

INFORMED CONSENT AND MEDICAL MALPRACTICE: WHERE DO WE GO FROM HERE?

DEAN I. SCALETTA*

The problem addressed by this paper is the manner in which the courts should assess the adequacy of information given by a physician to a patient prior to the administration of some kind of medical treatment, most often surgery. The main issue in this context is the criteria which should be used to determine the existence, or absence, of valid "informed consent" in any given situation.

Subsumed into this main issue are the following subsidiary issues: (1) Are the relevant risks, procedures, alternative procedures, and expected benefits adequately disclosed and what is to be considered "adequate" in any given situation? (2) Is there sufficient understanding on the part of the patient concerning the information given to him and how should this understanding be measured (*i.e.*, objectively or subjectively)? (3) Must a doctor meet a higher standard of care when responding to specific questions from a patient and, if so, what is the extent of that higher standard? Finally, an issue which is inextricably meshed with the main issue as outlined above may be formulated as follows: In cases where the adequacy of information is called into question, where should the line be drawn so as to distinguish between battery and negligence as appropriate causes of action in any given situation?

With respect to these issues, American and Canadian courts have adopted similar approaches but differ in several notable aspects. These similarities will be discussed first and then, more importantly, the differences will be noted. The relevance of such a comparative analysis is highlighted by the fact that the three recent Canadian decisions, *Lepp v. Hopp*,¹ *Reibl v. Hughes*,² and *Kelly v. Hazlett*,³ have shown a movement toward the adoption of several aspects of the American approach to these problems. This is especially true with regard to the appropriate cause of action in a given fact situation.

Similarities

Since the American and the Canadian positions with regard to the criteria used to determine the existence, or absence, of a valid "informed consent" are fairly consistent, a Canadian article will be used as the basis for this discussion. In 1973, L.E. Rozovsky published a concise and cogent summary of the law of consent in Canada with regard to medical treatment.⁴ He correctly pointed out that: "Once proven, the manner in which the patient consented is irrelevant."⁵ He then went on to discuss five criteria which must be satisfied to constitute a truly "informed" consent: (1) the consent must be voluntary (*i.e.*, there must be a real and substantial choice between consent and refusal on the part of the patient), (2) the con-

* Student, Faculty of Law, University of Manitoba.

1. *Lepp v. Hopp* (1979), 15 A.R. 472; [1979] 3 W.W.R. 409; 8 C.C.L.T. 260 (C.A.).

2. *Reibl v. Hughes* (1977), 16 O.R. (2d) 306, 78 D.L.R. (3d) 35 (H.C.); *rev'd.* (1978), 21 O.R. (2d) 14, 89 D.L.R. (3d) 112, 6 C.C.L.T. 227 (C.A.); leave to appeal granted 89 D.L.R. (3d) 112 n.

3. *Kelly v. Hazlett* (1976) 15 O.R. (2d) 290; 75 D.L.R. (3d) 536; 1 C.C.L.T. 1 (H.C.).

4. L.E. Rozovsky, "Consent to Treatment" (1973), 11 O.H.L.J. 103.

5. *Id.*, at 106.

sent must be made after appropriate information has been conveyed to the patient, (3) the consent must not be so broad and all-encompassing that it loses all meaning (*i.e.*, it cannot purport to give the doctor permission to do virtually anything he pleases), (4) the consent must imply that a particular person, or persons, will be administering the treatment, and (5) it must be given by the person who is to be operated upon and that person must be legally capable of giving the required consent.⁶

This legal capacity to consent is basically vested only in adults and with regard to such adults: "If the person is not mentally [in]capable [sic] of consenting for one reason or another, and he is not in an emergency state, nor under guardianship, in the absence of legislation, there is *no* person who can stand in his place for the purposes of consent."⁷ Rozovsky also pointed out that special care must be taken to safeguard the rights of deaf, blind, illiterate, and non-English speaking people,⁸ that consent cannot be "implied" where it has been specifically refused,⁹ and that all of the requirements for "informed consent" in a doctor-patient situation must be even more stringently applied and adhered to in an experimental context.¹⁰ It is very doubtful that courts on either side of the border would take objection to any of these principles.

Differences

Standards for Disclosure

The first major difference between the Canadian and American approaches is the standard applied to determine the adequacy of disclosure. In the United States, the "full disclosure" standard is applied; in Canada, the "professional" standard is applied. Although the standards are defined quite differently, in practice the differences are more illusory than real.

As it implies, the term "full disclosure" requires that the doctor impart to the patient all of the details, particularly the unpleasant ones, concerning the potential complications and their probability of occurrence, the necessary procedures, the convalescence periods and the other related factors of the proposed medical treatment. The full disclosure standard, when strictly applied, severely restricts the discretion exercised by the doctor in determining the nature and amount of information he will give to the patient. It leaves him very little latitude to consider such factors as the mental and emotional stability of the patients, including their ability to make a rational decision once all of the required information is given to them.

In practice, however, the full disclosure standard requires disclosure of only those factors and risks deemed to be material *after* professional judgment has been exercised.¹¹ American cases have also endorsed this inter-

6. *Id.*, at 107-11.

7. *Id.*, at 110. (Emphasis added).

8. *Id.*, at 111.

9. *Id.*, at 111-12.

10. *Id.*, at 112. See also *Halushka v. University of Sask.* (1965), 53 D.L.R. (3d) 436; 52 W.W.R. 608 (Sask. C.A.).

11. E.J. Picard, "The Tempest of Informed Consent", in Klar (ed), *Studies in Canadian Tort Law*, (1977) 141.

pretation of the full disclosure standard.¹² Further developments in New York have led to the requirement that a reasonable and full disclosure include a discussion of relevant alternatives. It is contended that although a patient fully understands the recommended treatment, he cannot be held to have given "informed consent" unless he has been made fully aware of all of the alternative treatments.¹³

Finally, one American author has suggested the following test for determining the parameters of the full disclosure standard:

A physician is under an obligation (1) to make a full disclosure of all known *material* risks in a proposed operation or course of treatment *except* for those risks of which the patient is likely to know or (2) to prove the reasonableness of any lesser disclosure or the immateriality of the undisclosed risk.¹⁴

It is established in Canada that the "professional standard" — that is, the generally accepted custom within the medical community — will be used to assess the adequacy of disclosure concerning medical treatment which a doctor has given to a patient. If the patient can show that recognized members of the medical profession would have disclosed more, or perhaps different, information than that disclosed by his own physician he will have established the first two steps in a negligence action; namely, a duty of care owed to the patient by the doctor and a breach of that duty by the doctor. In practice, however, the standard itself may be very difficult to establish. Most doctors are naturally loath to give evidence at trial against a fellow practitioner, particularly when the case concerns malpractice.

The standard is unarguably pro-doctor and has been severely criticized as being insensitive to the importance that a particular patient may attach to a certain item, or items, of undisclosed information.¹⁵ Nevertheless, the concept is firmly entrenched in Canadian law.¹⁶ No contrary case has come to the attention of this writer and there seems to be no indication that this is going to change in the foreseeable future.¹⁷ It has, however, been the subject of much Canadian judicial and academic discussion.

One of the first notable cases was the 1932 Ontario Court of Appeal decision in *Kenny v. Lockwood*.¹⁸ In that case, the plaintiff consulted the defendant doctor with reference to the swelling of her palm. On the advice of the defendant and another physician, an operation was performed. The operation proved to be unsuccessful although not improperly performed and the plaintiff claimed that it should not have been performed. In commenting on the requisites of adequate disclosure, Hodgins, J.A. felt that

12. *E.g., Canterbury v. Spence* (1972), 464 F. 2d 772 (D.C. Cir.).

13. S.L. Edwards, "Failure to Inform as Medical Malpractice" (1970), 23 *Vanderbilt L. Rev.* 754, at 771. *See also Supra* n. 5.

14. M.J. Myers, "Informed Consent in Medical Malpractice" (1967), 55 *Calif. L. Rev.* 1396, at 1407. (Emphasis added).

15. E.S. Glass, "Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship" (1970), 79 *Yale L.J.* 1533, at 1558.

16. *See Wilson v. Swanson*, [1956] S.C.R. 804.

17. *See Supra* n. 1 and n. 2. *See also Petty v. MacKay* (1979), 10 C.C.L.T. 85 (B.C.S.C.) per Anderson J. In the *Petty* case, an exotic (nude) dancer desired abdominal cosmetic surgery, but the result was somewhat disfiguring. In a *Case Comment, Id.*, at 98, E. Picard contends that the case re-affirms the view that the "professional" standard of disclosure is still applicable in Canada.

18. [1932] O.R. 141 (C.A.).

“[T]he necessity, character and importance of the operation and its probable consequences. . .”¹⁹ were among the most important factors to consider. He further stressed that it was not necessary to give all of the details nor to frighten the patient.²⁰

Although not decided on this continent, the oft-quoted 1964 New Zealand Supreme Court judgment of Woodhouse, J. in *Smith v. Auckland Hospital Board*²¹ has had a profound effect on jurisprudence both in Canada and in the United States. In that case, the plaintiff was undergoing a process whereby radio opaque dye was put into his blood for the purpose of outlining the arteries to enable examination through x-rays. The flow of blood to the right leg was unexpectedly interrupted and the leg eventually had to be amputated. The plaintiff claimed that he had not been given adequate information concerning the treatment. Perhaps the most quoted lines of the judgment are those expressing his views on the considerations which should come into play when a doctor is deciding how much information to disclose to a patient contemplating surgery:

[T]he gravity of the condition to be treated, the importance of the benefits expected to flow from the treatment or procedure, the need to encourage [the patient] to accept it, the relative significance of its inherent risks, the intellectual and emotional capacity of the patient to accept the information without such distortion as to prevent any rational decision at all, and the extent to which the patient may be seen to have placed himself in his doctor's hands with the invitation that the latter accept on his behalf the responsibility for intricate or technical decisions.²²

Woodhouse, J. went on to point out that no medical treatment is infallible and that the patient should be aware of this without being expressly told.²³

In 1977, Gould, J. in *McLean v. Wier, Goff and Royal Inland Hospital*,²⁴ commented on how, if at all, a court should interfere with the judgment of a medical doctor.²⁵ In that case, a diagnostic procedure left the plaintiff permanently and substantially quadriplegic. The medical evidence did not indicate any negligence in the procedure itself, but the plaintiff had also alleged negligence against both the referring physician, Weir, and the operating physician, Goff, for failure to warn him of the danger of paralysis from the procedure. The Court found that (a) risks of paralysis were slight, (b) that Weir had no duty to warn of paralysis and (c) that Goff had given adequate disclosure.²⁶

Finally, in 1979, the majority in the *Lepp* case²⁷ expressed the view that

19. *Id.*, at 160.

20. *Id.*, at 161.

21. [1964] N.Z.L.R. 241 (S.C.).

22. *Id.*, at 250.

23. *I.D.*, at 250-51.

24. [1977] 5 W.W.R. 609, 3 C.C.L.T. 87 (B.C.S.C.).

25. *Id.*, at 627; 3 C.C.L.T., at 108. The learned Judge stated: "How much to tell a patient has long been an ethical and sometimes a legal problem of the medical profession. Insofar as the communication goes beyond mere communication and touches directly upon health and treatment, the communication is part of the therapy of medicine. The less the courts try to tell doctors how to practise medicine the better." *Ibid.*

26. *Ibid.*

27. *Supra.* n. 1.

the relative convenience, expertise and risk of performing an operation in one place as opposed to another — in this case, Lethbridge or Calgary — must be discussed as “To do less. . . is inadequate and even misleading.”²⁸ This case seems to place an even heavier onus on the doctor in such circumstances and its desirability is questioned by both the minority in that case²⁹ and by this writer.³⁰

In short, it may be safely asserted that in Canada a doctor must exercise good professional judgment in disclosing enough information to a patient so that that patient can make — if he wishes and is mentally capable of doing so — a reasoned decision, yet stopping short of so frightening the patient that a rational decision becomes impossible. Further, where a physician exercises this judgment in good faith and within recognized standards, a court should be very wary of questioning the soundness of that judgment.

Standards for Comprehension by Patients

Another well-settled area of American jurisprudence in this context is the standard to be applied in assessing how much the patient understands before “informed consent” results. It is undisputed in the United States that the understanding of the patient is based on an objective standard;³¹ *i.e.*, given the information disclosed by the doctor, would the reasonable person have a sufficient grasp of the nature and ramifications of the particular medical treatment to make an intelligent decision as to whether or not to undergo the treatment?

On the other hand, it is well-settled in Canada that the understanding by a patient of medical information will be assessed “subjectively.” E.J. Picard suggests that this test involves asking such questions: “Did *this* plaintiff have adequate information and comprehension? Was it put to him in terms *he* could understand [in a battery context]? In a negligence action, would *this* plaintiff have accepted the risk had he known it?”³² It is further contended by Picard that comprehension by the patient is particularly relevant in a negligence context because of the necessity of proving causation. If a patient can show that he would not have undergone the treatment had he been given more comprehensive information by the doctor,³³ the necessary causal link has been established.³⁴

28. *Id.*, at 500; [1979] 3 W.W.R., at 432; 8 C.C.L.T., at 289.

29. *Id.*, at 481-82; [1979] 3 W.W.R., at 416; 8 C.C.L.T., at 298.

30. In the *Reibl* case at trial, (1977), 78 D.L.R. (3d) 35 (Ont. H.C.), Haines, J., suggested at 43-44, that a doctor is bound to employ relevant statistics (*i.e.*, concerning the incidence of particular risks actually materializing) in order to be held to have given adequate disclosure to a patient. Haines, J. found that the defendant had inadequately disclosed the risks involved (in part by failing to use statistics) and held him liable in negligence. This notion concerning the use of statistics was, however, soundly rejected by the Court of Appeal. *Supra*, n. 2 at 239. In that judgment, Brooke, J.A. correctly points out that the informational value of such statistics is very likely to be offset by the confusion and distress their use is likely to arouse in the patient. The case was ordered returned for a new trial, but at the date of this writing, the appeal from that order, which was granted by leave from the Supreme Court of Canada on November 21, 1978, 89 D.L.R. (3d) 112n, had not been heard so the eventual outcome of the case is still uncertain.

31. *E.g.*, *Supra*, n. 12.

32. *Supra*, n. 11, at 142.

33. *E.g.*, *Koehler v. Cook* (1976), 65 D.L.R. (3d) 766, at 767 (B.C.S.C.).

34. *Supra*, n. 11, at 141.

One final point made by Picard on this regard is that: "The subjective standard is pro-plaintiff and must be applied cautiously but it can be an effective counterbalance to the pro-doctor professional disclosure standard."³⁵ It should also be noted that in the *Reibl* case,³⁶ Brooke, J.A. discusses and expresses support for the objective standard of patient understanding prevalent in American courts, but still holds the subjective standard to be the proper one on this side of the border.³⁷

Effect of Patient's Questions

The American authorities also generally agree that specific questions directed by a patient to a doctor do not "enlarge" the duty to disclose as outlined above.³⁸ It is submitted that this position dove-tails with the concept of full disclosure and enhances the internal consistency of the American approach to this area of the law.³⁹

The most recent Canadian authority on the question is, unfortunately, a minority opinion. The opinion was expressed by Prowse, J.A. in *Lepp v. Hopp*.⁴⁰ In that case, a patient with a "slipped disc" underwent an unsuccessful operation by the defendant orthopedic surgeon. The defendant recommended a certain neurologist who in turn referred the plaintiff to a neurosurgeon. The latter performed an operation which left the plaintiff permanently injured. At trial, the learned Judge found the orthopedic surgeon not liable in negligence for failure to adequately disclose all of the relevant risks pertaining to surgery. The majority of the Court of Appeal reversed the negligence finding and held the defendant liable in battery as well. The minority found liability in negligence only.

In his judgment, Prowse, J.A. held that there is a distinction between the disclosure standards required when: (a) obtaining consent for surgery, and (b) responding to specific questions from the patient. In his opinion, the former requires simply a "fair and reasonable" explanation of the probable effect and unusual risks of a particular course of treatment.⁴¹ The latter however requires the "reasonably frank and full disclosure" of risks which are "mere possibilities if the patient's questions reasonably direct the surgeon's attention to risks of that nature and if they are such that the surgeon, in all of the circumstances, could reasonably foresee would affect the patient's decision."⁴²

35. *Id.*, at 142.

36. *Supra.* n. 2.

37. *Id.*, at 243. See also, *Supra.* n. 17. In the *Petty* case, Anderson, J. advocates the use of the objective test, but goes on to apply the subjective test in keeping with Canadian authority in the area.

38. *E.g.*, *Supra.* n. 12.

39. The New Zealand Supreme Court also endorsed the view that the doctor's duty of care was not expanded by direct questions from the patient *Supra.* n. 21, at 252, but that view was rejected by the appellate court. [1965] N.Z.L.R. 191.

40. *Supra.* n. 1. See also *Calder v. Gilmour* (1978), Unreported (Sask. Q.B.) per Halvorson, J. In that case, the plaintiff had a 'wandering' eye and the effort required to keep it aligned with her right eye caused her to suffer bad headaches. The defendant recommended and performed corrective surgery which resulted in long-standing diplopia (double vision). The evidence indicated that the plaintiff would have refused the treatment if she had been informed of the possibility of such an outcome. The learned Judge states that because the patient had specifically asked about the danger of diplopia, the doctor "had a particular responsibility to give her a full and accurate reply." It was held that there had been no informed consent given by the plaintiff. *Id.*, at 6.

41. *Supra.* n. 1, at 408; [1979] 3 W.W.R., at 415; 8 C.C.L.T., at 297.

42. *Id.*, at 481; [1979] 3 W.W.R., at 416; 8 C.C.L.T., at 298. (Emphasis added).

Although this is a minority judgment, it is recent and comes from a very reputable Canadian Court. It is submitted, therefore, that this view should be given consideration by courts in this country which will have to adjudicate on this point some time in the future.

Battery and Negligence

Before discussing the reasonably settled American approach and the emerging Canadian approach with respect to the appropriateness of each of these causes of action in a given fact situation, it would be useful to describe the nature of each action and the manner of procedure in each instance.

A "battery" involves a direct and intentional application of force to the person of another. The tort is complete even in the absence of harm to the victim.⁴³ Further, so long as the contact itself is either intended or substantially certain to result, it is "not necessary that the actor intended to inflict bodily harm."⁴⁴ The term "battery" is often confused with the term "assault" although they are, and will remain so for the purposes of this discussion, technically distinct. The latter is committed merely by causing the victim to have a reasonable apprehension that a battery is about to be inflicted. Although the two terms have essentially become fused in a criminal context, in a tort context one can, and often does, occur in the absence of the other.⁴⁵

On the other hand, "negligence" is loosely defined as "conduct that falls below the standard regarded as normal or desirable in a given community."⁴⁶ An important constituent feature of the tort is that it is unintentional, as opposed to battery which is intentional.

For the purposes herein, however, the most important distinction between the two torts is in the proof required and the burden of that proof. In a suit for negligence, the plaintiff must establish a duty of care owed to him by the defendant, a breach of that duty and a substantial and causally-linked harm to himself resulting from that breach.⁴⁷ In an action for battery, however, the case for the plaintiff is complete once an application of force to the person of that plaintiff has been shown. In both of the actions, the defence of consent may be proven by the defendant. The question of what constitutes an appropriate "consent" has already been discussed.

The American Approach

It was common in the United States, until the late 1950's to plead (and decide) most cases of failure to disclose the consequences of medical treatment, either adequately or altogether, in battery.⁴⁸ The same was true of most cases of outright misrepresentation in this regard. The vast majority of such cases in the last decade or so in the United States indicate that "the

43. J.G. Fleming, *The Law of Torts* (5th ed. 1977) 24.

44. *Ibid.*

45. *Ibid.*

46. *Id.*, at 103.

47. *Id.*, at 104-05.

48. *Supra*. n. 11, at 130. See also *Salgo v. Leland Stanford Jr. University Board of Trustees* (1957), 154 Cal. App. 2d 560 (C.A.).

trend is clearly in the direction of treating all types of wrongful non-disclosure as negligence."⁴⁹ There has been a marked tendency to attempt to restrict the applicability of battery, as an action, to cases where the physician has *deliberately* deviated from the actual consent known to have been given by the patient.⁵⁰

The aforementioned article by S.L. Edwards⁵¹ lends support to this trend. The author suggested that: "The failure of the physician to make an adequate disclosure should be measured in terms of negligence since negligence is a matter of unreasonable conduct in the face of unreasonable risk."⁵² Also, in that same article, the author briefly discussed the defence of "privilege" and how it relates to the subject matter of the distinctions between the actions of battery and negligence with regard to consent. He states:

A privilege is recognized in the area of *intentional* torts [e.g. battery] as an affirmative defense to conduct which the defendant admits is wrong. If the physician is justified in refusing to disclose frightening information to the unduly apprehensive patient, his conduct does not amount to a legal wrong; rather, the utility of his conduct outweighs the harm that might result from nondisclosure. There can be no privilege, however, to commit a negligent act [*i.e.*, an *unintentional* tort].⁵³

In short, Edwards seemed to suggest that disclosure going to the issue of consent is very relevant in a battery context⁵⁴ (in the narrow American version of the tort) and that the defence of privilege can play an important role. But, I submit that he was also suggesting, when that lack of disclosure becomes such that negligence is the "appropriate" action, the doctor can no longer rely on the defence of privilege. This proposition is logically consistent with the American trend towards negligence as the sole ground of liability in malpractice cases.⁵⁵

The Canadian Approach

The point of departure between cases appropriately framed in negligence and those appropriately framed in battery has been the subject of a flurry of judicial opinion in the last three years. This "point of departure," as will be seen, has proved to be a very elusive concept. The 1976 Ontario High Court case of *Kelly v. Hazlett*⁵⁶ was the first of three recent cases to address the question. The final resolution of the issue still seems to be a long way off.

In the *Kelly* case, the plaintiff had a deformity and stiffness in her right elbow as well as a numbness in her right hand. The defendant orthopedic surgeon agreed to perform surgery to relieve the numbness in the hand and

49. *Supra.* n. 13, at 763.

50. *Cobbs v. Grant* (1972), 502 P. 2d 1 (Cal. S.C.).

51. *Supra.* n. 13.

52. *Id.*, at 766.

53. *Ibid.* (Emphasis added).

54. *Id.*, at 764.

55. *Id.*, at 765.

56. *Supra.* n. 3.

the stiffness in the elbow, but recommended against the operation to cure the deformity; that is, an osteotomy. Even when the plaintiff insisted on the osteotomy, the defendant failed to tell her there was a risk that more temporary and permanent stiffness could result. As a result of the osteotomy, the plaintiff experienced greater stiffness. She brought her action in both battery and negligence. Liability in the latter was found.

In his attempt to draw the line between battery and negligence, the learned trial Judge approached the problem from a number of angles. In defining the nature of each action, Morden, J. expanded the notion of the requisite duty of care in a negligence action to include several elements of the American standard which had not been previously enunciated as being applicable in Canada. He said:

Broadly speaking, a battery is the intentional, unconsented to, touching of the person of the plaintiff by the defendant, while negligence (in the context of a case such as this) consists of the substandard execution of a duty of care by the doctor resulting in damage. The doctor's general duty of care includes not only the duty to exercise due skill and competence in diagnosis and treatment but also to give *reasonable information and advice* to the patient.⁵⁷

Prior cases had not included the informational aspect as an element of a negligence action.

After mentioning the considerable discretion exercised by a doctor in determining the nature and extent of this "reasonable information and advice" — a discretion which is severely limited in the United States by the American standard of so-called "full disclosure" — Morden J. went on to assert that:

The issue of the 'informed consent' can arise in both battery and negligence cases: with respect to the former a lack of proper information communicated by the doctor to the patient can vitiate an apparent consent while, with respect to the latter, failure to see to it that the patient is properly advised can amount, in certain circumstances, to an act of negligence.⁵⁸

After enunciating this second criterion for distinguishing between the two actions, Morden J. expanded on the consent question. In adopting a dichotomy expounded by M.L. Plante⁵⁹ he stated:

If the *basic nature and character* of the operation performed is substantially that of which the plaintiff was advised, and then agreed to, then there has not been an unconsented-to invasion of the person of the plaintiff, regardless of any failure to disclose any *collateral risks* flowing from the operation. However, such failure to disclose collateral risks, if it can be shown to have resulted in damage to the patient, and was justified by reasonable medical considerations, may properly be subject-matter for a claim based on negligence.⁶⁰

After recognizing that this dichotomy presents numerous problems as to the proper classification of a particular risk factor, he attempted to define the term as follows:

57. *Id.*, at 310; 75 D.L.R. (3d), at 555; 1 C.C.L.T., at 23. (Emphasis added).

58. *Id.*, at 310; 75 D.L.R. (3d) at 555-56; 1 C.C.L.T., at 23.

59. M.L. Plante, "An Analysis of 'Informed Consent'" (1968), 36 *Fordham L. Rev.* 639.

60. *Supra*. n. 3, at 313; 75 D.L.R. (3d) at 558; 1 C.C.L.T., at 27. (Emphasis added).

The more *probable* the risk the more it could be an integral feature of the nature and character of the operation. Further, even if a risk is truly collateral, but still material, if it could be said that the disclosure is *so* essential to an informed decision to undergo the operation that lack of disclosure should vitiate the consent.⁶¹

In 1977, E.J. Picard expounded upon the practical and theoretical difficulties which could undoubtedly arise should the somewhat surreal dichotomy of Morden, J. be adopted.⁶² Among the practical difficulties she mentioned are such matters as onus of proof, proof of causation and damages, the role of medical evidence and others.⁶³ Most of these practical problems stem from the use of the "professional standard" of disclosure. Unless some legal presumption in favour of the plaintiff is ruled to be applicable, the plaintiff must always satisfy the Court, on the balance of probabilities, that the defendant actually committed the tort alleged. This is a positive burden on the plaintiff; that is, the failure to prove each and every element of the tort will leave the plaintiff without a remedy. In instances such as those under discussion, the plaintiff must rely on the medical community to aid in his proof of the duty of care, the breach of the duty, and the causal link between the breach and the harm complained of. As has been mentioned earlier, the plaintiff will often not receive much cooperation in this regard. It is submitted, therefore, that to require the plaintiff to also fulfill the nebulous requirements as set out by Morden, J. would make recovery well nigh unattainable so long as the professional standard is retained.

Picard also stressed the theoretical problem, raised in the case, of classifying a particular fact as either "basic" or "collateral" and characterized it as follows:

If [fact] 'A' is a certain and serious part of the procedure it goes to the basic nature and character of the operation. But even if 'A' is decided to be collateral it may go to the 'nature and character' if it is *material*. The determination of the [proper] place of facts like 'A' will give the medical and legal professions pause.⁶⁴

She further pointed out that matters such as the measures of the materiality of the information, the standards required of physicians with regard to disclosure and of patients with regard to their understanding, the breadth of information necessary to constitute a so-called "informed consent," and others, are very much "open" questions in Canada.⁶⁵

It was not long before the Ontario Court of Appeal endorsed the views of Morden, J. and attempted yet another step toward clarifying the distinction by restricting the use of the battery action in cases of this nature. The case was *Reibl v. Hughes*.⁶⁶ In that case, the defendant neurosurgeon performed an elective surgery on the plaintiff patient. The patient suffered a stroke, paralysis and permanent disablement. Towards the end of the judg-

61. *Id.*, at 313; 75 D.L.R. (3d) at 559; 1 C.C.L.T., at 27-28. (Emphasis added).

62. *Supra*. n. 11.

63. *Id.*, at 136.

64. *Id.*, at 137.

65. *Ibid.*

66. (1978), 21 O.R. (2d) 14, 89 D.L.R. (3d) 112, 6 C.C.L.T. 227 (C.A.).

ment, Brooke J.A., speaking for the majority, stated that most Canadian cases of this nature which are pleaded in battery involve:

[A]n *intentional deviation* from the consent given, or fraud, or a serious misrepresentation as to procedure and/or risks. . . They. . . are not simply cases in which there is an allegation of negligent conduct in the surgeon's failure to disclose or adequately explain a risk inherent in surgery that he in good faith had otherwise explained and recommended to his patient.⁶⁷

The learned Judge expanded this notion by remarking:

In the circumstances when the evidence is consistent only with the fact that the doctor had acted in good faith and in the interests of the patient, but in so doing was negligent in failing to make disclosure of a risk inherent in treatment which he recommends and as a result has caused his patient loss or damage, *the action should properly be in negligence and not in battery.*⁶⁸

In an annotation to the case report, E.J. Picard argued with some merit that the *Reibl* decision effectively deprives plaintiffs of the very useful action of battery without providing them with the protection afforded by the American standard of full disclosure. Instead of merely proving that his person has been violated and casting the onus upon the doctor to prove consent, the patient is forced (in all but a few cases) to use a standard *established by the physician's own peers* to prove all of the requisite elements of negligence.

Conclusion

While this writer lauds these judicial attempts to clarify the law in this regard and endorses the restrictive definition imposed on the battery action, it is felt that the *Reibl* case points very clearly to the injustices to which the restrictive definition, in combination with the prevailing professional standard of disclosure, can give rise. The plaintiff is effectively subjected to the worst of both situations; that is, he must satisfy the more numerous requirements of negligence (as opposed to battery) and he must do that using the physicians' standards. It is strongly suggested that this injustice can be largely mitigated if the American standard of "full disclosure" is adopted by Canadian Courts. It is felt, further, that this is a more viable solution to the problem at hand than that of continuing to attempt to pinpoint the line of demarcation between the two torts. Some courts in this country have failed to clearly and succinctly establish anything but a restrictive definition of battery. In light of the opinion just expressed that this definition is appropriate, it is suggested that the courts abandon this futile course of endeavour, adopt the *Reibl* definition of battery, and impose the full disclosure standard. To do otherwise will only perpetuate the injustice.

67. *Id.*, at 28-29; 89 D.L.R. (3d), at 127; 6 C.C.L.T., at 245. (Emphasis added).

68. *Id.*, at 29-30; 89 D.L.R. (3d), at 128; 6 C.C.L.T., at 246-47. (Emphasis added).

