Commission of Inquiry on Hormone Receptor Testing

THE LEGAL DUTY OF PHYSICIANS TO DISCLOSE MEDICAL ERRORS

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I. INTRODUCTION

As a result of a series of legal decisions beginning in the mid 1980's, it is now well established in Canadian law that if in the course of medical treatment a doctor makes an error which harms (or which has the potential to harm) the patient, the doctor has a legal obligation to disclose this fact to the patient (Gilmour, 2006, p. 67; Hébert, Levin, & Robertson, 2001; Picard & Robertson, 2007, pp. 204-208; Robertson, 2002; Waite, 2005).

However, although this legal obligation is now well established, many issues relating to its precise scope remain unclear. This paper begins with a discussion of the legal cases which establish the physician's duty to disclose medical error, including a discussion of the underlying legal basis for the duty. It also examines the legal consequences which flow from a breach of the duty of disclosure. The paper then explores in more detail a number of specific aspects of the duty, including the content and timing of disclosure and whether the duty extends beyond physicians to other health professionals such as nurses.

II. THE CASE-LAW

The first Canadian case to impose a legal duty on physicians to disclose medical errors to their patient was *Stamos v. Davies* (1985), a decision of Mr. Justice Krever of the Ontario High Court. The case involved an internist who pierced the patient's spleen while performing a trephine needle lung biopsy, causing a serious haemorrhage. On receiving

the pathologist's report two days later, and discovering that he had biopsied the spleen rather than the lung, the doctor told the patient that he had received no results from the biopsy because he had not obtained what he had wanted. When asked by the patient what in fact had been obtained, the doctor replied "something else", but provided no other details. The patient was discharged from hospital but returned to the emergency department three days later, at which time his spleen was surgically removed. Mr. Justice Krever held that the doctor had been negligent in puncturing the spleen during the biopsy. Relying upon an earlier decision of the English Court of Appeal (*Lee v. South West Thames R.H.A.*, 1985), Justice Krever also held that the doctor had a legal duty to inform the patient of what had happened, and that he had breached that duty in failing to be candid with the patient.

The physician's duty to disclose medical errors was affirmed in two later Ontario cases, both of which involved surgeons who operated on the wrong disc during back surgery (*Vasdani v. Sehmi*, 1993; *Gerula v. Flores*, 1995). In *Vasdani* the surgeon mistakenly operated at the L3-4 level instead of L4-5. He was unaware of his error until one year later, when advised of it by doctors at the Workers' Compensation Board. The surgeon decided not to inform the patient of this, because by then the care of the patient had passed to another surgeon. Seven years later a law student who was examining the patient's WCB file for the purposes of an appeal discovered the truth and informed the patient, who then commenced an action for damages against the surgeon. The Court held that the doctor had a legal duty to inform the patient of his error, and was not relieved of

this responsibility merely because care of the patient had passed to another doctor. In the words of the Court:

> Dr. Sehmi, while not denying that there was a duty of disclosure, takes the position that the duty was no longer his when care and treatment of Vasdani was assumed by another doctor. I do not think that position is tenable. The duty of disclosure may have become complicated by the interposition of another doctor in that it may have required consultation to determine when, how and by whom, the disclosure should be made; but the duty was first, last and always, that of Dr. Sehmi, and was not fulfilled (para. 34).

In *Gerula v. Flores* (1995) the surgeon mistakenly performed a laminectomy on the L4-5 level instead of L3-4, and discovered the error a few months later. Not only did the surgeon fail to inform the patient of the mistake, he also altered the hospital records in an attempt to cover it up. The Ontario Court of Appeal held that the surgeon's conduct was in flagrant disregard of the patient's right to be informed, and it awarded punitive damages of $40,000 against the surgeon.

Punitive damages were also awarded in a British Columbia case in which a six-foot long gauze roll was left inside the patient's abdomen during gynaecological surgery (*Shobridge v. Thomas*, 1999). The surgeon later performed a second operation, to investigate the cause of the patient's continuing abdominal infection and pain, at which point the retained gauze roll was discovered. The surgeon instructed the nursing staff not to include this discovery in the patient's chart, and not to prepare an incident report as required by hospital policy. He also made no mention of the abdominal roll in his operative report, nor in a subsequent consultation report, and he waited two months before finally

disclosing the facts to the patient, and only then after he was told to do so by the vice-president of the hospital. The Court held that the surgeon was in breach of his legal duty to inform the patient of the discovery of the retained abdominal roll "as soon as reasonably practical" (para. 89). In addition, the Court concluded that he had engaged in "covering up his own failures to avoid legal responsibility" (para. 94), which was deserving of an award of punitive damages.

The physician's duty to disclose medical error to the patient has also been recognized in cases from other provinces, including Alberta (*V.A.H. v. Lynch*, 1998, para. 134; *Fehr v. Immaculata Hospital*, 1999, para. 34), New Brunswick (*Kueper v. McMullin*, 1986), and Quebec (*Kiley-Nikkel v. Danais*, 1993).

Another Ontario case - *Pittman Estate v. Bain* (1994) - is important for its discussion of whether there may be exceptional circumstances which justify a doctor withholding information from the patient. This is referred to as the defence of "therapeutic privilege", and it has arisen from time to time in the context of informed consent (Picard & Robertson, 2007, pp. 173-175). Mr. Pittman received a blood transfusion in 1984 while undergoing cardiac surgery. Five years later the hospital notified Mr. Pittman's family doctor that the blood may have been contaminated with HIV. The doctor decided not to inform Mr. Pittman, partly because he was concerned about the effect which this news might have on Mr. Pittman's physical and emotional health. Mr. Pittman died the following year of AIDS-related pneumonia, and his wife also became infected with HIV as a result of sexual

relations with her husband. The Court held that the family doctor was negligent in failing to inform Mr. Pittman of the possibility that he had received contaminated blood, and the doctor was not justified in withholding the information because of his concerns about the possible effect it would have on his patient. The Court recognized that in exceptional circumstances a doctor may be justified in withholding information, but it stressed that those situations are very limited. In the words of the Court:

> With regard to therapeutic privilege, there will be cases where a patient is unable or unwilling to accept bad news from his or her physician. In those circumstances, a physician is obliged to take reasonable precautions to ensure that the patient has communicated their desire not to be told, or that the patient's health is so precarious that such news will undoubtedly trigger an adverse reaction that will cause further unnecessary harm to the patient (p. 399).

III. THE UNDERLYING LEGAL BASIS FOR THE DUTY TO DISCLOSE

Two theories have been relied upon in the case-law to ground the physician's duty of disclosure (Picard & Robertson, 2007, p. 204; Robertson, 2002, pp. 357-358; Waite, 2005, pp. 15-16). The earlier cases based it on the doctrine of informed consent. Patients have a fundamental (and indeed, constitutionally protected) right to make their own medical decisions, and to be free from unwanted medical treatment (*Starson v. Swayze*, 2003; *Rodriguez v. British Columbia (Attorney General)*, 1993; *Ciarlariello Estate v. Schacter*,

1993; *Fleming v. Reid*, 1991; *Reibl v. Hughes*, 1980; *Hopp v. Lepp*, 1980). In order to make this a meaningful right, Canadian law has recognized that patients also have a right to information concerning proposed treatment, to enable them to make an informed decision whether or not to undergo the treatment. Accordingly, it is well established in Canadian law that doctors have a duty to inform their patient of the material risks of proposed treatment, "material risks" being those which a reasonable person in the patient's circumstances would want to know (*Reibl v. Hughes*, 1980; Picard & Robertson, 2007, chpt. 3).

Although at first sight it may seem odd to base the duty to disclose medical errors (which arises after the treatment is performed) on the doctrine of informed consent (which applies prior to treatment), in principle the two are linked. As is stated in Picard & Robertson (2007, p. 204), "if a patient has the right to be told what may go wrong, surely the patient also has a right to be told what has in fact gone wrong." This is also consistent with the well established principle that the duty of disclosure arising from the doctrine of informed consent does not end after the treatment is finished, but extends to include any material information which is obtained after the treatment is performed (Robertson, 2002, p. 357).

The more recent cases have grounded the duty to disclose medical error on the concept of fiduciary obligation. The relationship between doctor and patient is a fiduciary one, that is, a relationship of utmost trust which imposes on the doctor additional

responsibilities and obligations towards the patient (*McInerney v. MacDonald*, 1992; Picard & Robertson, 2007, pp. 4-7). Cases such as *Vasdani v. Sehmi* (1993), *Gerula v. Flores* (1995), and *Shobridge v. Thomas* (1999) have held that the fiduciary nature of the doctor-patient relationship imposes a duty on the doctor to disclose medical errors to the patient.

It is interesting to note that all of the cases which are discussed above, which impose a duty on physicians to disclose medical error, were decided at a time when the ethical code of the profession did not explicitly recognize such a duty (Robertson, 2002). That has now changed. The Canadian Medical Association's *Code of Ethics* provides, "Take all reasonable steps to prevent harm to patients; should harm occur, disclose it to the patient" (Canadian Medical Association, 2004, para. 14). In addition, the College of Physicians and Surgeons in all provinces has either expressly adopted the CMA's duty of disclosure or has developed its own disclosure policies (Canadian Patient Safety Institute, 2006; Vandergrift, 2007).

This express recognition of a professional and ethical obligation of disclosure strengthens the legal duty and adds an underlying basis to it. The overall duty of care owed to the patient requires the physician to exercise reasonable skill and judgment - to act as a reasonable physician would do in similar circumstances (Picard & Robertson, 2007, chpt. 4). Therefore, it is open to the court to conclude that in addition to the concepts of informed consent and fiduciary duty, the physician's ordinary duty of care imposes a duty of disclosure to patients, because that is what is expected by the profession itself as

evidenced by its ethical codes and disclosure policies. Thus, for example, although the Canadian Disclosure Guidelines recently published by the Canadian Patient Safety Institute state that they are "not intended to define or serve as a legal or professional standard of care" (Canadian Patient Safety Institute, 2008, p. 10), it is possible that a court might choose to adopt them as reflecting the appropriate standard of disclosure, in the same way as it may adopt other professional guidelines as being indicative of the standard of care (Picard & Robertson, 2007, p. 360).

IV. LEGISLATION

The doctor's legal duty of disclosure is (at least for the time being) entirely a product of the common law; there is no statutory duty of disclosure. Although Manitoba and Quebec have recently introduced legislation requiring disclosure of adverse events to patients, the duty is placed on the health authority or health care institution rather than on individual health care professionals (*Regional Health Authorities Amendment and Manitoba Evidence Amendment Act*, 2005; *An Act Respecting Health Services and Social Services*, 2002). The legislation in Quebec does impose a duty on individuals to report adverse events to the executive director of the institution (but not to the patient), whereas in Manitoba the legislation provides that health professionals *may* report adverse events to the institution, but are not required to do so (Canadian Patient Safety Institute, 2006; Vandergrift, 2007).

Another important legislative development is the recent enactment in British Columbia, Manitoba, and Saskatchewan of "apology" laws (*Apology Act*, S.B.C. 2006; *Apology Act*, S.M. 2007; *Evidence Act*, S.S. 2006). Modelled on similar legislation in the United States, their purpose is to encourage health professionals to apologize to patients when an adverse event has occurred, without the risk of that apology later being used against them in legal proceedings as an admission of liability. The legislation provides that an apology does not constitute an express or implied admission of fault or liability, and is not admissible in court as evidence of fault or liability (Bailey, Robertson, & Hegedus, 2007; Waite, 2005).

It should be noted that although the legislation prevents an apology from being used as evidence of fault or liability, the apology can still be relevant (and admissible as evidence) with respect to other matters. For example, in a recent B.C. case, evidence that the physician apologized to the patient for having performed the wrong operation was one of the factors which the Court took into account in deciding not to award punitive damages against the physician (*Cochran v. Hunter*, 2004).

There is a significance to the apology legislation which goes well beyond the legal protection it confers. It highlights that to the extent that physicians are reluctant to discharge their duty to disclose errors to their patients - and there is substantial empirical evidence that they are (Levinson & Gallagher, 2007) - one reason is that perception often trumps reality. There appears to be no reported case in Canada in which a physician's

apology to a patient has been used as evidence of an admission of liability (Waite, 2005), and yet the perception that it could be has led to the enactment of the apology laws. Likewise, physicians often report being reluctant to disclose medical errors to their patients because of a fear of being sued, whereas the empirical evidence suggests that open and candid disclosure actually reduces the risk of being sued (Levinson & Gallagher, 2007; Picard & Robertson, 2007, p. 208; Robertson, 2002; Waite, 2005).

V. THE LEGAL CONSEQUENCES OF NON-DISCLOSURE

Sometimes the breach of a physician's duty to disclose medical error will cause no additional harm to the patient, and therefore no legal consequences will flow from it. *Stamos v. Davies* (1985) is an example of this; the surgeon's failure to tell the patient that he had punctured the spleen during the course of the lung biopsy caused no additional harm to the patient, and hence no damages were awarded for the breach of disclosure.

However, in many instances the breach of the duty of disclosure will have legal consequences. For example, as is discussed above, if the court finds that failure to disclose the error (particularly if it is coupled with active steps at covering up) constitutes egregious and reprehensible conduct deserving of sanction, it may award punitive damages against the doctor (*Gerula v. Flores*, 1995; *Shobridge v. Thomas*, 1999).

Other legal consequences which may flow from the breach of the duty to disclose

error include an award of damages for the patient's emotional suffering in not being told the truth. For example, in a Quebec case a patient underwent a mastectomy following a biopsy which indicated breast cancer. When the surgeon subsequently discovered that the pathologist's report of the biopsy was incorrect, he waited six years before informing the patient. In the subsequent legal action against the surgeon the patient was awarded damages for the anxiety and stress which she suffered during those six years, worrying that her cancer might recur (*Kiley-Nikkel v. Danais*, 1993). Likewise, in the *Shobridge* case, the patient was awarded substantial aggravated damages for the emotional distress which she suffered upon discovering that her doctor had deliberately concealed the truth from her concerning the abdominal roll which had been left inside her during surgery (*Shobridge v. Thomas*, 1999).

Another important legal consequence of non-disclosure relates to limitation periods. Legislation imposes a "limitation period" for civil actions, that is, a time within which the action must be commenced, otherwise it is time-barred. In most provinces that time-period is two years from the date when the plaintiff discovered (or ought reasonably to have discovered) the material facts, subject to an overriding limitation of 10 years (in some provinces, 15 years) from the date of the negligent act (Picard & Robertson, 2007, pp. 375-385). This overriding limitation period means that even if the plaintiff is unaware of the injury, or of the material facts surrounding it, the action will be time-barred after 10 (or 15) years. However, this is subject to an exception for fraudulent concealment; if the defendant fraudulently conceals the existence of the cause of action, the limitation period does not

start to run until the plaintiff discovers (or ought reasonably to have discovered) the fraud. It has been held that a doctor's failure to disclose medical error constitutes fraudulent concealment, thereby postponing the running of the limitation period for an action against the doctor (Picard & Robertson, 2007, pp. 384-385; Robertson, 1987).

VI. WHEN DOES THE DUTY OF DISCLOSURE ARISE?

As noted above, although the existence of the physician's duty of disclosure is well established, some issues concerning its precise scope remain uncertain. One of the most important of these relates to the point at which the duty arises. What event or types of event will trigger the legal duty to disclose? Specifically, does the duty arise only if the patient has suffered harm? What about possible actual harm? What if there is the potential for future harm? What about incidents where an error occurs which almost causes harm to the patient (the "near miss" cases)?

As noted above, the CMA's Code of Ethics speaks of disclosure of harm - if the physician causes harm to the patient, this must be disclosed (Canadian Medical Association, 2004, para. 14) - perhaps implying that there is no ethical obligation of disclosure in the absence of harm. Likewise, in keeping with many disclosure policies across the country, the Canadian Disclosure Guidelines developed by the Canadian Patient Safety Institute require disclosure of an "adverse event", which is defined as "An event which results in unintended harm to the patient, and is related to the care and/or services provided to the patient rather than to the patient's underlying medical condition"

(Canadian Patient Safety Institute, 2008, p. 30). As with the CMA's Code of Ethics, the Canadian Disclosure Guidelines focus on "harm" to the patient as the triggering event for disclosure. However, it should be noted that they also contemplate a duty of disclosure in cases of potential future harm. They provide that:

> The need to disclose when there is no immediate harm but the potential for harm exists is influenced by the future likelihood of severe consequences, the severity of possible consequences and the potential to prevent, identify or mitigate future harm through clinical testing or treatment. When uncertain about whether harm has occurred, it is recommended that disclosure take place; however, further consultation may be required before proceeding. Consider consulting with an ethics committee or another similar body of experts for advice about the clinical risk of future harm and the need to disclose (Canadian Patient Safety Institute, 2008, p. 18).

With respect to the legal duty of disclosure, it cannot be assumed that it applies only in cases where the patient has suffered harm. Indeed, some of the cases suggest otherwise. For example, in the *Vasdani* and *Gerula* cases, discussed above, in which the surgeon mistakenly operated on the wrong part of the patient's back, there was no real "harm" to the patient (other than the fact that the operation did not cure the underlying problem and had to be repeated), and yet the surgeon was held to have a duty to inform the patient of what had happened (*Vasdani v. Sehmi*, 1993; *Gerula v. Flores*, 1995).

In addition, the case-law makes it clear that if the physician knows that an error may have caused harm to the patient, there is a duty to inform the patient. The *Pittman* case establishes this: on being notified that Mr. Pittman may have been transfused with HIV contaminated blood, his family physician had a legal duty to inform him of this (*Pittman*

Estate v. Bain, 1994).

It seems, therefore, that the physician's legal duty of disclosure may be broader than that envisaged in documents such as the CMA's Code of Ethics, in that it is not confined to cases where the patient has suffered actual harm. This is consistent with one of the underlying theories upon which the legal duty of disclosure is based, namely, the doctrine of informed consent. As is discussed above, the guiding principle which is applied in informed consent cases to determine what information must be disclosed to patients is whether a reasonable person in the patient's circumstances would have wanted the information (*Reibl v. Hughes*, 1980; Picard & Robertson, 2007, chpt. 3). Applying that principle in the context of medical error, the duty to inform the patient of what has happened would arise if it is something which a reasonable person in the patient's circumstances would want to know. Indeed, that principle is recognized in the Canadian Disclosure Guidelines (Canadian Patient Safety Institute, 2008, p. 18). Certainly in the case of possible harm, and potential future harm, and perhaps even in cases of serious "near misses", one could argue that a reasonable patient would want to be informed of this.

Another issue with respect to when the duty of disclosure arises relates to timing: how soon must disclosure be made? In this respect the policy guidelines and the law are consistent. As noted above, the *Shobridge* case held that disclosure must take place "as soon as reasonably practical" (*Shobridge v. Thomas*, 1999, para. 89). Likewise, the

Canadian Disclosure Guidelines provide that disclosure should take place "as soon as reasonably possible after the event", and "at the earliest practical opportunity and preferably within one to two days after discovery of the adverse event" (Canadian Patient Safety Institute, 2008, pp. 16 and 20).

VII. WHAT MUST BE DISCLOSED?

Policy guidelines, such as the CPSI's Canadian Disclosure Guidelines, emphasize that disclosure should be limited to facts, and in particular, should avoid "speculation, opinion or attribution of blame" (Canadian Patient Safety Institute, 2008, p. 21).This is consistent with the duty imposed by law. In particular, it has been held that the doctor's duty of disclosure is limited to facts and does not extend to disclosure of evidence or opinions (*V.A.H. v. Lynch*, 1998, para. 134; *Fehr v. Immaculata Hospital*, 1999, paras. 34 and 39).

VIII. WHOSE DUTY?

Two issues arise under this heading, The first is whether the physician's legal duty of disclosure is non-delegable, or can be discharged by someone else on the physician's behalf. The second is whether the legal duty of disclosure extends to other health professionals, including nurses.

Many of the recent policies and protocols which have been adopted with respect to disclosure, including the CPSI's Canadian Disclosure Guidelines, adopt a "team approach" to disclosure. They do not place sole responsibility on the physician. Even the policy guidelines (such as the ones in Alberta and Newfoundland) which provide that the most responsible physician should take a lead role in disclosure conversations, do not contemplate that the physician must necessarily be the one who personally discloses the information to the patient (Canadian Patient Safety Institute, 2006; Vandergrift, 2007).

This is consistent with the case-law which establishes the physician's legal duty of disclosure. There is no indication in those case that the physician must personally inform the patient, so long as he or she takes reasonable steps to ensure that the patient is informed, including delegating the task to someone else. For example, in the Quebec case in which the patient was incorrectly diagnosed with breast cancer (and underwent unnecessary surgery), the error was that of the pathologist in examining the biopsy. On discovering his error the pathologist informed the surgeon, who advised him that he would tell the patient (which he did not). The Court held that the pathologist was not liable for failing to inform the patient, because it was reasonable for him to rely on the surgeon's assurance that he would tell the patient (*Kiley-Nikkel v. Danais*, 1993).

Support for the position that the duty of disclosure can be delegated is also found in the *Pittman* case, discussed above (*Pittman Estate v. Bain*, 1994). In that case the Court held that upon learning that the patient may have received a transfusion of HIV

contaminated blood, it was reasonable for the hospital to decide to notify the patient's family physician and leave it to him to inform the patient, so long as appropriate support and advice were made available to the family physician to enable him to carry out this responsibility.

In summary, although the cases impose a duty of disclosure on the physician personally, the legal position is probably consistent with that reflected in the policy guidelines, namely, that so long as the physician takes reasonable steps to ensure that the patient is informed, the actual disclosure does not necessarily have to be made by the physician, and can be delegated to others (in particular, other medical staff or hospital administration).

The other issue which arises in this context is whether other health professionals (in particular, nurses) have a legal duty to disclose errors to the patient. This was discussed in the *Shobridge* case, which involved a patient who had a retained gauze roll in her abdomen following surgery (*Shobridge v. Thomas*, 1999). The Court held that the nurses who were present when the abdominal roll was discovered had no legal duty to inform the patient, even when it became apparent to them that the surgeon was not going to tell the patient; the nurses' only obligation was to prepare an incident report for hospital administration.

As Michael Waite (2005) points out, this aspect of the *Shobridge* decision is problematic, particularly since the nursing staff was negligent (along with the surgeon) in failing to do a proper sponge count in the initial operation, which led to the abdominal roll being left inside the patient. In other words, it was partly the nurses' error which led to the adverse event, and yet the Court held that they had no legal duty to inform the patient; sole responsibility for disclosure lay with the surgeon.

Admittedly it may be more difficult to construct a legal basis for imposing a duty of disclosure on nurses. The ones which have been used to ground the doctor's duty of disclosure - informed consent and fiduciary duty - do not easily apply to nurses. Nurses do not have a legal duty to obtain a patient's informed consent to treatment which is performed by (or under the direction of) a physician (Picard & Robertson, 2007, p. 172), nor have Canadian courts characterized the relationship between nurse and patient as a fiduciary one (Waite, 2005, pp. 19-20). Nevertheless, given that the ethical code of the nursing profession recognizes a duty to "admit mistakes" (Canadian Patient Safety Institute, 2006; Vandergrift, 2007), it is certainly possible that a Canadian court could impose such a duty (Waite, 2005, p. 20). Indeed, Picard & Robertson (2007) suggest that:

> In view of the modern "team approach" to health care delivery, with nurses playing an important role in patient care in a hospital setting, the correctness of the *Shobridge* decision on this issue is questionable. Both with respect to their own errors, and those of other members of the team, nurses should be regarded as having a duty to take reasonable steps to ensure that the patient

is advised of the error [footnotes omitted] (p. 207).

IX. CONCLUSION

The physicians' legal duty of disclosure of medical error is well established. Whether it is grounded upon the doctrine of informed consent, or upon principles of fiduciary law, or upon the general duty of care imposed by the law of tort (and contract), the duty of disclosure is clear. Yet many of its parameters have still to be determined by the courts. In particular, is it a duty confined to doctors, or is it shared by other health professionals (and indeed, health care institutions)? Is it triggered only in cases of actual harm, or does it arise in cases of possible or future harm, and in cases of "near misses"? Although the case-law sheds some light on these issues, the precise scope of the duty to disclose medical error is not yet clear, and awaits further judicial clarification. However, it is noteworthy that Canadian courts have taken a very broad and expansive interpretation of physicians' fiduciary obligations to their patients, as well as their duties with respect to informed consent (Picard & Robertson, 2007), both of which underlie the duty to disclose medical error. This may well suggest that in the future Canadian courts will also take an equally expansive interpretation of the duty to disclose medical error to patients.

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