

Informed Consent 20 Years Later

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I. Introduction

The title of this paper is an allusion to a previous article, published in the Canadian Bar Review in 1991, entitled *Informed Consent Ten Years Later: The Impact of Reibl v. Hughes*.¹ The purpose of the 1991 article was to examine developments in the law of informed consent following the seminal decision of the Supreme Court of Canada in *Reibl v. Hughes*.² The 1991 study identified certain themes and trends which were apparent in the ten years after *Reibl*. The purpose of the present article is to update that study: are the themes and trends which were evident in 1991 still true today?

II. The Importance Of *Reibl v. Hughes*

The legal significance of the *Reibl* decision is two-fold.³ First, the Supreme Court held that the standard of disclosure should be the “reasonable patient” test rather than the “reasonable physician” test. In other words, a risk must be disclosed if a reasonable patient in the plaintiff’s circumstances would have wanted to know about it, regardless of whether a reasonable physician would have disclosed it. This approach rejects the usual “reasonable physician” standard in medical negligence, in favour of a patient centered approach.⁴

The second significant aspect of *Reibl* relates to causation. Instead of applying a purely subjective test, which would focus on the question of whether the *plaintiff* would have declined the treatment if properly informed, *Reibl* adopted a

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¹ Gerald Robertson, “Informed Consent Ten Years Later: The Impact of *Reibl v. Hughes*” (1991) 70 Can. Bar Rev. 423.

² [1980] 2 S.C.R. 880 [*Reibl*].

³ In addition, another important aspect of the decision is its conclusion that the remedy for non-disclosure lies in negligence rather than battery.

⁴ In the words of the Supreme Court of Canada in *Arndt v. Smith*, [1997] 2. S.C.R. 539 at 553 [*Arndt*], *Reibl* “...marks the rejection of the paternalistic approach to determining how much information should be given to patients.” For a detailed discussion of this see Ellen I. Picard & Gerald B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3rd ed. (Toronto: Carswell, 1996) at 118-119; Bernard M. Dickens, “Informed Consent”, in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and Policy*, 2nd ed. (Toronto: Butterworths, 2002) 129 at 132-136.

modified objective test – would a *reasonable person* in the plaintiff's position have declined (or delayed)⁵ the treatment if properly informed?⁶

III. The Trends In The 1991 Study

The 1991 study revealed three particular trends in the post-*Reibl* case-law:⁷

- patients almost always lose in informed consent litigation;
- the duty to disclose has been interpreted very expansively by Canadian courts, and is becoming increasingly onerous;
- causation is very difficult to prove in informed consent litigation.

IV. Are These Trends Still True Today?

1. Patients Almost Always Lose in Informed Consent Litigation

The 1991 study, based on an analysis of the 117 post-*Reibl* cases, indicated that patients were unsuccessful in 82% of informed consent cases. That trend continues today. For example, of the 20 informed consent cases reported in 2002,⁸ plaintiffs were unsuccessful in 16 (80%). Likewise, in 2001, plaintiffs lost in 19 of the 22 reported cases (86%).⁹ Thus, the overall trend is as clear now as it was in 1991 – plaintiffs lose in the vast majority of informed consent cases.

⁵ It is sufficient to establish causation if a reasonable person in the plaintiff's position would have *delayed* the treatment, even if they would eventually have undergone it: see *Reibl*, *supra* note 2; *Felde v. Vein and Laser Medical Centre*, [2002] O.J. No. 3686 (Sup. Ct. Jus.) (QL); *Chester v. Afshar*, [2002] E.W.J. No. 2496 (C.A.) (QL).

⁶ See generally Picard & Robertson, *supra* note 4 at 157-169.

⁷ *Supra* note 1.

⁸ *Barber v. Barnett*, [2002] O.J. No. 2882 (Sup. Ct. Jus.) (QL); *Boschman v. Azad*, [2002] B.C.J. No. 1317 (S.C.) (QL); *Brics v. Stroz*, [2002] O.J. No. 1089 (Sup. Ct. Jus.) (QL); *Brownjohn v. Ng*, [2002] B.C.J. No. 1709 (S.C.) (QL); *Carere v. Cressman*, [2002] O.J. No. 1496 (Sup. Ct. Jus.) (QL); *Chypyha v. Toronto Hospital*, [2002] O.J. No. 1199 (Sup. Ct. Jus.) (QL); *Crocker v. Awan*, [2002] N.S.J. No. 261 (S.C.) (QL); *Felde v. Vein and Laser Medical Centre*, *supra* note 5; *Harrison v. Stephany*, [2002] B.C.J. No. 2648 (S.C.) (QL); *Keane v. Adams*, [2002] A.J. No. 93 (Q.B.) (QL); *Kerby v. Carr*, [2002] B.C.J. No. 2397 (S.C.) (QL); *Kovalik Estate v. Griffin*, [2002] M.J. No. 261 (C.A.) (QL); *Martin v. Inglis*, [2002] S.J. No. 251 (Q.B.) (QL); *Matuzich v. Lieberman*, [2002] O.J. No. 2811 (Sup. Ct. Jus.) (QL); *Nichols v. Young*, [2002] O.J. No. 515 (Sup. Ct. Jus.) (QL); *Phillips v. Central Cariboo Chilcotin Council*, [2002] B.C.J. No. 1245 (S.C.) (QL); *Pozdzik (Next friend of) v. Wilson*, [2002] A.J. No. 450 (Q.B.) (QL); *Robinson v. Taves*, [2002] B.C.J. No. 2384 (S.C.) (QL); *Sookram v. MacDonald*, [2002] O.J. No. 732 (Sup. Ct. Jus.) (QL); *Stepkowski v. Zwiercan*, [2002] B.C.J. No. 1339 (Prov. Ct.) (QL).

⁹ *Baksh-White v. Cochen*, [2001] O.J. No. 3397 (Sup. Ct. Jus.) (QL); *Brandon v. Jordan*, [2001] B.C.J. No. 308 (S.C.) (QL); *Brito (Guardian ad litem of) v. Woolley*, [2001] B.C.J. No. 1692 (S.C.) (QL); *Caves v. Bederman*, [2001] O.J. No. 3834 (Sup. Ct. Jus.) (QL); *Clare v. Ostolosky*, [2001] A.J. No. 1492 (Q.B.) (QL); *Guist v. Boulton*, [2001] S.J. No. 242 (Q.B.) (QL); *Halkyard v. Mathew*, [2001] A.J. No. 293 (C.A.) (QL); *Jantzen v. Hobbs*, [2001] B.C.J. No. 2049 (Prov. Ct.) (QL); *Jaskiewicz v. Humber River Regional Hospital*, [2001] O.J. No. 6 (Sup. Ct. Jus.) (QL); *Lyne v. McClarty*, [2001] M.J. No. 195 (Q.B.) (QL); *Lyne v. McClarty*, [2001] M.J. No. 443 (Q.B.) (QL); *McArdle Estate v. Cox*, [2001] A.J. No. 395 (Q.B.) (QL);

What seems to have changed, however, is the reason for that trend. In the 1991 study the main reason which was identified for the plaintiffs' lack of success was causation. As is discussed below, that remains true today. However, another significant reason is that doctors seem to be disclosing the required information much more often than before. For example, in 45% of the cases in 2001, the doctor was held to have disclosed the required information. Although this issue was not part of the 1991 study, it does appear that the number of cases in which the required information is in fact disclosed has increased. If this is indeed the case, it raises the question of whether that increase is due (at least in part) to the decision in *Reibl*. Certainly there is empirical data which suggests that *Reibl* has had an impact on clinical practice in terms of the amount of information which is disclosed by physicians,¹⁰ and recent case-law is consistent with that empirical data.

2. Expansive Interpretation of the Duty to Disclose

The second theme evident in the 1991 study was that courts have interpreted the duty to disclose very liberally and expansively, with the result that the physician's duty to disclose is becoming increasingly onerous. Based on the analysis of case-law since 1991, it is clear that this trend has continued, and if anything, has become more pronounced.

This can be illustrated in a number of ways. For example, courts still routinely characterize statistically remote risks as material, especially if they involve death or serious injury.¹¹ Secondly, it is now well established that the duty is to disclose all material information (not just risks), including any alternative treatment which may be available.¹² Thirdly, following the 1993 Supreme Court of Canada decision in *Ciarlariello Estate v. Schacter*,¹³ it is clear that the duty of disclosure includes a duty to take reasonable steps to ensure that the patient actually understands the information.¹⁴ This is especially applicable if, for example, the patient's first

McEwan v. Velshi, [2001] O.J. No. 4625 (Sup. Ct. Jus.) (QL); *McKay v. Hall-Findlay*, [2001] A.J. No. 1674 (Q.B.) (QL); *Mann (Next friend of) v. Burnaby General Hospital*, [2001] B.C.J. 1342 (S.C.) (QL); *Michaels v. Wong*, [2001] O.J. No. 3470 (Sup. Ct. Jus.) (QL); *Ryan v. Said*, [2001] N.B.J. No. 48 (Q.B.) (QL); *Stopyn v. Loopstra*, [2001] O.J. No. 4628 (Sup. Ct. Jus.) (QL); *Teubner v. Gasewicz*, [2001] O.J. No. 5216 (Sup. Ct. Jus.) (QL); *Thibault v. Fewer*, [2001] M.J. No. 382 (Q.B.) (QL); *Tremblay v. McLauchlan*, [2001] B.C.J. No. 1403 (C.A.) (QL); *Whissell v. Trus*, [2001] O.J. No. 14 (Sup. Ct. Jus.) (QL).

¹⁰ See Bernard M. Dickens, "The Effects of Legal Liability on Health Care Providers" in *Liability and Compensation in Health Care*, App. B, vol. 2 (Toronto: University of Toronto Press, 1990); Frank Sellers, "Report of the Survey of the Impact of Medical/Legal Liability on Patterns of Practice" in *Liability and Compensation in Health Care*, App. B., vol. 2 (Toronto: University of Toronto Press, 1990).

¹¹ See generally Picard & Robertson, *supra* note 4 at 120-124.

¹² See e.g. *Seney v. Crooks* (1998), 223 A.R. 145 (C.A.). See generally Picard & Robertson, *ibid.* at 129-131.

¹³ [1993] 2 S.C.R. 119.

¹⁴ For a detailed list of the factors which a doctor is expected to consider in determining whether the patient understands the disclosed information see *Lue v. St. Michael's Hospital*, [1997] O.J. No. 255 (Gen. Div.) (QL).

language is not English,¹⁵ or if other circumstances make it difficult for the patient to understand (as, for example, in the case of a patient discussing tubal ligation after having been in labour for 13 hours),¹⁶ or if the doctor uses terminology which is overly technical and difficult to understand.¹⁷

3. The Hurdle of Causation

The 1991 study identified causation as the greatest obstacle facing plaintiffs in informed consent litigation. It remains so today. For example, in 2001, in the 18 cases in which the issue was considered by the court,¹⁸ causation was established in only three.¹⁹ Likewise, in 2002, causation was established in only three cases,²⁰ out of a total of 15 in which the issue was addressed by the court.

The difficulties which plaintiffs face in establishing causation in informed consent cases are well documented,²¹ and became apparent very soon after the decision in *Reibl*. Many commentators (including the present author) have ascribed these difficulties to the modified-objective test adopted in *Reibl*.²² The traditional view of *Reibl* has been that although it was pro-plaintiff with respect to its articulation of the standard of disclosure (that is, the reasonable patient test), it was equally pro-defendant (if not more so) in its adoption of a modified objective test of causation. Indeed, a great deal of criticism, both academic and judicial, has been advanced against the modified objective test of causation, and it has been expressly rejected (in favour of a subjective test) by courts in a number of other jurisdictions.²³

¹⁵ As in *Reibl*, *supra* note 2. See also *Adan v. Davis*, [1998] O.J. No. 3030 (Gen. Div.) (QL).

¹⁶ *Smith v. Tweedale* (1995), 4 B.C.L.R. (3d) 324 (C.A.). See also *Felde v. Vein and Laser Medical Centre*, *supra* note 5 (discussion of the risks taking place immediately prior to the surgery, after the patient was already in the operating theatre – disclosure held to be inadequate).

¹⁷ See e.g. *Paradis v. Labow*, [1996] O.J. No. 1326 (Gen. Div.) (QL) where a 23-year-old patient testified that the surgeon used “big words and stuff” in explaining breast reduction surgery and the surgeon’s explanation was held to be inadequate. See also *Finch v. Carpenter*, [1993] B.C.J. No. 1918 (S.C.) (QL) where a written explanation of the risks of oral surgery were held to be too technical and not understandable.

¹⁸ In some cases where it was held that the doctor had not been negligent in failing to disclose the information, the court did not address the issue of causation.

¹⁹ *Guist v. Boulton*, *supra* note 9; *Lyne v. McClarty*, *supra* note 9; *Tremblay v. McLauchlan*, *supra* note 9.

²⁰ *Carere v. Cressman*, *supra* note 8; *Keane v. Adams*, *supra* note 8; *Matuzich v. Lieberman*, *supra* note 8.

²¹ See Robertson, *supra* note 1.

²² See, for example, Barry S. Wortzman, “Professional Liability – Health Care Providers” in Special Lectures of the Law Society of Upper Canada, *Torts in the 80s* (Toronto: DeBoo, 1983) 417 at 423; P.H. Osborne, “Causation and the Emerging Canadian Doctrine of Informed Consent to Medical Treatment” (1985) 33 C.C.L.T. 131; Erin Nelson & Timothy Caulfield, “You Can’t Get There from Here: A Case Comment on *Arndt v. Smith*” (1998) 32 U.B.C. L. Rev. 353; Mitchell McInnes, “Causation in Tort Law: A Decade in the Supreme Court of Canada” (2000) 63 Sask. L. Rev. 445.

²³ See generally Picard & Robertson, *supra* note 4 at 167-169.

However, over the last ten years, there appears to have been a very significant change in how Canadian courts are interpreting and applying the test of causation in informed consent cases. Plaintiffs are still losing, but not because of an **objective** test of causation: it is because the test is being interpreted and applied much more **subjectively**. Of course, one still finds cases where purely objective factors are decisive, such as those where other doctors testify that their patients normally go ahead with the treatment even when properly informed of the risks,²⁴ or cases where empirical evidence is adduced concerning research studies involving patient decision-making in specific situations.²⁵ However, in recent years, it is becoming increasingly apparent that purely subjective factors are playing a decisive role in determining causation in informed consent cases.²⁶

This trend refutes one of the fundamental premises underlying the causation analysis in *Reibl*, namely, that if a court were to apply a subjective approach to causation, it would have to accept the plaintiff's own evidence (driven by the plaintiff's "hindsight"), thereby inevitably leading to a finding in favour of the plaintiff.²⁷ Numerous recent cases have applied a very subjective approach to causation and have found against the plaintiff, notwithstanding the plaintiffs' own evidence that they would have declined the treatment if properly informed.²⁸

In a sense this pro-subjective development is ironic in view of the Supreme Court of Canada's reaffirmation of the modified-objective test in *Arndt*, in 1997.²⁹ However, that case contains the seeds of a much more subjective approach.³⁰ It has a powerful dissent, written by Justices Sopinka, Iacobucci, and McLachlin, in favour of a purely subjective approach. And even the majority judgment, which reaffirmed the *Reibl* test of causation, was willing to accept that a number of very subjective factors should be taken into account in applying that test. In particular, the Court accepted that subjective factors such as the plaintiff's suspicion of mainstream medicine, and the fact that her pregnancy was planned, were relevant in deciding whether a reasonable woman in her position would have elected to

²⁴ See, for example, *Jantzen v. Hobbs*, *supra* note 9; *Jaskiewicz v. Humber River Regional Hospital*, *supra* note 9; *Robinson v. Taves*, *supra* note 8. See also the cases cited in Picard & Robertson, *supra* note 4 at 165, n. 388.

²⁵ See e.g. *Brandon v. Jordan*, *supra* note 9.

²⁶ A high degree of subjectivity is evident in some of the older cases – see Robertson & Picard, *supra* note 4 at 159-160; Osborne, *supra* note 22 – but it has become a much more pronounced trend in recent years.

²⁷ See *Reibl*, *supra* note 2 at 898.

²⁸ The same is true of foreign jurisdictions (such as England and Australia) which apply the subjective test of causation – their courts do not appear to have been hamstrung by the plaintiffs' own evidence: see McInnes, *supra* note 22.

²⁹ [1997] 2 S.C.R. 539.

³⁰ Note also the Supreme Court's adoption of a subjective test of causation in the context of products liability: see *Hollis v. Dow Corning Corp.*, [1995] 4 S.C.R. 634. For a discussion of the inconsistency between *Reibl* and *Hollis*, see McInnes, *supra* note 22; Vaughan Black & Dennis Klimchuk, "Torts-Negligent Failure to Warn-Learned Intermediary Rule- Causation-Appellate Court Powers", Case Comment (1996) 75 Can. Bar Rev. 355.

terminate the pregnancy if informed of the slight risk of serious fetal abnormality associated with chicken pox during pregnancy.³¹

Recent cases are replete with examples of courts taking a very subjective approach to causation, almost always in favour of the defendant (as the statistics discussed above indicate). Nor is there any consistency in the types of subjective factors which are likely to result in a finding against the plaintiff. Indeed, in some cases the **presence** of a particular subjective factor is emphasized in concluding that a reasonable patient in the plaintiff's circumstances would have gone ahead with the treatment even if properly informed, whereas in other cases the **absence** of the very same subjective factor is used to support the same conclusion. For example, it is very common to find cases where the court describes the patient as "assertive" or "independent minded", and then uses this to support the conclusion that the patient had already made up their mind in favour of the treatment and hence would not have been dissuaded by disclosure of the risks.³² Conversely, it is equally common to find cases where patients are described as depending a great deal on the trust which they had in their doctor,³³ and hence likely to have followed their doctor's recommendation in favour of the treatment even in properly advised of the risks.³⁴

Many of the assumptions which underlie the application of this new subjectively focussed test of causation are highly questionable. For example, cases which emphasize the fact that the patient was informed of a statistically higher or more serious risk and still went ahead with the treatment,³⁵ invite a criticism of risk-comparison fallacy. So too do the cases which emphasize that the patient had previously undergone treatment which involved greater (disclosed) risks than the (undisclosed) risks of the present treatment.³⁶ Most questionable are the cases which focus on other "risk-taking" aspects of the plaintiff's lifestyle – such as the fact that the plaintiff smoked cigarettes and took marijuana, even though she knew that these were bad for her health – to justify the conclusion that the plaintiff would still have gone ahead with the proposed treatment even if properly informed of the risks to her health.³⁷

³¹ For excellent critiques of the reasoning in *Arndt* see Nelson & Caulfield, *supra* note 22; McInnes, *supra* note 22.

³² See e.g. *Baksh-White v. Cochen*, *supra* note 9; *Jaskiewicz v. Humber River Regional Hospital*, *supra* note 9; *Teubner v. Gasewicz*, *supra* note 9.

³³ See e.g. *Robinson v. Taves*, *supra* note 8.

³⁴ "Human nature being what it is, people tend to consent to procedures recommended by their doctors" – *Meyer Estate v. Rogers* (1991), 78 D.L.R. (4th) 307 at 318 (Ont. Ct. Gen. Div.).

³⁵ See e.g. *Beckley v. Toppin*, [1989] B.C.J. No. 1881 (S.C.) (QL); *Casey v. Provan* (1984), 11 D.L.R. (4th) 708 (Ont. H.C.); *Louie v. Robinson*, [1985] B.C.D. Civ. 2631-01 (S.C.); *Parkinson v. MacDonald* (1987), 40 C.C.L.T. 90 (B.C.S.C.).

³⁶ See e.g. *Baksh-White v. Cochen*, *supra* note 9; *Findlay v. Holmes*, [1998] O.J. No. 2796 (C.A.) (QL); *Thibault v. Fewer*, *supra* note 9.

³⁷ *Brandon v. Jordan*, *supra* note 9. See also *Harrison v. Stephany*, *supra* note 8.

V. Conclusion

Overall, informed consent “20 years later” is much the same as “10 years later”. Patients still lose – badly – usually because of causation, but increasingly because the required information has in fact been disclosed by the physician, which may be an indication that the legal standard is having a positive impact on medical practice. The one significant doctrinal change in the last ten years relates to causation. Courts have increasingly emphasized subjective factors in determining causation, and this shift appears to have made it even **more** difficult for plaintiffs to establish the causation requirement in informed consent cases. It is arguable that many of the assumptions which underlie the causation analysis in these cases are highly questionable.

For this trend to change, it is submitted that courts have to become much more sophisticated in their assessment of what makes people decide to accept risk, and plaintiffs’ counsel have to become much more resourceful and imaginative in the type of expert evidence which they lead in helping courts to do this.

