LEGAL LIABILITY IN INFORMED CONSENT CASES: WHAT ARE THE RULES OF THE GAME?

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Introduction

Informed consent is an important tenet of the Western medical care system, serving a number of functions. Firstly, it addresses the imbalance of knowledge between physicians and patients about the complexities of medical care. Secondly, it protects the patient's right to self-determination when choosing medical treatment. Thirdly, it imposes a duty on the physician to pass the material information about the proposed treatment to his or her patient, emphasizing the importance of effective physician-patient communication.

This paper discusses the evolution of the doctrine of informed consent. It will outline how informed consent cases are properly pled, the parameters of the physician's duty to disclose, and what the scope of this duty is. It will examine the legal test of causation in informed consent cases and discuss the latest cases from the Supreme Court of Canada considering this cause of action.

I. In the Beginning

Prior to the decisions in *Hopp v Lepp*[1] and *Reibl v Hughes*,[2] there was considerable debate in the medical and legal community about the amount and content of medical information a doctor should disclose to his or her patient.

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[1] [1980] 2 SCR 192, 112 DLR (3d) 67, 22 AR 361 [*Hopp v Lepp* cited to SCR].

[2] [1980] 2 SCR 880, 114 DLR (3d) 1, 33 NR 361, 14 CCLT 1 [*Reibl v Hughes* cited to SCR].

Should these cases be pled as actions in battery or in negligence? What was the scope of the duty to disclose information to patients? Should the courts defer to the standards set by the medical community, as occurs in most other aspects of medical malpractice law?

II. Battery or Negligence?

Does a physician's failure to inform the patient of the risks involved in a treatment or procedure invalidate consent and result in liability based in battery? This issue was settled in *Hopp v Lepp*, *Reibl v Hughes*, and the decisions that followed.[3] The Supreme Court determined, and repeatedly affirmed, that non-disclosure of risks or medical information was to be subsumed into the law of negligence, not battery. In the words of the Supreme Court of Canada in *Reibl v Hughes*, an action in battery would only be appropriate "where surgery or treatment has been performed or given to which there has been no consent at all or where, emergency situations aside, … there was misrepresentation of the surgery or treatment for which consent was elicited and a different surgical procedure or treatment was carried out."[4]

These principles are still at play today, as illustrated in *Mohsina v Ornstein*,[5] where the plaintiff succeeded in her action in battery against her gynecologist. Here, the plaintiff consented to surgery to remove her right ovary, which had a cyst. The signed consent form authorized such measures as were "immediately necessary" during the operation.[6] During the surgery, the plaintiff experienced bleeding in the area of both the right and left fallopian tubes, requiring stitching. The doctor was concerned that the stitches on the left side could lead to a future ectopic pregnancy, and decided to apply clips (i.e. perform a tubal ligation) to prevent this occurrence; the tubal ligation resulted in the plaintiff's infertility. The defendant argued that the procedure fell within the terms of the consent form. Citing *Reibl v Hughes*, the court found for the plaintiff, explaining that while claims in negligence are suitable where the patient is not advised of the material risks, a claim in battery is available in "cir-

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[3] See *Ciarlariello v Schacter*, [1993] 2 SCR 119, 100 DLR (4th) 609, 62 OAC 161 [cited to SCR]; *Hollis v Dow Corning Corp*, [1995] 4 SCR 634, 129 DLR (4th) 609, 14 BCLR (3d) 1 [*Hollis* cited to SCR]; *Arndt v Smith*, [1997] 2 SCR 539, 148 DLR (4th) 48, BCLR (3d) 187 [cited to SCR]. These cases are discussed later in the paper.

[4] *Supra* note 2 at 890-91.

[5] 2012 ONSC 6678, 99 CCLT (3d) 247, 225 ACWS (3d) 576.

[6] *Ibid* at para 30 (quoting the consent form).

cumstances [such as this] where informed consent is given for a particular procedure and another procedure for which consent has not been given is performed."[7]

III. The Duty to Disclose and the Standard of Disclosure

The legal parameters of a physician's duty to disclose were articulated in *Hopp v Lepp*, a case in which a 66 year-old retired man suffered a spinal disc injury and underwent a hemilaminectomy operation in Lethbridge, Alberta. The case was pled in both negligence and battery, alleging that the patient's consent was not informed because the surgeon failed to advise the plaintiff that it was his first operation since becoming a qualified orthopaedic surgeon, and because his assertion that the surgery could be performed just as competently in Lethbridge as in Calgary was supposedly incorrect.

The Court found that the surgeon did not have to disclose to the patient that it was his first operation since becoming qualified and that the routine operation could be performed just as well in Lethbridge as in Calgary. In describing the duty to disclose, Laskin CJ stated the following for the Court:

> [I]n 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. However, having said that, it should be added that the scope of the duty of disclosure and whether or not it has been breached are matters which must be decided in relation to the circumstances of each particular case.[8]

With these words, Laskin CJ laid the foundation for the test on informed consent that is still in use today.

Laskin CJ expanded on the framework enunciated in *Hopp v Lepp* in *Reibl v Hughes*.[9] In that case, the plaintiff suffered a stroke during or immediately after an elective operation that was performed solely to reduce the risk of a lat-

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[7] *Ibid* at para 31.

[8] *Hopp v Lepp*, *supra* note 1 at 210.

[9] *Supra* note 2; for a fuller presentation of the facts, see the decision of the Court of Appeal, *Reibl v Hughes*, 21 OR (2d) 14, 89 DLR (3d) 112.

er stroke. The plaintiff's pension was scheduled to vest 18 months after the surgery. As a result of the stroke he suffered during the surgery, he became partially paralyzed, was unable to return to work, and therefore did not become eligible for pension benefits. Laskin CJ repeated the principles set out in *Hopp v Lepp* that required all material risks to be disclosed to the patient, and added that "even if a certain risk is a mere possibility which ordinarily need not be disclosed, yet if its occurrence carries serious consequences, as for example, paralysis or even death, it should be regarded as a material risk requiring disclosure."[10]

IV. The Scope of the Duty: What Information Must Be Disclosed?

Reibl v Hughes also changed the scope of the duty to disclose information to patients. Previously, courts had relied on the medical profession to determine the scope of disclosure to a patient. *Reibl v Hughes* rejected that approach and adopted a new objective standard that focused on what a reasonable patient would want to know, which broadened the scope beyond what the medical standards of the day considered appropriate. Laskin CJ commented as follows:

> To 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, of 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 other treatment.*[11]

Reibl v Hughes also narrowed the test for determining causation in informed consent cases, which will be discussed in further detail later in this paper.

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[10] *Reibl v Hughes*, *supra* note 2 at 884-85.

[11] *Ibid* at 894-95 [emphasis added].

V. Patient's Right to Bodily Autonomy and the Right to Withdraw Consent

The judgments of the Supreme Court of Canada concerning the scope of disclosure that subsequently came out in the 1990s emphasized the patient's right to make decisions regarding his or her own body. This right was recognized as one of the main purposes of the "duty to disclose" doctrine.

This principle is illustrated in *Ciarlariello v Schacter*.[12] In that case, an angiogram was performed to determine the exact location and extent of the plaintiff's aneurism. The risks were adequately explained and consent was given. The patient withdrew consent during the procedure upon experiencing hyperventilation, but consented once again upon calming down after a discussion. When the procedure was resumed, the patient suffered an immediate adverse reaction, which rendered her a quadriplegic. The Supreme Court reiterated the principles enunciated in *Reibl v Hughes*, underscoring that every patient has the right to bodily integrity, including the right not only to consent to a procedure, but also to withdraw that consent and halt the procedure. Cory J, writing for the Court, said:

> It should not be forgotten that every patient has a right to bodily integrity. … This concept of individual autonomy is fundamental to the common law and is the basis for the requirement that disclosure be made to a patient. *If, during the course of a medical procedure a patient withdraws the consent to that procedure, then the doctors must halt the process. This duty to stop does no more than recognize every individual's basic right to make decisions concerning his or her own body.*[13]

Two years later, in *Hollis v Dow Corning Corp*,[14] a case that examined the duty of the manufacturer of breast implants to warn physicians and patients of the risks associated with the use of the implants, La Forest J, speaking for the Court (on this issue), stated:

> there is an important analogy to be drawn in this context between the manufacturer's duty to warn and the doctrine of "informed consent" developed by this Court in recent years with respect to the doctor-patient relationship. … *The doctrine of "informed*

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[12] *Supra* note 3.

[13] *Ibid* at 135 [emphasis added].

[14] *Supra* note 3.

> *consent" dictates that every individual has a right to know what risks are involved in undergoing or foregoing medical treatment and a concomitant right to make meaningful decisions based on a full understanding of those risks*.[15]

VI. What Information is Material and What is Not?

The duty of disclosure does not require a physician to disclose all potential risks to a patient. Only risks that are "material" need to be disclosed. A useful starting point for courts in determining which risks must be disclosed is found in *Rawlings v Lindsay*,[16] where McLachlin J (as she then was) stated:

> [A] medical person must disclose those risks to which a reasonable patient would be likely to attach significance in deciding whether or not to undergo the proposed treatment. In making this determination, the degree of probability of the risk and its seriousness are relevant factors.[17]

In *Brito (Guardian ad litem of) v Woolley*,[18] a case involving injuries that occurred to the infant plaintiff during his birth, the governing legal principles relating to determination of what risks are material were summarized as follows by Sinclair Prowse J:

> What constitutes a special, material, or unusual risk will depend on the particular facts of the case. A mere possibility will be included as a material risk if the occurrence of that mere possibility is serious, for example, if it can result in paralysis or death … *Material risks include those risks which the doctor knows, or ought to know, that a reasonable person in the patient's position would consider in deciding whether to undergo a procedure or treatment*.[19]

Although we usually think of the disclosure of material *risks* as the key to the provision of information to patients, other information can also be material to a patient's decision making. In *Seney v Crooks*, Conrad JA, writing for the majority of the Alberta Court of Appeal, upheld the trial judge's finding that

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[15] *Ibid* at para 24 [emphasis added].

[16] (1982), 20 CCLT 301, 13 ACWS (2d) 376 (BCSC) [cited to CCLT].

[17] *Ibid* at 306.

[18] 2001 BCSC 1178, 107 ACWS (3d) 518, [2001] BCTC 1178.

[19] *Ibid* at para 133 [emphasis added].

the defendant surgeon owed a duty to inform the patient that there was an alternative method of treatment of her broken wrist that was preferred by some specialists and might have prevented the damage she sustained. Included in the duty to inform is information on both an alternative mode of treatment and the material risks of that treatment.[20]

VII. What if the Risk of Injury to the Patient is Small?

Almost all procedures and treatments involve risks; some of these risks are inherent in the procedure itself and occur regularly, and others may be statistically unlikely to occur. The clinical significance of the risks may also vary, for example, from short-term minor pain created by a surgical incision to paralysis. This range of risks presents an interesting exercise in judicial discrimination.

How significant must the risk be before the duty to disclose is triggered? An answer to that question is offered in *Bryan v Hicks*.[21] In that case, the defendant orthopaedic surgeon removed an annoying and painful ganglion from the plaintiff's wrist. The surgery was done appropriately, but the plaintiff developed a recognized potential complication: reflex sympathetic dystrophy. The plaintiff's hand became permanently disfigured and essentially useless. She sued, and the court found the defendant liable for failing to properly inform her of the risks of this complication. The defendant appealed on the basis that the risk was so low that there was no duty to disclose it. In rejecting that submission, Ryan JA, speaking for the Court, stated that "[A] risk may be remote, yet considered to be material. …"[22] The judge relied on Justice McLachlin's reasons in *Rawlings v Lindsay*:

> … an "unusual" or improbable risk should be disclosed if its effects are serious. Conversely, a minor result should be disclosed if it is inherent in or a probable result of the process.
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> Other factors which may be relevant in determining a reasonable standard of disclosure include the gravity of the condition to be treated, the importance of the benefits expected to flow from the treatment and the intellectual and emotional capacity of the

[20] 1998 ABCA 316, 223 AR 145, 166 DLR (4th) 337 at paras 53, 55.

[21] [1995] 10 WWR 145, 10 BCLR (3d) 239, 1995 CanLII 172 (BCCA).

[22] *Ibid* at paras 22-23.

> patient to accept the information without such distortion as to prevent any rational decision at all.[23]

VIII. Causation in Informed Consent Cases: The Modified Objective Test

In order to succeed in an "informed consent" case, the plaintiff must satisfy two causation tests – the modified objective test, outlined here, and the "but for" causation test that applies to all tort cases. The "but for" causation test will be described further below.

The modified objective causation test in informed consent cases is established by demonstrating that a reasonable person in the patient's circumstances would have declined the treatment had full disclosure been made.[24] This test imports a certain level of subjectivity into the assessment of what a reasonable person would do. The question then becomes: how far do courts go in allowing a particular patient's circumstances to influence the application of an objective test?

Impact of the Plaintiff's Circumstances on the Modified Objective Test

In the past 15 years or so, there has been a judicial trend towards giving more weight to the plaintiff's personal circumstances when applying the "modified objective test" in informed consent cases. Perhaps this trend was predictable in light of its point of origin: the modified objective test for causation was adopted in *Arndt v Smith*,[25] although a purely subjective test was favoured in the concurring reasons of Justice McLachlin (now Chief Justice) and the dissenting judgment of Justices Sopinka and Iacobucci.

In that case, the plaintiff sued her physician for costs incurred in raising her daughter, who was born with injuries caused by chickenpox that the plaintiff had contracted during her pregnancy. The plaintiff asserted that she would have terminated her pregnancy had she been advised of the risks of congenital defects. The trial judge found that the plaintiff would have continued with the pregnancy based on her personal circumstances: the pregnancy was carefully planned, the baby was much wanted, and the plaintiff was sceptical of "mainstream" medical intervention. In addition, the evidence was that the risk of injury to the foetus was small and that the medical doctors would have advised

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[23] *Ibid*; *Rawlings v Lindsay*, *supra* note 18 at 306.

[24] *Reibl v Hughes*, *supra* note 2 at 898-99, 928.

[25] *Supra* note 3.

against the abortion.[26] The Court of Appeal found that the trial judge applied the wrong test and ordered a new trial, but the Supreme Court of Canada restored the trial judge's dismissal of the claim.

Cory J had the following to say on behalf of the majority on the issue of how personal circumstances should be appropriately considered in application of the modified objective test:

> In 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, desires 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.[27]

The recent Ontario case of *Husain v Daly*[28] illustrates just how much weight the trial courts are willing to allocate to the personal circumstances of a particular plaintiff. In that case, a gynecologist was sued for wrongful hysterectomy. The plaintiff and her husband were desperate to have a baby and had plans to see a fertility specialist. However, the plaintiff suffered from excessive bleeding and considerable pelvic pain, and was suspected to have uterine fibroids that needed to be addressed first. While performing a myomectomy to remove the suspected uterine fibroids, the defendant gynecologist discovered that the source of the plaintiff's symptoms was instead a uterine condition called adenomyosis. Having diagnosed this condition intra-operatively, the defendant decided to remove the plaintiff's uterus, thereby rendering her incapable of becoming pregnant.

Prior to the procedure, the risk of excessive bleeding during the procedure that would necessitate an emergency hysterectomy was discussed with the plaintiff and she accepted it. However, the hysterectomy was performed to treat the discovered condition, and not to deal with an intra-operative emergency. The defendant argued that even if there was no consent, a reasonable

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[26] *Ibid* at para 69, citing the trial decision, *Arndt v Smith*, [1994] 8 WWR 568, 93 BCLR (2d) 220.

[27] *Ibid* at para 9 [emphasis added].

[28] 2012 ONSC 919, 214 ACWS (3d) 285.

person in the plaintiff's circumstances would have agreed to a non-emergency hysterectomy due to her age and the debilitating symptoms she was suffering. The plaintiff argued that she had not been ready to give up on her hope to have children yet, and would not have agreed to a non-emergency hysterectomy simply to relieve her symptoms of pain and bleeding. The court found that a reasonable person in the plaintiff's shoes would have lived with the pain if it meant that there was still a possibility of becoming pregnant through artificial methods. In assessing the reasonableness of the plaintiff's beliefs, fears, desires and expectations, the court found that it was not unreasonable for the plaintiff to want to have a baby at age 46, even though it was statistically unlikely.[29]

Another example where the court focused on the patient's circumstances is *Cojocaru v British Columbia Women's Hospital and Health Centre*.[30] In that case, the infant plaintiff suffered brain damage during his birth. His mother had previously given birth to a child by Caesarean section ("C-section") and wanted to deliver her second baby by the same method since that was the recommendation of her previous obstetrician.

Dr. Yue, Ms. Cojocaru's prenatal care obstetrician, advised Ms. Cojocaru to attempt to deliver her second baby by vaginal birth after C-section or "VBAC." During labour, Ms. Cojocaru experienced a uterine rupture and an emergency C-section was performed. The baby was born with brain damage, which led to cerebral palsy. The trial judge found Dr. Yue liable for failing to obtain Ms. Cojocaru's informed consent to the VBAC procedure. He included evidence of the plaintiff's unique circumstances in the factors that led him to conclude that had she been advised of the risks of uterine rupture, she would have never consented to VBAC. These circumstances included the fact that her first child had been born with a cleft palate and the cultural stigmas of her home country associated with children with disabilities.[31]

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[29] *Ibid* at paras 26-27.

[30] *Cojocaru (Guardian Ad Litem) v British Columbia Women's Hospital*, 2009 BCSC 494, 65 CCLT (3d) [*Cojocaru*], aff'd 2013 SCC 30, 357 DLR (4th) 585, 226 ACWS (3d) 838 [*Cojocaru* SCC] (Author Paul McGivern was lead counsel at trial and on appeal to the SCC).

[31] *Cojocaru*, *supra* note 30 at paras 20-21, 100. On appeal, the Supreme Court upheld the trial judge's finding of negligence on the informed consent issue (*Cojocaru* SCC, *supra* note 30 at para 88).

A patient's level of comprehension is perhaps the most important personal circumstance to be considered. In *Tiglao v Sleightholm*,[32] the plaintiff who spoke minimal English underwent a breast augmentation and a tummy tuck with liposuction. The plaintiff argued that the risk that the procedure would lead to undesirable results was never fully explained to her. All the consultations and office visits at the clinic were conducted in English. The plaintiff's husband, a native English-speaker, attended with the plaintiff at most of her consultations. The court found that "a doctor cannot relegate his obligation to ensure informed consent is given to an employee or a spouse of the patient."[33] The court quoted Justice Shelley in *Malinowski v Schneider*,[34] where she stated:

> When faced with a patient whose personal characteristics might suggest there is a language barrier to his or her understanding of a consent form, the medical practitioner ought to take steps to ensure that language limitations have not prevented or limited the patient's understanding of the form that the patient has been asked to read and sign…. When faced with such a patient, medical practitioners should ensure that the patient understands the meaning of the words and expressions as well as the overall meaning of the document.[35]

The court in *Tiglao* concluded: "There is a 'special duty' placed on the doctor in these circumstances to be certain that his/her patient understands the risks and the alternatives available to the patient."[36]

As will be discussed below, the Supreme Court of Canada recently affirmed that a patient's capacity to comprehend is a vitally important personal characteristic that raises the bar for a physician in making sure that all the information that is given is understood by the patient. This duty to ensure the patient understands extends beyond problems due to language barriers; the patient must not only be informed of the risks, they also need to understand the implications of those risks.

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[32] 2012 ONSC 3092, 219 ACWS (3d) 217.

[33] *Ibid* at para 46.

[34] 2010 ABQB 734, 494 AR 201, 79 CCLT (3d) 36.

[35] *Ibid* at para 70, cited in *Tiglao v Sleightholm*, *supra* note 32 at para 32.

[36] *Tiglao v Sleightholm*, *supra* note 32 at para 45.

IX. Latest Word from the Supreme Court of Canada

In two decisions in the spring of 2013, the Supreme Court again addressed the informed consent issue and the scope of the duty to disclose. Essentially, the Court has stated that it is not enough for a physician to tell a patient of the material risks and their statistical probability. A physician must ensure that the significance of these risks is impressed upon a patient, that is, that the patient understands what would happen if a risk were to materialize.

In *Ediger (Guardian ad litem) v Johnston*,[37] the Supreme Court of Canada dealt with a question of causation that turned on the proper interpretation of the standard of care. Although the issue of informed consent was considered only peripherally, the case illustrates the need to inform the patient of the risk and ensure that they understand what would happen if the risk materialized. In that case, Cassidy Ediger was born with severe and permanent brain damage. She sued the obstetrician who delivered her for negligence. During her mother's labour, the defendant decided to attempt a mid-level forceps procedure to deliver Cassidy. The obstetrician did not warn the mother of the risks; one such risk was compression of the baby's umbilical cord, which could lead to persistent foetal bradycardia, and in turn cause severe brain damage. The obstetrician did not determine the availability of medical personnel to assist with an emergency C-section in case these complications occurred. On this basis, the trial judge found the obstetrician liable for Cassidy's injuries. She also found that he had failed to obtain informed consent from Cassidy's mother. The Supreme Court of Canada upheld the trial judge's finding that in order for there to have been informed consent to the procedure in the absence of a surgical team on standby, the obstetrician would have had to tell the mother that "proceeding with the mid-level forceps delivery included the risk of bradycardia, and that in the event that the 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."[38]

In this way, the Supreme Court set the stage for the decision discussed earlier, *Cojocaru*,[39] which came out a month later. In that case, the Supreme Court upheld the finding of the learned trial judge that insufficient information had been provided to Ms. Cojocaru. There was evidence that the methods of deliv-

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[37] 2013 SCC 18, 356 DLR (4th) 575, 100 CCLT (3d) 1 [*Ediger*] (Author Paul McGivern was also counsel at trial and on appeal to the SCC in this case).

[38] *Ibid* at para 58.

[39] *Cojocaru* SCC, *supra* note 30.

ery were discussed, and that Ms. Cojocaru may have been informed that the chance of success with VBAC was 80% and that the risk of uterine rupture was 1 in 200. However, there was no evidence that anything more than the statistical risks of uterine rupture were conveyed to Ms. Cojocaru, and there was "no indication that the significance of that statistic was brought home to Ms. Cojocaru."[40] Moreover, the trial judge found that even if Dr. Yue did convey the risk of 1 in 200 to Ms. Cojocaru, it was not enough to meet the duty of disclosure.[41]

"But for" Causation – The Second Test

It is important not to overlook the requirement for "but for" causation in informed consent cases. It is not sufficient for a plaintiff to establish, using the modified objective test, that the plaintiff would not have consented to the medical treatment had the risks associated with the treatment been properly outlined. It is necessary to go further and establish that "but for" the treatment rendered, the injury would have been avoided. Thus, in *Cojocaru*, the Supreme Court set aside the finding of the learned trial judge that Dr. Yue should be held liable for failure to obtain Ms. Cojocaru's informed consent to the induction. The court held that there was no proper causation analysis conducted by the trial judge regarding this claim, and no evidence that the uterine rupture would not have occurred but for the induction. Absent evidence capable of supporting a causal link between the induction and the uterine rupture, that aspect of the claim could not be sustained.[42]

Conclusion: Where Are We Now?

The legal principles of informed consent or the physician's duty to disclose can be summarized as follows:

> (i) A physician owes a duty to his or her patient to disclose any special, material, or unusual risks associated with the treatment or procedure and, in certain circumstances, to disclose alternative treatments reasonably available to the patient. The duty to disclose is a patient-oriented test, the determining factor being what a reasonable person in the patient's circumstances would want to know.

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[40] *Cojocaru*, *supra* note 30 at para 93.

[41] *Ibid* at para 107.

[42] *Ibid* at paras 97-101.

(ii) Although a particular risk may only be a mere possibility, if its occurrence carries serious consequences (e.g. paralysis or death), it is a "material risk" and requires disclosure. Conversely, a risk that carries only minor consequences requires disclosure if it is a probable result.

(iii) Expert medical evidence as to whether a particular risk is or is not normally explained to a patient is relevant, but the determination must be made on the basis of what the reasonable patient in the circumstances of the plaintiff would want to know, not on the basis of what a reasonable physician thinks ought to be disclosed.

(iv) A physician must not only relay to a patient the material risks and their relative likelihood of occurrence, but must also explain the consequences of what would happen if the risks were to materialize.

(v) Causation is established by satisfying two tests – the usual "but for" test (which applies to almost all negligence litigation), and the modified objective test specific to informed consent litigation.

Informed consent litigation, more often than not, turns on the question of causation. The defence is successful in the majority of cases, not because the risks of the medical treatment have been disclosed, but because the plaintiff is unable to prove that a reasonable person in the situation of the plaintiff would have refused treatment. This is because:

a) Patients have medical conditions they want treated;

b) Patients, when asked, will concede that they trust their treating physicians and will normally abide by the advice given;

c) When remote risks are outlined to patients, they usually conclude that the material risks will happen to other people, not to them.

In order to overcome this defence, it is necessary to have a "hook" – something specific about the client that distinguishes him or her from the "usual patient" who will usually consent. Examples of successful cases where counsel were able to differentiate their clients from the usual patient include *Husain*[43] and *Cojocaru*.[44]

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[43] *Supra* note 28.

[44] *Supra* note 30.

It may also be necessary to ensure that the patient's refusal is specific to the risk that materialized. In other words, the plaintiff must prove that he or she would have refused treatment if the risks associated with the specific complication that arose had been explained. The Australian High Court decision in *Wallace v Kam*[45] highlights this point. In that case, the plaintiff underwent a surgical procedure that had various inherent risks. One of these risks – bilateral femoral neurapraxia – materialized. The evidence indicated that the plaintiff likely would have consented if the only risk was neurapraxia and it had been disclosed, but would not have consented to the procedure if another inherent risk, the risk of paralysis, had been explained to him. He did not experience paralysis, but argued that he had not provided an informed consent because he was not advised of the risk of paralysis, and had he been so advised he would have refused treatment, thereby avoiding the complication that did arise.

The case was dismissed, and the High Court upheld the dismissal. The case was argued within the context of the local legislation (which is similar in many respects to the common law regarding the duty of disclosure). The High Court found that the duty of disclosure had been breached. Nevertheless, liability was not imposed because a plaintiff "is not to be compensated for the occurrence of physical injury the risk of which he was prepared to accept."[46] This judgment has, to date, not been considered in any Canadian court, but is in accord with the earlier judgment of the PEI Court of Appeal in *Knickle v Rayner*,[47] where the court suggested that the plaintiff must prove that the specific risk that materialized is a foreseeable risk of which he or she was not advised. It remains to be seen whether the Canadian courts will follow the restrictive course laid down in Australia.

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[45] [2013] HCA 19, 297 ALR 383.

[46] *Ibid* at para 39.

[47] (1991), 88 Nfld & PEIR 214, 25 ACWS (3d) 967.