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INFORMED CONSENT TEN YEARS LATER: THE IMPACT OF REIBL V. HUGHES

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In 1980 the Supreme Court of Canada introduced major doctrinal changes in the law of informed consent in its decision in Reibl v. Hughes. This article assesses the significance of that decision by examining its impact in a number of areas. Based on an analysis of 117 cases since Reibl, the article concludes that the decision has had very little impact on the frequency and severity of malpractice claims. Reibl has also had little impact on legal developments in other areas of health law or in jurisdictions outside Canada, and its effect on medical practice remains unclear. The article concludes that the true significance of Reibl may lie in its symbolic importance as reflecting a fundamental change in the doctor-patient relationship and the power and authority underlying that relationship.

Dans sa décision de Reibl v. Hughes rendue en 1980, la Cour suprême du Canada a apporté des changements de doctrine importants en ce qui concerne le droit sur le consentement en connaissance de cause. Dans cet article, l'auteur évalue la portée de cette décision en examinant son effet dans un certain nombre de domaines. Après avoir analysé 117 affaires jugées après Reibl, l'auteur en conclut que la décision a eu très peu d'effet sur le nombre et la gravité des revendications pour négligence professionnelle. Reibl n'a aussi eu que peu d'effet sur le développement du droit médical dans d'autres domaines ou dans les juridictions en dehors du Canada et son effet sur la pratique médicale n'est pas certain. L'auteur conclut que son importance est surtout symbolique en ce qu'elle reflète le changement fondamental apporté aux rapports entre docteur et malade et au pouvoir et à l'autorité qui sont à la base de ces rapports.

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Introduction

Ten years have now passed since the Supreme Court of Canada handed down its landmark decision in *Reibl v. Hughes*,¹ dealing with the law of "informed consent" to medical treatment.² Together with the Supreme Court's earlier decision in *Hopp v. Lepp*,³ *Reibl* has been described as representing a "dramatic change"⁴ and "significant new directions in Canadian law of informed consent",⁵ and as having "radically reformulated" the law in this area.⁶ Indeed, general counsel to the Canadian Medical Protective Association stated in 1981 that "[n]o 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*".⁷

The purpose of this article is to assess the significance of the Supreme Court's decision by examining its impact in a number of areas. After briefly summarizing the theoretical importance of the decision, the article will examine the impact which *Reibl* has had in later cases (both in Canada and elsewhere), and also the effect which it has had on medical practice. The final section of the article will discuss the symbolic significance of the decision.

I. *The Theoretical Significance of Reibl v. Hughes*

From a strictly doctrinal standpoint, *Reibl* is of considerable importance, and represents probably the most significant doctrinal development in Canadian health law in the last two decades. Its importance lies in three main areas,⁸ the first of which relates to the applicable cause of action. According to *Reibl*, if a physician fails to inform a patient of material risks associated with proposed treatment, this failure gives rise to a cause

¹ [1980] 2 S.C.R. 880, (1980), 114 D.L.R. (3d) 1.

² Because it is now so well entrenched in Canadian law, the term "informed consent" is used throughout this article despite the fact that many commentators (and the Supreme Court of Canada) have suggested that the term be avoided because of its tendency to confuse battery and negligence—see *Reibl v. Hughes, ibid.*, at pp. 889 (S.C.R.), 8-9 (D.L.R.); B.M. Dickens, *The Doctrine of "Informed Consent": Informed Choice in Medical Care*, in R.S. Abella and M.L. Rothman (eds.), *Justice Beyond Orwell* (1985), pp. 243-244.

³ [1980] 2 S.C.R. 192, (1980), 112 D.L.R. (3d) 67.

⁴ E.I. Picard, *Patients, Doctors and the Supreme Court of Canada* (1981), 1 Oxford J. Leg. Studies 441, at p. 445. See also E.I. Picard, *Consent to Medical Treatment in Canada* (1981), 19 Osgoode Hall L.J. 140.

⁵ M. Gochnauer and D.J. Fleming, *New Directions for Medical Disclosure* (1981), 15 U.B.C. L. Rev. 475, at p. 495.

⁶ S. Rodgers-Magnet, *Recent Developments in the Doctrine of Informed Consent to Medical Treatment* (1981), 14 C.C.L.T. 61, at p. 76.

⁷ C.M.P.A. Annual Report (1981), p. 39. For a discussion of the impact of *Reibl v. Hughes* on medical practice, see *infra*, Section IV.

⁸ For a detailed discussion, see E.I. Picard, *Legal Liability of Doctors and Hospitals in Canada* (2d ed., 1984), pp. 67-115.

of action in negligence but does not vitiate the patient's consent so as to ground an action in battery.⁹ Thus, the scope of battery as a basis of liability of health care professionals is significantly restricted.¹⁰ In the words of Laskin C.J.C.:¹¹

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.

This standard would comprehend cases where there was misrepresentation of the surgery or treatment for which consent was elicited and a different surgical procedure or treatment was carried out.

The second area of importance relates to the standard of disclosure. In *Reibl* the Supreme Court held that the standard of disclosure is to be measured by what a reasonable person in the patient's position would want to know, rather than by the traditional test of what a reasonable physician would decide to disclose. The adoption of the reasonable patient test as the standard of disclosure is especially important, given that in every other area of professional liability, negligence has traditionally been determined by applying the test of the reasonable practitioner in similar circumstances.

The last significant doctrinal change concerns causation. For there to be a causal link between the physician's failure to disclose the information (for example, information concerning the risks of the proposed treatment) and the patient's injury, it must be shown that the information would have had an effect on the patient's decision to undergo the treatment.

⁹ Of the few cases since *Reibl* in which failure to disclose risks has been pleaded in battery, none has succeeded—see *Arnold v. Bonnell* (1984), 144 A.P.R. 385, 55 N.B.R. (2d) 285 (N.B.Q.B.); *Bickford v. Stiles* (1981), 128 D.L.R. (3d) 516, 94 A.P.R. 328, 36 N.B.R. (2d) 328 (N.B.Q.B.); *Casey v. Provan* (1984), 11 D.L.R. (4th) 708, 47 O.R. (2d) 147 (Ont. H.C.); *Ciarlariello v. Schacter*, 3 November 1987, No. 7448/81 and 11750/81, 7 A.C.W.S. (3d) 51 (Ont. H.C.), aff'd *sub nom. Ciarlariello Estate v. Schacter* (1991), 76 D.L.R. (4th) 449 (Ont. C.A.); *Ferguson v. Hamilton Civic Hospitals* (1983), 144 D.L.R. (3d) 214, 40 O.R. (2d) 577, 23 C.C.L.T. 254 (Ont. H.C.), aff'd (1985), 33 C.C.L.T. 56 (C.A.); *Lokay v. Kilgour* (1984), 31 C.C.L.T. 177 (Ont. H.C.).

¹⁰ The reluctance to find health care professionals liable in battery is also apparent in areas other than disclosure of information. For example, it is evident in cases dealing with the scope and interpretation of consent forms: see, for example, *Brushett v. Cowan* (1990), 3 C.C.L.T. (2d) 195 (Nfld. C.A.); *Pridham v. Nash* (1986), 33 D.L.R. (4th) 304, 57 O.R. (2d) 347 (Ont. H.C.). It is also evident in cases in which plaintiffs have alleged that they withdrew consent during the course of the procedure—see *Bonnell v. Moddel*, 5 February 1987, No. 1399/82, 3 A.C.W.S. (3d) 441 (Ont. H.C.); *Ciarlariello v. Schacter*, *supra*, footnote 9; *Mitchell v. McDonald* (1987), 40 C.C.L.T. 266 (Alta. Q.B.); but see *Nightingale v. Kaplovitch*, 20 April 1989, No. 2982/85, 15 A.C.W.S. (3d) 42 (Ont. H.C.), in which liability was imposed. See also *Malette v. Shulman* (1990), 67 D.L.R. (4th) 321, 72 O.R. (2d) 417 (Ont. C.A.) (blood transfusion on unconscious patient who carried a card indicating that she was a Jehovah's Witness and should not be given blood products held to constitute a battery—damages of \$20,000 awarded).

¹¹ *Supra*, footnote 1, at pp. 890-891 (S.C.R.), 10 (D.L.R.).

In principle this causal link should be assessed subjectively, by considering whether *this particular patient* (that is, the plaintiff) would have declined the treatment if the risks had been disclosed. However, according to the Supreme Court in *Reibl*, the defendant would be the victim of the plaintiff's "hindsight and bitterness"¹² if a subjective test of causation were to be applied, and thus a partly objective test is to be preferred. Accordingly, the court must determine whether a reasonable person in the plaintiff's position would have declined the treatment if the information had been disclosed.

II. Impact of *Reibl v. Hughes* in Malpractice Litigation

It would be incorrect to suggest that the doctrinal changes effected by *Reibl*, or indeed the whole development of the doctrine of informed consent, are unimportant. A concept which is scarcely mentioned in Canadian law prior to the 1970s, but which now occupies forty-eight pages of discussion in the leading Canadian text on health care liability,¹³ cannot be dismissed as inconsequential. However, one must be careful not to overestimate the practical significance of the changes enunciated in *Reibl*. As is apparent from the statistics discussed in the next section, the evidence indicates that the concept of informed consent plays only a minor role in malpractice litigation, and that the fundamental doctrinal changes introduced by the Supreme Court of Canada, far from expanding professional liability, have in fact restricted it.

A. Statistics

Table A¹⁴ is based on an analysis of Canadian common law cases¹⁵ since (and including) *Reibl v. Hughes* in which the plaintiff has alleged that the defendant was negligent in failing to disclose material information relating to proposed treatment. A total of 117 cases were analyzed, almost one-half of them unreported.¹⁶ A complete list of these cases is contained in the Appendix II¹⁷ to this article.

Column 1 in Table A corresponds to the case number in the list of cases found in the Appendix II. Column 2 is the date of the decision. Where a decision was appealed, the date shown is the date of the appellate judgment. Column 3 identifies the Canadian common law province involved.

¹² *Ibid.*, at pp. 898 (S.C.R.), 15 (D.L.R.), quoting Comment, Informed Consent—A Proposed Standard for Medical Disclosure (1973), 48 N.Y.U.L. Rev. 548, at p. 550.

¹³ Picard, *op. cit.*, footnote 8, pp. 67-115.

¹⁴ Appendix I, *infra*, pp. 441-443.

¹⁵ Cases from Quebec were excluded from the analysis, because technically *Reibl v. Hughes* is not binding in that province and indeed the Quebec Court of Appeal has refused to follow the decision on a number of occasions: see, *infra*, Section III.

¹⁶ The cases were identified through the Health Law Institute Database at the University of Alberta.

¹⁷ *Infra*, pp. 444-448.

Column 4 indicates whether a failure to disclose material information was the sole basis of the plaintiff's claim; a "No" denotes that it was not. Column 5 indicates whether the plaintiff succeeded in establishing that the defendant was negligent in failing to disclose material information. Column 6 shows whether causation was established, that is, whether the court was satisfied that a reasonable person in the plaintiff's position would have declined the treatment if the material information had been disclosed. A "N/A" denotes that, having decided that the information was disclosed or that the defendant was not negligent in failing to disclose it, the court considered it unnecessary to deal with the causation issue. Column 7 indicates whether the defendant was found liable; "og" signifies that liability was imposed on grounds other than informed consent (usually negligent performance of the treatment), whereas "oga" indicates that liability was imposed on the basis of informed consent and other grounds as well. Column 7 shows the amount of damages awarded, if any, with "?" being inserted where the amount was either not decided or not apparent from the case report. A "?" in any other column indicates that the information was not apparent from the case report.

A number of important conclusions can be drawn from the data in Table A. First, the figures in column 4 confirm that informed consent is rarely the sole basis of a plaintiff's claim. In only 13 of the 117 cases analyzed (that is, approximately 11%) did the plaintiff rely exclusively on an alleged failure to disclose material information. This in itself does not justify an inference that informed consent is having little impact on the frequency of malpractice claims in Canada. It is clear that an informed consent claim is almost always brought in conjunction with an allegation of negligent treatment rather than on its own. What is not clear is whether these suits would still have been brought were it not for the development of the doctrine of informed consent. In other words, is the informed consent claim merely added to bolster what is in reality a claim for negligent treatment, or is the converse true? The figures in column 7 shed some light on this issue. These indicate that in 81% of the cases in which the plaintiff was successful, the defendant was found to have performed the treatment negligently. In more than half of the successful cases (56%), negligent treatment was the sole basis of liability and the informed consent claim was dismissed. This *tends* to suggest that informed consent is probably being used merely as an ancillary ground in negligent treatment cases, and thus in itself is having only a minor impact on the frequency of claims. If this inference is valid, it is contrary to the position in the United States as reflected in a number of empirical studies, particularly those conducted by Professor Danzon.¹⁸

¹⁸ P.M. Danzon, *Medical Malpractice: Theory, Evidence, and Public Policy* (1985); P.M. Danzon, *The Frequency and Severity of Medical Malpractice Claims* (1984), 27 *J. Law & Economics* 115. See also E.K. Adams and S. Zukerman, *Variations in the*

With respect to the impact of informed consent on individual cases, the figures in Table A are unequivocal—informed consent claims rarely succeed. The informed consent claim was dismissed in 82% of the cases analyzed.¹⁹ The statistics for the last two years are particularly striking: the informed consent claim failed in every one of the 23 cases recorded for 1990 and 1991. It is also interesting to compare the success rate (18%) of informed consent claims with the overall disposition pattern for medical malpractice claims in Canada. In the period 1976-1986, plaintiffs succeeded in approximately 54% of all medical malpractice claims which went to trial.²⁰

Columns 5 and 6 provide some information as to why the overwhelming majority of informed consent claims fail. In particular, it is apparent that causation is proving to be a formidable obstacle for plaintiffs. Some of the reasons for this are discussed below. It can be seen from columns 5 and 6 that in 45 cases the defendant was held to have been negligent in failing to disclose material information to the patient, but that in 25 (56%) of these the plaintiff failed to satisfy the test of causation. As Wortzman notes:²¹

The common belief was that the rejection of the professional standard in favour of full disclosure, factoring in circumstances relating to the particular patient, would result in a tipping of the scales in favour of the patient. This does not appear to have occurred.

In interpreting and applying *Reibl* and *Hopp*, the courts have carefully balanced the full disclosure standard against the objective standard of causation. The result: in the majority of cases, the doctor is absolved of liability even if his disclosure is inadequate.

This statement was made in 1983, and the subsequent cases demonstrate that it is as true today as it was then.²² The two components of the informed

Growth and Incidence of Medical Malpractice Claims (1984), 9 J. Health Politics, Policy & Law 475.

¹⁹ The success rate is calculated by taking the number of cases in which the defendant was found liable, and discounting those in which liability was imposed solely on grounds other than informed consent.

²⁰ See Report of the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care (Chairman: J.R.S. Prichard), Liability and Compensation in Health Care: Working Paper, Appendix A (1990), p. 38.

²¹ B.S. Wortzman, Professional Liability—Health Care Providers, in Special Lectures of the Law Society of Upper Canada, Torts in the 80s (1983), p. 423. See also G.B. Robertson, Overcoming the Causation Hurdle in Informed Consent Cases: The Principle in *McGhee v. N.C.B.* (1984), 22 U. West Ont. L. Rev. 75.

²² C.J. Bruce, Testing the Hypothesis of Common Law Efficiency: The Doctrine of Informed Consent (1984), 6 Research in Law & Economics 227, at p. 262, states that “the doctrine of informed consent which has developed in Canada in the last decade is both favourable to patients and, down to the extremely detailed level of hypotheses developed in this paper, consistent with the view that the common law is efficient”. However, his study was based on only 17 reported cases, from 1976 to 1982, and his conclusion that the law is “favourable to patients” is not borne out by the data in Table A.

consent claim—standard of disclosure and causation—are discussed in detail below. Canadian courts appear to be taking very different approaches to each of these components. On the standard of disclosure issue, a fairly liberal (pro-plaintiff) approach is discernible in many cases, whereas the causation requirement is being applied in a way which is extremely favourable to defendants.

B. *Standard of Disclosure*

The liberal interpretation of the standard of disclosure is evident in a number of different ways. For example, the actual test for disclosure, as enunciated by Laskin C.J.C. in *Reibl v. Hughes*, focuses on those risks which the defendant knows or ought to know a reasonable person in the patient's position would want disclosed. However, in applying this test, few courts have paid much attention to what the defendant knew or ought to have known.²³ Rather, the test is commonly interpreted as meaning that a risk is material if a reasonable person in the patient's position would want to know about it. Thus, in cases where patients have special characteristics or circumstances which make a particular risk material to them, it is rare to find the court considering whether the defendant knew or ought to have known of these special circumstances.²⁴

The case-law also demonstrates that courts are not slow to characterize risks as material (or "special or unusual"), even where these risks are statistically remote, particularly in elective procedures²⁵ where the risk is one of death or serious injury.²⁶ For example, courts have held that the following risks ought to have been disclosed: the risk (estimated at between 1 in 40,000 and 1 in 100,000) of a fatal reaction to a contrast media dye used in an intravenous pyelogram;²⁷ the risk (estimated at 1 in 1,000)

²³ The position is different where the defendant claims to have been unaware of the existence of the particular risk. The question of whether the defendant ought to have been aware of it is judged by the standard of the reasonable practitioner. See *Hollis v. Birch*, 7 May 1990, Vancouver Registry No. C891761, [1990] B.C.D. Civ. 2632-10 (S.C.); *Konkolus v. Royal Alexandra Board of Governors* (1982), 21 Alta. L.R. (2d) 359 (Alta. Q.B.); *Mang v. Moscovitz* (1982), 37 A.R. 221 (Alta. Q.B.); *Reynard v. Carr* (1986), 10 B.C.L.R. (2d) 121, 38 C.C.L.T. 217 (B.C.C.A.).

²⁴ But see *Hunter v. McNeil* (1988), 44 C.C.L.T. 101 (B.C.S.C.) and *Videto v. Kennedy* (1981), 125 D.L.R. (3d) 127, 33 O.R. (2d) 497, 17 C.C.L.T. 307 (Ont. C.A.), which suggest that the onus lies with the patient to bring these special circumstances to the attention of the physician.

²⁵ But note that in *Dunn v. North York General Hospital* (1989), 48 C.C.L.T. 23 (Ont. H.C.), the court stressed that even in elective procedures the physician is not required to disclose *all* risks no matter how remote.

²⁶ This is consistent with what was said by Laskin C.J.C. in *Hopp v. Lepp*, *supra*, footnote 3, at pp. 209 (S.C.R.), 80-81 (D.L.R.).

²⁷ *Meyer Estate v. Rogers* (1991), 78 D.L.R. (4th) 307 (Ont. Gen. Div.). See also *Lachambre v. Nair*, [1989] 2 W.W.R. 749 (Sask. Q.B.).

of an I.U.D. perforating the uterine wall;²⁸ the risk (described as "infinitely small") of contracting hepatitis through a blood transfusion;²⁹ and the risk (described in evidence as a "rare occurrence") of suffering a stroke during neck manipulation by a chiropractor.³⁰

Another key aspect of the standard of disclosure relates to alternative treatment. It is now well established that the physician's duty of disclosure extends beyond simply informing the patient of the risks involved in proposed treatment, and requires an explanation to be given of the available alternatives, particularly if these alternatives are more conservative and present fewer risks to the patient.³¹ In some Ontario decisions, however, this principle has been restricted. For example, in *Bonnell v. Moddel*³² Griffiths J. was of the view that:

It seems to me that the principle . . . that the physician is under a duty to disclose the alternatives to the recommended procedure and the risks of those alternatives, should be limited to the case where in the opinion of the physician the alternative procedures offer some advantage and are reasonably likely to achieve a beneficial result. If there is a duty in law cast on the physician to discuss even those alternative procedures that the physician will frankly explain to the patient as having no diagnostic value, then applying the objective test of *Reibl v. Hughes*, the reasonable patient is inevitably likely to reject the alternative.

There is also some indication of courts interpreting *Reibl v. Hughes* as requiring physicians to satisfy themselves that the patient understands

²⁸ *Rolof v. Morris* (1990), 109 A.R. 128 (Alta. Q.B.). But see *Rayner v. Knickle* (1988), 223 A.P.R. 271, 47 C.C.L.T. 141 (P.E.I.S.C.), rev'd in part 20 February 1991, Action No. AD-0095, 25 A.C.W.S. (3d) 967 (C.A.), in which the Court of Appeal held that the risk of an amniocentesis needle striking the umbilical vein, thereby causing a haematoma leading to partial asphyxiation of the fetus and severe brain damage, was so rare that it did not have to be disclosed.

²⁹ *Kitchen v. McMullen* (1989), 62 D.L.R. (4th) 481, 50 C.C.L.T. 213 (N.B.C.A.), leave to appeal to S.C.C. refused, [1990] 1 S.C.R. viii.

³⁰ *Mason v. Forgie* (1984), 59 N.B.R. (2d) 320, 31 C.C.L.T. 66 (N.B.Q.B.), aff'd (1986), 30 D.L.R. (4th) 548, 38 C.C.L.T. 171 (N.B.C.A.), leave to appeal to S.C.C. refused (1987), 39 C.C.L.T. xxxi (S.C.C.).

³¹ *Coughlin v. Kunz* (1987), 17 B.C.L.R. (2d) 365, 42 C.C.L.T. 142 (B.C.S.C.), aff'd, [1990] 2 W.W.R. 737, 42 B.C.L.R. (2d) 108, 2 C.C.L.T. (2d) 42 (B.C.C.A.); *Ferguson v. Hamilton Civic Hospitals*, *supra*, footnote 9; *Frerotte v. Irwin* (1986), 51 Sask. R. 108 (Sask. Q.B.); *Haughian v. Paine* (1987), 37 D.L.R. (4th) 624, [1987] 4 W.W.R. 97 (Sask. C.A.), leave to appeal to S.C.C. refused, [1987] 6 W.W.R. lix (S.C.C.); *Schanczl v. Singh*, [1988] 2 W.W.R. 465, (1987), 56 Alta. L.R. (2d) 303 (Alta. Q.B.); *Zimmer v. Ringrose* (1981), 124 D.L.R. (3d) 215, 28 A.R. 69 (Alta. C.A.), leave to appeal to S.C.C. refused (1981), 37 N.R. 289, 28 A.R. 92 (S.C.C.).

³² *Supra*, footnote 10, transcript judgment at p. 31. Similar views were expressed by the trial judge in *Bucknam v. Kostuik* (1983), 3 D.L.R. (4th) 99, 44 O.R. (2d) 102 (Ont. H.C.), but in affirming the trial judgment the Court of Appeal in *Bucknam* offered no view on this issue (1986), 55 O.R. (2d) 187 (C.A.). The trial judge's opinion in *Bucknam* was followed in *Ferron v. Yadav*, 30 March 1990, No. 344/86, 20 A.C.W.S. (3d) 436 (Ont. H.C.).

the information which is given,³³ a potentially onerous duty in light of studies which indicate that many patients understand little of what their doctors tell them and remember even less.³⁴ For example, in finding a surgeon liable for failing to disclose a material risk to a 75 year old patient, the trial judge in *Kellett v. Griesdale*³⁵ commented that:

It may very well be that the defendant gave a warning but, if so, it did not make a sufficient impression on the plaintiff. The defendant was aware of the problem I mentioned earlier about patients tending to push aside any considerations of risk. That being so, it was incumbent on him to ensure that the plaintiff clearly understood the risk of significant hearing loss....

Likewise, in *Schanczl v. Singh*³⁶ the Alberta Court of Queen's Bench imposed liability on a physician for failure to disclose material risks, and in so doing emphasized the plaintiff's difficulty in understanding English. The court stated that this difficulty "placed a special duty on ... [the defendant] to be certain that his patient understood the alternatives available to him".³⁷

*Reibl v. Hughes*³⁸ appears to accept the existence of what is commonly referred to as "therapeutic privilege": the emotional condition of the patient may justify the physician in withholding or generalizing information which would otherwise have to be disclosed. Most writers take the position that the concept of therapeutic privilege should be construed very narrowly and applied only in the most exceptional circumstances.³⁹ It is clear that Canadian courts are adopting this position.⁴⁰ There is only one reported

³³ There is some indication of this requirement in *Reibl v. Hughes*, *supra*, footnote 1, at pp. 927 (S.C.R.), 34 (D.L.R.). Many writers have criticized such a duty as being unrealistic and impractical: see, for example, Picard, *op. cit.*, footnote 8, pp. 110-111; M.A. Somerville, Structuring the Issues in Informed Consent (1981), 26 McGill L.J. 740, at pp. 776-783; I. Kennedy, Treat Me Right: Essays in Medical Law and Ethics (1988), p. 191; H. Teff, Consent to Medical Procedures: Paternalism, Self-Determination or Therapeutic Alliance (1985), 101 Law Q. Rev. 432, at p. 441.

³⁴ See, for example, B.R. Cassileth, Informed Consent—Why are Its Goals Imperfectly Realized? (1980), 302 New Eng. J. Med. 896; C.O. Leonard, Genetic Counseling: A Consumer's View (1972), 287 New Eng. J. Med. 433. But see the criticism of the methodology of these and similar studies in A. Meisel and L.H. Roth, Toward an Informed Discussion of Informed Consent: A Review and Critique of the Empirical Studies (1983), 25 Arizona L. Rev. 265.

³⁵ 26 June 1985, Vancouver Registry No. C833053, [1985] B.C.D. Civ. 3385-09, transcript judgment, at p. 11 (B.C.S.C.). (Emphasis added).

³⁶ *Supra*, footnote 31.

³⁷ *Ibid.*, at pp. 474 (W.W.R.), 313 (Alta. L.R.).

³⁸ *Supra*, footnote 1, at pp. 895 (S.C.R.), 13 (D.L.R.). See also *Casey v. Provan*, *supra*, footnote 9; *Haughian v. Paine*, *supra*, footnote 31; *Stamos v. Davies* (1985), 21 D.L.R. (4th) 507, 52 O.R. (2d) 10 (Ont. H.C.); *Videto v. Kennedy*, *supra*, footnote 24.

³⁹ See, for example, Picard, *op. cit.*, footnote 8, p. 99; Somerville, *loc. cit.*, footnote 33, at pp. 767-773; Dickens, *loc. cit.*, footnote 2, at pp. 260-263; Kennedy, *op. cit.*, footnote 33, p. 205.

⁴⁰ This is true also of courts in the United States: see D.W. Louisell and H. Williams, *Medical Malpractice*, vol. 2 (rev. ed., 1990), para. 22.06.

case in which it has been held that the emotional condition of the patient was such as to justify the physician in generalizing information concerning potential risks of proposed treatment.⁴¹ Indeed, one recent Ontario trial decision goes so far as to conclude that the concept of therapeutic privilege does not form part of Canadian law.⁴²

The question of who must disclose the information to the patient has been discussed in several cases. These indicate that ultimate responsibility lies with the physician who is to perform the procedure.⁴³ That physician will be liable if he or she incorrectly assumes that the information has been given to the patient by someone else, such as the referring physician, a nurse or an assistant. On the other hand, courts have accepted that a defendant should be absolved from liability for negligently failing to disclose information, if the patient is shown to have received the information from some other source.⁴⁴

Finally, there is some indication of a willingness to impose liability on hospitals for a physician's failure to disclose material information to a patient. In a recent Saskatchewan decision⁴⁵ it was held that hospitals have a non-delegable duty to ensure that informed consent is obtained from patients prior to medical treatment being performed.⁴⁶

⁴¹ *Hajgato v. London Health Association* (1982), 36 O.R. (2d) 669 (Ont. H.C.), aff'd (1983), 44 O.R. (2d) 264 (Ont. C.A.).

⁴² *Meyer Estate v. Rogers*, *supra*, footnote 27.

⁴³ *Considine v. Camp Hill Hospital* (1982), 133 D.L.R. (3d) 11, 98 A.P.R. 631 (N.S.T.D.); *Coughlin v. Kunz*, *supra*, footnote 31; *Meyer Estate v. Rogers*, *supra*, footnote 27; *Schanczl v. Singh*, *supra*, footnote 31; see also the pre-*Reibl* cases of *McLean v. Weir*, [1980] 4 W.W.R. 330, (1980), 18 B.C.L.R. 325 (B.C.C.A.), and *Strachan v. Simpson*, [1979] 5 W.W.R. 315, (1979), 10 C.C.L.T. 145 (B.C.S.C.). A similar position has been adopted in the United States: see Louisell and Williams, *op. cit.*, footnote 40, para. 22.02.

⁴⁴ *Davidson v. Connaught Laboratories* (1980), 14 C.C.L.T. 251 (Ont. H.C.); *Ferguson v. Hamilton Civic Hospitals*, *supra*, footnote 9; see also *Goguen v. Crowe* (1987), 200 A.P.R. 36, 40 C.C.L.T. 212 (N.S.T.D.); *Hopps v. Robinson*, 19 November 1984, Vancouver Registry No. C826010, 29 A.C.W.S. (2d) 161 (B.C.S.C.); *Leerentveld v. McCulloch* (1985), 33 A.C.W.S. (2d) 104 (Ont. M.C.); *MacDuff v. Vrabec (No. 2)* (1982), 24 C.C.L.T. 239 (B.C.S.C.).

⁴⁵ *Lachambre v. Nair*, *supra*, footnote 27. Another interesting aspect of the decision is that, despite finding that the plaintiff had failed to establish causation (because a reasonable person in the plaintiff's position would probably have consented to the medical procedure even if the risk had been disclosed), the court awarded the plaintiff "nominal damages" of \$5,000.

⁴⁶ In the United States most courts have refused to impose such a duty: see S.R. Conlin, Hospital Corporate Negligence Based Upon a Lack of Informed Consent (1985), 19 Suffolk Univ. L. Rev. 835; C.A. Tillotson, Hospitals and Informed Consent: Physician's Duty Alone? (1989), 39 Federation Insur. & Corp. Counsel Q. 292; R.D. Miller, Problems in Hospital Law (6th ed., 1990), p. 245.

C. Causation

Professor Osborne has observed that "what the Court [in *Reibl*] gave on the disclosure issue it took away on the causation issue by favouring a degree of objectivity".⁴⁷ As the statistics discussed above clearly indicate, causation is proving to be a major problem for plaintiffs in informed consent cases. In part this is due to the fact that, by its very nature, the *Reibl* test of causation is more demanding (from the plaintiff's perspective) than a purely subjective test,⁴⁸ especially in view of its (questionable) assumption that there is only one "reasonable" response to proposed medical treatment in any given situation.⁴⁹ However, the difficulties facing plaintiffs also stem from the way in which the new test of causation is being applied by Canadian courts: Although, as Osborne notes,⁵⁰ there is a lack of uniformity, particularly in the range of personal factors which are taken into consideration, the overall trend appears to be towards applying the test in a way which is extremely favourable to defendants.⁵¹

One example of this is the growing acceptance by Canadian courts that the greater the confidence and trust which a patient has in a physician, the less likely a reasonable person in that patient's position would decline treatment recommended by the physician, even if full disclosure of material risks and alternatives were made. In *Bucknam v. Kostuik*⁵² Krever J. observed that:

[The plaintiff] had, over the many months she had been attended by the defendant, developed complete confidence in him and his skill and knew of and was impressed by his fine reputation in the field. The surgeon in whom she had that justifiable confidence was strongly of the view that for her condition the proper treatment was fusion of the sacrum and Harrington instrumentation and, had he mentioned

⁴⁷ P.H. Osborne, *Causation and the Emerging Canadian Doctrine of Informed Consent to Medical Treatment* (1985), 33 C.C.L.T. 131, at p. 143.

⁴⁸ For a criticism of the objective test of causation, see D. Giesen, *International Medical Malpractice Law* (1988), pp. 344-351; J. Katz, *Informed Consent—A Fairy Tale?: Law's Vision* (1977), 39 Univ. Pitt. L. Rev. 137, at p. 163; M. Brazier, *Patient Autonomy and Consent to Treatment: The Role of Law?* (1987), 7 Legal Studies 169, at p. 187. Note that the Ontario Court of Appeal has rejected the *Reibl* test of causation in favour of a subjective test in the context of a pharmaceutical company's liability for failing to provide proper information as to the possible side-effects of the contraceptive pill: see *Buchan v. Ortho Pharmaceutical (Canada) Ltd.* (1986), 25 D.L.R. (4th) 658, 54 O.R. (2d) 92 (Ont. C.A.).

⁴⁹ See Katz, *ibid.*, at p. 163; Gochnauer and Fleming, *loc. cit.*, footnote 5, at pp. 493-494; Robertson, *loc. cit.*, footnote 21, at p. 77.

⁵⁰ Osborne, *loc. cit.*, footnote 47.

⁵¹ Note that in a number of cases since *Reibl* the court has dismissed the plaintiff's claim on the basis of a subjective test of causation, where the plaintiff has admitted in evidence that he or she would probably have gone ahead with the treatment even if there had been full disclosure of the risks: see *Ferron v. Yadav*, *supra*, footnote 32; *MacPherson v. Allen*, 28 February 1990, No. 318/86 (Ont. H.C.); *Nevison v. Hayward*, 25 July 1989, Vancouver Registry No. C863813, [1989] B.C.D. Civ. 2632-13 (S.C.).

⁵² *Supra*, footnote 32, at pp. 114 (D.L.R.), 117 (O.R.).

the possibility of a single fusion as an alternative that another surgeon might recommend, would surely, and reasonably, have assured the patient that in his experienced professional judgment his recommendation was the right one for her. . . . In short, any reasonable patient in the plaintiff's position would have undergone the surgery recommended and carried out by the defendant. . . .

Likewise, in *Diack v. Bardstey*⁵³ the trial judge "indulged . . . in the construction of a hypothetical dialogue", in which the defendant disclosed the material risk to the plaintiff but advised him to go ahead with the treatment. The trial judge concluded that "[I]ike most of our citizens who consult professionals, I think . . . [the plaintiff] would have decided to go ahead with the procedure which was recommended".⁵⁴

The element of "trust and confidence" has played a significant role in many other cases in which the plaintiff has failed to establish causation.⁵⁵ In *Schanilec Estate v. Harris*⁵⁶ the British Columbia Court of Appeal rejected this factor as being too subjective, but ironically it did so in order to justify its finding that causation had not been established. The trial judge, in concluding that a reasonable person in the patient's position would have declined the operation, placed importance on the fact that the patient had only met the defendant on the eve of the operation. In reversing the trial judge's decision, the Court of Appeal held that the level of confidence which the plaintiff had in the defendant was not a proper factor to take into consideration in applying the objective test of causation.

The approach evident in these cases can be summarized in simple terms: reasonable patients trust their doctor, and thus are likely to accept recommended treatment even if the risks are disclosed. As was said in one recent Ontario decision, "[h]uman nature being what it is, people tend to consent to procedures recommended by their doctors".⁵⁷ These assumptions seem inconsistent with the policy reasons which led the Supreme Court of Canada in *Reibl* to reject the professional standards test as the basis for determining how much information patients ought to receive.

Expert evidence has also played a significant role in determining causation in the present context. In a number of cases in which the court has concluded that a reasonable person in the plaintiff's position would have gone ahead with the treatment, importance has been attached to

⁵³ (1983), 46 B.C.L.R. 240, at p. 248, 25 C.C.L.T. 159, at p. 168 (B.C.S.C.), aff'd (1984), 46 B.C.L.R. xlv, 31 C.C.L.T. 308 (B.C.C.A.).

⁵⁴ *Ibid.*, at pp. 250 (B.C.L.R.), 170 (C.C.L.T.).

⁵⁵ *Casey v. Provan*, *supra*, footnote 9; *Dezward v. Misericordia Hospital* (1988), 64 Alta. L.R. (2d) 72 (Alta. Q.B.), aff'd (*sub nom. Dezward v. Schulze*) (1990), 105 A.R. 312 (Alta. C.A.); *Dunn v. North York General Hospital*, *supra*, footnote 25; *Ferguson v. Hamilton Civic Hospitals*, *supra*, footnote 9; *Kueper v. McMullin* (1986), 30 D.L.R. (4th) 408, 37 C.C.L.T. 318 (N.B.C.A.); *Meyer Estate v. Rogers*, *supra*, footnote 27; *Zimmer v. Ringrose*, *supra*, footnote 31. But see *Haughian v. Paine*, *supra*, footnote 31.

⁵⁶ (1987), 39 C.C.L.T. 279, 36 D.L.R. (4th) 410, (*sub nom. Rocha v. Harris*) (B.C.C.A.).

⁵⁷ *Meyer Estate v. Rogers*, *supra*, footnote 27, at p. 318.

evidence from other doctors that most of their patients accept the treatment even when the risks are disclosed.⁵⁸

One final example of the difficulties in establishing causation relates to the plaintiff's acceptance of more serious risks than the one which materialized. In a number of cases the court has referred to the fact that the plaintiff was informed about more serious risks than the one which materialized but still consented to the treatment. The court has then inferred from this that disclosure of the less serious risk would have had no effect on the plaintiff's decision to undergo the treatment.⁵⁹ While there may be some force to this reasoning, it does tend to overlook the cumulative effect which risks can have on a person's decision with respect to proposed medical treatment.

In summary, despite the Supreme Court's adoption of the reasonable patient standard of disclosure and the fairly liberal way in which that standard has been interpreted, plaintiffs in informed consent cases are almost always unsuccessful, and often this is because of the requirement of causation. Indeed, unless the treatment itself is unreasonable (in which case the patient will have a cause of action for negligent treatment) or is truly elective, the claim for non-disclosure of information is almost doomed to fail, since "reasonable patients" will usually be presumed to follow the recommendation and advice of their physician.⁶⁰

D. Impact in Other Areas

The Supreme Court's decision in *Reibl* does not appear to have had much influence in other areas of health law in Canada. In particular, the erosion (or at least diminution) of professional autonomy underlying the Supreme Court's rejection of the reasonable physician standard of disclosure has not been reflected in other areas of medical malpractice law, where doctrines such as accepted medical practice, the respectable minority rule, and error of clinical judgment continue to protect professional independence.⁶¹

⁵⁸ *Andree v. Pierce* (1985), 35 Man. R. (2d) 244 (Man. Q.B.), varied (1986), 39 Man. R. (2d) 215 (Man. C.A.); *Ciarlariello v. Schacter*, *supra*, footnote 9; *Diack v. Bardsley*, *supra*, footnote 53; *Meyer Estate v. Rogers*, *supra*, footnote 27; *Rayner v. Knickle*, *supra*, footnote 28; *Schanzcl v. Singh*, *supra*, footnote 31; but see *Haughian v. Paine*, *supra*, footnote 31. In civil law countries in Europe (where a subjective test of causation is applied), this type of evidence has been rejected as inadmissible: see Giesen, *op. cit.*, footnote 48, p. 350.

⁵⁹ See, for example, *Beckley v. Toppin*, 19 October 1989, New Westminster Registry No. C850987, [1989] B.C.D. Civ. 2630-02 (B.C.S.C.); *Casey v. Provan*, *supra*, footnote 9; *Louie v. Robinson*, 18 January 1985, Vancouver Registry No. C831898, [1985] B.C.D. Civ. 2631-01 (S.C.); *Parkinson v. MacDonald* (1987), 40 C.C.L.T. 90 (B.C.S.C.).

⁶⁰ See A.M. Dugdale, *Diverse Reports: Canadian Professional Negligence Cases* (1986), 2 Prof. Neg. 108, at pp. 109-110; A.D. Twerski and N.B. Cohen, *Informed Decision Making and the Law of Torts: The Myth of Justiciable Causation*, [1988] Univ. Ill. L. Rev. 607, at p. 615.

⁶¹ See generally Picard, *op. cit.*, footnote 8, pp. 229-243.

However, the doctrine of informed consent has played an important role in one related area, namely the responsibility of physicians when a medical mistake occurs. Lawyers have an ethical duty to inform their clients if they make a mistake which is or may be damaging to the client.⁶² That duty is also a legal one, and a lawyer who fails to inform a client that a mistake has been made is guilty of fraudulent concealment which will postpone the running of the limitation period in respect of a claim by the client against the lawyer.⁶³ Prior to 1985 there was no indication in Canadian case-law of a similar duty being imposed on physicians.⁶⁴ In recent years, however, courts in Ontario have taken the position that a physician *is* under a duty to disclose medical mistakes. For example, in *Stamos v. Davies*⁶⁵ a surgeon punctured the patient's spleen in the course of performing a lung biopsy. Krever J., relying on a decision of the English Court of Appeal,⁶⁶ held that the surgeon was negligent not only in the performance of the procedure, but also in failing to inform the patient of what had happened.⁶⁷

The corollary between the duty to disclose risks and the duty to disclose errors is a novel one, but it appears logically sound. If, in the famous words of Cardozo J., a patient "has the right to determine what shall be done with his own body",⁶⁸ surely the patient also has a right to know what has in fact been done. The duty to disclose medical mistakes may have significant implications for the liability of health care professionals

⁶² Canadian Bar Association, Code of Professional Conduct (1988), pp. 10-11.

⁶³ *Vienneau v. Arsenaault* (1982), 41 N.B.R. (2d) 82 (N.B.C.A.).

⁶⁴ In *Johnston v. Board of Governors, Regina General Hospital* (1981), 129 D.L.R. (3d) 499, [1982] 1 W.W.R. 15 (Sask. Q.B.), the court commented that where a patient thinks that a medical procedure which went wrong was performed by Dr. X when in fact it was performed by Dr. Y, and hence the patient sues Dr. X, neither X nor Y has a duty to volunteer the correct facts to P. But note that the plaintiff in *Johnston* was allowed to substitute Y for X after the expiry of the limitation period.

⁶⁵ *Supra*, footnote 38.

⁶⁶ *Lee v. South West Thames Regional Health Authority*, [1985] 1 W.L.R. 845, [1985] 2 All E.R. 385 (C.A.). See also *Naylor v. Preston Area Health Authority*, [1987] 1 W.L.R. 958, [1987] 2 All E.R. 353 (C.A.); *Fowler v. Greater Glasgow Health Board*, [1990] S.L.T. 303 (Ct. Sess.). For a discussion of the case-law in the United States, see J. Vogel and R. Delgado, *To Tell the Truth: Physicians' Duty to Disclose Medical Mistakes* (1980); 28 U.C.L.A. L. Rev. 52; T.R. LeBlang and J.L. King, *Tort Liability for Non-Disclosure: The Physician's Obligation to Disclose Patient Illness and Injury* (1984), 89 Dick. L. Rev. 1.

⁶⁷ See also *Branche v. MacArthur* (1986), 30 D.L.R. (4th) 301, 56 O.R. (2d) 71 (Ont. Div. Ct.); *Hadley v. Allore* (1985), 24 D.L.R. (4th) 694, 35 C.C.L.T. 204 (Ont. H.C.), aff'd (1988), 54 D.L.R. (4th) 702, 43 C.C.L.T. 106 (Ont. C.A.); *Kueper v. McMullin*, *supra*, footnote 55.

⁶⁸ *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, at p. 93, 211 N.Y. 125, at pp. 129-130 (N.Y.C.A., 1914).

and hospitals,⁶⁹ particularly with respect to issues such as limitation periods⁷⁰ and disclosure of quality assurance and risk management reports.⁷¹

III. *Impact of Reibl v. Hughes in Other Jurisdictions*

The Supreme Court's decision in *Reibl* has had very little impact on legal developments outside of the common law provinces of Canada. It was expressly rejected in *Sidaway v. Board of Governors of the Bethlem Royal Hospital*,⁷² in which the House of Lords declined to adopt the reasonable patient standard of disclosure. The House of Lords held that disclosure is a matter of clinical judgment, to be measured by the standard of the reasonable physician, subject (perhaps) to one qualification, namely, that physicians ought to disclose substantial risks of grave adverse consequences. Some writers have taken an optimistic view of *Sidaway*,⁷³ regarding it as a small but significant step in the direction of accepting the doctrine of informed consent. However, later decisions both in England⁷⁴ and in Scotland⁷⁵ suggest that this optimism may be misplaced. In Australia, *Reibl* has had minimal impact; the courts tend to favour a professional standard of disclosure (subject to the court's power to reject such a standard as unreasonable),⁷⁶ and the objective test of causation enunciated in *Reibl*

⁶⁹ Note that in 1989 the Royal Victoria Hospital in Montreal introduced guidelines concerning the disclosure of unexpected incidents to patients and their families. The guidelines provide: "Generally speaking, the facts of the incident, once collected, will be disclosed to the patient." See A. Peterkin, Guidelines Covering Disclosure of Errors Now in Place at Montreal Hospital (1990), 142 Can. Med. Assoc. J. 984.

⁷⁰ This is discussed in G.B. Robertson, *Fraudulent Concealment and the Duty to Disclose Medical Mistakes* (1987), 25 Alta. L. Rev. 215.

⁷¹ The duty to disclose medical mistakes may translate into a duty to disclose the contents of quality assurance and risk management reports. However, in some provinces such reports are subject to evidentiary privilege: see D.G. Duff, *Evidentiary Privilege for Hospital Quality Assurance and Risk Management: Assessing Statutory Reform* (1989), 47 U.T. Fac. L. Rev. 526.

⁷² [1985] A.C. 871, [1985] 1 All E.R. 643 (H.L.).

⁷³ See, for example, Kennedy, *op. cit.*, footnote 33, pp. 193-215; Giesen, *op. cit.*, footnote 48, pp. 266-267; S. Lee, *Operating Under Informed Consent* (1985), 101 Law Q. Rev. 316; J.K. Mason, *Informed Consent—An Overview*, in Law Reform Commission of Victoria, *Informed Consent Symposia* (1986), p. 133.

⁷⁴ *Gold v. Haringey Health Authority*, [1988] Q.B. 481, [1987] 2 All E.R. 888 (C.A.); *Blyth v. Bloomsbury Area Health Authority*, 11 February 1987 (C.A.), reproduced in I. Kennedy and A. Grubb, *Medical Law: Text and Materials* (1989), p. 271.

⁷⁵ *Moyes v. Lothian Health Board*, [1990] S.L.T. 444 (Ct. Sess.); *Goorkani v. Tayside Health Board*, [1991] S.L.T. 94 (Ct. Sess.).

⁷⁶ *F. v. R.* (1983), 33 S.A.S.R. 189 (S.C. in banco); *Battersby v. Tottman* (1985), 37 S.A.S.R. 524 (S.C. in banco); *Gover v. State of South Australia* (1985), 39 S.A.S.R. 543 (S.C.). For a discussion of the Australian case-law, see Law Reform Commission of Victoria, *Informed Decisions About Medical Procedures* (Report No. 24, 1989); D. Manderson, *Following Doctors' Orders: Informed Consent in Australia* (1988), 62 Aust. L.J. 430; C.J.H. Thomson, *Conditions for Judicial Emergence of the Doctrine of Informed Consent: An American-Australian Comparison* (1988), 7 Med. & Law 15.

has been expressly rejected in favour of a subjective test.⁷⁷ The objective test of causation has also been rejected by the Quebec courts.⁷⁸

IV. *Impact of Reibl v. Hughes on Medical Practice*

The results of an empirical study published in 1984 indicated that the Supreme Court's decision in *Reibl* had had little impact on medical practice in Canada.⁷⁹ The study, which was based on a survey of 1,000 surgeons across Canada approximately two years after the *Reibl* decision, concluded that 75% of the respondents were unaware of the Supreme Court's decision. The study also found that a majority of the respondents held opinions which were incompatible with *Reibl*; in particular, they were of the view that the question of whether to inform patients of risks associated with proposed treatment is entirely a matter for the doctor's clinical judgment, and that in this regard doctors should be guided more by what they think the patient ought to be told than by what they think the patient would want to be told. Moreover, of those respondents who were aware of the decision in *Reibl*, only 42% indicated that it had resulted in their spending more time with patients discussing the risks associated with proposed treatment.

More recent evidence, however, suggests that with the passage of time *Reibl* may now be having some (indirect) effect on medical practice in Canada. That evidence comes from empirical studies which were undertaken as part of the work of the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care.⁸⁰ These studies indicate that physicians are now spending more time with their patients discussing the risks and benefits associated with proposed treatment, and that the main reason for this is fear of potential liability. As Professor Dickens notes:⁸¹

[P]hysicians appear to have absorbed the message of the law, expressed in *Reibl v. Hughes*, that they must communicate more adequately with their patients. Spending more time in discussion does not ensure, of course, that the time is well spent; increased quantity of interactive time does not guarantee the quality of the discourse and critical information exchange. An increase in time spent may, however, be

⁷⁷ *Ellis v. Wallsend District Hospital* (1989), 17 N.S.W.L.R. 553 (C.A.); *Gover v. State of South Australia*, *supra*, footnote 75.

⁷⁸ *Boyer v. Grignon* (1988), 46 C.C.L.T. 47, [1988] R.J.Q. 829 (Que. S.C.); *Dodds v. Schierz* (1986), 40 C.C.L.T. 167, [1986] R.J.Q. 2623 (Que. C.A.). The same is true of most European civil law countries: see Giesen, *op. cit.*, footnote 48, p. 347.

⁷⁹ G.B. Robertson, *Informed Consent in Canada: An Empirical Study* (1984), 22 Osgoode Hall L.J. 139.

⁸⁰ For a discussion of these empirical studies, see B.M. Dickens, *The Effects of Legal Liability on Health Care Providers*, and F. Sellers, *Report on the Survey of the Impact of Medical/Legal Liability on Patterns of Practice*, both of which are published in the Report of the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care (Chairman: J.R.S. Prichard), *Liability and Compensation in Health Care*, Appendix B, vol. 2 (1990).

⁸¹ *Ibid.*, p. 51.

positively related to, and may even be a precondition of, achievement of the required quality of human interaction. Accordingly, increased time spent in the physician-patient interaction may indicate that the value embodied in the judgment in *Reibl v. Hughes* is being respected and perhaps achieved.

It is ironic that fear of legal liability should be cited by physicians as the main reason for their spending more time in discussion with patients, given that, as we have seen, the vast majority of claims based on lack of disclosure of material information are unsuccessful. However, it is probably the *perception* of increased liability (rather than its reality) that may be having an impact on medical practice with respect to disclosure of information to patients. To what extent this change can be attributed to the Supreme Court's decision in *Reibl* is difficult to assess. For example, there is some evidence that the amount of information which doctors give patients concerning proposed treatment has increased over the last ten years even in jurisdictions where the courts have expressly declined to follow the Supreme Court's decision in *Reibl*.⁸² As was stated by the Law Reform Commission of Victoria:⁸³

During the last 20 years, there has been a gradual but significant change in the relationship between doctor and patient. Communication between doctors and patients has improved. There has been growing recognition, particularly among younger doctors, that patients should have more information about their condition, prognosis and treatment options and that patients are entitled to make decisions about their treatment.

In summary, the most recent empirical studies in Canada indicate that physicians are spending more time with patients discussing risks and benefits of proposed treatment, and that they are doing so primarily because of a fear of legal liability. However, it is not entirely clear whether this fear of liability can be attributed to the decision in *Reibl*, or to factors unrelated to that decision.

V. Symbolic Significance of *Reibl v. Hughes*

We have seen that the Supreme Court's decision in *Reibl* has had no real impact on either the frequency or the severity of malpractice claims, and that its impact on medical practice is somewhat unclear. However, perhaps the real significance of *Reibl* lies in its symbolic importance, in particular its emphasis on the patient's "right to know" and its rejection of a paternalistic approach to determining how much information is to be given to patients. A number of writers have emphasized the importance of informed consent as affecting the nature of the doctor-patient relationship

⁸² See *Moyes v. Lothian Health Board*, *supra*, footnote 75, at p. 449, where the trial judge referred to the evidence that the practice of disclosing risks involved in an angiography had increased in the last ten years, and that this "movement towards more openness has seemingly been prompted by medico-legal reasons as much as by purely medical reasons". See also Teff, *loc. cit.*, footnote 33, at p. 453.

⁸³ Law Reform Commission of Victoria, *op. cit.*, footnote 76, p. 3.

and the power base underlying that relationship.⁸⁴ The doctrine of informed consent, and in particular the rejection of the professional standard of disclosure, represent a significant restriction on professional autonomy and independence, in the same way as a rejection of the doctrine and an insistence on the professional standard of disclosure represent a deference to the autonomy (and power) of the medical profession. For example, referring to the House of Lords' decision in *Sidaway*,⁸⁵ Teff observes that:⁸⁶

The law alone cannot effect a substantial change in the routine behaviour of doctors, but it could have some symbolic impact on their perception of what is appropriate in relationships with patients. *Sidaway* suggests that medical paternalism remains in essence unexceptionable.

In the final analysis, the importance of *Reibl v. Hughes* may lie in what it tells us about the relationship between doctor and patient, and the relative power and autonomy within that relationship. Ultimately, that symbolism may have an impact on medical practice. As Professor Katz notes:⁸⁷

Doctors and judges will have to learn to live at least with the doctrine's symbolic significance. While it has always been the fate of symbols to be honored more in words than in deeds, and informed consent will prove to be no exception, symbols can nag and prod and disturb and ultimately bring about some change.

⁸⁴ See, for example, J. Katz, *The Silent World of Doctor and Patient* (1984); M.A. Somerville, *Informed Consent: An Introductory Overview*, in Law Reform Commission of Victoria, *op. cit.*, footnote 73, p. 2.

⁸⁵ *Sidaway v. Board of Governors of the Bethlem Royal Hospital*, *supra*, footnote 72.

⁸⁶ Teff, *loc. cit.*, footnote 33, at p. 453.

⁸⁷ Katz, *op. cit.*, footnote 84, p. 60.

APPENDIX I
TABLE A
POST-REIBL v. HUGHES CASES

1 CASE #	2 YEAR	3 PROV.	4 INF. CON. ALONE?	5 NEG. FOUND?	6 CAUSATION FOUND?	7 LIABILITY IMPOSED?	8 DAMAGES (\$)
93	80	Ont	No	Yes	Yes	Yes	225,000
117	81	Alta	No	Yes	No	Yes (og)	5,000
35	81	BC	No	No	N/A	No	
7	81	NB	No	Yes	No	No	
110	81	Ont	No	No	N/A	Yes (og)	?
116	81	Ont	No	No	N/A	Yes (og)	21,182
47	82	Alta	No	No	N/A	No	
64	82	Alta	No	No	No	No	
61	82	Alta	No	No	N/A	Yes (og)	10,887
91	82	BC	No	Yes	Yes	Yes	20,000
18	82	NS	No	Yes	No	No	
32	82	Ont	No	No	No	Yes (og)	12,500
114	82	Ont	No	Yes	Yes	Yes (oga)	11,423
98	83	BC	Yes	No	No	No	
88	83	Man	No	No	N/A	No	
59	83	NS	No	No	N/A	Yes (og)	11,500
36	83	Ont	No	No	No	No	
80	83	Ont	No	Yes	No	Yes (og)	85,582
22	84	BC	Yes	Yes	No	No	
39	84	BC	No	No	No	No	
84	84	BC	Yes	Yes	No	No	
101	84	BC	No	No	N/A	No	
4	84	NB	No	No	N/A	No	
34	84	NB	No	Yes	No	No	
16	84	Ont	No	Yes	No	No	
56	84	Ont	No	No	No	No	
108	85	Alta	No	Yes	No	Yes (og)	6,500
13	85	BC	No	No	No	No	
43	85	BC	Yes	Yes	Yes	Yes	13,500
57	85	BC	Yes	No	No	No	
85	85	BC	No	No	No	No	
102	85	BC	Yes	Yes	Yes	Yes	10,503
109	85	Man	No	Yes	No	No	
41	85	NS	No	?	?	Yes (og)	40,000
10	85	Ont	No	Yes	Yes	Yes (oga)	18,342
27	85	Ont	No	Yes	No	No	
71	85	Ont	No	No	N/A	No	

1 CASE #	2 YEAR	3 PROV.	4 INF. CON. ALONE?	5 NEG. FOUND?	6 CAUSATION FOUND?	7 LIABILITY IMPOSED?	8 DAMAGES (\$)
103	885	Ont	No	Yes	No	Yes (og)	28,104
82	86	Alta	No	No	No	No	
11	86	BC	No	No	N/A	Yes (og)	12,500
55	86	BC	No	No	N/A	No	
70	86	BC	No	Yes	No	No	
94	86	BC	No	Yes	Yes	Yes (oga)	451,000
107	86	BC	No	No	No	No	
112	86	BC	No	No	No	No	
3	86	Man	No	No	No	Yes (og)	31,300
49	86	NB	Yes	Yes	No	No	
66	86	NB	No	Yes	Yes	Yes	213,953
15	86	Ont	No	No	No	No	
33	86	Ont	No	Yes	Yes	Yes (oga)	783,280
48	86	Ont	No	No	N/A	No	
89	86	Ont	No	No	No	No	
30	86	Sask	No	Yes	Yes	Yes (oga)	50,200
68	87	Alta	No	No	N/A	No	
87	87	Alta	No	Yes	No	Yes (og)	225,062
99	87	Alta	No	Yes	Yes	Yes (oga)	110,000
29	87	BC	Yes	Yes	Yes	Yes	2,500
42	87	BC	No	No	No	No	
78	87	BC	No	Yes	Yes	Yes (oga)	9,065
81	87	BC	No	No	No	No	
100	87	BC	No	Yes	No	No	
90	87	Man	No	No	No	No	
113	87	NB	No	No	N/A	No	
31	87	NS	No	No	N/A	No	
9	87	Ont	No	No	No	No	
79	87	Ont	No	Yes	No	Yes (og)	7,000
83	87	Ont	No	No	N/A	Yes (og)	735,515
37	87	Sask	No	Yes	Yes	Yes	?
6	88	BC	No	?	No	Yes (og)	45,000
40	88	BC	No	No	N/A	No	
46	88	BC	No	No	N/A	Yes (og)	22,076
1	88	NB	No	Yes	Yes	Yes (oga)	174,230
54	88	Ont	No	No	No	No	
72	88	Ont	No	No	No	No	
74	88	Ont	No	No	N/A	No	
111	88	Ont	No	Yes	Yes	Yes (oga)	17,000
105	88	Sask	No	No	No	No	

1 CASE #	2 YEAR	3 PROV.	4 INF. CON. ALONE?	5 NEG. FOUND?	6 CAUSATION FOUND?	7 LIABILITY IMPOSED?	8 DAMAGES (\$)
58	89	Alta	No	No	N/A	No	
69	89	Alta	No	Yes	Yes	Yes (oga)	39,051
5	89	BC	Yes	Yes	No	No	
19	89	BC	No	Yes	Yes	Yes (oga)	146,600
53	89	BC	No	Yes	Yes	Yes (oga)	429,628
75	89	BC	No	?	No	Yes (og)	53,125
45	89	NB	Yes	Yes	No	No	
2	89	NS	No	No	No	No	
8	89	Ont	No	No	N/A	No	
20	89	Ont	Yes	Yes	Yes	Yes	33,204
24	89	Ont	Yes	No	No	No	
50	89	Ont	No	No	No	No	
76	89	Ont	No	?	No	Yes (og)	70,000
77	89	Ont	No	Yes	No	Yes (og)	143,606
104	89	Ont	No	No	No	No	
106	89	Ont	No	?	No	Yes (og)	118,815
51	89	Sask	No	Yes	No	Yes	5,000
21	90	Alta	No	No	No	No	
26	90	Alta	No	Yes	No	Yes (og)	?
63	90	Alta	No	No	N/A	No	
95	90	Alta	No	Yes	No	No	
25	90	BC	Yes	No	No	No	
38	90	BC	No	No	N/A	No	
52	90	BC	No	No	N/A	Yes (og)	?
65	90	BC	No	No	N/A	No	
86	90	BC	No	No	N/A	Yes (og)	?
97	90	BC	No	No	N/A	No	
115	90	BC	No	No	No	No	
14	90	Nfld	No	Yes	No	Yes (og)	?
73	90	Nfld	No	No	N/A	No	
23	90	Ont	No	No	N/A	No	
28	90	Ont	No	No	No	No	
60	90	Ont	No	No	No	Yes (og)	2,000
62	90	Ont	No	No	No	No	
96	90	Ont	No	No	N/A	No	
12	91	BC	No	N/A	No	No	
44	91	BC	No	No	N/A	No	
17	91	Ont	No	No	No	No	
67	91	Ont	No	Yes	No	No	
92	91	PEI	No	No	No	Yes (og)	60,000

APPENDIX II
LIST OF CASES ANALYZED

1. *Allen v. Farrell* (1988), 86 N.B.R. (2d) 50 (Q.B.).
2. *Anderson v. Grace Maternity Hospital* (1989), 93 N.S.R. (2d) 141 (S.C.).
3. *Andree v. Pierce* (1985), 35 Man. R. (2d) 244 (Q.B.), varied (1986), 39 Man. R. (2d) 215 (C.A.).
4. *Arnold v. Bonnell* (1984), 55 N.B.R. (2d) 385 (Q.B.).
5. *Beckley v. Toppin*, 19 October 1989, New Westminster Registry No. C850987, [1989] B.C.D. Civ. 2630-02 (S.C.).
6. *Bera v. Marr*, [1988] B.C.D. Civ. 2632-15, 3393-01 (S.C.).
7. *Bickford v. Stiles* (1981), 128 D.L.R. (3d) 516 (N.B.Q.B.).
8. *Biggs v. Richter* (1989), 18 A.C.W.S. (3d) 101 (Ont. Dist. Ct.).
9. *Bonnell v. Moddel*, 5 February 1987, No. 1399/82, 3 A.C.W.S. (3d) 441 (Ont. H.C.).
10. *Brain v. Mador* (1985), 32 C.C.L.T. 157 (Ont. C.A.), leave to appeal to S.C.C. refused 64 N.R. 240 (S.C.C.).
11. *Brisbois v. Robinson*, 21 January 1986; Vancouver Registry No. C834946, [1986] B.C.D. Civ. 2632-01 (S.C.).
12. *Brooks v. Spencer*, 15 January 1991, Duncan Registry No. 2148, 25 A.C.W.S. (3d) 368 (B.C.S.C.).
13. *Brown v. Roque*, 29 March 1985, Victoria Registry No. 821257, [1985] B.C.D. Civ. 2630-01 (S.C.).
14. *Brushett v. Cowan* (1990), 3 C.C.L.T. (2d) 195 (Nfld. C.A.).
15. *Bucknam v. Kostuik* (1983), 44 O.R. (2d) 102 (H.C.), aff'd (1986), 55 O.R. (2d) 187 (C.A.).
16. *Casey v. Provan* (1984), 11 D.L.R. (4th) 708 (Ont. H.C.).
17. *Ciarlariello v. Schacter*, 3 November 1987, No. 7448/81 and 11750/81, 7 A.C.W.S. (3d) 51 (Ont. H.C.), aff'd *sub nom. Ciarlariello Estate v. Schacter* (1991), 76 D.L.R. (4th) 449 (Ont. C.A.).
18. *Considine v. Camp Hill Hospital* (1982), 133 D.L.R. (3d) 11 (N.S.S.C.).
19. *Coughlin v. Kunz* (1987), 17 B.C.L.R. (2d) 365 (S.C.), aff'd (1989), 2 C.C.L.T. (2d) 42 (C.A.).
20. *Cupido v. Sargeant*, 7 March 1989, No. 15804/86 and 3405/87, 14 A.C.W.S. (3d) 217 (Ont. H.C.).
21. *Dezward v. Misericordia Hospital* (1988), 64 Alta. L.R. (2d) 72 (Q.B.), aff'd (*sub nom. Dezward v. Schulze*) (1990), 105 A.R. 312 (C.A.).
22. *Diack v. Bardsley* (1983), 25 C.C.L.T. 159 (B.C.S.C.), aff'd (1984), 31 C.C.L.T. 308 (C.A.).
23. *Dods v. Richard* (1987), 10 A.C.W.S. (3d) 242 (Ont. H.C.), aff'd (1990), 20 A.C.W.S. (3d) 1156 (C.A.).
24. *Dunn v. North York General Hospital* (1989), 48 C.C.L.T. 23 (Ont. H.C.).
25. *Erbatur v. Carruthers*, 3 April 1990, Vancouver Registry No. C885767, [1990] B.C.D. Civ. 2630-01 (S.C.).
26. *Feist v. Gordon* (1989), 67 Alta. L.R. (2d) 283 (Q.B.), aff'd (1990), 76 Alta. L.R. (2d) 234 (C.A.).
27. *Ferguson v. Hamilton Civic Hospitals* (1983), 23 C.C.L.T. 254 (Ont. H.C.), aff'd (1985), 33 C.C.L.T. 56 (C.A.).
28. *Ferron v. Yadav*, 30 March 1990, No. 344/86, 20 A.C.W.S. (3d) 436 (Ont. H.C.).

29. *Flores v. McLeod*, 9 November 1987, Vancouver Registry No. C861399, [1988] B.C.D. Civ. 2631-01 (S.C.).
30. *Frerotte v. Irwin* (1986), 51 Sask. R. 108 (Q.B.).
31. *Goguen v. Crowe* (1987), 40 C.C.L.T. 212 (N.S.S.C.).
32. *Gonda v. Kerbel* (1982), 24 C.C.L.T. 222 (Ont. H.C.).
33. *Graham v. Persyko* (1986), 27 D.L.R. (4th) 699 (Ont. C.A.).
34. *Grey v. Webster* (1984), 57 N.B.R. (2d) 396 (Q.B.).
35. *Guertin v. Kester* (1981), 20 C.C.L.T. 225 (B.C.S.C.).
36. *Hajgato v. London Health Association* (1982), 36 O.R. (2d) 669 (H.C.), aff'd (1983), 44 O.R. (2d) 264 (C.A.).
37. *Haughian v. Paine*, [1987] 4 W.W.R. 97 (Sask. C.A.), leave to appeal to S.C.C. refused, [1987] 6 W.W.R. lix (S.C.C.).
38. *Hollis v. Birch*, 7 May 1990, Vancouver Registry No. C891761, [1990] B.C.D. Civ. 2632-10 (S.C.).
39. *Hopps v. Robinson*, 19 November 1984, Vancouver Registry No. C826010, 29 A.C.W.S. (2d) 161 (B.C.S.C.).
40. *Hunter v. McNeill* (1988), 44 C.C.L.T. 101 (B.C.S.C.).
41. *Jodrey v. Dhalla* (1985), 66 N.S.R. (2d) 245 (C.A.), leave to appeal to S.C.C. refused, 59 N.R. 160 (S.C.C.).
42. *Keeping v. Hein*, 21 September 1987, Vancouver Registry No. C860935, [1987] B.C.D. Civ. 2632-06 (S.C.).
43. *Kellett v. Griesdale*, 26 June 1985, Vancouver Registry No. C860935, [1987] B.C.D. Civ. 2632-06 (S.C.).
44. *Kita v. Braig*, 10 January 1991, Vancouver Registry No. C873694, 24 A.C.W.S. (3d) 1167 (B.C.S.C.).
45. *Kitchen v. McMullen* (1989), 50 C.C.L.T. 213 (N.B.C.A.), leave to appeal to S.C.C. refused, [1990] 1 S.C.R. viii.
46. *Koerts v. Yoneda*, 2 September 1988, Victoria Registry No. 851605, [1988] B.C.D. Civ. 2632-13 (S.C.).
47. *Konkolus v. Royal Alexandra Board of Governors* (1982), 21 Alta. L.R. (2d) 359 (Q.B.).
48. *Koskimaki v. Reed* (1985), 33 A.C.W.S. (2d) 55 (Ont. H.C.), aff'd 18 December 1986, No. 97/85 (C.A.).
49. *Kueper v. McMullin* (1986), 37 C.C.L.T. 318 (N.B.C.A.).
50. *Kungl v. Fallis*, 10 January 1989, No. 12482/83 (Ont. H.C.).
51. *Lachambre v. Nair*, [1989] 2 W.W.R. 749 (Sask. Q.B.).
52. *Latin v. Children's Hospital*, 16 March 1990, Vancouver Registry No. C825691, [1990] B.C.D. Civ. 2632-06 (S.C.).
53. *Levitt v. Carr*, 27 June 1989, Vancouver Registry No. C843378, [1989] B.C.D. Civ. 2631-01, 2632-10 (S.C.).
54. *Lipton v. Morgan*, 2 February 1988, No. 52815/80, 8 A.C.W.S. (3d) 139 (Ont. H.C.).
55. *Litke v. Bouaziz*, 6 June 1986, Vancouver Registry No. C850242, [1986] B.C.D. Civ. 2632-05 (S.C.).
56. *Lokay v. Kilgour* (1984), 31 C.C.L.T. 177 (Ont. H.C.).
57. *Louie v. Robinson*, 18 January 1985, Vancouver Registry No. C831898, [1985] B.C.D. Civ. 2631-01 (S.C.).
58. *Lucich v. Hunka* (1989), 101 A.R. 161 (Q.B.).
59. *MacDonald v. Ross* (1983), 24 C.C.L.T. 242 (N.S.S.C.).
60. *MacPherson v. Allen*, 28 February 1990, No. 318/86 (Ont. H.C.).

61. *McBride v. Langton* (1982), 39 A.R. 61 (Q.B.).
62. *McGregor v. Royal Victoria Hospital of Barrie*, 5 February 1990, No. 2899/85, 19 A.C.W.S. (3d) 613 (Ont. H.C.).
63. *Malbeuf v. Wannas*, [1990] Alta. D. 2632-02 (Q.B.).
64. *Mang v. Moscovitz* (1982), 37 A.R. 221 (Q.B.).
65. *Martin v. Reeve*, 30 March 1990, Vancouver Registry No. C854300, [1990] B.C.D. Civ. 2632-07 (S.C.).
66. *Mason v. Forgie* (1984), 31 C.C.L.T. 66 (N.B.Q.B.), aff'd (1986), 38 C.C.L.T. 171 (C.A.), leave to appeal to S.C.C. refused (1987), 39 C.C.L.T. xxx (S.C.C.).
67. *Meyer Estate v. Rogers* (1991), 78 D.L.R. (4th) 307 (Ont. Gen. Div.).
68. *Mitchell v. McDonald* (1987), 40 C.C.L.T. 266 (Alta. Q.B.).
69. *Montaron v. Wagner* (1988), 57 Alta. L.R. (2d) 273 (Q.B.), varied (1989), 70 Alta. L.R. (2d) 86 (C.A.).
70. *Moore v. Bogoch* (1986), 36 C.C.L.T. 150 (B.C.C.A.).
71. *Moore v. Knowlton*, 10 May 1985, No. 52897/80, 31 A.C.W.S. (2d) 72 (Ont. H.C.).
72. *Morrison v. Patel* (1988), 44 C.C.L.T. 264 (Ont. H.C.).
73. *Murphy v. Attuah*, 13 September 1990, No. 1985 G.F. (D.C.) 242, 25 A.C.W.S. (3d) 369 (Nfld. S.C.).
74. *Nemeth v. Clarke Institute of Psychiatry* (1988), 12 A.C.W.S. (3d) 179 (Ont. H.C.).
75. *Nevison v. Hayward*, 25 July 1989, Vancouver Registry No. C863813, [1989] B.C.D. Civ. 2632-13 (S.C.).
76. *Nightingale v. Kaplovitch*, 20 April 1989, No. 2982/95, 15 A.C.W.S. (3d) 42 (Ont. H.C.).
77. *Norris v. LeBlanc*, 30 May 1989, No. 17464/84, 15 A.C.W.S. (3d) 408 (Ont. H.C.).
78. *Oberst v. Proctor*, 24 April 1987, Vancouver Registry No. C845538 (B.C.S.C.).
79. *O'Connell v. Gelb* (1987), 3 A.C.W.S. (3d) 305 (Ont. H.C.).
80. *O'Connell v. Munro* (1983), 22 A.C.W.S. (2d) 349 (Ont. H.C.).
81. *Parkinson v. MacDonald* (1987), 40 C.C.L.T. 90 (B.C.S.C.).
82. *Pawluk v. Dobson* (1986), 77 A.R. 260 (C.A.).
83. *Perciballi v. Leamington District Memorial Hospital*, 6 March 1985, No. 4490/80, 30 A.C.W.S. (2d) 116 (Ont. H.C.), aff'd (1987), 4 A.C.W.S. (3d) 337 (C.A.).
84. *Petty v. MacKay* (1984), 31 C.C.L.T. 155 (B.C.C.A.).
85. *Pike v. Peace Arch District Hospital Society*, 23 August 1985, New Westminster Registry No. A811734, [1985] B.C.D. Civ. 2632-03 (S.C.).
86. *Pilon v. Bouaziz*, 13 September 1990, Vancouver Registry No. C885416, [1990] B.C.D. Civ. 2632-15 (S.C.).
87. *Poole v. Morgan*, [1987] 3 W.W.R. 217 (Alta. Q.B.).
88. *Poulin v. Health Sciences Centre* (1983), 23 Man. R. (2d) 313 (C.A.), leave to appeal to S.C.C. refused, 26 Man. R. (2d) 318 (S.C.C.).
89. *Pridham v. Nash* (1986), 57 O.R. (2d) 347 (H.C.).
90. *Puranen v. Thomson* (1987), 46 Man. R. (2d) 55 (Q.B.).
91. *Rawlings v. Lindsay* (1982), 20 C.C.L.T. 301 (B.C.S.C.).
92. *Rayner v. Knickle* (1988), 47 C.C.L.T. 141 (P.E.I.S.C.), rev'd in part 20 February 1991, Action No. AD-0095, 25 A.C.W.S. (3d) 967 (C.A.).
93. *Reibl v. Hughes*, [1980] 2 S.C.R. 880.
94. *Reynard v. Carr* (1986), 38 C.C.L.T. 217 (B.C.C.A.).

95. *Rolof v. Morris* (1990), 109 A.R. 128 (Q.B.).
96. *Rothwell v. Raes* (1988), 66 O.R. (2d) 449, additional reasons (1989), 69 O.R. (2d) 62 (H.C.), aff'd (1990), 76 D.L.R. (4th) 280 (C.A.).
97. *St. Jules v. Chan*, 9 January 1990, Nanaimo Registry No. SC8412, [1990] B.C.D. Civ. 2632-01 (S.C.).
98. *Sanderson v. Lamont*, 29 June 1983, Vancouver Registry No. C803801, [1983] B.C.D. Civ. 2630-01 (S.C.).
99. *Schanczl v. Singh* (1987), 56 Alta. L.R. (2d) 303 (Q.B.).
100. *Schanilec Estate v. Harris* (1987), 39 C.C.L.T. 279 (B.C.C.A.).
101. *Schinz v. Diockinson* (1984), 31 C.C.L.T. 313 (B.C.C.A.).
102. *Sinclair v. Boulton* (1985), 33 C.C.L.T. 125 (B.C.S.C.).
103. *Stamos v. Davies* (1985), 52 O.R. (2d) 10 (H.C.).
104. *Stewart v. Chan*, 16 February 1989, No. 1928/82, 14 A.C.W.S. (2d) 95 (Ont. H.C.).
105. *Stewart v. Ross* (1988), 64 Sask. R. 271 (Q.B.).
106. *Sture v. Henderson General Hospital*, 3 March 1989, No. 4689/84 (Ont. H.C.).
107. *Thomson v. Kootenay Lake District Hospital and Health Services Society*, [1986] B.C.D. Civ. 2630-01 (S.C.).
108. *Thorne v. Murphy* (1985), 65 A.R. 86 (Q.B.).
109. *Van Ginkel v. Hollenberg* (1985), 36 Man. R. (2d) 291 (Q.B.).
110. *Videto v. Kennedy* (1981), 17 C.C.L.T. 307 (Ont. C.A.).
111. *Walker v. Law* (1986), 59 O.R. (2d) 46 (H.C.), aff'd (1988), 63 O.R. (2d) 799 (Div. Ct.).
112. *Walton v. Song-Hing*, 14 July 1986, Vancouver Registry No. C841697, [1986] B.C.D. Civ. 2630-03 (S.C.).
113. *Whalen v. McLaughlin* (1987), 78 N.B.R. (2d) 91 (Q.B.).
114. *White v. Turner* (1981), 15 C.C.L.T. 81 (Ont. H.C.), aff'd (1982), 12 D.L.R. (4th) 319 (C.A.).
115. *Wilson v. Guichon*, 7 August 1990, Vancouver Registry No. C863922 and C865281, [1990] B.C.D. Civ. 2631-01 (S.C.).
116. *Zamparo v. Brisson* (1981), 16 C.C.L.T. 66 (Ont. C.A.).
117. *Zimmer v. Ringrose* (1981), 124 D.L.R. (3d) 215 (Alta. C.A.), leave to appeal to S.C.C. refused, 28 A.R. 92 (S.C.C.).