

# Informed Consent in 2001: “Don’t Leave the Office Without It”

Eleanore A. Cronk - Lax O’Sullivan Cronk

## Informed Consent: A Complex Legal and Ethical Issue Viewed in Current Legal Climate

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Dentists, like many other health-care practitioners, often struggle with the question of how to apply the ethical and legal concepts of informed consent in their daily practice. To help our members understand the current complex legal and ethical considerations, this issue of *Dispatch* contains as a special insert a lengthy article on informed consent by Eleanore Cronk. Ms. Cronk is an eminent litigator in civil, public and administrative law.

This article by Ms. Cronk is an adaptation of an excellent presentation that she made at a Council educational session in January of this year at the suggestion of the College’s Patient Relations Committee. Now, at the request of the College’s Executive Committee, an abbreviated version of her presentation is being shared with membership.

Ms. Cronk addresses this complicated topic with remarkable clarity and insight. She is a partner in the law firm of Lax O’Sullivan Cronk. Ms. Cronk is a Bencher with the Law Society of Upper Canada, a past chair of the Society’s Discipline Committee and current chair of its Professional Development and Competence Committee. She has represented, from time to time, numerous regulators, including RCDSO.

The article outlines a list of suggested operating principles that will assist to guide dentists in developing a meaningful approach to informed consent. Ms. Cronk then gives these operating principles fuller meaning by placing them in the context of the general principles that define and shape the law of informed consent, and the significant features of recent governing case law.

It is worth noting that, although most of the reported cases in Canada which examine the law of informed consent concern the alleged conduct of medical doctors, the principles which have emerged from the cases to date generally apply to all health-care practitioners.

If you have any questions about this informed consent article or about what it means to you in your practice, please contact RCDSO’s Registrar Irwin Fefergrad by phone at 416-934-5625 (direct line), by e-mail at ifefergrad@rcdso.org or by fax at 416-961-5814.

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## Overview

Given the complexity of the legal and ethical considerations which inform the assessment of whether informed consent has been secured in a given situation, it is not surprising that it is often difficult to determine in the clinical setting what is required to establish informed consent. The problem is compounded because many practitioners continue to believe that a patient's signature on a form entitled "Consent" is sufficient informed consent to avoid liability in the event of a lawsuit.

In my view, in the current legal climate, it is both inaccurate and unwise to assume that a signed consent form will be sufficient to establish informed consent should the need arise to do so. Rather, a signed consent form is simply evidence of a discussion between the health-care practitioner and the patient.

The key to obtaining and being able to establish informed consent is evidence of the nature and scope of the discussion or discussions held by a dentist with his or her patient before a proposed procedure or treatment is carried out. If the discussions are not held directly by the dentist with the patient, it is imperative that the dentist be in a position to demonstrate that his or her delegate had the relevant discussions with the patient and that the chosen delegate was competent to have the discussions.

I have heard it said, in the context of the practice of dentistry, that when a "patient opens their mouth, they give consent" or "if the patient remains

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### **INFORMED CONSENT IS NOT A SIGNATURE ON A CONSENT FORM. IT IS NOT A SINGLE EVENT... IT IS A PROCESS OF DIALOGUE BETWEEN THE DENTIST AND THE PATIENT... CONTINUING THROUGHOUT THE COURSE OF TREATMENT.**

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in the chair, they are consenting." In my respectful view, under the current law, these propositions are as reliable, and as valuable, as fool's gold. A more meaningful approach to the issue of informed consent is to attempt to glean from the available case

law and the reported decisions those operating principles which should guide the obtaining of informed consent.

I offer the following suggestions as to what those operating principles might entail:

1. Informed consent is not a signature on a consent form. It is not a single event. Rather, it is a process of dialogue between the dentist and the patient, starting with the obtaining of an initial, detailed history and continuing throughout the course of treatment.
2. A signed consent form is only evidence that some discussion between the dentist and the patient took place regarding the proposed procedure or treatment. It is not, without more, evidence of informed consent. More particularly, it is not evidence that the discussion which took place was full and complete, that the patient understood the nature of the information communicated by the dentist, and that the discussion involved disclosure of all material, special or unusual risks associated with the proposed procedure or treatment. These matters must be established by additional means.
3. The courts have indicated that a full recording of consent discussions between a health-care practitioner and a patient is necessary. If a full recording of these discussions is not available, a dentist's ability to avoid liability in the event of a negligence suit is severely, if not fatally, impaired. The best evidence of a full and complete discussion regarding consent to treatment is still the practitioner's own clinical notes. Although it may seem trite, full and complete charting is still crucial to document the occurrence of consent discussions and the nature and scope of those discussions.
4. Care should be taken in relying on the use of lists of potential risks. The danger with lists, of course, is that to prepare one is to forget something. It is an easy matter for a plaintiff/patient to point to a list and identify something that has been missed and to then characterize the missing item as

material. Moreover, if lists are used, they must be continually updated in accordance with new and emerging clinical and authoritative information. In addition, the preparation and use of a list of risks is no assurance that a patient actually reads

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the list and understands it. Thus, while the use of lists may be of assistance, they cannot be regarded in isolation as sufficient to establish informed consent.

5. Guidance is provided by the *Health Care Consent Act, 1996* (Ontario) and the relevant case law concerning the types of information which should be provided by a health-care practitioner during informed consent discussions. These include:
- the nature of the proposed treatment;
  - the expected benefits of the proposed treatment;
  - the material risks and side effects of the proposed treatment;
  - alternative courses of action;
  - the likely consequences of not having the proposed treatment; and
  - the answers to any questions the patient has regarding the proposed treatment.

6. It is a fundamental principle that the advice given to a patient regarding risks of treatment must relate to the condition and circumstances of the particular patient. The courts have clearly

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indicated that a patient has a right to know what type of impact the proposed treatment or

procedure will have on his or her lifestyle. If the proposed treatment or procedure carries with it attendant risks of severe or prolonged consequences, the risks will be regarded as material by the courts and they must be disclosed to the patient. Additionally, the courts have taken the position that where a treatment is undertaken for purely cosmetic or aesthetic and elective reasons, the duty to advise of complications is a higher one.

7. The patient has a right to be given an opportunity to ask any questions and raise any concerns about the proposed procedure or treatment, and the health-care practitioner has an affirmative duty to respond truthfully to such questions with reasonable answers or information. Both the consent form and the patient's chart should document that this opportunity has been afforded the patient.

8. It is also important that the patient be given time to consider his or her options. In appropriate cases it is necessary that the health-care practitioner suggest that a second opinion be obtained. In *Ferguson v. Hamilton Civic Hospitals et al.* (1983), the court stated:

Informed consent entails the opportunity to evaluate knowledgeably the options available and the risks attendant upon each option.

9. Of equal importance, the health-care practitioner must take steps to ensure that the patient understands the information being provided. Where, for example, the health-care practitioner and the patient do not speak the same language, there is an obligation on the health-care practitioner to ensure that a translator is involved to ensure that the patient is being provided with information in a language which he or she can understand. For example, this might mean a close family member or friend who speaks the same language as the patient.

10. Care should also be taken to explain the consequences of declining or foregoing treatment.

11. Make sure that you have developed an informed usual practice that you can rely upon if you are called upon to give evidence. That means that you must both establish and follow your usual practice.

It is fair to suggest that there is a constant struggle for health-care practitioners in determining where to draw the line between providing a patient with too much information, which can cause the patient to be confused or fearful and to decline to follow the recommendations of the health-care practitioner; and disclosing too little information, thereby becoming exposed to a suit in negligence.

What remains of fundamental importance is that the health-care practitioner be engaged in

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discussions with the patient about the proposed procedure or treatment and its attendant risks. Further, the fact of the occurrence of these discussions must be documented.

Discussions between the health-care practitioner and the patient are not necessarily one-time events. If the relationship continues after the initial visit, the health-care practitioner must ensure that there is an ongoing dialogue with the patient as the course of treatment progresses to ensure that the patient does understand the information that has been disclosed and has had an opportunity to understand and evaluate the information.

#### **Recognition of a Duty to Disclose**

It is well-established in Canada that health-care practitioners, including dentists, have both an ethical and legal duty to ensure that the informed consent of patients is obtained prior to the provision of health-care treatment. In 1980, in several cases, the Supreme Court of Canada considered the necessary legal ingredients of informed consent and the requirements of disclosure necessary to

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#### **THE STANDARD OF DISCLOSURE FOCUSES ON THE PATIENT AND ON WHAT A REASONABLE PERSON IN THE PATIENT'S POSITION WOULD NEED TO KNOW.**

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demonstrate that informed consent was obtained in any given treatment situation. As a result of these cases, the Court has stated that the requirement is to disclose all material, special or unusual risks associated with a proposed procedure or treatment. This requirement is known as a standard of disclosure. It must be met in all circumstances to establish that the patient actually consented, on an informed basis, to the relevant procedure or treatment.

Importantly, the Supreme Court of Canada has also held that this standard of disclosure is not simply what a reasonable and prudent practitioner would regard as relevant to disclose. Rather, the standard focuses on the patient, and on what a reasonable person in the patient's position would need to know. This constitutes the minimum threshold standard of disclosure required of all health-care practitioners. The obligation of the dentist or other health-care practitioner, however, does not end there.

The health-care practitioner is also expected to disclose any information or risks that the patient has inquired about, or any information that the health-care practitioner should know the patient would regard as relevant, given the patient's circumstances and having regard to the information that the patient has provided to the health-care practitioner. In the seminal 1980 case of *Hopp v. Lepp*, informed consent and the requirement of disclosure were considered in detail for the first time by the Supreme Court of Canada. The Court recognized that the term "informed consent" derived from a series of cases in the United States involving alleged negligence by surgeons or physicians.<sup>1</sup> The Canadian Court unanimously held that the term "informed consent":

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<sup>1</sup> Although most of the reported cases in Canada which examine the law of informed consent concern alleged conduct by medical doctors, the principles which have emerged from the cases to date generally apply to all health-care practitioners.

...reflects the fact that although there is, generally, prior consent by a patient to proposed surgery or therapy, this does not immunize a surgeon or physician from liability for battery or for negligence if he has failed in a duty to disclose risks of the surgery or treatment, known or which should be known to him, and which are unknown to the patient. The underlying principle is the right of a patient to decide what, if anything, should be done with his body...It follows, therefore, that a patient's consent, whether to surgery or to therapy, will give protection to his surgeon or physician only if the patient has been sufficiently informed to enable him to make a choice whether or not to submit to the surgery or the therapy. The issue of informed consent is at bottom a question whether there is a duty of disclosure, a duty by the surgeon or physician to provide information and, if so, the extent or scope of the duty.

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**IT WAS MADE CLEAR BY THE COURT THAT INFORMED CONSENT, ESSENTIALLY, INVOLVES THE ISSUE OF A DUTY OF DISCLOSURE.**

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The Court expressly concluded that a duty of disclosure does exist as a precondition to the obtaining of informed consent. The scope of this duty of disclosure was described by the then Chief Justice of Canada, on behalf of the entire Court, as follows:

In summary, the decided cases appear to indicate that, in obtaining the consent of a patient for the performance upon him of a surgical operation, **a surgeon, generally, should answer any specific questions posed by the patient as to the risks involved and should, without being questioned, disclose to him the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation.** However, having said that, it should be added that the scope of the duty of disclosure and whether or not it has been breached are matters which must be decided in relation to the circumstances of each particular case. [Note: emphasis added.]

Several important features of the decision in *Hopp v. Lepp* require emphasis.

1. It was made clear by the Court that informed consent, essentially involves the issue of a duty of disclosure. The particular circumstances of each case will determine the scope of the duty applicable in a given situation to the involved health-care practitioner.
2. To avoid liability, the health-care practitioner, even if not asked any questions by the patient, must disclose the nature of the proposed treatment or procedure, its seriousness, any material risks associated with the proposed procedure or treatment and, further, any special or unusual risks attendant upon it.
3. In addition, when asked any questions about the proposed procedure or treatment by the patient, the practitioner has an affirmative obligation to answer the questions truthfully and directly. No obfuscation, no avoidance of the question, no shading of the answer, and no minimization of known risks, even when intended to be reassuring to the patient, is permitted.
4. Moreover, the basic standard of disclosure requires the practitioner to disclose the risks of the procedure known, or which should be known, to the practitioner. This latter aspect of the standard imports an obligation on the practitioner to remain current with the state of medical/dental literature and clinical knowledge relevant to the proposed procedure or treatment. Wilful blindness, as lawyers call it, to the state of the literature and the available reported experience of the profession in relation to a proposed treatment or procedure will result in liability.

**Causation: The Link Between Non-Disclosure and Injury**

The Supreme Court's consideration of informed consent did not end with *Hopp v. Lepp*. Also in 1980, the Court considered a second case which raised issues related to the concept of informed consent. *Reibl v. Hughes* involved a lawsuit by a

patient against a surgeon for allegedly failing to warn him of a risk of paralysis associated with elective surgery performed on the patient by the surgeon. One of the specific defences raised by the surgeon, among others, was the argument that even if the surgeon had disclosed all of the risks of the procedure, the patient nonetheless would have proceeded with the operation.

Once again, the Supreme Court of Canada was unanimous in adopting a test to determine whether the failure to disclose actually caused or influenced the patient's decision to proceed with the procedure. The test, as enunciated by the Court, requires an examination of what a reasonable patient in the circumstances of the plaintiff/ patient would have done, if faced with the same situation. This is known as an objective standard. It is applied to determine causation, that is, to determine whether non-disclosure of risks by a practitioner is causally linked to the injuries suffered by the plaintiff/ patient. In this context, any special considerations which affect the particular patient are relevant.

This is not the same thing, however, as suggesting that the patient's particular circumstances govern causation and hence, liability. Instead, special considerations, particular to the affected patient, must be viewed objectively. Although they emerge from the patient's particular circumstances, they must be assessed objectively according to what the Supreme Court of Canada described as:

...what the average prudent person, the reasonable person in the patient's particular position, would agree to or not agree to, if all material and special risks of going ahead with the surgery or foregoing it were made known to him.

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**...IT BECAME CLEAR THAT THE OPERATIVE STANDARD OF DISCLOSURE FOCUSED ON THE PATIENT, AND NOT THE PRACTITIONER. ...THE OBJECTIVE STANDARD REQUIRES CONSIDERATION OF WHAT A REASONABLE PATIENT, WITH REASONABLY BASED CONCERNS, WOULD HAVE DONE IF IN THE CIRCUMSTANCES OF THE PATIENT AND FACED WITH THE SAME SITUATION.**

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There is one important caveat, however, to this articulation of the test. The Court made it clear in *Reibl v. Hughes* that the patient's particular concerns must be reasonably based. If this were not the case, the peculiarities of a patient's concerns would govern causation, leading to liability. Instead, fears which are not related to the material risks which should have been disclosed by the practitioner are not to be regarded as causative factors. As summarized by the Supreme Court of Canada:

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.

### **The Legacy of *Hopp v. Lepp* and *Reibl v. Hughes***

The combined effect of *Hopp v. Lepp* and *Reibl v. Hughes* was to establish a new standard of disclosure in relation to the obtaining of informed consent. Prior to the articulation of this new standard by the Supreme Court of Canada, a reading of many of the cases across Canada suggested that, although a duty of disclosure was recognized, the standard of disclosure focused on the health-care practitioner rather than the patient. In other words, if the evidence in any particular lawsuit established that the defendant/practitioner had made the same level of disclosure as would any reasonable health-care practitioner, liability tended to be avoided.

Following the decisions in *Hopp v. Lepp* and *Reibl v. Hughes*, however, it became clear that the operative standard of disclosure focused on the patient, and not the practitioner. Further, the standard was an objective, not a subjective one. The objective standard requires consideration of what a reasonable patient, with reasonably based concerns, would have done if in the circumstances of the plaintiff/ patient and faced with the same situation.

The application of this standard requires examination of the special circumstances particular to the plaintiff/patient. These special circumstances will not determine liability. Instead, they must be identified and then viewed objectively in an effort to determine what a reasonable person in the patient's particular position would agree to, or not agree to, if all necessary risks had been revealed

prior to the treatment or procedure.

At the risk of over-simplification, the concepts embodied in this standard include the following:

1. The basic threshold question of whether, if disclosure had been made to the patient, it would have made any difference to a reasonable person in the same circumstances as the plaintiff/patient.
2. To answer this question, the courts are required to consider any particular concerns of the affected patient. Once these are identified, an assessment must then be made as to whether the particular concerns were reasonably based. This is required because idiosyncratic fears (i.e. fears unrelated to the material or special risks of the procedure or the treatment) are not relevant.
3. Further, to answer this question, the courts are also required to consider whether any special considerations affected the particular patient which, if also applicable to a reasonable patient in the same circumstances of the plaintiff/patient, would influence their decision.

### **Why Is It Important to Determine the Circumstances of the Patient?**

It is clear from the governing case law, some of which has already been highlighted, that the patient's own personal circumstances must be taken into consideration when determining what information is material so as to require disclosure. In other words, it is necessary to determine the circumstances of the patient in order to ensure that information material to the patient is in fact disclosed. This may vary from patient-to-patient.

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The following examples, drawn from various court judgments, may help to illustrate the point.

The risk of permanent scarring from surgery has been regarded by some courts to be more relevant in the case of younger, single patients or, in the case of dancers or actors, than in the case of other patients. Some patients may be more self-conscious about their appearance than others; if so, this is a factor to be taken into consideration. As well, the patient's financial and family situation may be relevant. For example, if the patient is the sole supporter of young children, the risk of serious or prolonged disability, or death, is more relevant for such a patient than for others.

In *Reibl v. Hughes*, for example, one of the plaintiff/patient's concerns related to the fact that, at the time of surgery, he was approximately one and one-half years away from earning a lifetime retirement pension from his employer. Due to the adverse consequences of the surgery, at the time at which they occurred, he was not eligible for extended disability benefits available under the collective agreement between his employer and hourly employees of lengthy standing. The patient claimed at trial that if he had been properly informed of the magnitude of the risk involved in the surgery, he would have elected to forego it, at least until his pension had vested.

The Supreme Court of Canada, in its unanimous judgment in the case, concluded that these economic circumstances were one factor to be taken into account in determining causation and in assessing whether a reasonable person, in the same economic circumstances as the plaintiff/patient, in fact would have declined surgery until he was fully vested in his pension benefits plan.

### **How Do You Determine the Circumstances of the Patient?**

Given this legal framework, how is a dentist expected to go about determining the circumstances of his or her patient?

In the main, the response to this question focuses on communication procedures and skills. In practical terms, the dentist must ask his or her patient sufficient questions about their situation, history and concerns to establish their circumstances. This requires a complete initial history and updating of it over time. Moreover, the prudent dentist is required to listen carefully to the questions asked

by the patient. The courts have held that these questions, especially, reveal the patient's concerns and provide an indication of the patient's subjective state of mind. Both of these factors are highly relevant to a determination of the circumstances of the patient.

### **What Does Informed Consent Mean in Non-Emergency Situations?**

The case law also emphasizes that the scope of required disclosure may vary depending on whether the patient presents in an emergency or non-emergency situation.

In *Reibl v. Hughes*, for example, there was no emergency making surgery imperative at the time it was undertaken. This was considered a relevant factor in assessing whether a breach of the duty of disclosure had occurred and, further, in determining whether a reasonable person in the plaintiff/patient's position would have declined surgery until a future occasion when his pension entitlements had fully vested.

The recent decision of the Court of Appeal for Ontario in *Lue v. St. Michael's Hospital*, decided in 1999, is of particular interest in this connection. In that case, a patient sued a neurosurgeon after an operation to remove a brain aneurysm left the patient with permanent paralysis in several parts of his body. The patient claimed at trial that at the

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time he consented to surgery the neurosurgeon had not told him of the risk of permanent paralysis following the operation.

The patient further claimed that he would have postponed the surgery had he known of the risk of paralysis because two months after the date of the surgery he could have been eligible for long-term disability benefits and life insurance through his employer. The neurosurgeon/defendant acknowledged that permanent paralysis was a material risk of the surgery, and therefore should have been explained to the patient, but claimed that, in fact, he had told the patient about this risk.

At trial, the case was decided in favour of the neurosurgeon/defendant. The decision was made not on the basis that, as claimed, he had told the patient about the risk of permanent paralysis, but rather on the basis that the patient failed to establish that a reasonable patient in his position would have declined or postponed surgery had he been told of the risk of permanent paralysis. The Court made it clear that it was the patient's obligation to establish causation, that is, a causal link between the non-disclosure of permanent paralysis and the decision to proceed with surgery.

In essence, the trial judge found that the neurosurgeon/defendant had failed to obtain the patient's informed consent to the surgery. However, the trial judge also concluded that a reasonable person in the patient's position would nonetheless have consented to the surgery. On this basis, she dismissed the claim.

In doing so, however, she distinguished between emergency and non-emergency situations and reviewed at length the rules applicable to informed consent. The trial judge suggested that in non-emergency situations, as applied in the case before her, the Court would look to objective criteria as markers of the patient's understanding of the proposed treatment or procedure.

She suggested that such criteria might include, in non-emergency situations, the following:

1. Whether the patient asked any questions. A failure to ask appropriate questions may indicate the patient is overwhelmed and uncomprehending. As a corollary, the comments or questions that the patient does raise may also reveal comprehension of the material risks.
2. Whether diagrams or other visual aids are relevant. Depending on the intellectual abilities of the patient, pictorial descriptions sufficient to communicate seriousness may be part of the process.
3. Whether the patient can restate what the physician has communicated. At some point after the disclosure, can the patient describe, in his or her own terms, the procedure and risks which are about to unfold.

4. Whether the patient has asked for a second opinion. Patients are understandably reluctant to be perceived as doubting the advice of the doctor by suggesting a second opinion. But when the “organ of our humanity” is involved the doctor should consider raising it as a possibility and explain to the patient how that course of action could be implemented.

5. Whether any information is put in writing. For example, does the patient have access to brochures which describe the generic condition with usual questions and answers? Did the physician write a note or letter to the patient, or a letter to the general physician with a stated expectation that the latter would review it with the patient? Did the doctor make a note in the patient’s chart? Is there a protocol in writing for the physician to follow and was it followed?

6. Whether the time spent with the patient is realistic in terms of enabling the patient to hear, understand and evaluate. Is the information communicated in the language most likely to be understood, and on more than one occasion is its seriousness reinforced? Is the patient afforded an opportunity to ask questions which did not occur to the patient in the anxiety of the original disclosure.

7. Whether the patient is dependent on family members for assistance in decision-making or whether the treatment, or lack thereof, could result in impaired cognitive abilities. In either case, involvement of the family is not a courtesy: it is a necessity. If others are involved, whether their recollection of events coincides with the doctors. The more obviously the patient is dependent on such people, the more importance should be attached to points 1-6 above, in the context of those others.

8. Whether the patient or family express spontaneous surprise when the event, allegedly described in advance as a material risk, unfolds.

The import of searching for “objective criteria” as

indicators of a patient’s understanding, or lack of understanding, of information disclosed in non-emergency treatment situations, is to suggest that merely because the health-care practitioner says “the right thing”, it will not be concluded automatically that the patient understood what was communicated, thereby being informed.

As pointed out by the trial judge in the *Lue* case, a “standard based primarily upon an assertion by the [health-care practitioner that the patient had understood], is inappropriate.” Rather, there must be objective criteria present which establish, or tend to establish, that the patient understood the information disclosed to him, thus rendering him in a position to give informed consent.

It is of significance that in the *Lue* case, the neurosurgeon/defendant had made extensive notes in the patient’s record indicating that a full consent discussion had taken place. The patient, however, had indicated a wish to have a family meeting at which the procedure could be explained. The trial judge concluded that this desire for a family meeting illustrated the patient’s inability to comprehend and his need to review all of the issues in the presence of others whom he could trust to ask all the right questions. The family meeting itself was also regarded by the trial judge as inadequate to satisfy the requirements for informed consent. At that meeting the neurosurgeon/defendant had drawn a

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rough diagram to explain the procedure and a relative of the patient had asked many questions. However, neither the patient nor his relative were asked to restate risks of procedure, no second opinion was solicited and no written information was received. The entire meeting lasted about 15 minutes. Further, the patient’s paralysis after the surgery was apparently a great shock to the patient and his family members. On all of these facts, the

trial judge concluded that there was no objective basis for concluding that the patient or his family understood that the surgery might not be successful and that as a result of it, the patient might be permanently paralyzed.

On appeal to the Court of Appeal for Ontario, the trial judge's decision to dismiss the action was upheld. The Court of Appeal concluded, much as the trial judge had, that the plaintiff/patient had failed to produce sufficient evidence that the reasonable patient in the plaintiff/patient's position would have delayed the surgical procedure had he been told of the risk of permanent paralysis, and had he anticipated becoming eligible for long-term disability benefits shortly after the date of the surgery. The Court confirmed that the onus was on the plaintiff/patient to establish material non-disclosure.

### **What Is A Material Risk?**

As noted, *Hopp v. Lepp* clearly established an obligation on health-care practitioners to disclose to patients all material, special or unusual risks associated with the proposed procedure or treatment. In this context, what determines materiality?

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### **...THE COURTS MAY IMPOSE A HIGHER STANDARD OF DISCLOSURE IN RELATION TO COSMETIC TREATMENTS AND PROCEDURES THAN IN THE CASE OF MEDICALLY OR THERAPEUTICALLY NECESSARY TREATMENTS AND PROCEDURES.**

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Not all possible risks are material risks. The courts have held that a risk which is a mere possibility does not normally have to be disclosed unless its occurrence may result in serious consequences. In *Hopp v. Lepp*, the Supreme Court of Canada suggested that if the occurrence of the risk carries serious consequences, it is material even if the chances of it occurring are remote. Thus, if the proposed procedure or treatment could result in death, paralysis, loss of sensation, chronic pain or disability, scarring or other disfigurement, or a lesser complication if likely to be permanent, the risk will generally be regarded as material, thereby triggering a need for disclosure.

It is also important, in assessing materiality of risk, to be aware that the courts may impose a higher standard of disclosure in relation to cosmetic treatments and procedures than in the case of medically or therapeutically necessary treatments and procedures. This flows from the reasoning that when the non-essential, elective procedure or treatment is undertaken, any type of level of risk may be that much more material for the person's decision to consent to it being performed. This is so, arguably, because a patient may be presumed to be more likely to forgo non-essential, elective treatments or procedures if they carry with them significant risk of serious consequences.

### **The Importance of Following and Being Able to Demonstrate an Established, Usual Practice**

In some situations a dentist who is sued may be unable to testify that he or she has a clear recollection of having personally informed the patient of all material, special or unusual risks. In these circumstances to avoid a finding of negligence, it is desirable, and may be necessary, for the dentist to be able to demonstrate that she had a usual practice of informing all patients in similar circumstances of specific risks.

This point was emphasized by the Court in the recent controversial case of *Marchand (Litigation Guardian of) v. Public General Hospital Society of Chatham*, considered by the Court of Appeal for Ontario in November 2000. The case involved an action against various health-care professionals, including a physician and various nurses, and a hospital, who were involved in the prenatal care and birth of a child who was born suffering from cerebral palsy, mental retardation and epilepsy. One of the allegations in the case was that the physician had failed to advise the mother of the significance of reduced fetal movement as her pregnancy went beyond term.

At trial, the judge found as a fact that the patient had not reported to the treating physician a significant reduction in fetal movement. Further, the trial judge concluded that had she done so, the treating physician, in accordance with his usual practice, would have had a complete discussion

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with the patient about the implications of fetal movement.

On appeal to the Court of Appeal for Ontario, that Court affirmed the proposition that even where the treating health-care practitioner does not recall specifically having a discussion with the patient about a particular risk, the fact that the health-care practitioner (in that case, a medical doctor) has a usual practice of informing patients about a particular risk can be sufficient, if established at trial, to support the conclusion that the health-care practitioner in fact provided adequate health care in the circumstances.

This case illustrates the importance of every health-care practitioner developing and following an established, usual practice with respect to the disclosure of significant risks associated with different types of procedures and treatments. Further, it may be anticipated that the usual practice of the defendant/practitioner will be contrasted at trial with the usual practice of other knowledgeable practitioners through the expert evidence of colleagues or peers. Accordingly, it is important that every health-care practitioner, in developing and adhering to a usual practice, do so in reliance on established and evolving knowledge of treatments and risks as reflected in the relevant literature, the standards set by the College and clinical experience.

**The Health Care Consent Act, 1996, S.O. 1996, c.2, Schedule A**

Subsection 11(1) of the *Health Care Consent Act*, 1996 (the “*Act*”), defines the requisite elements of consent to treatment as follows:

1. The consent must relate to the treatment.
2. The consent must be informed.
3. The consent must be given voluntarily.

4. The consent must not be obtained through misrepresentation or fraud.

Subsection 11(2) of the *Act* then defines informed consent as follows:

- (2) A consent to treatment is informed if, before giving it,
  - (a) the person received the information about the matters set out in subsection (3) [detailed below] that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and
  - (b) the person received responses to his or her requests for additional information about those matters.

Subsection 11(3) of the *Act*, in turn, defines the matters for which information should be provided as:

1. The nature of the treatment;
2. The expected benefits of the treatment;
3. The material risks of the treatment;
4. The material side effects of the treatment;
5. Alternative courses of action;
6. The likely consequences of not having the treatment.

Under section 12 of the *Act*, unless it is not unreasonable to do so in the circumstances, a health-care practitioner is entitled to presume that consent to a treatment includes:

- (a) consent to variations or adjustments in the treatment, if the nature, expected benefits, material risks and material side effects of the changed treatment are not significantly different from the nature, expected benefits, material risks and material side effects of the original treatment; and
- (b) consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks and material side effects of the treatment as a result of the change in the setting in which it is administered.

These provisions of the *Act* are of considerable assistance in understanding the requisite elements of informed consent, the matters in respect of

which disclosure should be made to obtain informed consent, and the justifiable presumptions about the scope of consent to treatment that may be made by the health-care practitioner.

Section 11 of the *Act* makes it clear that a health-care practitioner is obliged to outline all alternative options to the patient. In this context, alternative courses of action include the option of saying no to the treatment or the procedure.

It has been said by some that “visiting a dentist isn’t the same as shopping at your local supermarket.” This expression is shorthand for the concept that, in legal terms, a patient is not entitled to receive every treatment or procedure that they may wish to receive. Rather, it is an obligation of the practitioner to ensure that the patient understands that one alternative course of action is to forgo treatment and that, in some situations, this is the

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**...THERE MAY WELL BE CIRCUMSTANCES IN WHICH IT IS THE OBLIGATION OF THE PRACTITIONER TO DECLINE TREATMENT OR A PROCEDURE IF ITS THERAPEUTIC NECESSITY OR DESIRABILITY IS NOT CLEARLY DEMONSTRABLE.**

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preferred option. Further, there may well be circumstances in which it is the obligation of the practitioner to decline treatment or a procedure if its therapeutic necessity or desirability is not clearly demonstrable.

### **In Summary**

With the clarification of the law of informed consent which emerged in the 1980s from decisions of

the Supreme Court of Canada, a sea change in the standard of disclosure, and the test for its evaluation, occurred. As noted in *Ferguson v. Hamilton Civic Hospitals et al. (1983)*: “Historically, if it was accepted that the doctor said the right thing, it was accepted that the patient understood and therefore was informed. Furthermore, if the doctor asserted that the patient understood, that assertion was accepted.”

The courts have rejected that approach in recent years and now apply an objective standard to assess whether the duty of disclosure has been met. Mere assertions by health-care practitioners are no longer adequate. An objective analysis will be undertaken by the courts to ascertain whether adequate disclosure occurred, and whether it is probable that the patient understood the disclosure that was made. In these circumstances, even where a health-care practitioner cannot specifically recall having a particular consent discussion(s) with a patient, the usual practice of the health-care practitioner in relation to the disclosure to patients of risks becomes critical.

Dentists, therefore, should be alert to develop a standard practice of informing patients about material, special and unusual risks and should define that practice, amending it over time as necessary, based on the circumstances of each patient.

This means, in the end, that a dentist must know her patient from the time of initial consultation, throughout the entire course of treatment. What is required is an ongoing dialogue or conversation with the patient concerning any significant procedure or treatment. The obtaining of informed consent to treatment is a necessity — both legally and ethically. As the pundit said: “Don’t leave the office without it.”



Royal College of  
Dental Surgeons of Ontario

*Ensuring Continued Trust*

6 Crescent Road  
Toronto, ON Canada M4W 1T1  
T: 416.961.6555 F: 416.961.5814  
Toll Free: 800.565.4591 [www.rcdso.org](http://www.rcdso.org)