YOU CAN'T GET THERE FROM HERE: A CASE COMMENT ON *ARNDT* v. *SMITH*

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> [I]t is time the Supreme Court of Canada reconsidered the question of causation in those medical malpractice cases where the negligence alleged consists of a failure to make all reasonable disclosure necessary to an informed decision by the patient on a course of treatment . . . the rule in *Reibl* v. *Hughes* is inadequate to the point where injustice can surely result from its application. That is particularly so in cases such as this, where any treatment decision involves a delicate balancing of overlapping personal, ethical, and medical considerations which can lead to more than one "reasonable" choice.[1]

Introduction

For those who follow developments in Canadian health law, the decision of the Supreme Court of Canada in *Arndt* v. *Smith*[2] was the ultimate anti-climax.

The decision is disappointing principally because the Supreme Court declined to consider in any meaningful way the number of problems with the doctrine of informed consent that have been identified by academic commentators and judges alike.[3]

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1 *Arndt* v. *Smith* (1995), 6 B.C.L.R. (3d) 201 at 226 (C.A.), Wood J.A. [hereinafter *Arndt (B.C.C.A.)*]. The Court as a whole reiterated this sentiment at the conclusion of the judgment when it stated at 229:

> Having regard to our reasons, we all agree that the task of the trial judge on the new trial will be a difficult one unless the Supreme Court of Canada is willing to consider and resolve the central problems in relation to the issue of causation that are raised by this appeal.

2 *Arndt* v. *Smith*, [1997] 2 S.C.R. 539, 148 D.L.R. (4th) 48 [hereinafter *Arndt* cited to D.L.R.].

3 See *supra* note 1. See also J. Katz, "Informed Consent—A Fairy Tale? Law's Vision" (1977-78) 39 U. Pitt. L. Rev. 137; G. B. Robertson, "Informed Consent Ten Years Later: The Impact of *Reibl* v. *Hughes*" (1991) 70 Can. Bar Rev. 423; E. I. Picard & G. B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3rd ed. (Scarborough: Carswell, 1996) at 157-69.

Reibl v. *Hughes*[4] signaled a new era in health law; the paternalistic "professional" standard of disclosure was replaced with a patient-centred standard which recognizes the central relevance of individual autonomy to medical decision-making. Indeed, at the time it was decided, *Reibl* was considered to be a most significant and potentially influential health law case, and the principles which have flowed from the decision permeate virtually all of the subsequent case law where the issue of autonomy is raised.[5] Despite all of its perceived advantages over previous case law, however, the doctrine set out in *Reibl* has some significant flaws—flaws which, as noted by Wood J.A., have the potential to result in substantial injustice. *Arndt* seemed to provide the Supreme Court with the ideal opportunity to address these insufficiencies.

This case comment will review the law on informed consent in Canada, including the recent developments with respect to product liability. We will note the flaws in the modified objective causation test and argue for a move toward a more subjective standard of causation, one that is informed by the intensely personal characteristics of the plaintiff that have a role in that person's decision-making. A subjective test could also go a long way toward addressing one of the main concerns raised in *Arndt*: what is a court to do when faced with the possibility that there is more than one "reasonable" course of action?

The Law: Informed Consent after Reibl *v.* Hughes

Reibl v. *Hughes* marked the departure of Canadian courts from the professional standard of disclosure with regard to proposed medical treatment. Prior to *Reibl* (and its precursor, *Hopp* v. *Lepp*),[6] Canadian courts considering a plaintiff's claim that his or her consent to treatment was not "informed" employed the standard of the reasonable physician. The test was: what would the reasonable physician tell his or her patient?[7] In *Reibl*, the Supreme Court of Canada rejected that standard and replaced it with a patient-centred test: what would the reasonable person in this patient's position want to know before making a decision

4 *Reibl* v. *Hughes*, [1980] 2 S.C.R. 880, 114 D.L.R. (3d) 1 [hereinafter *Reibl* cited to D.L.R.].

5 See *e.g. Malette* v. *Shulman* (1990), 72 O.R. (2d) 417, 67 D.L.R. (4th) 321 (Ont. C.A.); *Fleming* v. *Reid* (1991), 4 O.R. (3d) 74, 82 D.L.R. (4th) 298 (Ont. C.A.); *McInerney* v. *MacDonald*, [1992] 2 S.C.R. 138; *Region 2 Hospital Corp.* v. *Walker* (1994), 150 N.B.R. (2d) 366, 116 D.L.R. (4th) 477 (C.A.).

6 *Hopp* v. *Lepp*, [1980] 2 S.C.R. 192.

7 See Picard & Robertson, *supra* note 3 at 115. The cases which are taken as the "classical statement" of the professional standard are: *Smith* v. *Auckland Hospital Board*, [1964] N.Z.L.R. 241 and *Male* v. *Hopmans*, [1966] 1 O.R. 647, 54 D.L.R. (2d) 592 (Ont. H.C.).

about the treatment?[8] The Court noted that the principle underlying the doctrine of informed consent is that of autonomy—the right of the patient to make his or her own decisions as to which medical interventions to accept and which to refuse.[9] As Cory J. so eloquently stated in *Ciarlariello* v. *Schacter*:

> It should not be forgotten that every patient has a right to bodily integrity. This encompasses the right to determine what medical procedures will be accepted and the extent to which they will be accepted. . . . This concept of individual autonomy is fundamental to the common law and is the basis for the requirement that disclosure be made to a patient.[10]

Reibl modified the law of informed consent in other ways as well, both by limiting informed consent claims to negligence actions and by setting out the standard of causation applicable in such cases. While the Court recognized a broad right to disclosure, it established a more stringent test for causation, creating what has come to be known as the "modified objective" test.[11] In making a determination as to causation, the question that the court must ask itself is whether, having had the benefit of the disclosure, a reasonable person in the position of the plaintiff would have declined to proceed with the treatment. If the treatment would have been accepted in any event (for example, despite the plaintiff having been fully informed), causation is not made out and the plaintiff cannot recover.

The primary reason for the court's reluctance to adopt a more subjective test of causation was the fear that a more subjective perspective would place the defendant at the mercy of the plaintiff's "hindsight and bitterness," and that recovery would be virtually inevitable in every case where failure to disclose is established.[12]

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8 Much has been written about the nature and extent of the duty of disclosure outlined in *Reibl* v. *Hughes*. See *e.g.* D. J. Roy, J. R. Williams & B. M. Dickens, *Bioethics in Canada* (Scarborough: Prentice Hall Canada, 1994) at 115-19; T. A. Caulfield & D. E. Ginn, "The High Price of Full Disclosure: Informed Consent and Cost Containment in Health Care" (1994) 22 Man. L.J. 328; E. Etchells, *et al.*, "Bioethics for Clinicians: Disclosure" (1996) 155 Can. Med. Assoc. J. 387; B. Sneiderman, J. C. Irvine & P. H. Osborne, *Canadian Medical Law: An Introduction for Physicians, Nurses & Other Health Care Professionals*, 2d ed. (Scarborough: Carswell, 1995) at 62-70; Picard & Robertson, *supra* note 3 at 109-57.

9 *Reibl*, *supra* note 4 at 13.

10 *Ciarlariello* v. *Schacter*, [1993] 2 S.C.R. 119, 100 D.L.R. (4th) 609 at 618.

11 Although Laskin J. did not refer to the test as such, this is how it is commonly referred to in subsequent cases and in academic commentary. See *e.g.* P. H. Osborne, "Causation and the Emerging Canadian Doctrine of Informed Consent to Medical Treatment" (1985) 33 C.C.L.T. 131 at 132; M. Crow, "Confusion over Causation: A Journey through *Arndt* v. *Smith*" (1998) 7 Health L. Rev. 3 at 4.

12 *Reibl*, *supra* note 4 at 15-16.

Criticisms of the Modified Objective Test

Numerous problems with the modified objective test have been pointed out in academic and judicial commentary since the decision in *Reibl*, including its inconsistent application[13] and the fact that the test rarely permits recovery for those claiming that their consent to treatment was not informed.[14] As Osborne notes, the inconsistency in the application of the modified objective test results from the fact that different judges consider different ranges of subjective factors to be relevant to the causation inquiry.[15] This diversity in approach is unsurprising, given the lack of guidance provided by the *Reibl* decision as to which particular personal factors are relevant to the test and which are irrelevant.[16]

One obvious problem with the modified objective test is the complete absence of any ability to deal with the situation of a plaintiff who has two potential courses of action, either of which may have been chosen by a reasonable person in the patient's position.[17] *Arndt* seemed to provide the Court with the ideal opportunity to consider this very issue—faced with information that their child might be born with severe brain damage and other medical problems, there are some reasonable women who would opt for abortion and others who would choose to carry the pregnancy to term and hope for the best. Indeed, Lambert J.A. noted that this was the very issue in *Arndt (B.C.C.A.)*: "what happens if some reasonable patients in the actual patient's position would have under-

13 See *e.g.* Osborne, *supra* note 11 at 133-40; Picard & Robertson, *supra* note 3 at 159.

14 Crow, *supra* note 11; Picard & Robertson, *supra* note 3 at 162-63. Robertson, *supra* note 3 at 427, 441-43, noted that in only 21 out of 117 cases did the informed consent claim succeed.

15 Osborne, *supra* note 11 at 133.

16 *Reibl*, *supra* note 4. The extent of the guidance provided by Laskin J. on this point is as follows at 17:

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

See also Osborne, *supra* note 11 where he gives some examples of subjective factors at 136-39 including: being determined to have an abortion in *Mang* v. *Moscovitz* (1982), 37 A.R. 221 (Q.B.); the fact that the plaintiff was "mature," "rational," and "sensible" in *Diack* v. *Bardsley* (1983), 25 C.C.L.T. 159 (B.C.S.C.); being attractive and enjoying "eating in public restaurants with friends, wearing make-up, and kissing her husband" in *Rawlings* v. *Lindsay* (1982), 20 C.C.L.T. 301 (B.C.S.C.); and having a "compulsive desire" for cosmetic surgery in *Lokay* v. *Kilgour* (1984), 31 C.C.L.T. 169 (Ont. H.C.).

17 See *e.g.* P. H. Osborne, "Annotation: *Arndt* v. *Smith*" (1995), 25 C.C.L.T. (2d) 264.

gone the treatment and others would not?"[18] This question was not even raised, much less considered by, the majority of the Supreme Court of Canada.[19] This fact is made all the more surprising when one considers that this point was emphasized in the application for leave to appeal as a justification for the Court's guidance on a point which is otherwise settled law.[20]

A more recent development which has led to further dissatisfaction with the modified objective test is the holding in *Hollis* v. *Dow Corning*.[21] In that case, the Supreme Court of Canada held that where manufacturers are concerned (product liability cases), the causation test is subjective; at the same time, however, the Court affirmed its view that in cases against physicians, the modified objective test remains appropriate. Apparently recognizing this anomalous distinction, the Court nonetheless held it to be valid, stating that:

> [T]he duty of the doctor is to give the best medical advice and service he or she can give to a particular patient in a specific context. . . . The manufacturer, on the other hand, can be expected to act in a more self-interested manner. In the case of a manufacturer, therefore, there is a greater likelihood that the value of a product will be overemphasized and the risk underemphasized. It is, therefore, highly desirable from a policy perspective to hold the manufacturer to a strict standard of warning consumers of dangerous side-effects to these products.[22]

In his reasons in *Arndt*, Cory J. quotes extensively from *Hollis* confirming that, in his view, manufacturers of medical products are self-interested and must therefore be held to a more stringent standard than

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18 *Arndt (B.C.C.A.), supra* note 1 at 213.

19 McLachlin J., Sopinka and Iacobucci JJ. would not have been required to deal with this issue, since each of them would have adopted a subjective test focusing on what the actual patient would have done had he or she been fully informed.

20 See *Arndt (B.C.C.A.), supra* note 1, leave to appeal to S.C.C. requested (Appellant's leave to appeal application at para 25) where Dr. Smith argued that:

> A number of Canadian judicial decisions suggest that there is a possibility, in these elective or risk avoidance situations, for more than one reasonable choice. . . . The issue then arises as to how far the courts can and should go in considering the personal, subjective characteristics and circumstances of a particular plaintiff in determining what a fully informed reasonable patient would have done. In other words, to what extent should subjective considerations influence the "modified" objective test of causation described in *Reibl* v. *Hughes*?

This issue was likely an important factor in the Court's decision to grant leave to appeal, given that the Court grants leave in cases where the issues are of "national importance" and not to correct errors in the courts below. See *Supreme Court Act*, R.S.C. 1979, c. S-19, s. 40; see also J. Sopinka & M. A. Gelowitz, *The Conduct of An Appeal* (Toronto: Butterworths, 1993) at 165-67.

21 *Hollis* v. *Dow Corning*, [1995] 4 S.C.R. 634,129 D.L.R. (4th) 609 [hereinafter *Hollis* cited to D.L.R.].

22 *Ibid.* at 634.

medical professionals.[23] Yet the Court has also recognized that, at least in some circumstances, medical professionals are capable of acting in a self-interested manner and without regard for the best interests of their patients—this is why the principles of fiduciary law are so integral to the physician-patient relationship.[24] In fact, one could argue that the unique nature of the physician-patient relationship, relied upon by Cory J. (and La Forest J. in *Hollis*) as justifying a *lesser* standard for physicians in informed consent cases, poses an even greater danger to patients. Perhaps few physicians are inclined to act out of pure self-interest, but those who do certainly have the ability to inflict far more devastation upon the patient than does a self-interested manufacturer.[25]

As noted above, the principal reason for the adoption of an objective test for causation was to avoid the imposition of liability on the basis of the plaintiff's hindsight. In *Arndt*, we see the majority emphasize the fact that the patient's "reasonable beliefs, fears, desires and expectations"[26] are appropriately considered in the scope of the modified objective test; in contrast, the patient's idiosyncratic or irrational fears and concerns do not inform the causation inquiry.[27] But a person's beliefs, fears, desires and expectations are at the heart of an individual's identity.[28] In our view, the consideration of only those fears which are

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23 *Arndt*, *supra* note 2 at 52.

24 *McInerney* v. *MacDonald*, [1992] 2 S.C.R. 138, *Norberg* v. *Wynrib*, [1992] 2 S.C.R. 226 [hereinafter *Norberg*]. In *Norberg*, McLachlin J. employed a fiduciary analysis in holding Dr. Wynrib liable for sexually exploiting Ms. Norberg, his patient. She noted at 275:

> Dr. Wynrib was in a position of power vis-à-vis the plaintiff; he had scope for the exercise of power and discretion with respect to her. He had the power to advise her, to treat her, to give her the drug or to refuse her the drug. He could unilaterally exercise that power or discretion in a way that affected her interests. And her status as a patient rendered her vulnerable and at his mercy, particularly in light of her addiction.... All the classic characteristics of a fiduciary relationship were present. Dr. Wynrib and Ms. Norberg were on an unequal footing. He pledged himself—by the act of hanging out his shingle as a medical doctor and accepting her as his patient—to act in her best interests and not permit any conflict between his duty to act only in her best interests and his own interests—including his interest in sexual gratification—to arise. As a physician, he owed her the classic duties associated with a fiduciary relationship—the duties of "loyalty, good faith and avoidance of a conflict of duty and self-interest."

See also *Henderson* v. *Johnston*, [1956] O.R. 789, 5 D.L.R. (2d) 524 (Ont. H.C.), aff'd [1959] S.C.R. 655, 19 D.L.R. (2d) 201.

25 K. Christensen, "Commentary: A Physician's Perspective on Conflicts of Interest" (1997) 25 J.L. Med. & Ethics 199.

26 *Arndt*, *supra* note 2 at 54.

27 For an interesting discussion of what constitutes an "unreasonable" concern, see M. Gochnauer & D. J. Fleming, "Case Comment on *Hopp* v. *Lepp* and *Reibl* v. *Hughes*" (1981) 15 U.B.C. L. Rev. 475 at 491-92. The authors suggest that the only "unreasonable" concern is one which "fails to reflect properly the personal ranking of the individual's basic values."

28 See T. Honoré, "Causation and Disclosure of Medical Risks" (1998) 114 L. Q. Rev. 52 at 53 where Honoré notes, using Cory J.'s example of the irrational concern that a rash indicates the presence of evil spirits:

"reasonable" illustrates that the modified objective test is itself arbitrary and subjective. Either the test is dictating what the particular patient (and society as a whole) should consider to be reasonable fears and concerns (an incredibly paternalistic stance), or it is simply a subjective analysis that filters out unwanted evidence. The former explanation is an enormous step backward from the apparent affirmation of autonomy in *Reibl*, and the latter is arbitrary, unpredictable, and potentially unjust. Indeed, the application of the modified objective test to the facts in this case stands as a good example. Here, the Court relied on the evidence relating to Arndt's suspicion of mainstream medicine but failed to consider that her reaction to information about the risk to her fetus could have reasonably led to a decision to terminate the pregnancy. Both are subjective elements, but only one had an impact on the decision. It could be argued that the Court allowed an idiosyncratic concern (distrust of mainstream medicine) to outweigh an objectively reasonable fear (fear of the potential impact of chicken pox on the fetus).

In our view, Cory J. is only partially correct in his confident assertion that *Reibl* marked the rejection of the paternalistic approach to informed consent. The standard of disclosure adopted in *Reibl* does reject a physician-centred approach in favour of one which focuses on the patient. However, as illustrated by the causation requirement itself and by the specious distinction created in *Hollis*, we have yet to see the end of the era of judicial paternalism or, as Lewans calls it, the "anachronistic allegiance to a paternalistic interpretation of the doctor-patient relationship."[29] It is scant comfort to patients that the medical profession is attempting to move away from the paternalistic model, given that judges seem determined to continue treating the doctor-patient relationship in this manner.

While the Court's stance on the disclosure requirement stems from its commitment to autonomy, it appears that this commitment amounts to nothing more than lip service, given that the causation standard is capable of recognizing autonomy only to the extent that the plaintiff's choices are "reasonable."[30] If there is a single characteristic that symbolizes "autonomy," it is the freedom to make bad, or unreasonable,

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Even given a duty to disclose, it would often not be negligent to fail to mention the risk of a temporary rash. But if it was, so that an ordinary patient would have had reason to decline to run the risk, why should it make a difference that this plaintiff would have declined to do so for a bizarre reason connected with a belief in evil spirits?

29 M. Lewans, "Subjective Tests and Implied Warranties: Prescriptions for *Hollis* v. *Dow Corning* and *ter Neutzen* v. *Korn*" (1996) 60 Sask. L. Rev. 209 at 217.

30 See Osborne, *supra* note 11 at 142-43; *Reibl*, *supra* note 4 at 15-17; and *Arndt*, *supra* note 2 at 53-55.

decisions. As one author notes, ". . . autonomy and the right to self-determination includes the right to take decisions based on factors other than pure reason, and embraces the right to take a *wrong* decision."[31] Of course, the necessary implication of the idea that a patient may make a "wrong" decision is that there exists an arbiter of what is a "right" or a "wrong" medical decision. As Brazier points out, however, there is no one in a position to determine this other than the patient him or herself:

> [O]n what criteria can or should a decision be judged to be wrong? A pregnant woman refusing chemotherapy because of the risk to her unborn child makes a "wrong" decision in the context of her chances of prolonging her own life. Yet she is likely to be commended for her selflessness. A non-pregnant woman declining chemotherapy because she fears hair loss makes an unreasonable decision by *my* criteria of the quality of life. But she must be the judge of that. Quality of life is intensely personal. Surveys on the treatment of cancer of the throat show that 20% of patients surveyed would elect for radiation therapy rather than surgery albeit the survival rate for the latter is markedly better. But surgery deprives the patient of normal speech. Who but the patient can judge whether prolongation of life is worth that price?[32]

In *Arndt*, Cory J. termed Laskin's words in *Reibl* "as persuasive today as they were when they were written."[33] In our view, the accuracy of this statement is questionable. Cost containment pressures and advances in medical technology have created a health care environment in which the only constant is change.[34] It seems only reasonable to expect that informed consent laws must also evolve in order to keep pace with the rapidly changing context in which they function. For example, there have been huge strides made in the area of molecular genetics which have introduced a myriad of new technologies. Many of these services have complex non-medical and highly personal ramifications that must be disclosed. For example, genetic testing may have an impact on future insurability, it may have a profound impact on self-image, or it may

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31 M. Brazier, "Patient Autonomy and Consent to Treatment: The Role of the Law?" (1987) 7 Legal Studies 169 at 175.

32 *Ibid.*

33 *Arndt*, *supra* note 2 at 52.

34 For a review of the impact of financial constraints on the health care environment, see *e.g.* E. J. Emmanuel & N. N. Dubler, "Preserving the Physician-Patient Relationship in the Era of Managed Care" (1995) 273 J.A.M.A. 323; J. Hurley & R. Card, "Global Physician Budgets as Common-Property Resources" (1996) 154 Can. Med. Assoc. J. 1161; Canadian Bar Association, *What's Law Got To Do With It?: Health Care Reform in Canada* (Ottawa: Canadian Bar Association, 1994); and T. A. Caulfield, "Health Care Reform: Can Tort Law Meet the Challenge?" (1994) 32 Alta. L. Rev. 685.

adversely affect family dynamics.[35] The law should recognize that there are a multitude of "reasonable" ways in which an individual could react to the information provided by genetic technologies. Unfortunately, the Supreme Court of Canada's decision in *Arndt* leaves us with little confidence that the law *will* recognize this fact.

Alternative Approaches

As is obvious from the foregoing, the modified objective test has been vigorously criticized; it is a standard which is arbitrary and potentially unjust. As such, it seems all the more surprising that the Supreme Court of Canada has once again demonstrated its allegiance to this test of causation. The primary concern for Laskin J. with the choice of a subjective test for causation was that, in all cases, plaintiffs would testify that they would not have consented to the treatment had they been made aware of the undisclosed risk. In other words, liability would be virtually automatic upon a finding of failure to disclose the risk in question.[36] While this concern may have been valid at the time of the decision in *Reibl*, developments since that time belie its legitimacy. As Osborne has noted, the modified objective test is occasionally applied in such a manner that makes it indistinguishable from a subjective test.[37] In some of the cases in which this apparently subjective standard has been applied, recovery has been denied.[38] Further, Cory J. appears to recognize this very possibility himself in his reasons in *Arndt*. In noting that a failure to consider a plaintiff's reasonable fears and beliefs could lead to "absurd results," Cory J. contemplates the hypothetical example of a woman who sued her physician after giving birth to a disabled child, for failure to disclose the significant risk of disability. He continues:

> If the plaintiff's beliefs are not to be considered, the trier of fact could conclude that a reasonable person in the position of the plaintiff would have chosen to terminate the pregnancy and find in favour of the patient even if the plaintiff was so resolutely and unalterably opposed to abortion that she would never have terminated the pregnancy.[39]

In Cory J.'s view, "this example demonstrates why it is important to include some subjective aspects in the assessment of what the reasonable

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35 See generally Ontario, *Report on Genetic Testing* (Toronto: Ontario Law Reform Commission, 1996).

36 *Reibl*, *supra* note 4 at 16.

37 Osborne, *supra* note 11; Picard & Robertson, *supra* note 3 at 159-61.

38 *Diack* v. *Bardsley*, *supra* note 16. See also *Lokay* v. *Kilgour*, *supra* note 16, *Gonda* v. *Kerbel* (1982), 24 C.C.L.T. 222 (Ont. H.C.).

39 *Arndt*, *supra* note 2 at 55.

person in the position of the plaintiff would have done if all the risks had been disclosed."[40] In our view, it also demonstrates that, contrary to Laskin and Cory JJ.'s fears, incorporating more subjective factors into the causation analysis would not lead certainly to liability in every case of failure to disclose.

Even if we are incorrect in suggesting that Cory J. has himself pointed out the flaw in this argument for retaining an objective test of causation, there remains a serious concern with the ability of the causation test to achieve justice. In their case comment on the decision in *Hollis*, Black and Klimchuk point out that in that case:

> [A]ll the judges agree that in principle the subjective test is the proper measure of the scope of the manufacturer's duty to warn, a duty it fails to discharge when the information it withholds would, had it been made available to the plaintiff, have affected her decision to use the product. That the scope of duty is so measured reflects the value attached by the law to personal autonomy.[41]

If the scope of the manufacturer's duty is measured subjectively in recognition of the central role of autonomy in medical decision-making, then it only seems appropriate that the scope of the physician's duty must also be so measured. It is absurd to say that personal autonomy requires a subjective test of disclosure where a medical *product* is the alleged cause of the plaintiff's injury but that an objective test is appropriate where medical *service* is claimed to have resulted in damage.

If, as certainly appears to be the case, the sole reason for rejecting the subjective standard of causation centres on the "unique policy concerns associated with the doctor-patient relationship,"[42] then there are a great many policy considerations which ought to be included but which have been thoroughly overlooked by the majority in *Arndt*. One such consideration is whether we should be concerned about providing compensation to those who suffer damages as a result of a physician's failure to disclose.[43] The current situation seems unfairly biased in favour of physicians. As well, a more (if not entirely) subjective test for causation would allow informed consent law to function as a deterrent mecha-

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40 *Ibid.*

41 V. Black & D. Klimchuk, "Case Comment: *Hollis* v. *Dow Corning*" (1996) 75 Can. Bar Rev. 355 at 363.

42 *Arndt*, *supra* note 2 at 52, Cory J.

43 As noted earlier, patients in informed consent cases rarely succeed. Robertson, *supra* note 3, at 428 estimated the success rate in 1991 at 18%. The low rate and arbitrary nature of compensation in medical negligence cases have been noted by numerous commentators. See generally J. R. S. Pritchard, *Liability and Compensation in Health Care* (Toronto: University of Toronto Press, 1990).

nism. Such a test would compel broad disclosure—an important factor in an increasingly complex health care climate—which would have the additional positive effect of creating more informed consumers of health care. A subjective standard would also emphasize the importance of patient choice and would provide a mechanism whereby the courts could acknowledge the existence of more than one reasonable choice in any given situation. Finally, the shift from an objective to a subjective approach would prevent the inconsistent and arbitrary use of subjective information to deny recovery.

A further alternative to the modified objective test is the use of fiduciary principles where applying the test would yield uncertainty. This approach is suggested by Lambert J.A. in *Arndt (B.C.C.A.)*. In his view, the solution to the problem of two equally reasonable options is resort to fiduciary law. While it is beyond the scope of this brief case comment to undertake a thorough review of fiduciary law, we thought it important to at least mention this area of law and to note that some courts have begun to employ fiduciary law principles in the context of informed consent issues. For example, in *Seney* v. *Crooks*,[44] McIntyre J. held that Dr. Crooks had failed to live up to the standard of care with respect to "communication, disclosure and discussing options with his patient" and stated at 81 that:

> [I]n a fiduciary relationship the fiduciary cannot suggest the fully informed beneficiary would have acted the same way. As pointed out in *Arndt* v. *Smith, supra*, a fiduciary in breach of a duty to disclose and discuss cannot in law maintain an argument that the beneficiary would have acted the same way if the fiduciary's obligation had been discharged.

Conclusion

There is no doubt that the issues created by the high causation hurdle set out in *Reibl* are complex and that the justifications for leaning toward an objective test for causation seem compelling.[45] Nevertheless, the shortcomings of the current approach are far too conspicuous and have been articulated much too frequently to be ignored.[46] A primary advantage of

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44 *Seney* v. *Crooks* (1996), 189 A.R. 21, 30 C.C.L.T. (2d) 66 at 81 (Alta. Q.B.). The idea that physicians have a "fiduciary duty to communicate" with their patients has been suggested by other authors. See *e.g.* M. B. Kapp, "Health Care Delivery and the Elderly: Teaching Old Patients New Tricks" (1987) 17 Cumberland L. Rev. 437 at 454.

45 See *e.g.* Honoré, *supra* note 28 at 52-53.

46 As McLachlin J. noted in *Arndt*, *supra* note 2 at 69:

> [W]hile views diverge, the preponderance of authority in other common law jurisdictions as well as academic commentary support a test which asks what the particular plaintiff would have done in all the circumstances, but accepts that the reasonableness of the one choice over

the common law is its ability to evolve in response to changes in the social context. And, while it is no doubt difficult to keep pace with the rapidly changing health care environment, one would have hoped that, at the least, the Supreme Court of Canada would have given it a try. *Arndt* was a missed opportunity.

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another, as reflected in the medical advice the plaintiff would have received, is an important factor bearing on that decision.