Informed Consent in Canada: An Empirical Study

Gerald B. Robertson
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Abstract
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This article presents the results of an empirical study conducted in 1982 concerning informed consent and medical practice in Canada. The aims of the study were three-fold, namely:

1) To assess the impact on medical practice of the Supreme Court of Canada decision in Reibl v. Hughes;¹
2) To assess Canadian doctors' own perceptions of how they conduct their practice with regard to informed consent; and,
3) To assess the views of Canadian doctors on issues relevant to informed consent.

Although a number of empirical studies concerning informed consent have been conducted in the United States,² no such study appears to

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have been carried out in Canada.

Since the main goal was to assess the impact of a legal decision on medical practice, the study is focused on the aspect of informed consent with which the law is primarily concerned, namely disclosure of risks to patients. Thus the present study is more a measure of the extent of disclosure of risks, than of the extent to which doctors involve patients in decisions affecting their care and treatment.

I. THE DECISION IN REIBL V. HUGHES

From the point of view of medical practice, the significance of Reibl v. Hughes lies in its enunciation of the test to be applied in determining what information a doctor is required to disclose to his patient. Of particular importance is the apparent adoption of a "reasonable patient" test in preference to the traditional "reasonable doctor" test.

Doctors must now take into consideration what they know or ought to know their patients would want to be told. The theoretical importance of Reibl v. Hughes has led several commentators to assume that the decision will have an equivalent practical importance. For example, the General Counsel to the Canadian Medical Protective Association has observed that: "No legal event in the last fifty years has so disturbed the practice of medicine as did the decision of the Supreme Court of Canada in Reibl v. Hughes." In a similar vein, Linden J. has remarked that: "The ultimate effect of [Reibl v. Hughes] should be medical practitioners who are even more sensitive, concerned and humane than they now are. Moreover, the doctor-patient relationship should be improved greatly by the better communication between doctors and their patients." As will be seen below, the results of the empirical

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* "[T]he law's near-exclusive focus on the disclosure of risks - which has often led to standardized forms and recitations of risks, but not to a full dialogue with patients - has had an unfortunate impact on the very objectives the informed consent process is designed to achieve. Further, this preoccupation with risks is undoubtedly responsible for much of the medical community's skepticism about informed consent." Making Health Care Decisions, supra note 2, vol. 1 at 69; see also Katz, Informed Consent - A Fairy Tale?: Law's Vision (1977), 39 U. Pa. L. Rev. 137.


* White v. Turner, supra note 4, at 290.
study cast considerable doubt on the validity of these assertions.

II. RESEARCH METHODOLOGY

A. Sample Selection and Questionnaire Design

The study consisted of a seven-page questionnaire which was sent in June 1982 to 1,000 surgeons throughout Canada. The sample was restricted to those engaged in surgical practice, given that the issue of disclosure of risks to patients is generally more relevant to surgeons than to general practitioners. Names were chosen by random selection from the Canadian Medical Directory. The study was further confined to issues involving patients having capacity to give valid consent; the questionnaire therefore defined the term “patient” as meaning a conscious, sane, adult patient. Paediatric surgeons were accordingly excluded from the sample.

The first part of the questionnaire obtained demographic information from which it was possible to group and compare responses on the basis of the following variables - age, type of practice (for example, sole practitioner, partnership), size of community, specialist field, and province. The percentage of surgeons in each group is shown in the following table.

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TABLE A
Analysis of Respondents (n=620) According to Age, Type of Practice, Size of Community, Specialist Field, and Province

<table>
<thead>
<tr>
<th>Age</th>
<th>Specialist Field</th>
<th>Age</th>
<th>Specialist Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>1%</td>
<td>General Surgery</td>
<td>40%</td>
</tr>
<tr>
<td>30-39</td>
<td>21%</td>
<td>Orthopaedic</td>
<td>16%</td>
</tr>
<tr>
<td>40-49</td>
<td>35%</td>
<td>Urology</td>
<td>8%</td>
</tr>
<tr>
<td>50-59</td>
<td>31%</td>
<td>ENT</td>
<td>9%</td>
</tr>
<tr>
<td>60+</td>
<td>12%</td>
<td>Ophthalmology</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neurosurgery</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plastic Surgery</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cardio/Vascular</td>
<td>4%</td>
</tr>
</tbody>
</table>

Type of Practice

<table>
<thead>
<tr>
<th>Single</th>
<th>61%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnership</td>
<td>33%</td>
</tr>
<tr>
<td>Other</td>
<td>6%</td>
</tr>
</tbody>
</table>

Size of Community

<table>
<thead>
<tr>
<th>Less than 25,000</th>
<th>8%</th>
</tr>
</thead>
<tbody>
<tr>
<td>25,000-100,000</td>
<td>20%</td>
</tr>
<tr>
<td>100,011-300,000</td>
<td>24%</td>
</tr>
<tr>
<td>More than 300,000</td>
<td>48%</td>
</tr>
</tbody>
</table>

Province

| British Columbia | 15%       |
| Alberta         | 8%        |
| Saskatchewan    | 5%        |
| Manitoba        | 4%        |
| Ontario         | 34%       |
| Quebec          | 26%       |
| New Brunswick   | 3%        |
| Nova Scotia     | 4%        |
| Newfoundland & P.E.I. | 1% |

There were some, but not many, significant differences in answers within these groups, and these will be noted below.

B. Response Rate and Bias

Six hundred and twenty (620) completed questionnaires were returned, representing a response rate of sixty-five percent. This relatively high response rate achieved primarily by means of two follow-up letters sent to those who did not initially respond, reduces the chance of non-response bias, that is, the possibility that those who did

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* The initial sample of 1000 was reduced to 960 by excluding questionnaires returned by those no longer engaged in surgical practice or by those engaged in paediatric surgery; these respondents were considered to fall outside the scope of the sample (see Hoinville et al., id. at 71). Thus 620 completed questionnaires were returned out of a total of 960, representing a response rate of 65%.

* Two recent studies in the United States (Rosoff, supra note 2, and Faden et al., supra note 2) had response rates of 24% and 34% respectively.
not respond would have answered significantly differently from those who did respond. The only characteristic which was known about those who did not respond was the province in which they practised. Analysis using this information revealed no evidence of non-response bias. In other words, the response rate, perhaps unexpectedly, was approximately the same in all the provinces.

Given its nature, however, the study inevitably involves an element of non-response bias. It is reasonable to assume that those who took the trouble to respond to the questionnaire were more interested in its subject matter than those who did not. Those with an interest in informed consent are more likely to have heard of Reibl v. Hughes and are possibly more likely to disclose information to their patients. Thus this study probably exaggerates the extent to which Canadian surgeons are aware of the Supreme Court’s decision, and the extent to which they disclose information to their patients. This is accentuated by the possibility that certain answers were perceived by some respondents to be “acceptable”. Thus, there may have been a reluctance on the part of some respondents to admit the withholding of information from patients or of being unaware of the decision in Reibl v. Hughes. Once again this leads to an exaggeration of the impact of the decision and the extent of disclosure of information to patients.

III. THE IMPACT OF REIBL V. HUGHES

A. Awareness of the Decision

To suggest that a judicial decision will have an impact on medical practice assumes that the medical profession is aware of the existence of that decision. The present study tested the validity of that assumption with respect to Reibl v. Hughes by asking the following question:

Have you heard of a recent Supreme Court of Canada case (called Reibl v. Hughes) dealing with ‘informed consent’ to medical treatment?

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10 See generally, Hoinville et al., supra note 7, at 5-6 and 136-38; Moser and Kalton, supra note 7, at 166 et seq.; Gough and Hall, supra note 7.
11 A significantly higher than average response rate might have been expected from surgeons in Alberta and Quebec, because (a) the study was associated with the University of Alberta and (b) questionnaires sent to Quebec surgeons were accompanied by a letter of endorsement from the Corporation professionelle des medecins du Quebec. This, however, does not mean that the letter of endorsement had no effect on the response rate from Quebec; it may have raised to average what would otherwise have been a less than average response rate, particularly given that all questionnaires were in English. Enclosing the letter of endorsement with all questionnaires sent to Quebec thereby precluded an assessment of its effect.
12 See Faden et al., supra note 2, at 170.
13 Id. at 271.
This resulted in one of the study's most significant findings, namely that seventy-four percent of the doctors who responded to the survey answered this question in the negative. Given the probable element of response bias discussed above, the number of surgeons who are unaware of the decision in *Reibl v. Hughes* is probably even greater than seventy-four percent. The implications of this finding will be discussed below.¹⁴

A comparison of the answers within each group revealed significant variation. A much higher percentage of neurosurgeons (sixty percent) and surgeons in Ontario (thirty-nine percent) were aware of the Supreme Court decision. The former, and to some extent the latter, can be explained by the fact that the defendant in *Reibl v. Hughes* was a neurosurgeon practising in that province. The greater awareness of the decision amongst Ontario surgeons may also be due to the active steps which were taken by the Ontario College of Physicians and Surgeons to bring the decision to the attention of its members.¹⁵ Other findings of significant variation were that a much lower percentage of urologists (fourteen percent) and doctors over the age of sixty (eight percent) were aware of *Reibl v. Hughes*.

A few respondents identified what they considered to be a weakness in the wording of the above question. These respondents observed that the information contained in the question (the name of the case, and the fact that it was a recent decision of the Supreme Court of Canada dealing with informed consent) was insufficient for them to decide whether they had heard of the case. These respondents would have wished a summary of the facts of the case to help them identify it. It is unlikely, however, that this aspect of the question will have caused any significant error in the results. However, there is another aspect of this issue which must be considered, namely that some respondents, although unaware of the Supreme Court decision, may have been influenced by it unknowingly. For example, some respondents indicated that they had recently changed their practice with regard to informing patients because of recommendations issued by the hospital with which they were associated. These recommendations may have been generated by *Reibl v. Hughes*. An attempt was made to assess the extent of this type of indirect influence, and this will be discussed below.¹⁶

¹⁴ Section V, infra.
¹⁶ Section III E, infra.
B. Source of Awareness

Those who indicated having heard of *Reibl v. Hughes* were asked how they had learned of the case. Seventy-five percent identified media coverage or medical literature as being the source of their knowledge, including thirteen percent who specifically referred to the Annual Report of the Canadian Medical Protective Association.\(^{17}\) Other sources included medical colleagues (eight percent), medico-legal meetings (eight percent), lawyers (six percent) and personal acquaintance with Dr. Hughes (six percent).\(^{18}\)

C. Extent of Knowledge

Those who indicated having heard of *Reibl v. Hughes* were also asked what they recalled was decided in that case. In processing these answers it proved possible to group them into three different categories according to their appreciation of the importance of the decision. The first group (twenty percent) had no recollection of what was decided. The second group (forty-five percent) comprised those answers which were confined to the actual facts of the case; for example, answers such as “the doctor was found negligent in not disclosing the risk of a stroke.” The third group, a minority of thirty-five percent, indicated an awareness of the importance of the decision; for example, answers such as “the decision increases doctors’ responsibility in obtaining informed consent,” or “doctors must now take account of what their patients would want to know.”\(^{19}\)

D. The Perceived Effect

Having isolated those doctors who were aware of *Reibl v. Hughes*, the questionnaire then proceeded to determine whether they perceived the decision as having had any effect on their practice with regard to informing patients. In particular they were asked whether their knowledge of the case had generally led them to:

1. give more or less information than before to their patients

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\(^{17}\) The 1981 Annual Report contained a detailed account of *Reibl v. Hughes* by the Association’s General Counsel, in addition to suggested guidelines on how to meet the legal requirements enunciated by the Supreme Court - see, *supra* note 5, at 27-28 and 39-46.

\(^{18}\) Some respondents identified more than one source, hence the total is greater than 100 percent. Ten percent of the respondents could not remember how they had learned of *Reibl v. Hughes*.

\(^{19}\) Included in this third group were those doctors (9%) who, whilst appreciating the importance of *Reibl v. Hughes*, exaggerated its effect. A typical answer in this group was that “doctors must now inform their patients of all possible complications, however slight.”
about risks involved in proposed surgical operations;

(2) spend more or less time than before with their patients discussing risks involved in proposed surgical operations; and,

(3) ask their patients more or fewer questions than before when discussing risks involved in proposed surgical operations.

In relation to each of these questions the respondents were asked to circle one of the following answers: "considerably more," "more," "less," "considerably less," and "no difference." Respondents were also asked whether their knowledge of the case had had any other effect on their practice with regard to informing patients. An analysis of the answers is shown in the following table.

**TABLE B**

Analysis of the Perceived Effect of *Reibl v. Hughes* on Surgeons Aware of the Decision (n = 159)

<table>
<thead>
<tr>
<th>Nature of the Effect</th>
<th>% of Surgeons</th>
</tr>
</thead>
<tbody>
<tr>
<td>More or Considerably More Information Given</td>
<td>53%</td>
</tr>
<tr>
<td>More or Considerably More Time Spent</td>
<td>42%</td>
</tr>
<tr>
<td>More or Considerably More Questions Asked</td>
<td>34%</td>
</tr>
<tr>
<td>No Change</td>
<td>41%</td>
</tr>
</tbody>
</table>

It can be seen from the above that fifty-nine percent of doctors who were aware of *Reibl v. Hughes* regarded the decision as having had some effect on their practice with regard to informing patients. The most commonly cited effect (fifty-three percent) was the giving of more information to patients about risks involved in proposed surgery. The decision was also perceived by a minority of doctors as having increased the amount of time spent discussing risks with patients, and also the number of questions they ask patients during such discussions. A small number of doctors (ten percent) also indicated that their knowledge of the decision had led them to increase the amount of documentation involved in obtaining their patients' "informed" consent; for

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20 None of the respondents indicated that *Reibl v. Hughes* had resulted in a decrease in the amount of information given, time spent or questions asked.

21 Many of the respondents indicated that *Reibl v. Hughes* had had more than one effect on their practice; for example, it had led to them giving more information and spending more time with patients. Hence the total figure in this column exceeds 100%.
example, greater use of written consent forms, written information on risks involved in proposed surgery, and detailed written records of discussions with patients.

It should be stressed that these answers provide an indication only of the respondents' own subjective assessment of the effect of Reibl v. Hughes on their practice of informing patients. Moreover, the answers are limited to an indication of relative change; they may show that more information is being given than before, but they cannot show how much information is now being given. Later parts of the questionnaire, discussed below, attempt to introduce a more objective assessment of the effect of the decision on medical practice.

It is nevertheless significant to note that forty-one percent of doctors who were aware of Reibl v. Hughes indicated that the decision had had no effect on their practice with regard to informing patients. One of three possible conclusions can be drawn from this. First, it may be that the decision has had an effect on these doctors, but they are unaware of it. As will be discussed below, answers to other parts of the questionnaire militate against this conclusion and confirm that the Supreme Court decision had little or no effect on this section of the sample. Second, it may be that the practice of these doctors with regard to informing patients was such that no change was necessary to meet the legal requirements enunciated in Reibl v. Hughes. Once again, answers to later parts of the questionnaire suggest otherwise. The third conclusion and, it is submitted the correct one, is that this study demonstrates that Reibl v. Hughes failed to have any impact on forty-one percent of the doctors who had heard of the decision. When this is taken in conjunction with the percentage of respondents unaware of the decision, it is possible to concluded that Reibl v. Hughes has had no effect on the practice of approximately eighty-five percent of surgeons in Canada.

Answers to this question also revealed no significant difference as between respondents who appreciated the importance of Reibl v. Hughes and those who did not. Thirty-nine percent of the former,

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23 Section IV B, infra.
24 Id.
25 One qualification should be added to this conclusion. The group of doctors who regarded their knowledge of the decision as having had no effect on their practice contained a significantly higher percentage of those who were unable to recollect what the case had decided (34% as compared with 20%). This tends to suggest that this group may have included some doctors who, despite their answer to the contrary, were unaware of the Supreme Court decision. To the extent that this is true it would have the effect of overestimating the extent of awareness of Reibl v. Hughes amongst Canadian surgeons, while underestimating its effect on those who were aware of the decision.
26 Section III C, supra.
compared with forty-two percent of the latter, indicated that *Reibl v. Hughes* had had no effect on their practice. The significance of this finding will be discussed below.\(^2\)

E. *The Impact of Other Factors*

In discussing the impact of *Reibl v. Hughes*, whether perceived or actual, two additional considerations are relevant. The first is the possibility that respondents who were unaware of the decision may have been influenced by the decision unknowingly.\(^2\) The second is that changes in the practices and opinions of respondents who were aware of *Reibl v. Hughes* may have been attributable, at least in part, to factors other than their knowledge of the decision. In order to take account of these possibilities, the questionnaire asked respondents to indicate whether their practice with regard to informing patients had changed since 1980 for any reason other than their knowledge of *Reibl v. Hughes*.

Of respondents who were unaware of the case, fifteen percent indicated that their practice with regard to informing patients had changed since 1980, in the sense that they now gave more information to patients than before. The reasons given for this change were analyzed in order to identify those which could be construed as being a result of the Supreme Court decision. The following reasons for change were identified as capable of such interpretation, namely, professional literature and meetings, media coverage of informed consent, and changes in hospital policy. However, only three percent of respondents cited any of these reasons for their change in practice. The reason most commonly given was personal involvement in litigation (either as a defendant or as an expert witness) or a perceived increase in litigation. Thus it appears that the possibility of respondents being unaware of the impact of *Reibl v. Hughes* on their practice is slight.

Of respondents who were aware of *Reibl v. Hughes*, thirty-two percent indicated that factors other than their knowledge of the decision (most commonly personal involvement in litigation or a perceived increase in litigation) had changed their practice with regard to informing patients. This finding does not affect the above discussion of the perceived impact of *Reibl v. Hughes*, assuming that respondents were able to distinguish between changes attributable to their knowledge of the case and changes due to other factors. To the extent that

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\(^2\) Section V, infra.

\(^2\) Section III A, supra.
this assumption is incorrect, the above discussion will have exaggerated the perceived impact of the Supreme Court decision. Moreover, in later parts of this article, inferences will be drawn as to the impact of *Reibl v. Hughes* on respondents' attitudes towards disclosure of risks;²⁸ this impact may also be exaggerated, given that variations in attitudes as between respondents aware, and those unaware of the decision, may be attributable to factors other than the impact of the Supreme Court decision.

IV. MEDICAL PRACTICE AND DISCLOSURE OF RISKS

A. *Doctor's Perceptions of their Practice*

Part of the questionnaire was designed to ascertain doctors' own perceptions of their practice with regard to informing patients of risks involved in proposed surgery. Respondents were asked the following question:

> Do you (or someone on your behalf) inform your patient of all serious, unusual or special risks, if any, involved in a proposed surgical operation?

An analysis of the answers is shown in the following Table.

<table>
<thead>
<tr>
<th>TABLE C</th>
<th>Analysis of Respondents' Views of How Often they Disclose “Serious, Unusual or Special Risks” to their Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Always/Often</td>
</tr>
<tr>
<td>All Respondents (n=620)</td>
<td>75%</td>
</tr>
<tr>
<td>Respondents Unaware of <em>Reibl v. Hughes</em> (n=461)</td>
<td>72%</td>
</tr>
<tr>
<td>Respondents Aware of <em>Reibl v. Hughes</em> (n=159)²⁹</td>
<td>83%</td>
</tr>
</tbody>
</table>

A number of qualifications must be added to the above data. First, the term “special and unusual risks” was chosen to reflect the language used by the Supreme Court in *Hopp v. Lepp*³⁰ and reiterated in *Reibl*...
v. Hughes, but it is not a term which is easily defined. Consequently it may have been interpreted differently amongst the respondents. Moreover, it must be emphasized that the answers to the above question reflect what doctors claim they do, and are unlikely to provide a reliable indication of what doctors actually do. As one study observes: “Regarding health care, surveys are known to overstate the frequency with which information is disclosed and may present a rosier, more homogenous picture of medical practice than an on-site investigation of the same population would.” The results are in line with previous studies, in that they indicate that a high percentage of doctors claim that they usually (that is, either always or often) inform patients of risks involved in proposed surgery.

It is of interest to note the significant variation in answers as between respondents who were aware of Reibl v. Hughes and those who were not. A significantly higher percentage of the former claimed that they usually disclosed serious, unusual or special risks to patients. Since, as was noted above, this question was concerned only with doctors’ own perceptions of what they do, this variation cannot necessarily be taken as reflecting an impact of Reibl v. Hughes on the frequency of disclosure. The most that can be inferred is that the decision appears to have had some affect on what doctors claim they do with regard to informing patients of risks involved in proposed surgery.

Finally it should be noted that eighty-five percent of all respondents indicated that when they informed patients of risks involved in proposed surgery, they always did so personally rather than delegating the task to others such as nursing staff or junior colleagues. When taken in conjunction with those who indicated that they “often” gave the information personally, this figure increased to ninety-nine percent. Once again this finding confirms those of previous studies conducted in the United States. In the words of one writer:

[t]his is surprising, since it is a widespread impression that surgeons often allow house-staff physicians (that is, surgical residents) to do preoperative work-ups of their patients, including the task of explaining to the patients various as-

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81 Supra note 1, at 884.

82 An attempt was made by Linden J. in White v. Turner, supra note 4, at 285, and by McLachlin J. in Rawlings v. Lindsay, supra note 4, at 306.

83 See Rosoff, supra note 2, at 329.

84 Making Health Care Decisions, supra note 2, vol. 1 at 9.

85 See Rosoff, supra note 2, at 343; Making Health Care Decisions, supra note 2, vol. 1 at 79. In a questionnaire study conducted by the author in 1981 of 302 surgeons in England (response rate = 72%) 78% of respondents indicated that they usually informed patients of all serious, unusual or special risks involved in proposed surgery.

86 See Rosoff, supra note 2, at 351; Faden et al., supra note 2, at 269.
peets of the upcoming operations. Moreover, with a large proportion of surgical
treatment provided on a referral basis, it might be assumed that much of the
necessary information would be provided to the patient by the referring physi-
cian, thus relieving the surgeon of some of this burden. Judging from the re-
sponses . . . neither of these factors seems to have much impact.87

B. Doctor’s Opinions on Disclosure of Risks

As was explained above, information concerning what doctors
claim they do with regard to disclosing risks to patients is of limited
use, particularly as it is unlikely to provide a reliable indication of what
doctors actually do in practice. Accordingly, an attempt was made to
obtain a more objective assessment of doctors’ practice by seeking their
views on a number of issues relating to disclosure of risks to patients.
This approach was based on the premise that inferences concerning
doctors’ practice may legitimately be drawn from their views on in-
formed consent, and that these inferences are likely to provide a more
reliable indication of what is done in practice than information based
on what doctors claim they do. This part of the questionnaire was also
aimed at obtaining a more reliable indication of the impact of Reibl v.
Hughes.

Respondents were presented with a number of statements concern-
ing disclosure or risks to patients, and were asked whether they agreed
or disagreed with each of these statements. Of particular importance
were two statements which go to the root of the decision in Reibl v.
Hughes. The first of these was as follows:

The decision whether to inform a patient of any of the risks involved in a pro-
posed surgical operation is entirely a matter for the clinical judgment of the doc-
tor or doctors involved in the case.

An analysis of the reaction to this statement is show in the following
Table.

87 Rosoff, id.
TABLE D
Respondents’ Views on the Above Statement

<table>
<thead>
<tr>
<th></th>
<th>Agree</th>
<th>Disagree</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Respondents (n = 620)</td>
<td>55%</td>
<td>44%</td>
<td>1%</td>
</tr>
<tr>
<td>Respondents Unaware of <em>Reibl v. Hughes</em> (n = 461)</td>
<td>56%</td>
<td>43%</td>
<td>1%</td>
</tr>
<tr>
<td>Respondents Aware of <em>Reibl v. Hughes</em> (n = 159)</td>
<td>50%</td>
<td>49%</td>
<td>1%</td>
</tr>
<tr>
<td>Respondents Aware of <em>Reibl v. Hughes</em> and indicating that it had had some effect on their practice (n = 94)</td>
<td>44%</td>
<td>54%</td>
<td>2%</td>
</tr>
<tr>
<td>Respondents Aware of <em>Reibl v. Hughes</em> and indicating that it had had no effect on their practice (n = 65)</td>
<td>60%</td>
<td>40%</td>
<td>0%</td>
</tr>
<tr>
<td>Respondents Aware of <em>Reibl v. Hughes</em> and indicating an appreciation of its importance (n = 54)(^{38})</td>
<td>41%</td>
<td>59%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Respondents were also asked for their views on the following statement:

In deciding whether to inform a patient of a particular risk involved in a proposed surgical operation, a doctor should be guided more by what he or she thinks the patient ought to know than by what he or she thinks the patient would want to know.

An analysis of the reaction to this statement is shown in the following Table.

\(^{38}\) Section III C, *supra*.
Important inferences may be drawn from Tables D and E as to doctors' views on disclosure of risks and also as to the impact of *Reibl v. Hughes*. It can be seem that a majority of respondents (fifty-five percent) took the view that the decision whether to disclose risks to a patient is entirely a matter for the doctor's clinical judgment. Moreover, a slightly higher percentage (fifty-seven percent) agreed that in making the decision a doctor should be guided more by what he thinks his patient ought to be told than by what he thinks his patient would want to be told. These two views are the antithesis of what was said in *Reibl v. Hughes*, as can be seen from the following extract from the

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*Id.*

40 In the author's study of surgeons in England, *supra* note 35, 83% of respondents agreed with this view.
I think the Ontario Court of Appeal went too far, when dealing with the standard of disclosure of risks, in saying... that 'the manner in which the nature and degree of risk is explained to a particular patient is best left to the judgment of the doctor in dealing with the man before him.' Of course, it can be tested by expert medical evidence but that too is not determinative. . . . What the doctor knows or should know that the particular patient 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. . . . 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.

Reibl v. Hughes represents a fundamental change in judicial attitudes towards informed consent. Disclosure of risks is no longer an issue within the exclusive domain of the clinical judgment of the medical profession. It is no longer a question of what the individual doctor, or the medical community as a whole, decides the patient ought to be told. It is a question of the patient’s right to be informed, measured by what the doctor knows or ought to know the patient would want to be told. The present study suggests that a majority of surgeons in Canada have not recognized this fundamental change.

Tables D and E also confirm the doubts already expressed as to the reliability of doctors’ perceptions of their own practice with regard to disclosure of risks. Table E suggests that a majority of surgeons adopt a highly paternalistic approach, being guided more by what they believe the patient ought to be told than what they believe he would want to be told. Data obtained from other parts of the questionnaire, considered below, provides further evidence of this paternalism. Table D suggests that a majority of surgeons view the issue of disclosure of risks entirely in terms of their own clinical judgment, rather than, for example, in terms of the patient’s interest in self-determination and his right to be informed. It extremely difficult to regard these views as consistent with the claim made by most respondents that they usually inform their patients of all the serious, unusual or special risks involved in proposed surgery.

It should be noted, however, that Reibl v. Hughes appears to have had some impact on opinions expressed by respondents. It will be recalled that fifty-five percent of all respondents agreed with the statement that the decision whether to inform a patient of any of the risks in-

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41 Supra note 1, at 894 - 95.
42 Section IV C, infra.
Informed Consent

Informed Consent

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Informed Consent

155

Involving surgery is entirely a matter for the doctor’s clinical judgment. However, as is shown in Table D, only fifty percent of respondents who were aware of Reibl v. Hughes agreed with the statement. Moreover, of respondents who were aware of the decision and who indicated that it had had some effect on their practice, only forty-four percent agreed with the statement. A similar pattern of results is evident from Table E with respect to whether a doctor should be guided more by what he thinks his patient ought to know than by what his patient would want to know. It appears, therefore, that Reibl v. Hughes may have had some impact on doctors’ attitudes, in the sense that those who were aware of the decision and were conscious of it having changed their practice, were more likely to hold views consistent with those expressed in the case. It should be stressed, however, that the extent of this impact is small. Moreover, it should be noted that this variation in result may not necessarily be due entirely to the influence of the case, since, as was discussed above, the possibility exists that factors other than Reibl v. Hughes may have influenced respondents’ opinions on the issue of disclosure of risks to patients.

Tables D and E also indicate only a slight variation in answers as between respondents who appreciated the importance of Reibl v. Hughes and those who did not. The significance of this finding will be discussed below. Finally, it was noted above that forty-one percent of respondents who were aware of Reibl v. Hughes indicated that it had had no effect on their practice with regard to disclosing risks to patients. The results shown in Table D, and to a lesser extent those in Table E, confirm that the decision has had little or no effect on these respondents. Their views on the two statements were more in line with those of respondents who were unaware of Reibl v. Hughes than with those respondents who indicated that they were aware of the decision and that it had had some effect on their practice.

C. Factors Influencing Disclosure of Risks

The present section is concerned with identifying those factors which surgeons regard as important in deciding whether to inform a patient of a particular risk involved in proposed surgery. Respondents were presented with a list of factors and were asked the following

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43 Section III E, supra.
44 Section III C, supra.
45 Section V, infra.
46 Table B, supra.
question:

In deciding whether to inform your patient of a particular risk involved in a proposed surgical operation, how important are the following factors?

Relative importance was measured by means of a "semantic differential scale;" respondents were asked to indicate relative importance by circling a number on a numerical scale from one to five, number one representing "unimportant" and number five representing "very important." Results were processed and the mean calculated for each of the given factors. This calculation was done for each of three groups; the first comprised all respondents, the second comprised respondents who were unaware of Reibl v. Hughes, and the third group comprised respondents who were aware of the decision. The factors were then arranged in order of importance as indicated by their mean. The results are shown in the following Table.

47 See Moser and Kalton, supra note 7, at 373-76.
### TABLE F

Analysis of Relative Importance Given to Various Factors in Deciding Whether to Inform Patients of a Risk Involved in Proposed Surgery, Based on a Scale From 1 (unimportant) to 5 (very important)

<table>
<thead>
<tr>
<th>Factors</th>
<th>All Respondents (n=620)</th>
<th>Respondents Aware of Reibl v. Hughes (n=159)</th>
<th>Respondents Unaware of Reibl v. Hughes (n=461)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seriousness of damage to patient if risk were to materialize</td>
<td>4.44 (1)*</td>
<td>4.58 (1)</td>
<td>4.40 (2)</td>
</tr>
<tr>
<td>What you consider to be in your patient's best interests</td>
<td>4.34 (2)</td>
<td>4.11 (5)</td>
<td>4.42 (1)</td>
</tr>
<tr>
<td>The prognosis without the surgery</td>
<td>4.28 (3)</td>
<td>4.17 (4)</td>
<td>4.32 (3)</td>
</tr>
<tr>
<td>The chances of the risk materializing</td>
<td>4.26 (4)</td>
<td>4.46 (2)</td>
<td>4.19 (5)</td>
</tr>
<tr>
<td>The fact that the patient has asked about the risk</td>
<td>4.22 (5)</td>
<td>4.23 (3)</td>
<td>4.22 (4)</td>
</tr>
<tr>
<td>Patient's apparent ability to understand an explanation of the risk</td>
<td>3.83 (6)</td>
<td>3.90 (6)</td>
<td>3.81 (6)</td>
</tr>
<tr>
<td>The fact that patient would probably regard the risk as relevant to his decision</td>
<td>3.74 (7)</td>
<td>3.76 (7)</td>
<td>3.73 (7)</td>
</tr>
<tr>
<td>The knowledge that if you were in the patient's position you would undergo the surgery</td>
<td>3.54 (8)</td>
<td>3.31 (10)</td>
<td>3.62 (8)</td>
</tr>
<tr>
<td>Likely effect of disclosure of risk on patient’s health and state of mind</td>
<td>3.49 (9)</td>
<td>3.41 (9)</td>
<td>3.51 (9)</td>
</tr>
<tr>
<td>Prospect of being sued if risk were to materialize</td>
<td>3.39 (10)</td>
<td>3.53 (8)</td>
<td>3.34 (10)</td>
</tr>
<tr>
<td>Wishes expressed by patient's close relatives</td>
<td>2.86 (11)</td>
<td>2.75 (11)</td>
<td>2.90 (11)</td>
</tr>
<tr>
<td>How good a relationship you have with the patient</td>
<td>2.51 (12)</td>
<td>2.37 (13)</td>
<td>2.57 (12)</td>
</tr>
<tr>
<td>The common practice, if any, of other doctors</td>
<td>2.47 (13)</td>
<td>2.55 (12)</td>
<td>2.44 (13)</td>
</tr>
<tr>
<td>How busy you are</td>
<td>1.67 (14)</td>
<td>1.69 (14)</td>
<td>1.66 (14)</td>
</tr>
</tbody>
</table>

*Number in brackets indicates order of ranking according to mean.
The overall pattern of the results shown in Table F suggests that a fairly paternalistic approach is adopted in practice. This can be seen most clearly from the fact that respondents as a whole regarded the "patient’s best interests" as the most important factor, with far less importance being accorded to "the fact that the patient would probably regard the risk as relevant to his decision." The importance attached to "the prognosis without surgery" also confirms this view. The decision in Reibl v. Hughes does not appear to have had any significant impact in this respect. Those respondents who were aware of the decision did not accord high importance to the fact that the patient would regard the risk as relevant, although they did attach less importance to the "best interests" factor than respondents who were unaware of the decision. Generally, however, the results were similar in both groups.

It is interesting to compare the results in Table F with those of previous studies. The study conducted by Faden and her colleagues demonstrated that the decision to disclose a risk is influenced greatly by the extent of the risk, but not by the magnitude of harm which will be suffered if the risk materializes.48 Table F suggests that both of these factors are highly influential. Faden’s study also indicated that the decision to disclose is influenced significantly by the perceived consequences of disclosure on the patient’s health.49 This finding is not confirmed by the present study. The most recent American study indicates that the factors viewed as most relevant by American doctors are the patient’s ability to understand the information, his desire to be given the information, and the seriousness of his condition.50 The present study suggests that only the last of these three factors ranks amongst those viewed as most important by respondents as a whole.

Table F is also of interest with regard to the importance attached to the risk of being sued as a factor influencing disclosure. Although respondents as a whole attached little relative importance to this factor, a significant minority of respondents did consider it to be of great importance. Thus, thirty-five percent of all respondents gave this factor a “five” on the numerical scale provided. This confirms the findings of previous studies, that approximately one-third of doctors regard the prospect of being sued as one of the most important factors in deciding whether to inform a patient of a risk involved in proposed treatment.51

48 Faden et al., supra note 2, at 267 - 68.
49 Id. at 268.
50 Making Health Care Decisions, supra note 2, vol. 1 at 73.
51 See Rosoff, supra note 2, at 368.
V. CONCLUSIONS

The main conclusion to be drawn from this study is that Reibl v. Hughes has had little impact on medical practice with regard to disclosure of risks to patients. The primary reason for this is ignorance of the decision; seventy-five percent of respondents in the present study were unaware of the Supreme Court decision. Moreover, even in the case of respondents who were aware of the decision, most appeared not to appreciate its importance. These findings are consistent with previous studies in Canada and the United States, which reveal significant ignorance of the law of informed consent amongst the medical profession, yet they are surprising given the attention paid to Reibl v. Hughes in the national press, in medical and medical-legal literature and, particularly, in the Annual Report of the Canadian Medical Protective Association. Most doctors in Canada will have received a copy of the CMPA Annual Report, yet its detailed coverage of Reibl v. Hughes appears to have gone unnoticed by most members of the medical profession. This is unlikely to be due to a lack of interest in the subject; indeed eighty percent of respondents in this study who were unaware of Reibl v. Hughes accepted the offer of information summarizing the effect of the Supreme Court decision. It would seem that the attempts to inform doctors of the decision have, so far, been inadequate and further steps clearly are required to bring the implications of Reibl v. Hughes to the attention of the medical profession in Canada.

This need is particularly acute given the study’s finding that a majority of respondents expressed agreement with views which are incompatible with the main principles enunciated in Reibl v. Hughes. These respondents felt that the decision to disclose any risks to a patient is entirely a matter for the doctor’s clinical judgment, and that he should be guided more by what he thinks his patient ought to be told than by what he thinks his patient would want to be told. The paternalism reflected in these opinions is also evident from respondents’ views on what factors are important in deciding whether to inform a patient of a particular risk involved in proposed surgery.

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53 Section III C, supra.
55 Section IV C, supra.
59 Supra note 5.
The study also suggests that *Reibl v. Hughes* has had only a slight impact on respondents who are aware of the decision. A majority of these respondents (fifty-nine percent) indicated that the decision had changed their practice with regard to informing patients. However, this is not a reliable indication of the actual effect of *Reibl v. Hughes*, given that the response was based on doctors’ perceptions of the decision’s effect on their practice. Indeed, considering reasons such as non-response bias and the existence of other factors affecting respondents’ practice, this figure may exaggerate the impact of *Reibl v. Hughes*. Moreover, the study demonstrates that, even in the case of respondents who were aware of *Reibl v. Hughes*, approximately one-half held views which are incompatible with the decision. The fact that this figure was only slightly lower than that of respondents unaware of the decision, suggests that the actual impact of *Reibl v. Hughes* on those aware of the decision may be relatively small.

The present study therefore tends to confirm previous findings which suggest that judicial decisions have little impact on the medical profession. Although the main reason for this, in the present study, is that the profession is generally unaware of *Reibl v. Hughes*, there remains the fact that even a majority of doctors who are aware of the decision expressed views which are inconsistent with it. At first sight, it might be possible to explain this finding in terms of a lack of awareness of the full significance of *Reibl v. Hughes*. It will be recalled that a majority of respondents who were aware of the decision did not appear to appreciate its importance. However, the study also revealed no significant variation in answers as between respondents who appreciated the importance of the decision and those who did not. This suggests that *Reibl v. Hughes* has failed to have any significant impact even on those who were aware of both the decision and its importance.

This finding casts doubt over whether anything would be achieved by making the medical profession more aware of the implications of *Reibl v. Hughes*. It also provides evidence, not only of medical practitioners being impervious to change by judicial decision, but more generally, of the impotence of law (and judicial decisions in particular) as

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69 Section II B, supra.
60 Section III E, supra.
61 Section IV B, supra.
63 Sections III C, supra.
64 Sections III D and IV B, supra.
65 See Wiley, supra note 62.
an instrument of social change. Even assuming that the medical pro-
ession were to become aware of the implications of Reibl v. Hughes, to
suggest that this would have any meaningful effect, such as doctors
becoming "more sensitive, concerned and humane," is to attribute to
judicial decisions in general, and to Reibl v. Hughes in particular, a
degree of influence which they probably do not possess.

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66 See in particular, Griffiths, Is Law Important? (1979), 54 N.Y.U.L. Rev. 339; Epstein,
67 Supra note 6.