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Commentary

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Consent to Medical Treatment in Canada

Case Comment

CONSENT TO MEDICAL TREATMENT IN CANADA

By ELLEN PICARD*

In the recent case of *Reibl* v. *Hughes*,[1] the Chief Justice of Canada has prescribed some strong medicine to improve the doctor-patient relationship. His judgment raises some important questions: Is there a problem with the legal relationships of doctors and patients? Will the solution set out by the Supreme Court of Canada be helpful? What might the long-term effects of the solution be?

An uneasiness with regard to the state of the doctor-patient relationship has manifested itself in many ways in Canada in recent years. Patients are inquiring about their rights, and this has resulted in publications, seminars, movies and television programmes dealing with the topic.[2] Doctors are finding their traditional roles challenged by patients and other health care professionals. There has been a recent eruption of reported cases dealing with the liability of doctors.[3] Consequently, judges and lawyers have been reviewing problems within the doctor-patient relationship. These judgments have given academics the opportunity to examine the jurisprudence and make comparisons and criticisms.

A review of these cases reveals that a breakdown in the doctor-patient relationship often occurs when there is little or no communication between

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1 (1980), 33 N.R. 361, 14 C.C.L.T. 1 (S.C.C.).

2 See Rozovsky, *The Canadian Patient's Book of Rights* (Toronto: Doubleday, 1980); Sharpe, *Informed Consent* (Toronto: Butterworths, 1979).

3 *Hopp* v. *Lepp*, [1980] 4 W.W.R. 645, 22 A.R. 361, 13 C.C.L.T. 66 (S.C.C.); *Dendaas (Tylor)* v. *Yackel*, [1980] 5 W.W.R. 727, 12 C.C.L.T. 229 (B.C.S.C.); *Kelly* v. *Hazlett* (1976), 15 O.R. (2d) 290, 75 D.L.R. (3d) 536, 1 C.C.L.T. 1 (H.C.); *Allan* v. *New Mount Sinai Hosp.* (1980), 11 C.C.L.T. 229 (Ont. H.C.); *Cryderman* v. *Ringrose* (1978), 89 D.L.R. (3d) 32, [1978] 3 W.W.R. 481 (Alta. C.A.); *Zimmer* v. *Ringrose* (1978), 89 D.L.R. (3d) 646, 13 A.R. 181 (S.C.); *Petty* v. *MacKay* (1979), 14 B.C.L.R. 382, 10 C.C.L.T. 85 (S.C.); *Strachan* v. *Simpson*, [1979] 5 W.W.R. 315, 10 C.C.L.T. 145 (B.C.S.C.); *Holmes* v. *Bd. of Hosp. Trustees City of London* (1978), 17 O.R. (2d) 626, 5 C.C.L.T. 1 (H.C.); *Workman* v. *Grier* (1978), 90 D.L.R. (3d) 676 (Man. C.A.); *Lafleur* v. *Cornelis* (1979), 28 N.B.R. 569 (T.D.); *MacKinnon* v. *Ignacio* (1978), 29 N.S.R. (2d) 656 (S.C.).

the parties. It is a sad irony that the circumstances of each party militate against clear, thorough communication in a relationship of serious consequence. The doctor is likely balancing commitments to other patients, colleagues and committees. His medical education has prepared him to treat the disease but not necessarily the person, and the day-to-day demands on him may make getting to know the patient and his concerns seem impossible or unimportant. Meanwhile, the patient is anxious and quite possibly ill. He may even resent his state of health. In many cases relatives or friends are attempting to influence him and he sees the doctor in control of his future health care. These factors may affect the patient's perceptions and judgments and will certainly affect his ability to communicate well with the doctor. He may not know what to ask or to tell the doctor and if he overcomes his reluctance to ask he may not persist until he gets an answer he can understand. Thus, the relationship is vulnerable to the "you never told me" syndrome and a consequential lawsuit. The problem of the parties is then put before the courts.

Perhaps the courts can assist in improving the health of the doctor-patient relationship by establishing certain standards the parties must meet in their communications. It is submitted that such standards should be assessed by reference to a few basic criteria. Neither party should be unduly favoured or disadvantaged by the standards set for him and, if possible, there should be a balance. The expectations of the law must be as clear and precise as possible and thus any "tests" must be in substance what they promise in name. Finally, so far as possible, the general principles of tort law should be applicable unless compelling reasons exist for a departure from them. The Supreme Court of Canada set out certain standards recently through the judgment of Chief Justice Laskin in *Reibl* v. *Hughes.*

The facts of the case are simple. The patient Reibl was an intelligent, forty-four year old man whose command of English was limited. His complaint was of severe headaches. Tests showed an arterial occlusion that was reducing blood flow to the brain. This condition made Reibl vulnerable to a stroke or even death; risks that were also attendant on any elective surgery to correct the situation. Hughes was the neurosurgeon who operated on Reibl. He had previously done sixty to seventy such operations. During surgery or immediately following it, Reibl suffered a massive stroke that left him paralyzed on the right side of his body and impotent. The issue in the three courts that heard the case was whether Dr. Hughes had properly explained the risks of surgery to Mr. Reibl. Mr. Justice Haines at trial[4] held he had not and based liability in battery and negligence. The Ontario Court of Appeal,[5] by a majority, ordered a new trial but indicated a preference for negligence as the proper cause of action and for an objective test in regard to the causation issue.

A careful and thorough reading of the facts indicates that there was very poor communication between Hughes and Reibl. Reibl was told only

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[4] (1977), 16 O.R. (2d) 306, 78 D.L.R. 35 (H.C.).

[5] (1978), 21 O.R. (2d) 14, 89 D.L.R. 112, 6 C.C.L.T. 227 (C.A.).

that he would be better off having the operation. He was left under the erroneous impression that the surgery would relieve his complaint, the headaches. The situation was very similar to that in a number of earlier cases.[6] The doctor volunteers some information about the patient's condition and suggests a course of action, explaining few if any risks. The patient is, or feels he is, put to an election to take it or leave it. He takes it and suffers from a risk that materializes. Chief Justice Laskin chose to illustrate this breakdown in communication in a very effective way: thirty-three of the fifty-five pages of his judgment contain the questions and answers of the parties on the issue of the disclosure of risks.

Chief Justice Laskin concluded that the trial judgment should be restored. Hughes had not met the standard expected of him in disclosing the risks of surgery to Reibl. Reibl, measured as a reasonable person, succeeded in proving that on a balance of probabilities he would not have proceeded with the surgery if he had been informed of the risks. Hughes was liable in negligence but not in battery.

The Supreme Court of Canada has made major changes in the law through this case. It has limited the scope of the battery action, established full disclosure as the appropriate standard of disclosure for the doctor and rendered the objective test the proper one to apply to the patient when settling the issue of causation in the negligence action.

THE APPROPRIATE CAUSE OF ACTION: BATTERY OR NEGLIGENCE?

Chief Justice Laskin has dramatically curtailed the scope of the battery action where the patient alleges he had not given an informed consent.

> In my opinion, actions of battery in respect of surgical or other medical treatment should be confined to cases where surgery or treatment has been performed or given to which there has been no consent at all or where, emergency situations aside, surgery or treatment has been performed or given beyond that to which there was consent.[7]

He elaborated further:

> I can appreciate the temptation to say that the genuineness of consent to medical treatment depends on proper disclosure of the risks which it entails, but in my view unless there has been misrepresentation or fraud to secure consent to the treatment, failure to disclose the attendant risks, however serious, should go to negligence rather than to battery.[8]

Prior to this decision a Canadian patient could sue in battery or negligence or both where the allegation was that he had not been informed of a risk of medical treatment. Indeed, the majority of reported cases were brought in battery.[9] Although Chief Justice Laskin speaks of a confusion of battery and

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[6] See, *e.g.*, *Dendaas (Tylor)* v. *Yackel*, *supra* note 3.

[7] *Supra* note 1, at 370 (N.R.), 13 (C.C.L.T.).

[8] *Id.* at 371 (N.R.), 13-14 (C.C.L.T.).

[9] Picard, "The Tempest of Informed Consent" in Klar, ed., *Studies in Canadian Tort Law* (Toronto: Butterworths, 1977) at 129.

negligence and blames that confusion on the term "informed consent,"[10] there is no evidence that the absence of any restriction on the battery action or any resultant confusion caused great hardship to doctors or patients or even lawyers or judges in Canada. As the Chief Justice recognized,[11] the battery action has definite advantages for the patient over the negligence action. The patient does not have to prove causation or damage, nor does he have to find medical experts to testify on the issue of liability. The doctor carries the onus of proving consent to the treatment. The focus of the battery action against a doctor is the protection of an individual's right to be free from unauthorized touching, whereas the focus of the negligence action is the scope of the duty of care owed by a doctor to a patient. This sense of the battery action as being an appropriate means of dealing with aggressive, anti-social behaviour and not with the doctor-patient relationship, moved the courts of the United States to abandon battery for negligence as the proper cause of action where a doctor was the defendant.[12]

In 1976 a Canadian judge aware of this change in American jurisprudence put forward an innovative but complex suggestion for dealing with the two possible causes of action. In *Kelly* v. *Hazlett*[13] Mr. Justice Morden suggested that battery would be the appropriate action where there was no informed consent as to the basic nature and character of the medical treatment, but that negligence would be the action where a collateral risk was not explained to the patient. While in *Reibl* v. *Hughes*[14] Mr. Justice Haines, at trial, approved of and followed this approach in holding Dr. Hughes liable for both battery and negligence, the Court of Appeal was persuaded by American authority that battery was not a proper basis for liability. Mr. Justice Brooke said:

> In such cases as this, the notion of battery seems quite inappropriate. In the circumstances when the evidence is consistent only with the fact that the doctor has 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. The finding then of battery cannot stand.[15]

Chief Justice Laskin took a careful look at Mr. Justice Morden's proposed dichotomy but found it to be a difficult distinction to apply and one incompatible with the elements of battery.[16] Although the Chief Justice agreed with the Court of Appeal regarding the restriction of the battery action and referred to misrepresentation and fraud, he made no reference to the relevance of assessing the doctor's good faith.

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[10] *Supra* note 1, at 368-69 (N.R.), 11 (C.C.L.T.).

[11] *Id.* at 370 (N.R.), 12 (C.C.L.T.).

[12] Picard, *supra* note 9, at 130-31.

[13] *Supra* note 3.

[14] *Supra* note 4.

[15] *Supra* note 5, at 29-30 (O.R.), 128 (D.L.R.), 246-47 (C.C.L.T.).

[16] *Supra* note 1, at 370 (N.R.), 12 (C.C.L.T.).

Thus, in 1981 our jurisprudence with regard to the proper cause of action when there is no informed consent is virtually the same as that of the United States. The battery action has been partially withdrawn from patients.

THE APPROPRIATE STANDARD OF DISCLOSURE: PROFESSIONAL OR FULL?

In *Reibl* v. *Hughes* Chief Justice Laskin stated that the relationship between the doctor and his patient gives rise to a duty to disclose all material risks of a procedure. He then referred to his judgment in *Hopp* v. *Lepp*[17] for a description of the breadth of the information that should be conveyed to the patient. In summary, the doctor should:

1) Answer specific questions about risks; and
2) disclose voluntarily about the operation,
   a) the nature,
   b) the gravity,
   c) any material risks (which includes risks that are a mere possibility but that carry serious consequences), and
   d) any special or unusual risks.[18]

In order to determine the depth and detail of this "voluntary disclosure," a doctor must have reference to a standard. There are two standards available: the professional standard and the full disclosure standard.

The professional disclosure standard depends upon the medical profession itself and thus is similar to the standard by which a doctor would be measured on the issue of his negligence in the care or treatment of a patient. The information to be given to the patient, including the risks to be disclosed, is a matter of medical judgment based on the standard of what other doctors would reveal about the procedure in question. The professional disclosure standard has been the one applied quite consistently in Canada,[19] although full disclosure was required in cases of experimental procedure.[20] Indeed, in *Reibl* v. *Hughes* itself, both at trial and in the Court of Appeal, the professional disclosure standard was used. At trial, for example, Mr. Justice Haines said: "in the circumstances of this case, the duty of the surgeon as defined by accepted general practice in the neurosurgical community was to explain to the patient. . . ."[21]

By contrast, the full disclosure standard uses as its reference point not the medical community but the reasonable patient.[22] This standard is accepted in some of the United States and was set out in *Salgo* v. *Leland*

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[17] *Supra* note 3, at 660 (W.W.R.), 377 (A.R.), 87 (C.C.L.T.).

[18] *Supra* note 1, at 364 (N.R.), 6 (C.C.L.T.).

[19] Picard, *supra* note 9, at 139.

[20] *Halushka* v. *Univ. of Sask.* (1965), 53 D.L.R. (2d) 436, 52 W.W.R. 608 (Sask. C.A.).

[21] *Supra* note 4, at 313 (O.R.), 43 (D.L.R.).

[22] The Saskatchewan Court of Appeal described the test as the following: "The subject of medical experimentation is entitled to a full and frank disclosure of all facts, probabilities and opinions which a reasonable man might be expected to consider before giving his consent." *Supra* note 20, at 444 (D.L.R.), 617 (W.W.R.).

Stanford Jr. University Board of Trustees[23] and other American cases referred to by Chief Justice Laskin such as *Canterbury* v. *Spence*[24] and *Cobbs* v. *Grant*.[25] It requires disclosure of all information material to a reasonable person in the position of the patient.[26] The rationale for the full disclosure standard is that "disclosure is based on the patient's right to determine what should be done with his body. Such right should not be at the disposal of the medical community."[27]

In *Reibl* v. *Hughes*, Chief Justice Laskin rejected the professional disclosure standard:

> 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.[28]

Although he appreciated that by doing this he was rejecting the standard similar to that used to measure the doctor's professional activities, he felt justified in making the distinction:

> 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.[29]

Although he did not expressly use the term "full disclosure," the Chief Justice of Canada, by the words of his judgment and the authorities cited must be taken to have accepted the full disclosure standard as being the proper one for a doctor to follow in deciding the scope of his disclosure of risks to a patient.

This full disclosure standard, as the Chief Justice describes it, requires reference to two sources:

a) the patient and what he deems to be relevant to his decision; and

b) medical knowledge and material risks recognized therein.

Laskin C.J.C. set out these components of his standard by stating that, "What the doctor knows or should know that the particular patients deems relevant to a decision whether to undergo prescribed treatment goes equally to his duty of disclosure as do the material risks recognized as a matter of required medical knowledge."[30]

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[23] 154 Cal. App. 2d 560, 317 P. 2d 170 (1957).

[24] 464 F. 2d 772 (D.C. Cir. 1972), *cert. denied* 409 U.S. 1064.

[25] 8 Cal. 3d 229, 502 P. 2d 1 (1972).

[26] Comment, *Informed Consent—A Proposed Standard for Medical Disclosure* (1973), 48 N.Y.U.L. Rev. 548; see also Sharpe, *supra* note 2, at 39.

[27] *Zeleznik* v. *Jewish Chronic Disease Hosp.* (1975), 366 N.Y.S. 2d 163 at 205. Note that the *raison d'être* of the battery action is very similar.

[28] *Supra* note 1, at 374 (N.R.), 16-17 (C.C.L.T.).

[29] *Id.* at 374 (N.R.), 17 (C.C.L.T.).

[30] *Id.* at 373 (N.R.), 16 (C.C.L.T.).

On the issue of relevant evidence, he spoke of the role of the medical expert:

> 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 evidence alone.[31]

The role of the patient's evidence was also considered:

> The materiality of non-disclosure of certain risks to an informed decision is a matter for the trier of fact, a matter on which there would, in all likelihood, be medical evidence but also other evidence, including evidence from the patient or from members of his family. It is, of course, possible that a particular patient may waive aside any question of risks and be quite prepared to submit to the surgery or treatment, whatever they be. Such a situation presents no difficulty. Again, it may be the case that a particular patient may, because of emotional factors, be unable to cope with facts relevant to recommended surgery or treatment and the doctor may, in such a case, be justified in withholding or generalizing information as to which he would otherwise be required to be more specific.[32]

The full disclosure standard described and applied by the Chief Justice has two noteworthy attributes when contrasted with the full disclosure standard of the United States. The first is that Laskin C.J.C. seems to require reference to the medical profession for evidence of the risks and their materiality. This is to be contrasted with the position in the United States, where it is acknowledged that lay witness testimony may be enough. Chief Justice Laskin supported his position with a reference to an American author[33] who postulated that "even *Canterbury* specifically notes that expert testimony will still be required, in all but the clearest instances."[34] Yet there are other authorities who say that *Cobbs* v. *Grant*[35] (which followed *Canterbury* v. *Spence*[36]) made medical evidence unnecessary in establishing the scope of the doctor's duty to disclose risks: "The consequence of this ruling is that expert medical testimony is no longer necessary to establish the physician's duty to disclose risks of death or serious bodily harm—that duty has been set by law."[37]

There is a second difference between Chief Justice Laskin's standard of full disclosure and its American counterpart. Whereas the full disclosure standard as applied in the United States refers to the patient as a reasonable person, an objective evaluation, Chief Justice Laskin *seems* to use a subjective evaluation. He referred to the evidence of "the patient" and "his family" and evidence about emotional factors of "the particular patient."[38] The objective or subjective measurement of the patient with regard to the scope of

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[31] *Id.* at 374 (N.R.), 17 (C.C.L.T.).

[32] *Id.*

[33] *Id.*

[34] Comment, *New Trends in Informed Consent* (1975), 54 Neb. L. Rev. 66 at 90.

[35] *Supra* note 25.

[36] *Supra* note 24.

[37] Bamberg, *Informed Consent After Cobbs—Has the Patient Been Forgotten?* (1973), 10 San Diego L. Rev. 913 at 922.

[38] *Supra* note 1, at 374 (N.R.), 17 (C.C.L.T.).

disclosure should not be confused with the use of a subjective or objective test to decide the causation issue of the negligence action. It is important to realize that it was a subjective test that was applied in Canada in analyzing the patient with regard to both the proper scope of disclosure and the causation issue.[39] This tended to merge the assessment of the patient on the separate issues. While the Chief Justice seemed repulsed by a subjective test with regard to causation he said nothing specifically about the alternatives with regard to the issue of the scope of disclosure. Indeed, his acceptance as a ground of judgment against Hughes that Reibl was under a misapprehension about the value of the operation (*i.e.*, it did not relieve headaches) points to the use of a very subjective approach.[40] It is hard to see how the patient's particular misapprehension can be at all relevant if the doctor is only to disclose what would be material to a reasonable patient.

In summary, while the Chief Justice has decided that there must be a full disclosure of the risks of a procedure to a patient, he seems to have built into the Canadian version of that standard a requirement that there be expert evidence from the medical profession and a suggestion that there be a personal and thus rather subjective assessment of the patient before the issue of disclosure is decided for or against the doctor.

THE APPROPRIATE TEST FOR CAUSATION: SUBJECTIVE OR OBJECTIVE?

In any negligence action the plaintiff has the onus of proving the issue of causation. Thus, in an action by a patient alleging negligence for failing to disclose a risk, the patient must prove that the failure by the doctor was a cause-in-fact and a proximate cause of the patient's injuries. The patient has a heavy burden here. He has to prove a negative: that if he had known of the risk he would not have consented to the treatment that caused his injury.[41] The test applied in the provincial courts in Canada until Mr. Justice Laskin's judgment had been a subjective one,[42] as it was in the United States prior to *Canterbury* v. *Spence*[43] and *Cobbs* v. *Grant*.[44] The inquiry was: What would *this* patient have done if he had been told of the risk in issue? By contrast the reasonable person test would ask what the reasonable person would have done if he had been told of the risk in issue.

Mr. Justice Brooke in the Court of Appeal suggested a change to a combined objective-subjective test.

> In actions for negligence our Courts have adopted a subjective test.... The experience [of *Cobbs* v. *Grant* and *Canterbury* v. *Spence*] should not be ignored as those Courts were driven to this conclusion because justice could not be done

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[39] Picard, *supra* note 9, at 141-42.

[40] See Somerville, *Consent to Medical Care* (Ottawa: Minister of Supply and Services, 1979) at 25 wherein an "apparent subjective" test of comprehension, requiring the doctor to ensure the particular patient understood the risks, is suggested.

[41] *Supra* note 37, at 924.

[42] See, *e.g.*, *Strachan* v. *Simpson*, *supra* note 3, at 344 (W.W.R.), 182 (C.C.L.T.).

[43] *Supra* note 24.

[44] *Supra* note 25.

> between the parties other than by such an objective approach. It is never too late in the day to change. I think a safe practice here is to test the plaintiff's case objectively before proceeding to consider it subjectively.[45]

Brooke J. went on to show how the objective-subjective test should be used in the case: "In other words, if the plaintiff had been advised of his position in the manner described by Dr. Elgie whose evidence apparently the learned trial judge has accepted would the plaintiff or a reasonably prudent patient have rejected the recommendation and declined the treatment?"[46]

Laskin C.J.C. doubted if the combined test would "solve the problem,"[47] and went on to reject the subjective test in even more emphatic terms: "If Canadian case law has so far proceeded on a subjective test of causation, it is in Courts other than this one.... The matter is *res integra* here."[48] He took this position because he was concerned about exposing the doctor to "the patient's hindsight and bitterness."[49] The Chief Justice expressed grave reservations about a patient's evidence in stating that, "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 the accompanying risks."[50]

Another concern was predicated on negligence now being the only action:

> Since liability rests only in negligence in a failure to disclose material risks, the issue of causation would be in the patient's hands on a subjective test, and would, if his evidence was accepted, result inevitably in liability unless, of course, there was a finding that there was no breach of the duty of disclosure.[51]

It is submitted that the Chief Justice's conclusions are based on an unwarranted pessimism about the ability of the legal process to deal with evidence. The patient's attitudes, demeanour and his story are tested by examination-for-discovery and, at trial, by the adversary process. The trial judge can assess the credibility of the patient and his testimony. Surely the doctor deserves no more and no less protection than a defendant in, for example, a negligent misstatement action.

Yet a careful reading of Chief Justice Laskin's description of the objective test he would apply drives one to the conclusion that in fact he was using the combined objective-subjective approach suggested by Mr. Justice Brooke. Consider the following from his judgment:

> I think it is the safer course on the issue of causation to consider objectively how far the balance in the risks of surgery or no surgery is in favour of undergoing surgery. The failure of proper disclosure pro and con becomes therefore very material. And so too are any special considerations affecting the particular patient.

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[45] *Supra* note 5, at 27 (O.R.), 125 (D.L.R.), 243 (C.C.L.T.).

[46] *Id.* at 27 (O.R.), 125 (D.L.R.), 244 (C.C.L.T.).

[47] *Supra* note 1, at 377 (N.R.), 21 (C.C.L.T.).

[48] *Id.* at 376 (N.R.), 19-20 (C.C.L.T.).

[49] *Id.* The phrase comes from an American author: Comment, *supra* note 26, at 550.

[50] *Supra* note 1, at 377 (N.R.), 21 (C.C.L.T.).

[51] *Id.* at 378 (N.R.), 22 (C.C.L.T.).

> For example, the patient may have asked specific questions which were either brushed aside or were not fully answered or were answered wrongly. In the present case, the anticipation of a full pension would be a special consideration, and, while it would have to be viewed objectively, it emerges from the patient's particular circumstances. So too, other aspects of the objective standard would have to be geared to what the average prudent person, the reasonable person in the patient's particular position, would agree to or not agree to, if all material and special risks of going ahead with the surgery or foregoing it were made known to him. Far from making the patient's own testimony irrelevant, it is essential to his case that he put his own position forward.[52]

The Chief Justice added:

> In saying that the test is based on the decision that a reasonable person in the patient's position would have made, I should make it clear that the patient's particular concerns must also be reasonably based; otherwise, there would be more subjectivity than would be warranted under an objective test. Thus, for example, fears which are not related to the material risks which should have been but were not disclosed would not be causative factors. However, economic considerations could reasonably go to causation where, for example, the loss of an eye as a result of non-disclosure of a material risk brings about the loss of a job for which good eyesight is required. *In short, although account must be taken of a patient's particular position, a position which will vary with the patient, it must be objectively assessed in terms of reasonableness.*[53] [Emphasis added.]

Finally, the Chief Justice showed in his treatment of a thorny point that he was not using a purely objective test. The point was whether a reasonable patient could refuse medically sound treatment recommended by a doctor: "The patient's particular situation and the degree to which the risks of surgery or no surgery are balanced would reduce the force, on an objective appraisal, of the surgeon's recommendation."[54]

In other words, apply an objective test but with reference to the particular patient involved.

The reflection of an American author about the subjective test should be heeded in Canada:

> If the patient had been informed of risks inherent in the course of treatment when it was initially proposed, he would have had every right to have refused, even if such refusal had been irrational by objective standards. [Since the patient bears the entire risk of non-negligent injury and is concerned with his own interests as no other person can be, it is only fair to allow him to choose between accepting or rejecting the hazards of a proposed treatment *even if his choice* is irrational.] But, not having been informed of those risks, whatever subjective fears and hopes the plaintiff may have had for refusing treatment are not given an opportunity to function. If the patient is informed of the risks of treatment, he can refuse for any reason he chooses; if he is not informed of the risks of treatment, those reasons become irrelevant. The patient's subjective determination of what will be done with his body is only taken from him and given to the mythical reasonable man when the physician, not the patient, has breached a duty imposed upon him by law.[55]

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[52] *Id.* at 377-78 (N.R.), 21 (C.C.L.T.).

[53] *Id.* at 378-79 (N.R.), 22 (C.C.L.T.).

[54] *Id.* at 378 (N.R.), 21 (C.C.L.T.).

[55] Bamberg, *supra* note 37, at 925-26.

The combined objective-subjective test is to be preferred over the subjective test because it has a measure of fairness to each party. It may serve to protect the doctor from a patient's hindsight but also allows the patient input where the issue is a decision he faces about his body and his future.

CONCLUSION

Chief Justice Laskin seems to have been moved to improve the doctor-patient relationship by changing the law of Canada. How well does this new law fare when measured by the criteria of fairness, precision, lucidity and fidelity to tort law principles?

The restriction in the scope of the battery action favours doctors because the battery action has advantages over the negligence action for the patient. This new narrow definition of battery in medical cases has the effect of creating a special category of battery. The terms "battery" and "consent" thus have special meanings where the defendant is a doctor. The reason articulated for the change was that a failure to disclose a risk is not a test of validity of consent; that this statement of Mr. Justice Cardozo should not be taken "beyond the compass of its words": "[E]very human being of adult years and sound mind has a right to determine what shall be done with his body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages. . . ."[56] By this variation in the law, the Canadian patient has suffered a reduction in an ancient and basic human right.[57]

The acceptance of Chief Justice Laskin's version of full disclosure as the appropriate standard appears to favour the patient. Theoretically, by reference to both medical knowledge and the particular patient and with the specificity in the guidelines set out by the Chief Justice, the patient should get a thorough and helpful disclosure of risks. Yet this new law, heavily patterned after that in the United States, might lead to similar practices here as there. The easiest and least time-consuming way for a doctor to meet the standard is to disclose *all* risks. This might well be the advice given to doctors by their lawyers. The consequence of such a full disclosure may be that patients will refuse necessary medical treatment. One Canadian author, after reviewing *Reibl* v. *Hughes*, has suggested very practical and prudent steps for the doctor such as standardizing procedures and keeping written records to ensure full disclosure.[58] Both are practices in the United States, as are handing a written list of a procedure's risks to a patient and requiring an acknowledgement of its receipt.

Once again, we have a standard unique to the medical lawsuit. The standard of disclosure is no longer similar to that used in general negligence

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[56] *Schloendorf* v. *Soc. of N.Y. Hosp.*, 211 N.Y. 125 at 129, 105 N.E. 92 at 93 (1914).

[57] For a comment reflecting a concern for the patient in the United States, see Louisell and Williams, *Medical Malpractice* (New York: Matthew Bender, 1979) at 594-58—594-59.

[58] Rodgers-Magnet, *Recent Developments in the Doctrine of Informed Consent to Medical Treatment* (1981), 14 C.C.L.T. 61 at 77.

law in Canada, but neither is it the same as the full disclosure test used in the United States. Such a dramatic departure from the existing law might be justified if it did indeed improve the doctor-patient relationship. The Canadian full disclosure test seems, however, to have the potential of confusing the doctor and needlessly frightening the patient.

The Chief Justice has advocated the change from a subjective to an objective test to decide the issue of causation. While this test is potentially harsh for the patient, this effect is perhaps mitigated where there is a combined objective-subjective assessment such as that applied by Laskin C.J.C. A problem with this change in the law is that the test for causation must, as in the judgment in *Reibl* v. *Hughes*, be expressed as objective although it is, in reality, partially subjective. In this respect the new law is consistent with negligence law in general, wherein the test of the reasonable person in the circumstances is an objective test, but it has a subjective element because of its reference to "the circumstances."

In summary, the patient seems to come out the loser from the changes in the law effected by the Supreme Court of Canada in *Reibl* v. *Hughes*. Yet Reibl was successful in his lawsuit. These conclusions are reconcilable if one accepts that the Chief Justice of Canada was attempting to improve the doctor-patient relationship. This most worthy goal should be kept paramount as this case is interpreted by lawyers and judges in the years ahead.