sidaway v. Board of Governors of Bethlem Royal Hospital*, [1985] A.C. 871 the House of Lords had recognized “the fundamental importance that must be attached to the right of the patient to decide . . .” and observed that this “might be seen as a basic human right.”
27. *Ibid.*, para. 87 (emphasis added).
28. *Ibid.*, para. 93.
29. *Ibid.*, para. 101.
30. *Supra* note 8. Interestingly, in *Afshar* the trial judge noted that he would have reached the same result regardless of whether the relevant test was to ask what Ms Afshar would have done had she been adequately warned, or, in the alternative, what the reasonable person would have done in those same circumstances. The quotation is from para. 64 of the trial judge’s reasons, quoted in the Court of Appeal decision in *Afshar* (*supra* note 16) at para. 16.
31. Or, in the common law jurisdictions of Canada, the reasonable person.
32. Or at least to some comparable operation with roughly similar risks.
33. [1931] O.R. 438 at 446 (S.C.) (emphasis added). On appeal, the court overturned the trial judge’s finding of liability on the basis that in their view there had been proper disclosure of the risk of surgery: *Kenny v. Lockwood*, [1932] O.R. 141 (C.A.). The Court of Appeal did not address the temporal aspect of the trial judgment. This case was cited with approval in *Hopp v. Lepp*, [1980] 2 S.C.R. 192 which affirmed the principle of informed consent but where on the facts there was found to be no material difference in a surgical procedure being undertaken in Lethbridge and its being performed in Calgary.
34. *Supra* note 8.
35. *Ibid.* at 928 (emphasis added).
36. [2003] 1 A.C. 32. Lords Steyn and Walker mentioned *Fairchild* in *Afshar*, 0 note 12 at paras. 23 and 101 respectively.
37. [1995] 4 S.C.R. 634.
38. *Ibid.* at 675.
39. In *Athey v. Leonati*, [1996] 3 S.C.R. 458 and *Walker Estate v. York-Finch General Hospital*, [2001] 1 S.C.R. 647 the court noted that the but-for standard was unworkable in some circumstances and that when it was, resort might be had to the material contribution test.
40. This was the nature of the duty breached in *Banque Bruxelles Lambert SA v. Eagle Star Insurance Co.*, [1997] A.C. 191 (H.L.). That case presented causation problems analogous to those in *Afshar*, and since no exception was available for the defendant evaluators, their liability for the harm that (arguably) flowed from their careless evaluations was limited.
41. *Kenny v. Lockwood*, *supra* note 33.
42. *Hodgkinson v. Simms*, [1994] 3 S.C.R. 377 (not a medical malpractice case).
43. [1992] 2 S.C.R. 138 (access to patient records).
44. [1992] 2 S.C.R. 224 (physician taking advantage of addicted patient’s vulnerability).
45. [1995] 7 W.W.R. 378 at 386-87 (B.C.C.A.) (emphasis added).
46. *London Loan & Savings Co. of Canada v. Brickenden*, [1934] 2 W.W.R. 545 at 550-51 (P.C.), as quoted in *ibid.* at 393 (emphasis added).
47. Another approach to be considered potentially worth of resurrection in the context of breach of the duty to obtain informed consent is that of battery. Justice Laskin in *Reibl v. Hughes* (*supra* note 8) limited its application to circumstances wherein consent is absent, has been obtained by misrepresentation or fraud, or the procedure performed is outside the scope of consent. Nevertheless, the reasoning on which this limitation is based is not particularly strong, and should be revisited in future.

