# Supreme Court reaffirms landmark informed-consent ruling in chickenpox case



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**In brief**

A LITTLE-PUBLICIZED SUPREME COURT OF CANADA ruling released in June held an important message for physicians concerning informed consent. Lawyer Karen Capen discusses the judgement. She also predicts that laws on informed consent will face adjustments in the future and tells how physicians can prepare for them.

**En bref**

UNE DÉCISION PEU REMARQUÉE RENDUE PAR LA COUR SUPRÊME en juin lance un important message aux médecins au sujet du consentement éclairé. L'avocate Karen Capen en discute. Elle prédit que les lois sur le consentement éclairé auront à être modifiées à l'avenir et elle explique comment les médecins peuvent se préparer en conséquence.

In June the Supreme Court of Canada ruled that a British Columbia family physician had adequately discharged her duty to disclose even though she failed to tell her patient of a serious but very small increased risk to her fetus posed by a case of chickenpox.

The patient, Carole Arndt, gave birth in 1986 to a daughter who was diagnosed with congenital varicella syndrome. She requires feeding through a tube because she is unable to swallow. When asked about the possible effects of chickenpox on the patient's developing fetus, Dr. Margaret Smith had explained that there were frequently occurring risks of limb and skin abnormalities. However, she did not discuss more serious although less frequent risk of possible brain damage and other defects.

This case reaffirmed the landmark 1980 judgement in *Reibl* v. *Hughes* concerning the legal requirement for informed consent. The Supreme Court ruling also supported the ruling of the trial judge, who had dismissed Arndt's claim.

During that trial, Arndt contended that had Smith advised her appropriately of the serious risk of injury to her fetus, she would have terminated her pregnancy and thus have avoided the considerable expense of providing the long-term care for her daughter. Smith responded that her patient would not have had an abortion even if she had been fully advised. The trial judge concluded that Arndt would not have aborted the fetus. That conclusion supported Smith's request for dismissal of the claim, despite the patient's testimony to the contrary.

The judge made the decision because of evidence that:

- Arndt desired a child;
- she was sceptical of mainstream medicine;
- an abortion in the second trimester of pregnancy held increased risks; and
- an abortion at this stage would have required the approval of a committee on health-related grounds.

Other supportive testimony included evidence that the risk of serious injury to the fetus was very small and medical advisers would have recommended against abortion for a patient in Arndt's situation.

In ruling on *Arndt* v. *Smith*, the Supreme Court explained the significance of the *Reibl* precedent, stating that the case marked "the rejection of the paternalistic

approach to determining how much information should be given to patients . . . [and emphasized] the patient's right to know and [ensured] that patients will have the benefit of a *high standard of disclosure*."

However, the June decision recognized that this high standard of disclosure must be balanced by due consideration of protection of the medical system "in the face of liability claims for patients influenced by unreasonable fears and beliefs, while still accommodating all the reasonable individual concerns and circumstances of plaintiffs."

The *Reibl* case had determined that a judge hearing a patient's action for negligence against a physician must ensure that patients have received all requisite information needed to make an informed decision regarding a medical procedure, treatment or test that is being contemplated. Because of that 17-year-old ruling, the trial judge must conduct a legal analysis known as a modified objective test for causation. It asks this question: Would a reasonable person in the circumstances of the plaintiff have consented to the proposed treatment, procedure or test if all the risks had been disclosed? According to this analysis, both attendant (more common) risks and material (less common but serious) risks must be disclosed. A patient would then have to establish that the physician's failure to disclose caused harm for which monetary damages should be awarded.

The *Arndt* case helps illustrate the difference in a negligence action between simply failing to disclose and having to establish causation, which is a far more onerous task. This is the crucial aspect of the analysis used by the court to determine if actual negligence occurred. In the *Arndt* case, the patient argued that if she had been told of the material risk she would have terminated her pregnancy and thus would not have incurred the significant cost of the special care required for her child.

However, the physician's lawyer argued that Arndt wanted the expected child and would not have decided to undergo a second-trimester abortion, even if she had been told of the material risk. The trial judge agreed that the pregnancy would not have been terminated and the harm to the plaintiff was therefore not caused by the Smith's nondisclosure.

When the Supreme Court looked at the case, it found that a variety of factors had established Arndt's state of mind when she decided to continue with the pregnancy. It agreed with the trial judge that the physician's failure to disclose some of the risks to the fetus associated with maternal chickenpox, even though they were very serious, did not affect Arndt's decision to continue with the pregnancy. It followed, ruled the court, that the failure to disclose did not cause the heavy costs for which Arndt wanted compensation.

**The Supreme Court agreed with the trial judge that the physician's failure to disclose some of the risks to the fetus associated with maternal chickenpox, even though they were very serious, did not affect Arndt's decision to continue with the pregnancy.**

Although the Supreme Court has once again reaffirmed the legal requirement for informed consent that it established in 1980, physicians can still protect themselves against potential legal action by remembering a central feature of good clinical practice: the importance of good communication with patients. This communication, especially in situations requiring informed consent, should include full disclosure of both attendant and material risks during ongoing conversations with patients. Physicians should ensure, during the decision-making process that accompanies any treatment or procedure, that they pay careful attention to specific or special factors or considerations that affect each patient.

Physicians should also be aware that there is continuing concern among some legal experts that the informed-consent ruling in *Reibl* v. *Hughes* doctrine, supported by the *Arndt* ruling, is too harsh and may fail to protect individual plaintiffs, as it did in this case.

This means that judges will continue to hear arguments emphasizing the importance of placing more weight on patients' subjective perspectives on what they would have decided given specific and particular circumstances relevant to them at the time a decision was made.

What should physicians do to prepare for any future adjustments to the law on informed consent? Good communication with patients as a part of routine clinical practice is one important key to positive health outcomes. Physicians should keep in mind, as part of the process of securing informed consent, that this communication should include clear and understandable conversations about any special needs or considerations with every patient. Doctors must also keep detailed, careful and contemporaneous records of all discussions and responses to patients' questions (whether asked explicitly or alluded to) concerning prospective treatments or procedures. ?