MEDICAL MALPRACTICE

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INTRODUCTION

This is part 2 of our 8-part series on the anatomy of a medical negligence claim, within which we review the following topics:

- The Doctor-Patient Relationship and Duty of Care (*Verdict* Issue 163 – Winter 2019)
- **Consent**[1]
- Standard of Care
- Defences to a Claim of a Breach of the Standard of Care
- Causation – Basic Principles
- Causation – Application
- Expert Evidence
- Disclosure of Errors

THE EVOLUTION OF THE LAW OF INFORMED CONSENT

The Supreme Court of Canada decisions of *Hopp v. Lepp*[2] and *Reibl v. Hughes*[3] marked a shift in the law away from the medical paternalistic approach to informed consent toward a more patient-centered approach.

The issue first came before the Supreme Court of Canada *Hopp v. Lepp*. In this case, the plaintiff underwent a disc operation, competently performed, which left him with a permanent disability. The plaintiff sued the orthopedic surgeon for, among other things, failing to disclose to him that this was the surgeon's first such operation since completing his orthopedic fellowship training and failing to disclose the alternative of undergoing the operation in a larger facility.

Chief Justice Laskin, writing for a unanimous court, rejected the professional medical standard of disclosure, which essentially held that it was for the medical profession to decide what risks should be disclosed to patients, and instead held that physicians must inform their patients of risks that the "reasonable person in the position of the patient" would want to know. Laskin C.J., described the required standard of disclosure as follow:

> "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."[4]

Having found the defendant surgeon properly discharged his duty of disclosure to the plaintiff, Chief Justice Laskin declined to analyze the distinction between whether the claim would be one of battery or negligence, leaving that for another day.

That day came quickly, only a few months later, in the decision of *Reibl v. Hughes*. In that case, the plaintiff underwent an endarterectomy, also competently performed, which resulted in him suffering a stroke causing right-sided permanent paralysis. The plaintiff alleged the surgeon failed to inform him of the risk of stroke associated with the surgery. In particular, in response to his questions about the risk of stroke, the surgeon advised him that the risk of stroke was greater if he did not undergo the surgery, but failed to advise him of his risk of stroke if he did undergo the surgery. The plaintiff alleged that had he been informed of the risk of stroke associated with the surgery, he would have deferred the surgery until after his retirement pension had vested – 18 months hence. At trial, the defendant was found liable in both negligence and battery for failing to disclose this risk of surgery. This decision was overturned on appeal. The Court of Appeal ruled out battery as a ground for liability and ordered a new trial on the negligence claim. The decision was then appealed to the Supreme Court of Canada. Chief Justice Laskin took this opportunity to clearly distinguish between claims in battery and negligence arising from alleged failure to fully disclosure medical information in the course of obtaining consent for medical care, stating that breach of a duty of disclosure of attendant risks of medical care and treatment was to be subsumed into the law of negligence and an action in battery would only be appropriate "where surgery or treatment had been performed or given to which there has been no consent at all or where, emergency situations aside, surgery or treatment had been performed or given beyond that to which

there was consent".[5] He continued,

> "[i]n situations where the allegation is that attendant risks which should have been disclosed were not communicated to the patient and yet the surgery or the medical treatment carried out was that to which the plaintiff consented … I do not understand how it can be said that the consent was vitiated by the failure of disclosure so as to make the surgery or other treatment an unprivileged, unconsented to and intentional invasion of the patient's bodily integrity. …

[I]n my view, unless there had been misrepresentation or fraud to secure the consent to the treatment, a failure to disclose the attendant risks, however serious, should go to negligence rather than battery."[6]

Chief Justice Laskin also re-emphasized the patient-centered test for disclosure set out in Hopp v. Lepp, supra, stating,

> "[t]o 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, or 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 treatment."[7]

Together, the decisions of the Supreme Court of Canada in *Hopp v. Lepp*, supra, and *Reibl v. Hughes*, clarify that unless fraud or misrepresentation are involved in the process of obtaining consent to medical care or treatment, claims for failure to disclose material risks or alternatives to medical care or treatment are properly pled as negligence claims. The required standard for disclosure is what the reasonable patient in the position of the plaintiff would want to know, which is informed by the special circumstances of the plaintiff as well as questions asked by the plaintiff.[8] This was expanded upon by the Supreme Court of Canada in *Ediger (Guardian ad litem) v. Johnston* 2013 SCC 18, in which the court reaffirmed the trial judge's analysis that the required scope of disclosure included the fact that a reasonable person in the position of the plaintiff would want to know the *consequences of a given risk* (rather than just a recitation of the risks with their respective statistical probabilities). In this case, the scope of disclosure imposed a duty upon the defendant obstetrician to advise the plaintiff not only that proceeding with the proposed treatment included a risk of bradycardia, but also that in the event that that risk materialized, her baby would necessarily be born with severe and permanent brain damage because of the time required to arrange for surgical back-up.

In practice, whether or not a material risk was in fact disclosed is typically an evidentiary and credibility contest with the plaintiff's specific memory of not being told of the risk on the one hand, and the defendant physician's evidence of his or her standard, invariable practice on the other hand, usually in the context of a vague chart entry or consent form that generally references risks having been discussed without specific reference to which risks, and often many years after the encounter. While the findings by the court will be largely fact-driven, it bears noting that a defendant's evidence of his or her standard invariable practice has been accepted as cogent and reliable evidence by the court.[9]

THE CAUSATION TEST IN INFORMED CONSENT CASES

To succeed with any negligence action, the plaintiff must establish a causal link between the doctor's negligence and the injury which occurred.

In the context of informed consent cases, damages are not awarded to a plaintiff simply because the defendant physician failed to disclose material risks or alternatives to medical care or treatment, but only if the plaintiff has been injured by the undisclosed risk and can establish that, but for the failure to disclose the risk, the injury would not have occurred.

There are two separate causation tests built into this analysis:

1) The modified objective test; and
2) The "but for" test.

THE MODIFIED OBJECTIVE TEST

In *Reibl v. Hughes*, Mr. Justice Laskin grappled with the competing approaches of the purely subjective test (i.e. what the patient would have done), and the purely objective test (i.e. what the reasonable patient would have done) of causation, and the evidentiary/credibility quandries associated with each. He settled on a hybrid - the modified objective test, namely, what

a reasonable person in the plaintiff's position would have done had he or she been properly informed of the material risks and alternatives to the medical care or treatment.

Consistent with the standard for disclosure, this test imports a consideration of the plaintiff's unique circumstances. The modified objective test was reaffirmed and elaborated upon by the Supreme Court of Canada in *Arndt v. Smith*[10], a wrongful birth case. Cory J, writing for the majority of the court, described how personal circumstances should be appropriately considered in the application of the modified objective approach:

> "[i]n my view this means that the "reasonable person" who sets the standard for the objective test must be taken to possess the patient's reasonable beliefs, fears and expectations. Further, the patient's expectations and concerns will usually be revealed by the questions posed. Certainly, they will indicate the specific concerns of the particular patient at the time consent was given to a proposed course of treatment. The questions, by revealing the patient's concerns, will provide an indication of the patient's state of mind, which can be relevant in considering and applying the modified objective test".[11]

The reality is that most claims based on lack of informed consent fail on this branch of the analysis because of the difficulty in convincing the court that the reasonable person in the plaintiff's position would have declined the recommended medical treatment had he or she been properly informed of the attendant risks. The difficulty arises from the level of deference and trust afforded to medical professionals by the typical, reasonable patient. Simply put, patients tend to follow their physician's advice. This observation was made by Chief Justice McEachern (as he then was) in *Diack v. Bardsley* who concluded that, "[l]ike most of our citizens who consult professionals, I think he would have decided to go ahead with the procedure which was recommended."[12] Indeed, medicine is a complex discipline which often exceeds the understanding of the average patient, and physicians in our society enjoy an elevated status and level of respect. When a physician recommends a certain course of action, the patient is often ill suited to second guess the wisdom of that recommendation, and simply assumes the recommended medical treatment must be the best possible option available in the circumstances. Defence counsel typically lead expert evidence of the frequency with which patients simply follow their physicians' recommendations, and while the courts have made it clear that these cases are not determined by expert evidence, this type of evidence is persuasive, and is very effective in defending an allegation of lack of informed consent. For these reasons, there typically must be something unique about the plaintiff in order to persuade the court that the plaintiff would have acted contrary to his or her physician's recommendations. A good example of this is found in the case of *Cojocaru (Guardian ad litem) v. British Columbia Womens Hospital, 2009 BCSC 494*[13] in which the Plaintiff, who was of Romanian descent, had experienced trauma surrounding a malformation affecting her first child in a culture which was not very accepting of such differences. This heightened her concern to ensure everything possible was done to avoid problems with the health of her second child, making her unusually risk adverse, and unlikely to accept the risk associated with the recommended proposed medical care.

THE "BUT-FOR" TEST

It is also necessary to prove, on a balance of probabilities, that failure to inform the plaintiff of a material risk or alternative caused the plaintiff's injury. Simply put, it is not enough to prove that the reasonable patient in the plaintiff's position would have refused (or postponed) the surgery had they been properly informed of the materials risks, benefits and alternatives of the proposed medical treatment or procedure. It is also necessary to prove, as in all medical negligence cases, that "but for" the medical treatment or procedure, the injury would not have occurred.

While this aspect of the test does not arise in all informed consent cases, it is important to give careful consideration to its effect in certain factual scenarios. For example, the alternative of postponing the medical care or treatment gives rise to some interesting issues, especially when the effect of postponement may have implications for the injury suffered. This was the argument in the seminal case of *Reibl v. Hughes* where the plaintiff successfully argued that had he been advised of the risk of stroke associated with the surgery, he would have postponed it until after his retirement pension had vested. While he did not argue that but for the failure to disclose the material risk of surgery he would not have suffered the stroke, he did argue that this caused the loss of his retirement pension. The question arises, if there is, for example, a 10% risk of an injury occurring during surgery, can a plaintiff argue that had the surgery been postponed to a later date, the chance of it occurring during this later surgery was only 10% and therefore does not meet the threshold for causation?[14] Whether or not such a claim would succeed in Canada would be very fact-driven and depend upon the specific mechanism of injury, in particular whether the risk was related to patient, physician or facility related factors, and the statistical or epidemiological evidence relating to whether the outcome would have been different had the surgery been performed at a later date.

Another example is the case of *Cojocaru (Guardian ad litem) v. British Columbia Womens Hospital, 2013 SCC 30* in which it was found that while the defendant failed to disclose the risks of induction, and the plaintiff argued she would have declined induction had the risks been disclosed, there was no evidence upon which to find it was in fact the induction which caused the injury to the infant plaintiff (although the plaintiff was successful on lack of informed consent in relation to the VBAC). The Supreme Court of Canada held that the but-for test to causation had not been met, stating:

> [98] …The trial judge failed to conduct a separate causation analysis for the failure to obtain informed consent to *induction*, as distinct from the failure to obtain informed consent to VBAC. In my view, there is no evidence to support a causal relationship between

> the induction and the harm suffered.
> [99] There was no evidence to suggest that the alternative to induction — and, thus, the course of action that would have been followed had induction been refused — was a scheduled caesarean section. The most that can be said is that if Ms. Cojocaru had refused induction, her labour would not have been induced. The question is what harm flowed from the induction with prostaglandin gel.
> [100] The trial judge neither explicitly not implicitly found that the prostaglandin gel over-stimulated the uterus and caused the uterine rupture. Although there is evidence to support his finding that induction increases the risk of uterine rupture, it does not go so far as to show a causal relationship between the induction and the rupture in this case.
> [101] I would not sustain the finding of liability against Dr. Yue on this basis.[15]

CONCLUSION

In conclusion, cases based on lack of informed consent are highly fact-driven cases which are to be assessed on the basis of what a reasonable person would want to know, informed by any relevant unique circumstances of the plaintiff, and including a discussion of the consequences of those risks, and what a reasonable person in the position of the plaintiff would have done had they been properly informed. While this more patient-centered approach to informed consent in health care arose four decades ago out of a greater recognition and respect for patient autonomy, a review of the case law shows that these cases are rarely successfully, in part due to the continued deference patients afford to their care providers. V

1. The scope of this discussion is limited to competent adults.
2. 1980] 2 S.C.R 192
3. [1980] S.C.R. 880
4. *Hopp, Supra* note 2 at 210.
5. *Reibl, Supra* note 3 at 890.
6. *Reibl, Supra* note 3 at 891.
7. *Reibl, Supra* note 3 at 894
8. Also see Health Care (Consent) and Care Facility (Admission) Act RSBC 1996 C. 181 s. 6
9. *Belknap v. Meakes* (1989), 1 C.C.L.T. (2d) 192.
10 [1997] 2 SCR 539
11. *Ibid*, at 550.
12. 1983 CanLII 541 (BC SC) at para 47
13. Aff'd 2013 SCC 30
14. See *Chester v. Afshar* [2004] UK House of Lords 41.
15. *Cojocaru* at para 98-101.