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## INFORMED CONSENT: HOW TO TIP THE BALANCE IN FAVOUR OF YOUR CLIENT

### INTRODUCTION

It is well established that a physician may be found negligent for failing to obtain the patient's informed consent to medical treatment that causes injury, even where the medical treatment itself was performed in accordance with the expected standard of care. This is based on the notion of patient autonomy, specifically the right to be informed of the risks associated with medical treatment, which is firmly entrenched in Canadian law.

The decision of *Reibl v. Hughes*, [1980] SCJ No. 105, marked a shift in the law away from the medical paternalistic approach to informed consent toward a more patient-centered approach. 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. In other words, the standard of disclosure is now based on the perspective of a reasonable patient, rather than that of the physician.

This greater recognition of the importance of individual patient autonomy in the decision making process, however, has not translated into greater success in the courtroom in these types of cases. A review of the case law in British Columbia over the last decade reveals that while courts have taken an expansive view of the patient's right to know, and have been prepared to find that a physician has failed to meet the standard of disclosure required by *Reibl v. Hughes*, in all of those cases where such a breach was found, the court has dismissed the case on the causation branch of the analysis, namely that the reasonable person in the plaintiff's position would have proceeded with the recommended treatment even if he or she had been properly advised of the risks.<sup>1</sup> The result is that, in the last decade, plaintiffs in British Columbia have not been successful in obtaining compensation from the courts for injuries suffered as a result of the materialization of an undisclosed risk associated with recommended medical treatment.

In this paper I will discuss why these cases continue to fail, and what counsel can do to tip the balance in favour of their clients.

### The Law on Informed Consent in the Medical Context

In order to succeed in an action based on lack of informed consent, the plaintiff has the onus of proving the following:

1. That there was a material risk attending the proposed medical treatment which the physician did not disclose to the patient; and

2. That the reasonable person in the position of the plaintiff to whom that risk was disclosed would have declined the surgery.<sup>2</sup>

To succeed with an action, the plaintiff must establish a causal link between the doctor's negligence and the injury which occurred. Damages are not awarded to a plaintiff simply because he or she did not give informed consent, but only if he or she 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.<sup>3</sup>

In analyzing causation, the Supreme Court of Canada has specifically rejected the subjective test to causation on the basis that the reliability and credibility of the plaintiff's evidence that he or she would not have agreed to proceed with the medical treatment if the material risks had been properly disclosed may be suspect as it puts a premium on hindsight and may be self-serving.<sup>4</sup> Rather, the test is a "modified objective" one, that focuses on whether the reasonable person in the plaintiff's position, being the average prudent person who possesses the patient's reasonable beliefs, fears, desires and expectations,<sup>5</sup> would have declined surgery at the particular time had the risk been disclosed. If the reasonable person in the plaintiff's position would have consented to the surgery or treatment in any event, the doctor's negligence cannot be said to have been the cause of the patient's injury.

The reason most of these cases fail lies in 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."<sup>6</sup> This is understandable. Medicine is a complex discipline which exceeds the understanding of the average patient. Physicians in our society also enjoy an elevated status and level of respect. When people have a medical problem, especially one which is causing them significant pain and/or disability, or one that is progressively worsening, they go to a physician for help. 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.

This deferential treatment patients commonly afford their physicians in making medical decisions is at the forefront of the evidence led by defense counsel at trial of what reasonable patients would do. Specifically, defence counsel will routinely lead evidence from a medical expert who will testify that he or she discloses the particular risk to all of his or her patients, and that having fully explained this particular risk, all (or the vast majority of) patients still elect to proceed with the medical treatment. The statistics are stacked against your client. 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. The only way to overcome it, and to tip the balance in favour of your client, is to present your client as an outlier.

### TIPPING THE BALANCE

In order to overcome the causation hurdle, counsel must present a client who is an outlier, someone who does not simply follow the recommendations of his or her physician without applying independent thought to the decision making process. Counsel must also present a client who can point to specific life circumstances and experiences which would have influenced his or her decision making process at the relevant time, and swayed him or her to decline the recommended medical treatment.

#### 1. Don't allow your client to be led blindly down the garden path

In addition to expert evidence to support this notion of patient deference to physicians, defence counsel will seek to elicit such evidence directly from your client during your client's examination for discovery. Defence counsel will generally ask a series of questions designed to demonstrate that because the physician has the expertise in medicine, and because the plaintiff trusts the physician, the plaintiff would simply have done whatever the physician recommended was best, without further consideration.

Beware of your client being led down this proverbial garden path. If this is truly how your client thinks, then there is nothing that can be done, and his or her claim will likely fail. However, most people don't actually think in such simplistic terms. Their thought process is much more expansive. They take the information they receive from their physician and think about it. They may discuss it with trusted family members or friends. They may raise it with another physician, or they may do some on-line research on the issue. Most patients who are given a full explanation of the material risks of the recommended treatment and any potential alternative procedures, tend to mull it over. Each patient is unique, and is influenced by different factors. Further, if the rationale defence counsel propounds was true, there would be no reason to require physicians to disclose any risks at all, and we would be back to the paternalistic approach to medicine prevalent in the past.

It is the role of counsel to prepare his or her client to avoid falling into this trap. The discovery questioning may go something like this (and is most effective when done in relation to a physician other than the defendant physician):

Counsel: You sought out medical advice from Dr. X.

Witness: Yes.

Counsel: You trust Dr. X?

Witness: Yes.

Counsel: He certainly has more knowledge and experience than you do in relation to your [medical problem]?

Witness: Yes.

Counsel: When you saw Dr. X you were relying on him to give you his medical advice on how to treat your [medical problem].

Witness: Yes.

Counsel: You agreed to the surgery because Dr. X recommended it?

Witness: Yes.

Counsel: You understood at the time that there are risks and complications with every medical procedure?

Witness: Yes.

Counsel: You put yourself in Dr. X's hands as to the best treatment?

Witness: Yes.

Counsel: And that's what you do with all your physicians: you defer to their advice because they are the experts?

Witness: Yes.

If this is how your client's discovery goes, you have likely lost the case.

#### 2. Develop your client's life story

Informed consent cases rise or fall on the court's assessment of your client's credibility, namely the extent to which the court

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believes that your client would have declined to proceed with the treatment *at the time*, had the physician fully disclosed the material risks. It is not enough to rely solely upon your client's testimony that he or she would not have consented to the recommended treatment had he or she been properly advised of the risks, as genuine as that evidence may be. Such evidence has been viewed as inherently unreliable and self-serving and, when presented on its own, the court assigns little weight to it. As succinctly put by Laskin CJ in *Reibl v. Hughes*, "It could hardly be expected that the patient who is suing would admit that he would have agreed to have the surgery, even knowing all of the accompanying risks."

Your client's credibility depends upon the extent to which his or her life experiences, beliefs, fears, desires and expectations, are consistent with the assertion that he or she would have declined the medical treatment. The well-established approach for testing the credibility of an interested witness has been articulated as follows:

The test must reasonably subject his story to an examination of its consistency with the probabilities which surround the currently existing conditions. In short, the real test of the truth of the story of a witness in such a case must be its harmony with the preponderance of the probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions.<sup>7</sup>

In order to establish this "harmony with the preponderance of the probabilities," counsel must delve deeply into the lives of their clients in order to gain an understanding of their social and cultural beliefs and expectations. It is necessary to develop a story that is consistent and harmonious with the objective evidence. In other words, in order for your client's evidence about declining the medical treatment to be found credible, it must find support in specific life circumstances that would have influenced your client's decision. For example, in *Cojocar v. BC Women's Hospital*<sup>8</sup>, the trial judge accepted the evidence of the plaintiff that her negative experience with the birth of her first

child, coupled with her cultural beliefs unique to her Romanian background, made it clear that the reasonable person in her circumstances would not have accepted the risks associated with the procedure had those risks been properly explained.

Your client's other medical decisions and risk assessments must also be consistent with your client's evidence that he or she would have declined the medical treatment in question. Inconsistencies in your client's story may arise if your client agreed to undertake the same risk, or a more significant risk, in relation to past or subsequent medical treatment, which the client says would have caused him or her to decline the medical treatment at issue had this risk been disclosed. Such inconsistencies cannot be ignored as they will be exploited by defence counsel.

For these reasons, it is critical that you carefully review your client's medical history to find out if your client has consented to (or declined) other medical treatment with similar, or potentially more serious risks. Defence counsel will certainly do so during your client's discovery. Also consider any risks associated with the medical treatment at issue that were disclosed. If those risks were more serious than the undisclosed risk which did occur, this may weigh in favour of the court rejecting your client's evidence, unless a reasonable explanation can be provided. Consider the possible impact of any other risk taking behavior your client may have engaged in, such as smoking, illicit drug use, or undergoing an invasive cosmetic procedure. Canvass any important dates or plans in your client's future that may have impacted his or her decision to either decline or postpone the treatment had he or she been properly informed of the risks, such as a pension vesting, travel plans or work commitments. Any questions or special concerns your client may have raised with the physician or with others is good evidence of your client's unique beliefs, fears, desires or expectations that would have influenced his or her decision. Find out who your client discusses important medical decisions with, and whether or not any discussion took place.

Your client's assertion that he or she would have declined the recommended treatment had the material risks been disclosed will be tested against all of his or her past conduct, circumstances

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and attitudes at the time the decision would have been made, as well as his or her conduct and decisions made with respect to subsequent medical procedures. Ultimately, the more “special circumstances” the plaintiff can point to that would have influenced his or her decision to decline the procedure *at the time* (rather than in hindsight), and the more consistency that can be demonstrated with this position, the more credible his or her evidence will be.

### 3. Constructing the hypothetical dialogue

In applying the modified objective standard of causation, courts will attempt to construct a hypothetical dialogue to reflect the discussion and decision making process that would have taken place had the physician properly disclosed all material risks associated with the medical treatment.<sup>9</sup> By engaging in this process, the court will weigh the various objective and subjective factors to determine whether the reasonable person in the plaintiff’s position would have chosen to proceed with the recommended medical treatment.

On one end of the scale will be the evidence led from the defence regarding the statistical likelihood of a fully informed patient consenting to the recommended medical treatment, as well as any subjective evidence obtained from the plaintiff about the degree of trust and deference the plaintiff affords his or her treating physician. Defence counsel will also lead any evidence from the plaintiff’s past or subsequent conduct demonstrating a willingness to accept the risk at issue, or willingness to accept other similar or more significant risks.

As explained above, in order to tip the balance of probabilities in favour of your client, counsel must present a client who is different from the typical, deferential patient, and who can point to compelling special circumstances existing at the time the decision would have been made that would have swayed him or her to decline the medical treatment. During this part of the analysis it is important to focus on not only the specific risk, but also the consequences of that risk.<sup>10</sup> Consider, for example, the case of a pregnant woman who was not properly informed of the risks, in particular, the risk of uterine rupture, associated with undergoing a trial of labour following a previous caesarian section. The risk of a uterine rupture may not carry with it the same degree of concern as the consequences of that risk, namely, potential brain injury to the baby. It is often the consequences of the risk that will be more likely to invoke the type of fears and concerns that would cause the patient to decline the procedure. Perhaps she has a family member or close friend with a child who has a brain injury and she has witnessed first-hand the challenges and struggles associated with raising such a child, or perhaps she is a single working mother who, because of her life circumstances, was not prepared to take even the slightest risk of assuming the many challenges associated with raising a brain injured child. It is the consequences of a specific risk which will often have the most meaning for patients, and which will provide the most compelling rationale for why the plaintiff would have declined to proceed with the recommended medical treatment.

The hypothetical dialogue should also incorporate a consideration of any alternatives to the medical treatment recommended by the physician. A discussion of all reasonable alternatives to the recommended medical treatment is required in order to meet the standard of disclosure,<sup>11</sup> and is also stipulated as a required element of consent in the *Health Care (Consent) and Care Facility (Admission) Act*.<sup>12</sup> Alternatives may include a different procedure or, alternatively, the same procedure in a different setting, or at a different time. For example, in the case of *Ediger v. Johnston* which was recently heard by the Supreme Court of Canada,<sup>13</sup> one of the issues was that, when obtaining the plaintiff’s consent to proceed with a mid-forceps procedure to deliver the baby, the defendant physician failed to advise the plaintiff of the alternative of postponing the procedure until such time as an anesthetist and operating room staff were available to assist in the event of a fetal bradycardia. A fetal bradycardia is an obstetrical emergency requiring immediate delivery of the baby. In this case, a fetal bradycardia occurred shortly following the forceps attempt, and when the anesthetist was called to attend an emergency caesarian section, it was discovered that he was not immediately available as he was engaged in another surgery. Unfortunately, by the time the baby was delivered by emergency caesarian section, the baby had suffered significant oxygen deprivation causing brain injury. The plaintiff’s evidence was, in part, that had she been advised of the alternative of postponing the procedure until the anesthetist and operating room staff were available, she would have elected this option. Defence counsel, however, argued that the plaintiff failed to prove causation, namely that she failed to prove that if the procedure had been postponed until an anesthetist and operating room staff were available, that the baby could have been delivered in time to avoid brain injury.

In anticipation of these types of arguments from the defence, in working up the case, counsel must carefully investigate whether the risk to the plaintiff would have materialized in the “alternative procedure” scenario, or in the “postponement” scenario, in the same way that it did with the medical treatment which the plaintiff underwent.

### 4. Other considerations

There will be some situations where, regardless of risks involved, it cannot be said that the plaintiff would have declined the recommended treatment. In the strict analysis of these cases, they will fail on the causation branch of the test. However, the failure on the part of the physician to disclose the risks of the procedure, which ultimately materialized, may still have had an adverse effect on the patient which should not be ignored. Two examples highlight these special circumstances.

First, consider a patient who undergoes a dilation and curettage procedure for an unwanted pregnancy. One of the risks associated with this procedure is its failure to successfully terminate the pregnancy. In the case of *Roe v. Dabbs*,<sup>14</sup> the court found that the defendant physician did not disclose the risk of failure of the procedure, with the result that the plaintiff remained unaware of the continuing pregnancy until it was too late

for her to undergo a repeat procedure. The plaintiff sued the defendant physician for, among other things, the costs of raising the child. In the result, the defendant physician was found negligent in the performance of the procedure itself. He alleged however that the plaintiff was 90% responsible for her damages for failing to recognize the signs of her continuing pregnancy within a timeframe which would have allowed her to undergo a repeat procedure. However, the court found that due to the physician's failure to disclose the risk of the procedure failing to terminate the pregnancy, the blame for the delay in detecting the continuing pregnancy lay with him, and effectively undermined his allegation of contributory negligence.

Also consider the circumstance where the disclosure of a material risk would have resulted in the plaintiff simply delaying the medical treatment, rather than declining it. In such a case, a physician's failure to disclose the risk may still have a significant adverse result for the patient. For example, in *Reibl v. Hughes*, the physician failed to inform the patient that there was a risk of paralysis associated with the medical treatment, an internal carotid endarterectomy. The plaintiff was within 18 months of qualifying for his pension benefits, and testified that had he been informed of this risk, he would have delayed the surgery until he had qualified for his pension. As a result of the physician's breach of the standard of disclosure, the plaintiff was successful in claiming, among other things, his lost pension benefits. The losses associated with being deprived of the ability to anticipate or plan for a potential risk occurring can apply to a variety of cases.

Finally, consider the more novel argument that was accepted by the House of Lords in *Chester v. Afshar*.<sup>15</sup> In that case, the plaintiff underwent an operative procedure which carried with it a small risk of serious injury. As a result of the procedure, the plaintiff sustained the very injury from that material risk that her physician had failed to disclose. This case would have failed on a strict analysis of causation because the plaintiff would not have refused to proceed with the operative procedure had she been informed of the risk. However, the majority of the House of Lords emphasized the fundamental importance of the right of a patient to be told of risks and decide to accept or reject medical treatment. Based on this policy consideration, the majority concluded that it was appropriate to narrowly modify the traditional principles to allow compensation for the plaintiff. This approach has not (yet) been adopted by our courts.



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## CONCLUSION

Informed consent cases present unique challenges. In order to succeed with such a case, counsel must establish not only that the client suffered injuries from the materialization of an undisclosed risk, but must also present a client who is an outlier – someone who does not simply yield to the medical wisdom of his or her physician without any independent thought. Counsel must further present a client who, due to his or her unique life circumstances and experiences, would have been particularly adverse to undertaking the particular risk which materialized, had it been disclosed, and would have declined or postponed the medical treatment.

Susanne Raab obtained her law degree from the University of Victoria and was called to the bar in 2000. Susanne's practice focuses on representing individuals and families who have suffered injuries as a result of medical malpractice. Prior to joining Pacific Medical Law, Susanne spent much of her legal career representing physicians in complex medical malpractice actions, with an emphasis on catastrophic infant brain injury cases. Over the course of her career, Susanne has been involved in settling or litigating numerous medical malpractice actions. Susanne has appeared before the Provincial Court and Supreme Court of British Columbia, as well as the Supreme Court of Canada. Susanne is an active member of TLABC, sitting on both the seminar planning committee and the association's board of governors. She is also a member of the board of directors of the Cerebral Palsy Association of British Columbia, and is actively involved in advocating for individuals living with disabilities.

- 1 The informed consent issue was successfully argued at the trial level in both *Cojocaru v. BC Women's Hospital*, 2009 BCSC 494, and *Ediger v. Johnston*, 2009 BCSC 386. Both of those cases were overturned by the BC Court of Appeal, and have since been heard by the Supreme Court of Canada. Reasons for judgment remain pending at the time of submission of this paper. Also note the case *Sadlowski v. Yeung*, 2008 BCSC 456, wherein the physician was found negligent for failing to obtain the informed consent of the plaintiff prior to performing a hysterectomy. The case turned on the fact that the defendant physician did not take reasonable steps to ensure the plaintiff understood her medical condition, such that the plaintiff believed she had cancer, which was not the case.
- 2 *Reibl v. Hughes*, [1980] SCJ No. 105, *Arndt v. Smith*, [1997] 2 SCR 539
- 3 *Diack v. Bardsley*, 1983 CanLii 541 (BC SC)
- 4 *Reibl v. Hughes, supra, Arndt v. Smith, supra*
- 5 *Arndt v. Smith; supra.*
- 6 *Diack v. Bardsley, supra*, at para 47.
- 7 *Faryna v. Chorny*, [1951] BCJ No. 152 (BCCA) at p. 4
- 8 2009 BCSC 494 (under appeal at the SCC)
- 9 *Diack v. Bardsley, supra.*
- 10 *Berezowski-Aitken v. McGregor*, [1998] MJ No. 180, upheld on appeal at 1999 CanLii 18754
- 11 *Van Mol v. Ashmore*, 1999 BCCA 6
- 12 RSBC 1996, c. 181, s. 6
- 13 2011 BCCA 253
- 14 2004 BCSC 957
- 15 [2004] UKHL 41

