MEDICAL MALPRACTICE

Andrea Donaldson is an associate lawyer at Pacific Medical Law. Andrea obtained her law degree from the University of British Columbia, and was called to the British Columbia bar in 2016. Her practice involves representing severely injured plaintiffs who have suffered as a result of medical negligence. Before joining Pacific Medical Law as an articling student in 2015, Andrea worked at a civil litigation firm, gaining experience representing individuals injured in motor vehicle accidents and occupier's liability claims.

BY ANDREA DONALDSON
PACIFIC MEDICAL LAW

BREACH OF FIDUCIARY DUTY CLAIMS AGAINST PHYSICIANS

Fiduciary relationships are a special category of legal relationship in which one person (the fiduciary) has discretionary power over significant practical interests (such as the medical, legal, or financial interests) of another (the beneficiary). The fiduciary duty may be understood as one type of a more generalized duty by which the law seeks to protect vulnerable people in their transactions with others. The physician-patient relationship has long been recognized as one of the traditional categories of fiduciary relationship, and as such, doctors have an obligation to their patients to act with the utmost loyalty, good faith, and must never allow their personal interests to conflict with their professional duty.[1]

LEGAL FRAMEWORK AND APPLICATION

In dissenting reasons in *Frame v. Smith*,[2] Wilson J. outlined the following hallmarks of a fiduciary relationship:

1. The fiduciary has scope for the exercise of some discretion of power;
2. The fiduciary can unilaterally exercise that power or discretion so as to affect the beneficiary's legal or practical interests; and
3. The beneficiary is particularly vulnerable to, or at the mercy of, the fiduciary holding the discretion of power.

The fiduciary nature of the doctor-patient relationship was emphasized in the judgement of Justices L'Heureux-Dubé and McLachlin in *Norberg v. Wynrib*.[3] In that case, a young female patient, addicted to the painkiller Fiorinal from previous treatments, sought prescriptions from the defendant physician who agreed and provided them to her in exchange for sexual acts. The trial judge found that the defendant breached his fiduciary duty by engaging in sexual relations with the plaintiff, by continuing to prescribe painkillers to her, by capitalizing on the plaintiff's addiction, and by showing a total disregard for her best interests. However, because the plaintiff knowingly entered into an "illegal bargain," her claim was dismissed on the basis of *ex turpi causa*, which states that a plaintiff who engages in criminal conduct at the time of the injury may be denied all tort recovery for damages. The BC Court of Appeal upheld the dismissal.

The Supreme Court of Canada allowed the plaintiff's appeal, but offered three separate judgements. While La Forest J. and Sopinka J. analyzed the case on the basis of the doctrines of tort and contract, McLachlin J. found that these did not "capture the essential nature of the wrong done to the plaintiff",[4] finding that the claim ought to be analyzed on the basis of a breach of fiduciary duty. McLachlin J. went on to state that "the most fundamental characteristics of the doctor-patient relationship is its fiduciary nature"[5], which has trust, not self-interest, at its core. If a fiduciary relationship is shown to exist, then the proper legal analysis is one based squarely on the full and fair consequences of a breach of that relationship. For the purposes of this case, McLachlin J. noted that it need not be decided whether any sexual contact between a doctor and his or her patient is a breach of the doctor's fiduciary duty, but stated that where such a power balance exists and exploitation occurs, the doctor will be at fault. The defenses based on allegations of fault of the plaintiff were found to carry little weight in a breach of fiduciary duty claim.

A fiduciary duty of the physician to their patient has also been applied in other contexts, such as access to medical records and disclosure of medical errors. In *McInerney v. MacDonald,*[6] the SCC held that the duty of the physician to provide access to medical records is grounded in the nature of the patient's interest in his or her records, as "… information about oneself revealed to a doctor acting in a professional capacity remains, in a fundamental sense, one's own. The doctor's position is one of trust and confidence. The information conveyed is held in a fashion somewhat akin to a trust… The confiding of the information to the physician for medical purposes gives rise to an expectation that the patient's interest in and control of the information will continue."[7]

In *Shobridge v. Thomas*,[8] the plaintiff underwent laparotomy surgery in which a 6-foot long abdominal roll used to pack the bowel was inadvertently left inside her abdomen. The plaintiff suffered a significant infection post-operatively. After two further hospital admissions to treat the infection, the defendant physi-

cian performed an additional surgery during which the retained abdominal roll was discovered. At that point, he told the nurses involved in the second surgery that there would be no incident report filed. He finally revealed to the plaintiff that the roll had been retained several months later, at the urging of his colleagues. The plaintiff claimed damages from the physician, the hospital, and the nurses who participated in the initial surgery for negligence, breach of fiduciary duty, and deceit. Both the physician and the nurses were found liable in negligence for the retained roll, however the court found that the full burden of any damage flowing from the failure to disclose the error rested with the physician as he breached his fiduciary duty to inform the plaintiff of the error, and in doing so caused her further harm.

A claim for breach of fiduciary duty affords the plaintiff a number of advantages compared to the tort of negligence, as the court has resort to a broad range of remedies that are not necessarily related to direct or provable loss. The court can consider not only the impact of the fiduciary's conduct on the plaintiff, but the seriousness of the defendant physician's behavior and the need to protect the integrity of the doctor-patient relationship by clearly condemning and attempting to deter such conduct. In *Shobridge*, the court found that the defendant's deliberate attempt to suppress the truth from being revealed to the plaintiff was egregious conduct on the part of a medical professional and demonstrated bad faith deserving of rebuke, awarding both aggravated and punitive damages against the defendant.

In many cases of breach of fiduciary duty, the plaintiff's losses are not economic, and in those instances equitable damages may be available. The finding of a breach of a fiduciary duty also removes causation from the analysis - where this relationship is found to exist and the defendant breaches his duty, liability will be imposed.[9] However, if a claim for breach of fiduciary duty is based on the same particulars as a negligence claim and simply labelled as a breach of fiduciary duty, the fiduciary claim may not be adjudicated.[10]

FIDUCIARY DUTY AND INFORMED CONSENT

The concept of informed consent "underscores, and gives meaning to, the patient's right to medical self-determination," [11] as it is ultimately up to the patient to decide whether to accept a proposed treatment, no matter how beneficial it may be in the eyes of the physician. The courts have recognized that "this right is meaningless unless the patient has been given enough information to make an informed choice".[12] In *Reibl v. Hughes*,[13] the SCC "held that the doctor-patient relationship gives rise to a duty to disclose all material risks"[14]. The court formulated the appropriate test for determining whether a certain risk was "material" as a "modified objective test, which focusses on what a reasonable person in the patient's position would want to know".[15] Prior to *Reibl*, the extent of disclosure "was determined by asking what a reasonable doctor would tell the patient"[16], known as the "professional disclosure" standard.

Failing to inform a patient of all material risks will not generally be found to be a breach of a fiduciary duty, but may give rise to a negligence claim. In *Arndt v. Smith*,[17] serious injuries occurred to a child as a result of her mother being infected with chicken pox during pregnancy. The mother, Ms. Arndt, brought a claim for wrongful birth. The trial judge concluded that the defendant physician was negligent in failing to disclose to Ms. Arndt all of the risks of chicken pox contracted during pregnancy, but found that even if she had been advised of the nature and probability of risk to her baby, Ms. Arndt would not have chosen to terminate the pregnancy. The BC Court of Appeal reversed the trial decision, finding that the duty of disclosure of material risks is not like an ordinary duty of care in negligence, but more similar to a fiduciary duty of disclosure, with a standard of utmost good faith in the discharge of an obligation by a person in the position of power and control to a person in a position of dependency and reliance.

The SCC subsequently reversed the Court of Appeal, holding that the trial judge had applied the right test and did not err in dismissing the action. The SCC also rejected Ms. Arndt's claim for breach of fiduciary duty, as the effect would be to replace the factual analysis of standard of care and causation appropriate to negligence actions with a choice-based analysis that makes recovery virtually automatic upon proof of failure to provide relevant information. The Court saw no reason to depart from the failure to advise of medical risk under the law of negligence, absent special circumstances such as fraudulent misrepresentation or an abuse of power, neither of which was present in this case.

However, when a doctor is engaged in medical research and the relationship with the patient is also one of researcher and participant, fiduciary obligations impose a greater duty to disclose. It is no longer just material risks as per Reibl must be disclosed; rather, full and frank disclosure is required as per *Halushka v. University of Saskatchewan*,[18] in that case the court found that in these situations, there can be no exceptions to the requirements of disclosure as there may well be in ordinary medical practice as the researcher does not have to balance the probable effect of lack of treatment against the risk involved in treatment itself. The subject of a medical study is "entitled to a full and frank disclosure of all the facts, probabilities, and opinions which a reasonable person might be expected to consider before giving consent. The respondent necessarily had to rely upon the special

skill, knowledge and experience of the appellants who were … placed in a fiduciary position".[19]

The issue of informed consent in a research setting was again considered in the recent Ontario case of *Stirrett v. Cheema*.[20] Mr. Stirrett died as a result of undergoing an angiogram conducted as part of a clinical study to determine if intensive control of glucose levels with insulin would reduce the observed problem of re-blockage of arteries following angioplasty, particularly in diabetics.

To obtain the requisite approval and funding for the study, specific parameters were set out, including the requirement of a sufficient sample size to ensure there were enough participants for the results to meet the statistical validity requirements, and that the consent form to be signed and understood by participants would reflect the policy of full and frank disclosure of all information relevant to free and informed consent. The study required participants to undergo a follow up angiogram, which carried the 1/1000 risk of serious complications such as heart attack, stroke, or death. Importantly, it was not being done as part of regular clinical practice, but only for research purposes.

The study was initially supposed to run for three years, however at the end of the second year, funding was terminated due to the failure to secure sufficient participants. Despite this, the defendant physician continued to recruit participants in the third year, including Mr. Stirrett. During Mr. Stirrett's follow-up angiogram as part of the study, he suffered a dissection of his artery, and died two days later.

The trial proceeded before a jury based on allegations of negligence and breach of fiduciary duty. The jury found one of the defendant doctors breached the standard of care in several respects. However, it found the plaintiff had not made out the causation element of the negligence action. The trial judge then went on to rule that pursuant to the Courts of Justice Act of Ontario, he, rather than the jury, had jurisdiction to decide whether the defendant had breached his fiduciary duty as this was an equitable issue.

The trial judge ruled that not all duties owed by a doctor to a patient rise to the level of a fiduciary duty, but the patient does not have to be exploited (as in *Norberg*) for a breach to occur. This was medical research on humans where the patient to doctor relationship becomes participant to researcher. The court concluded that the defendant physician had a fiduciary duty to Mr. Stirrett which was to comply with the consent form as drafted and agreed to, which required the doctor to inform participants of new information about the study that might influence their willingness to continue in the study.

While the changes made to the study in terms of number of participants may not have been significant or changed the risk of harm to Mr. Stirrett, it was not for the doctor to decide. He was obligated to pass these changes on to Mr. Stirrett to permit him to re-evaluate his decision to participate and had he done so, he would have been protected from liability. By not providing the information about the study that varied from the consent form signed by Mr. Stirrett, the court found that the physician had breached his fiduciary duty. The alternate pleading of a breach of fiduciary duty provided a route to receiving an award where a negligence claim was unsuccessful.

CONCLUSION

The principles of fiduciary law will likely continue to impact the rights of patients and the professional liability of physicians. Fiduciary duty claims, where applicable, may confer certain advantages to plaintiffs, especially in situations where economic losses are not substantial, and offer another reason to think outside the box when drafting pleadings.

1. Gerald B. Robinson & Ellen I. Picard, Legal Liability of Doctors and Hospitals in Canada, 5th ed (Toronto: Thomson Reuters, 2017) at 5.
2. [1987] 2 S.C.R. 99 at 134
3. [1992] 2 S.C.R. 226
4. *Ibid* at pg. 269
5. *Ibid* at para 63
6. [1992] 2 S.C.R. 138
7. *Ibid* at para 22.
8. 1999 CanLII 5986 (BCSC)
9. *Norberg*, *supra* note 3 at para 98
10. See *McDonald-Wright (Litigation Guardian of) v. O'Herlihy*, [2005] O.J. No. 1636
11. Picard pg. 124
12. *Ibid*
13. [1980] 2 S.C.R. 880
14. Picard pg. 132
15. Picard pg. 133
16. Picard pg. 130
17. [1997] 2 S.C.R. 539
18. 1965 CanLII 439 (SK CA)
19. *Ibid* at para 29.
20. 2018 ONSC 2595