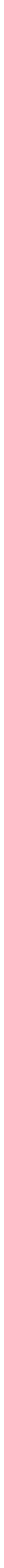


Section 1





Chapter 1



INTRODUCTION TO ISSUES

INTRODUCTION

Pediatric cardiac surgery is one of the most professionally difficult and personally satisfying medical disciplines in which to work. It demands precision and accuracy from the surgeon, as well as a high degree of efficiency and teamwork from the other doctors, nurses and technicians who form its operating-room teams. It is a field of medicine that has as its focus the very symbol of love and life in our society: the human heart. Pediatric cardiac surgery offers the promise of life to those who will otherwise die, and it offers to parents the opportunity to continue to raise and love a child they have been told might otherwise be lost to them.

Children with potentially fatal heart problems represent a particularly powerful symbol of vulnerability. Born with a condition that they had no hand in creating, they rely totally on adults to do what can and needs to be done to give them an opportunity to survive and to live as normal a life as possible. Invariably, the survival of children with heart problems depends on some sort of medical intervention. Recent medical developments, particularly in the field of surgery and pharmacology, have come to offer such children greater and greater hope for a long life well into adulthood.

Surgeons these days are performing medical feats on children's hearts that their professional predecessors would have considered impossible. Today, children's hearts are routinely opened, closed and rearranged in a manner that medical professionals of the past never dreamed of. These children can and often do go on to live in a manner that makes them no different from any other child.

But not all surgical outcomes are so rewarding. There are very few pediatric cardiac surgical cases that come with a one hundred per cent guarantee of success. As with any surgical procedure, almost all cardiac surgery has a small degree of risk associated with it.

Recognizing that risk, ensuring that the patient understands that risk before agreeing to surgery and performing its tasks in a manner that does not exacerbate that risk are primary obligations of the surgical team.

It is in keeping with the latter point that medicine has developed the aphorism “First, do no harm.”

During 1994, 12 children died while undergoing, or shortly after having undergone, cardiac surgery at the Children’s Hospital of Winnipeg.

GARY CARIBOU, born August 22, 1993, was the son of Charlotte Caribou and Morris Dell of Lynn Lake, Manitoba. He underwent a heart operation on March 14, 1994, and died on March 15, 1994, in the pediatric intensive care unit (PICU), within twenty-four hours of surgery. He was six months twenty days old.

JESSICA ULIMAUMI, born August 18, 1993, was the daughter of Emalee and John Ulimaumi of Arviat in the Northwest Territories. She underwent cardiac surgery on March 24, 1994. She died three days later on March 27, 1994, in the PICU. She was seven months nine days old.

VINAY GOYAL, born March 2, 1990, was the son of Virpan and Sheena Goyal of Winnipeg. Vinay had two operations in 1994, the first on March 17, and the second on April 18. The second operation was necessitated because the first operation was not successful. He died during the second operation. He was four years one month sixteen days old.

DANIEL TERZISKI, born March 18, 1994, the son of Danica and Kiril Terziski of Winnipeg, underwent cardiac surgery on April 20, 1994. He died the same day in the neonatal intensive care unit (NICU) within hours of leaving the operating room. He was 33 days old.

ALYSSA STILL, born November 14, 1993, was the daughter of Donna Still of Thunder Bay, Ontario. Alyssa had heart surgery on May 5, 1994. She died May 6, 1994, in the PICU, within hours of her operation. She was five months twenty-two days old.

SHALYNN PILLER, born July 20, 1994, was the daughter of Sharon and Ken Piller of Carman, Manitoba. Shalynn had a heart operation on August 1, 1994, and died August 3, 1994 within forty-eight hours of surgery. She was 14 days old.

ARIC BAUMANN, born December 7, 1993, was the son of Deanna and Curtis Baumann of Winnipeg. Aric underwent cardiac surgery on June 30, 1994. He died fifty-two days later on August 21, 1994, never having left the PICU. Aric was eight months fourteen days old when he died.

MARIETESS TENA CAPILI was born December 15, 1991, to Sarah Tena and Benedict Capili of Winnipeg. She had undergone two operations early in life to provide her with temporary relief. Both of them had been performed in 1992 by the pediatric cardiac surgeon then on staff at the Children’s Hospital, Dr. Kim Duncan. Marietess was scheduled to undergo a more definitive repair in 1994. She had that operation on September 13, 1994. She died September 14, 1994, within a few hours of being moved from the operating room to the PICU. Marietess was two years nine months old.

ERICA BICHEL was born September 29, 1994, to Judy and James Bichel of Winnipeg. Erica underwent a heart operation on October 4, 1994. She died while still in the operating room. She was five days old.

ASHTON FEAKES was born April 15, 1993, to Linde and John Feakes of Winnipeg. His operation took place November 1, 1994. He died November 11, 1994, while still in the PICU. He was one year three months twenty-seven days of age.

JESSE MAGUIRE was born November 25, 1994, to Lauren Maguire and Richard Shumila of Winnipeg. He had to undergo a heart operation on November 27, 1994. He died while still in the operating room. He was two days old.

ERIN PETKAU, born December 17, 1994, was the daughter of Walter and Barbara Petkau of Morden, Manitoba. Her heart operation took place on December 20, 1994. She died in the early morning hours of December 21, 1994 in the NICU shortly after leaving surgery. She was three days old.

The surgeon involved in these cases, Dr. Jonah Odim, had assumed the position of Chief of Service, Pediatric Cardiac Surgery at the Children's Hospital in February 1994. This was his first staff appointment and the operations he performed at the Children's Hospital were the first that he had undertaken without supervision.

Throughout 1994, concerns about the deaths of each of these 12 children and about the condition of children from other operations had been expressed to people in authority at the hospital by members of the nursing and medical staff, particularly the surgical and intensive care nurses and the doctors in the Section of Pediatric Cardiac Anaesthesia.

In May 1994, following the death of the fifth of the 12 children, the members of the Section of Pediatric Cardiac Anaesthesia unanimously agreed to refuse to participate in any further pediatric open-heart cases until a review had been undertaken. A review committee was appointed and the program continued to provide services for low-risk cases during the review period. Cases that could not await the outcome of the review were transferred to pediatric cardiac surgical facilities in other provinces. During this period of reduced services, two more children died following surgery in Winnipeg.

The review committee recommended that the program return to full service in September 1994. From that point until December 21, 1994, five more children died.

After the death of the twelfth child, the Head of the Children's Hospital directed that no further pediatric cardiac patients be referred for surgery to the Pediatric Cardiac Surgical Program until a review could be completed by an outside review team.

The outside review team presented its findings to the hospital in early February 1995. On receipt of the review, the HSC suspended the program for a further six months and issued a press release to that effect. Following this announcement the parents of the children who had died became aware for the first time of problems with the program in 1994 and some of them demanded a public inquiry into the events surrounding the deaths of their children.

THE CALLING OF THE INQUEST

The parents' demand for a public inquiry was communicated to the Minister of Justice. On March 5, 1995, following a meeting with the Minister of Justice and other representatives of the Department of Justice, Dr. Peter Markesteyn, Chief Medical Examiner for the Province of Manitoba, ordered that an inquest be held into the deaths of the 12 children. He directed that one inquest be convened to investigate all the 1994 deaths. The Minister of Justice declined to appoint a public inquiry, indicating that the matter might be reconsidered once the inquest had reported.

Inquest hearings began in the summer of 1995, with various parties applying for standing.

THE MANDATE OF THE INQUEST

Inquests in Manitoba are governed by statute, and to a certain extent by common law. Their legislative mandate is set out in the provisions of *The Fatality Inquiries Act, C.C.S.M. c. F-52* (hereafter referred to as the *Fatality Inquiries Act*).

Inquests in Manitoba are presided over by judges of the Provincial Court of Manitoba (*Fatality Inquiries Act*, s. 26). Their primary role is to determine the identity of the deceased, the facts surrounding the death, how the deceased came to die, and whether the death was preventable. Additionally, an inquest is mandated to inquire into whether any of the policies or programs of an institution or government should be changed in order to prevent a repeat of such a death (*Fatality Inquiries Act*, s 33(1)).

During the course of these proceedings, a number of legal issues presented themselves in addition to the legal issues that normally arise with respect to the admissibility of evidence. These issues include the following:

- Who should have standing
- The question of culpability
- What is informed consent
- The legal privilege of members of Medical Standards Committees
- *In camera* proceedings
- Disclosure of evidence

STANDING

A number of individuals and organizations interested in the outcome of these proceedings applied for standing early on in the process.

At common law, the public has no inherent right to attend inquest hearings (Granger: *Canadian Coroner Law*, 1984, The Carswell Company Limited, at page 243). Additionally, no one else had such a right, even the deceased's family. The *Fatality Inquiries Act* of Manitoba now provides that a person who, in the opinion of the presiding Judge, is "substantially and directly interested" in the inquest, may attend the inquest in person or by counsel and may examine or cross-examine witnesses called at the inquest. (*Fatality Inquiries Act*, s. 28(1)).

A Provincial Judge may limit examination or cross-examination of witnesses by a party granted standing where "the examination or cross-examination. . . is beyond what is necessary for the purpose of the Inquest."

The question of determining when a party is "substantially and directly interested in the Inquest" has been the subject of some consideration in the case law (Granger: *Canadian Coroner Law*, *supra*, at page 217 and page 307 *et seq*).

Based on the principles set out in those cases, and upon the facts of this case, certain individuals and groups of individuals were granted standing to participate in these proceedings. In October 1995, standing was granted to the following:

1. The families of the 12 children were granted full standing.

Although not all families sought standing, their right to standing was declared and recognized from the outset. Counsel appeared for the Terziski, Still, Baumann, Tena, Capili, Feakes, Maguire and Petkau families. The Caribou, Ulimaumi, Goyal, Piller and Bichel families neither appeared personally nor via counsel to ask questions or make submissions, despite being notified of their right to do so.

Additionally, while the Caribou, Goyal, Piller and Bichel families declined to appear via counsel or to examine witnesses, members of those families did testify. However, John and Emalee Ulimaumi, parents of Jessica, declined to attend in order to testify. Despite the obvious importance of their version of the events concerning their daughter, it was decided not to pursue the matter, especially given the magnitude of their loss, and the fact that much of what occurred concerning Jessica's death could be otherwise determined.

2. The Health Sciences Centre was granted full standing.
3. The Department of Health of the Province of Manitoba was granted full standing.
4. The Manitoba Association of Registered Nurses, representing the nurses involved in the care of the 12 children, was granted full standing.
5. The pediatric cardiac anaesthetists and pediatric intensivists involved in the care of the 12 children were granted full standing, to be represented by one counsel.
6. A group consisting of Dr. Jonah Odim and other surgeons involved in pediatric cardiac surgery at the Health Sciences Centre in 1994 was granted full standing.
7. A group consisting of neonatologists and other physicians involved in the delivery of medical care to patients in the neonatal intensive care unit in 1994 was granted full standing.
8. HSC pathologists were granted limited standing.

Standing was granted to each of the parties on the basis that they had a real and direct interest in the proceedings. Obviously the status of the families in that regard could hardly be questioned. The interest of the HSC in the proceedings was also deemed to be direct and substantial, given the issues of supervision and accountability that were raised by the evidence. Similarly, the Department of Health's role in funding and monitoring the hospital and the program was raised in the course of these proceedings, causing a substantial and direct interest to arise on their part.

The participation of the various medical professionals in the care and treatment of the 12 children who died resulted in sufficient interest on their part to justify standing. Additionally, however, because much of the evidence concerned personality conflicts between members of the health-care team, as well as miscommunication and professional disagreements over treatment, that further justified granting full standing to each of the parties.

At a later point in the hearings, limited standing was granted to a group consisting of the pathologists involved in performing autopsies on the deceased. There was a suggestion that delays in the performance

and completion of autopsy reports may have contributed to institutional delay in responding to growing problems within the pediatric cardiac surgery program, and on that basis, counsel for pathologists at the HSC was allowed limited standing to question witnesses who testified about that issue.

CULPABILITY

One of the limitations placed on inquests in Manitoba is that presiding judges are not permitted to make findings of culpability with regard to the deaths they investigate. The limitation is not restricted to presiding judges, however.

Section 7 (6) of the *Fatality Inquiries Act* provides:

In making an inquiry report under subsection (5), a medical examiner or investigator shall not express an opinion with respect to culpability in such manner that a person is or could be identified as a culpable party.

Section 14 (2) further provides:

In an investigation report, a medical examiner shall not express an opinion with respect to culpability in such manner that a person is or could be identified as a culpable party.

The limitation on presiding judges is found in section 33(2) of the *Fatality Inquiries Act*, which provides:

In a report made under subsection (1), a Provincial Judge

(a)...

(b) shall not express an opinion on, or make a determination with respect to, culpability in such manner that a person is or could be reasonably identified as a culpable party in respect of the death that is the subject of the Inquest.

Coroners' inquests once had the right to accuse persons of being responsible for the death of a deceased person, and to issue arrest warrants for those named. Such powers were taken away by statute, but inquests continued to be allowed to name those responsible for the death if they found sufficient evidence to do so. That ability was taken away by legislative amendment in 1990 (*S.M. 1989–90, c.30*).

While “culpable” and “culpability” are not defined in the legislation, culpability is nothing more than legal blaming. To find someone culpable is to determine that an individual has committed an act (either by commission or by omission) that amounts to a legal transgression and that the act is legally blameworthy or sanctionable.

The need to limit the ability of presiding officials at inquests to comment upon the issue of culpability is obvious. There are disciplinary, civil and criminal laws and procedures in place that are intended to address the issue of legal culpability. Those laws contain procedures that respect the rights of individuals (such as complainants, witnesses and defendants), including the right to notice, disclosure, counsel, reply, cross-examination etc.

Provisions in fatality inquiries legislation, on the other hand, allow for evidence to be heard informally, sometimes *in camera*, and for persons to be examined in a manner that is not necessarily consistent with the protective procedures that are normally in place during civil and criminal trials. That is because the purpose

of such legislation is not to place legal blame but to determine what happened in order to see if what happened can be prevented from recurring.

A potentially culpable party might not be a party to the inquest proceedings. They may not have standing to cross-examine witnesses who might testify as to something that the person may have done to cause the death of the deceased. A potentially culpable party is compellable as a witness and does not have the right to refuse to answer questions under oath. The *Fatality Inquiries Act* of Manitoba deems them to object to testifying as to any potentially culpable behaviour but the *The Manitoba Evidence Act R. S. M. 1987, c.E150* requires that they testify if ordered and protects such testimony from being included in other proceedings. However that protection might be moot if it leads to their being identified as a culpable party. The *Canada Evidence Act R. S. C. 1985, Chap. C-5*, which governs criminal proceedings in this country, contains a similar provision. The *Canadian Charter of Rights and Freedoms* protects compelled testimony from being used against a party as well (*Constitution Act 1982, Part 1, sec 13*).

Because of that, it is obvious that evidence may be obtained during the course of an inquest that might not otherwise be admissible in a civil or criminal legal proceeding, or might not have been tested in accordance with the usual procedures. Because safeguards available to an accused or defendant in criminal, disciplinary or civil proceedings may not be available during inquest proceedings, it is necessary to ensure that proceedings under fatality inquiries legislation not result in unfairness to individuals.

All of this is meant to show that there is good reason for the limitation in the legislation against pronouncing on culpability. For the same reason, however, judges presiding at inquests should be reticent about exonerating individuals. While the legislation does not specifically provide for such a limitation, it makes sense that if an inquest judge ought not to find culpability on the part of an individual, the judge should not declare individuals free from culpability.

As an inquest judge, therefore, I accept that I am not permitted to comment on culpability in the course of making my findings. Accordingly, this report will not comment on the culpability of any individual, corporation, group or collective of individuals.

That does not mean, however, that a presiding judge at an inquest cannot make findings of fact or of law in order to reach appropriate conclusions.

In *Swan v. Harris* (1992), 79 Man. R. (2d) (Q.B.), the report of an inquest by a judge referred to allegations of abusive conduct by the victim's father toward his wife and children. The father alleged that the judge exceeded his powers by referring to this abusive conduct, and that the alleged abuse was not relevant to the inquiry as the deaths were not linked to it. Jewers J. at page 191 held that the inquest judge made no finding of culpability. He also stated at pages 191–192 that it was appropriate and within the inquest judge's jurisdiction to receive evidence concerning the alleged abuse. Because there might have been some connection between this abuse and the deaths, it was essential to inquire into this for a full and proper inquest.

Jewers J. stated that had the judge inquired into a subject that was utterly remote and made that a part of the report, then he might have exceeded his powers.

Therefore while a judge cannot declare that a particular act makes a person legally culpable, he can make a finding that a particular act occurred, without declaring on the question of culpability, so long as the finding is relevant to a matter into which he or she is inquiring.

I am aware that civil proceedings have been undertaken as a result of the deaths of some of the children who are the subject of this inquiry. Those proceedings have been held in abeyance pending the completion of these proceedings. That is not to say that any findings from these proceedings will be binding on any other proceedings. That is in fact, and in law, not the case. However, I am aware that the findings of these proceedings may have an influence on the public's perception as to the issues between the parties to the civil proceedings. I intend, therefore, to be as careful as possible; however, that possibility cannot totally determine the content of this report.

Throughout this report, therefore, I intend to make whatever findings of fact, and of law, are essential for me to perform the mandate assigned to me by legislation, but I do not intend to make any findings of culpability. It is important to bear that limitation in mind throughout this report. The question of culpability is for others to decide if asked.

THE ISSUE OF CONSENT

These proceedings have given rise to a clear question of whether the parents of the deceased children gave proper consent to the operations that their children underwent before their deaths.

I recognize that to make a declaration of consent or lack thereof runs the risk of transgressing the very line about which I have spoken on the issue of culpability. To declare that a particular operation occurred without proper consent gives almost immediate rise to the conclusion that the party, or parties participating in the operation engaged in an illegal act, perhaps amounting to an assault on the patient. That is a reasonable conclusion from a finding of a lack of consent.

However, the question of what patients (or in this case parents of patients) were and ought to have been told and, in the future, ought to be told, is a matter that merits the attention of this report. Readers will note later on in the text that the question of what parents were told or ought to have been told is commented upon, but in so doing I have adopted the approach suggested by the case law.

THE LAW OF MEDICAL CONSENT

The law of medical consent has been undergoing changes in recent years. The abiding principle for consent was always that the consent had to be an informed one. Patients were to be told whatever needed to be known about a particular procedure in order that their consent could be valid.

For the most part, the question of what information was to be given to patients in order that they be in a position to give informed consent was governed by the practice of the medical profession. Medical practitioners were generally held to have fulfilled their legal obligation if they provided information to a patient in accordance with the practice among their colleagues.

However, recent case law in Canada, Australia, and the United States suggests that that principle is changing.

Generally, it is the patient, not the surgeon, who decides whether or not surgery will be performed, where it will be performed and by whom it will be performed (*Allan v. New Mount Sinai Hospital* (1980), 109 D.L.R. (3d) 634 at 642, rev'd on a procedural point 125 D.L.R. (3d) 276 (Ont. C.A.)).

Furthermore, a doctor's duty to inform relates to all material risks, including special and unusual risks of treatment. What is material is determined by what the reasonable patient would want to know, and not by what the reasonable doctor would like to disclose (*Hopp v. Lepp* [1980] S.C.R. 192 (S.C.C.) at 204).

Material risks are those risks that pose a real threat to the patient's life, health or comfort (*White v. Turner* (1981), 120 D.L.R. (3d) 269 at 284 (Ont. H.C.), aff'd (1982), 12 D.L.R. (4th) 319 (Ont. C.A.)).

A failure on the part of the doctor to fully inform the patient will generally be dealt with by negligence law, and not by battery (unless there has been misrepresentation or fraud to secure consent). In other words, a lack of properly informed consent does not give rise to an action for the improper application of force (*Reibl v. Hughes* [1980] 2 S.C.R. 880 (S.C.C.), at 891–892).

The fact that a patient has signed a consent form in which it is acknowledged that the nature of the operation has been explained does not necessarily prove that the duty to inform has been observed. The existence of the consent form does not protect the doctor from liability unless the patient has been informed to the satisfaction of the court (*Bickford v. Stiles* (1981), 128 D.L.R. (3d) 515 at 520 (NBQB)).

In an Ontario case, a surgeon who had failed to disclose to his patient that he had little experience with the technique being used was found to be negligent in the performance of the operation. However, on the question of the consent of the patient to the operation, the trial judge held that the surgeon failed in his duty to his patient by failing to disclose his inexperience and failing to give his patient the opportunity to have the procedure performed by another more experienced surgeon (*Miles v. Judges* (1997) 37 C.C.L.T. (2d) 160 (Ont. Ct. Gen Div.)).

In the case of *Hopp v. Lepp* (*supra*, at 197), the surgeon had told the patient that the facilities for performing the operation were as good in Lethbridge as they were in Calgary where the patient had thought of going. Laskin C.J. approved of the trial judge's finding that the operation was a routine one, and that although there was a possibility of complications as there is in any operation, there was no greater probability of complications of the operation being performed at Lethbridge as opposed to Calgary. In other words, there was no evidence that the assurance given by the surgeon was incorrect or that if the operation had been done in Calgary it might have produced a different result.

Every medical practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care (*Crits v. Sylvester* [1956] O.R. 132 (Ont. C.A.) at 143–144, aff'd [1956] S.C.R. 991). In the same vein, all those involved in the care of the patient, including the referring physician, nurses, anaesthetists and medical managers all owe such an obligation to the patient.

Whether a risk is material and whether there has been a breach of the duty of disclosure are matters that are not determined solely by the professional standards of the medical profession at the time. Professional standards are a factor to be considered, but the ultimate responsibility in determining if the professional met the appropriate standard lies with the court (*Videto et al. v. Kennedy* (1981), 33 OR (2d) 497 (Ont. C.A.)).

It is generally accepted in England that doctors have a duty to exercise reasonable care with their patients. This duty extends not only to examination, diagnosis and treatment, but also to the provision of appropriate information. In determining whether a medical practitioner has breached his or her duty of care to a patient, the courts of England had generally applied the *Bolam* principle, by which a doctor would not be found to be negligent if he or she acted in accordance with the practice accepted at the time as proper by

a responsible body of medical opinion (*Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 582). This was so even though other doctors might have followed a different practice. The basis of the principle is that it leaves room for differences of opinion in matters involving medical expertise. A medical practitioner would not be held negligent simply because his or her conclusion or approach differs from that of other practitioners.

Whether the *Bolam* principle applies in providing information and advice relevant to medical treatment was reconsidered by the British House of Lords in 1985 (*Sidaway v. Governors of Bethlem Royal Hospital* [1985] 1 AC 871).

In that case, the plaintiff alleged that the defendant surgeon failed to explain the risks of permanent damage to the spinal column (assessed at between one and two per cent), involved in an operation on the spine to relieve neck, shoulder and arm pain. The majority of the House of Lords held that the question of whether a failure to warn a patient of the risks inherent in proposed treatment constituted a breach of a doctor's duty of care was to be determined by applying the *Bolam* principle. Thus the issue was determined primarily on the basis of expert medical evidence, although a majority of the Law Lords took the view that doctors were under a duty to provide a patient with sufficient information.

In his dissenting opinion in *Sidaway*, Lord Scarman expressly rejected the *Bolam* principle in relation to cases involving advice or information. He concluded that while current medical opinion was a relevant consideration, it was not conclusive and it was for the court to decide whether the doctor had given the patient the relevant information to enable the patient to determine whether or not to accept the treatment proposed.

In 1998 the England and Wales Court of Appeal considered and accepted the *Sidaway* decision (*Pearce v. United Bristol Healthcare NHS Trust* [1998] EWJ No. 617), but added that a doctor must inform the patient of significant risks:

In a case where it is being alleged that a plaintiff has been deprived of the opportunity to make a proper decision as to what course he or she should take in relation to treatment, it seems to me to be the law, as indicated in the cases to which I have just referred, that if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt. (*Ibid*, at para. 18)

Further, with regard to whether a risk is material and how this is to be determined, the Court stated:

I am of opinion that the judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it. The kind of case I have in mind would be an operation involving a substantial risk of grave adverse consequences, as, for example, the ten per cent risk of a stroke from the operation which was the subject of the Canadian case of *Reibl v Hughes*. In such a case, in the absence of some cogent clinical reason why the patient should not be informed, a doctor, recognising and respecting his patient's right of decision, could hardly fail to appreciate the necessity for an appropriate warning. (*Ibid*, at para. 19)

This decision and the judgment of Lord Scarman in *Sidaway* are based on principles that were enunciated in a leading U.S. case (*Canterbury v. Spence* [1972] 463 F. 2d 772, U.S. Court of Appeals, District of

Columbia Circuit). The U.S. Court of Appeals for the District of Columbia held that a doctor was under a duty to disclose all ‘material’ risks. A risk was to be considered material if a reasonable person, in what the doctor knew, or ought to know, was the patient’s position, would be likely to attach significance to the information in determining whether to forgo or proceed with the proposed treatment.

As well, the U.S. case of *Johnson v. Kokemoor* held that a jury properly heard evidence on the extent of a surgeon’s experience in performing a complicated procedure, as well as evidence that compared morbidity and mortality rates between experienced and inexperienced surgeons, and evidence that the plaintiff could have obtained care nearby from more experienced surgeons. The jury concluded that the surgeon had not adequately informed the patient of the risks attending her surgery, including apparently, the risk associated with the level of the surgeon’s experience. In this case, the patient posed very specific questions to the surgeon before surgery, questions that the surgeon did not answer fully or accurately (*Johnson v. Kokemoor* Westlaw No. 93–3099, Supreme Court of Wisconsin (20 March 1996)).

The U.S. case of *Canterbury v. Spence* was cited with approval by the Supreme Court of Canada in *Reibl v. Hughes*, in which it was held that the medical practitioner’s ‘duty to warn’ arises from the patient’s right to know of material risks, a right that in turn arises from the patient’s right to decide for himself or herself whether or not to submit to the proposed medical treatment. The court accepted that expert medical evidence is relevant to a finding as to the risks that reside with recommended surgery or other treatment, and may have a bearing on the question of the materiality of the risk. But it concluded that the question of what risks are to be disclosed is not a question to be concluded on the basis of expert medical evidence alone. Account will be taken of a patient’s particular position as well.

In Australia it is generally accepted that the standard of care of doctors is not determined solely by reference to a responsible body of opinion in the relevant trade or profession. In both *Rogers v. Whitaker* (*Rogers v. Whitaker* (1992) 175 CLR 479) and *Chappel v. Hart* (*Chappel v. Hart* (1998) HCA 55), the *Bolam* principle was rejected, and it was accepted that, while evidence of medical practice was a useful guide, in the end it was for the courts to decide the appropriate standard of care in the circumstances.

In *Chappel v. Hart*, Chappel, an ear, nose and throat specialist, performed surgery on a patient, Hart, for the removal of a pharyngeal pouch in her esophagus. Hart would have required the operation eventually but it was still considered elective because she did not need it right away. Hart had expressed concern on what effect the operation might have on her voice. Chappel failed to warn her of a small risk of vocal damage if the esophagus were perforated and an infection set in. During surgery, Hart’s esophagus was perforated and infection did set in, which led to a paralysis of the right vocal cord. The failure of Chappel to warn Hart of the risk of damage to her voice was held to have set off a foreseeable chain of events permanently affecting Hart’s voice.

While Hart admitted that she still would have undergone the operation even if she had been warned of the risk, she testified that she would have deferred the operation, taken further advice and probably would have sought out the most qualified surgeon available. That surgeon was apparently not Chappel.

There was a difference of opinion between the majority and dissenting judges as to whether surgery by a more experienced surgeon would have carried a lower risk to the patient’s voice. The majority of the judges concluded that the risk would have been lower had a more experienced surgeon performed the operation.

More importantly, three of the five judges held that Chappel's failure to advise Hart of the risk led to her undergoing the procedure when and where she did, and vitiated her consent.

The Court therefore clearly held that a medical practitioner is under a duty to inform a patient of any foreseeable risk. It also went further, however, and held that where such a duty arises, it is necessary for the plaintiff to establish what she would have done if the information in question had been provided to her (*Ibid*, at para. 9).

The court in *Chappel* adopted a primarily subjective theory of causation in determining whether the failure to warn would have avoided the injury suffered.

Gaudron J. seemed most influenced by the evidence of a medical professor that suggested that the risk would have been less if Hart had had a more experienced surgeon. He stated:

It is not in doubt that a risk of perforation and infection was and is inherent in surgery of the kind performed on Mrs. Hart. In that sense, the risk of injury was the same, no matter when or by whom the surgery was performed. However, that is not to say that the likelihood of that risk eventuating was the same.

Professor Benjamin gave evidence from which it might be inferred that the risk of perforation, without which the injury sustained by Mrs Hart could not have occurred, diminished with the skill and experience of the surgeon concerned. (*Ibid* at para 17)

Similarly, Gummow J. found that Hart would not have undergone the procedure by Chappel, but would have wanted "the most experienced person with a record and reputation in the field, such as Professor Benjamin" (*Ibid*, at para. 78). Kirby J. held that "intuition and common sense suggest that the higher the skill of the surgeon, the less is the risk of any perforation of the oesophagus into the mediastinum" (*Ibid*, at para. 97).

Kirby J. also placed considerable significance on the fact that Hart had inquired into a possible risk to her voice. He said, "(t)his was not an ordinary patient. It was an inquisitive, persistent and anxious one who was found to have asked a particular question to which she received no proper answer" (*Ibid*, at para. 99).

In another very recent Australian case, the Court felt that the trial judge erred in failing to take into account the circumstances of the patient in deciding whether she would have undergone the procedure had she been properly informed. (*Percival v Rosenberg* [1999] WASCA 31 (25 May 1999)). It stated:

Applying the law as discussed in *Chappel* and *Rogers v Whitaker*, the learned trial Judge erred in finding that the respondent was not required to warn the appellant of the risks of TM joint problems and symptoms arising after the procedures which the appellant underwent.

The learned trial Judge rejected the proposition that the appellant would have not had the surgery had she been warned of the possible risks. However, in my view the submission of the appellant's counsel that in coming to an adverse view of the appellant's credibility the learned trial Judge did not take into account the important matter of the severe effects which the complications have had upon the appellant, both physically and mentally, is correct. His Honour did not discuss the ramifications of those matters. (*Ibid*, at paras. 99–100)

Thus the Court agreed that a more subjective approach should be taken when assessing whether a patient would have agreed to the operation.

Rogers v. Whitaker was another case that concerned the obligation of a doctor to advise on material risks. The issue was whether a surgeon should have warned the patient, in advance of an eye operation, of a particular complication shown to occur in one out of 14,000 such operations. Despite the patient expressing

her concerns about the operation, the doctor had given her no warning of the risk and the operation proceeded. The patient did develop the complication following surgery, and it led to blindness. The doctor led evidence from a body of medical practitioners that they would not have given such a warning. Then, invoking the protection of *Bolam*, the doctor contended that he was therefore not negligent.

The High Court disagreed and held that he was negligent because he knew that if he had warned the patient about this risk, she would have regarded it as significant. The Court formulated the duty as follows:

The law should recognize that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. (*Ibid*, at p. 490)

The *Chappel* decision supported the view that this test was the correct one to apply for determining issues of informed consent. This test is very similar to the test in Canada and seems to be the direction in which the English courts are also heading.

Most of the case law concerning medical consent arises in the field of tort law—that is, the law concerning claims for damages as a result of an improper act or omission. The cases centre on two questions: firstly, whether any consent to treatment was properly obtained; and secondly, if not, whether the lack of consent (or, perhaps more properly, the lack of information that voids consent) directly led to the damage or injury claimed.

The latter issue is not one about which I need be concerned, because of its fundamental attachment to the question of culpability.

Medical case law has made allowances for the fact that where a doctor's decision to treat a patient in a certain manner was reasonable, taking into account the risks involved and based on accepted medical practice, it was logical to conclude that a reasonable person, having been properly informed of the risks, would not have declined the treatment. In other words, a court would not inquire into the question of whether the information not disclosed to the patient would have resulted in the patient doing something different from what was done. The court went only so far as to determine, using the standards of the profession, whether a person acting in a reasonable manner would have declined the operation.

That principle has changed somewhat recently, however. Currently, the approach in failure to inform cases in Canada has moved to using a modified objective test that allows the court to consider the patient's personal circumstances (*Reibl v. Hughes, infra*).

The test now is to determine the matter from the perspective of whether a reasonable person *in the circumstances of the plaintiff* would have consented to the proposed treatment if all the risks had been disclosed.

In 1997, the Supreme Court had occasion to consider the issue once again. A pregnant woman suffered from chicken pox early in her pregnancy. The case centered on the duty of her doctor to disclose to her that the chicken pox entailed risks of serious birth defects for her unborn child. He made no such disclosure to her. The mother sued the doctor for damages after her child was born with serious disabilities as a result of the chicken pox. The mother testified that she would have terminated the pregnancy had she been advised of the risks. The trial judge found that a reasonable woman in the plaintiff's position would not have done that, but would have continued with the pregnancy despite the risks. In other words, her evidence as to what

she would have done was not determinative of the matter. A majority of judges in the Supreme Court of Canada agreed with the trial judge and with the test used for causation (*Arndt v. Smith* [1997] 2 SCR 539).

McLachlin J. (as she then was) delivered a separate decision in which she also agreed with the ultimate decision of the trial judge, but enunciated the test for causation to be one that asked what the particular plaintiff would have done in all the circumstances. She also accepted the trial judge's view that the reasonableness of the patient's choice is an important factor bearing on that decision. Both Sopinka J. and Iacobucci J. dissented. They agreed with the test of causation proposed by McLachlin J., but took the view that the trial judge had not applied that test properly by discounting the plaintiff's testimony.

A SUMMARY OF THE APPLICABLE LEGAL PRINCIPLES DEALING WITH MEDICAL CONSENT

From all of this it is possible to discern the following principles:

- It is the patient who decides whether, when, where and by whom surgery is to be performed.
- For a consent to medical treatment to be valid, it must be informed consent.
- What a patient is told is not to be determined solely by what the practice of the profession is, although knowing that practice can assist the court.
- A doctor must inform a patient of all material risks. What is material is determined by asking the question "what would a reasonable patient want to know?"
- Material risks are also those risks that pose a real threat to the patient's life, health, or comfort.
- A failure by a doctor to fully inform a patient is a matter for the law of negligence.
- The fact that a patient has signed a consent form does not determine the issue. It is for the court to determine if the facts show a fully informed consent.
- A surgeon's inexperience can be a factor affecting risk that a doctor must disclose to a patient.
- In Canada, in determining if the patient's consent to a procedure has been fully informed, the court must consider the question of whether all material facts have been disclosed, and if not, whether a reasonable person in the same position as the patient would have gone ahead with the procedure in any event.

In an article by the Hon. Paul de Jersey prepared for the Medico Legal Society of Australia, the question of medical consent was discussed (March 22, 1999. Found at <http://courts.qld.gov.au/sc&dc/speeches/medico.htm>). De Jersey points out that there is a change occurring through society in how people view their health, and in what they feel they are entitled to know. There is a movement away from the paternalistic 'doctor knows best' standard to one that involves the patient more, especially when it comes to surgical procedures. De Jersey points out that doctors have not always provided their patients with the information that patients felt they needed or were entitled to, for a variety of reasons. Perhaps, he suggests, that failure stemmed from a desire to protect the patient from anxiety or because it was too time-consuming and difficult. If so, that approach was going to have to change. The case law discussed above seems to support the conclusion that that approach is being reflected in the recent cases.

Technical skills are no longer enough for a doctor to fulfil his or her duties. Doctors must now have good communication skills. The court's finding for the plaintiff in *Chappel* reinforced the view that informed consent requires doctors at the very least, to listen to and respond to the questions and concerns of their patients.

The other cases also suggest that there may also be arising an obligation on the part of doctors to be more proactive in informing patients about matters of risk. Doctors can no longer defend themselves on the basis of what the 'usual practice' of the profession has been.

The decision of the Ontario court (General Division) in *Miles v. Judges* seems to best reflect that change. In that case it will be recalled, the trial judge held it was a doctor's duty to disclose his inexperience with respect to a particular surgical procedure that his patient required. This was so, even though it had generally been accepted that medical practitioners did not normally discuss their surgical experience with patients unless specifically asked.

The need for greater openness within the health system has been demonstrated by a recent medical scandal in England (Commission of Inquiry into the Bristol Royal Infirmary). It resulted in a General Medical Council Inquiry into fifty-three pediatric cardiac operations at the Bristol Royal Infirmary in which twenty-nine children died and four were left with brain damage following surgery.

Formal action by the General Medical Council resulted only after a consultant anaesthetist went over the head of the chief executive officer of the hospital and 'blew the whistle'. The factors that discouraged openness and frankness about a doctor's personal and professional performance were identified as key in explaining how the scandal occurred. It became evident, during the course of the Bristol Inquiry, that the parents of the children who had died had not been told of the significant medical dispute going on in that hospital over whether the hospital should continue to offer certain surgical procedures despite poor results. The General Medical Council suspended two of the doctors involved from practising medicine as a result of their conduct. On June 18, 1998, a Commission of Inquiry was appointed to look into the matter.

In this report, one of the major issues that will be explored is the question of whether the families of the deceased children were fully informed about events within the Pediatric Cardiac Surgery Program at the HSC in 1994. The Report will examine whether that information was something that the parents ought to have known before giving their consent to the surgical procedures involving their children. The Report will also explore the question of what the parents were told about the risks associated with the surgical procedure that their children were about to undergo, as well as the nature of what information surrounding risk they were told and ought to have been told.

In order to make any recommendations concerning what the hospital or government might have to do in the area of informing parents and patients of their rights, or ensuring that those rights are properly respected, conclusions will have to be reached as to what parents were told and whether their consents were or may not have been validly obtained.

In doing so, I recognize that I may be treading close to the line of pronouncing on the culpability of individuals or institutions. I feel, however, that in order to prevent the events of 1994 from being repeated, recommendations should be made about the nature and type of information that patients and their families are entitled to and ought to be provided. Therefore, when discussing this and other areas of similar importance, the language used will need to be carefully considered.

THE ONUS OF PROOF IN INQUEST PROCEEDINGS

The onus of proof in inquest and inquiry proceedings has been a matter of some discussion in the case law. Generally in order to make a finding of fact, a presiding judge, in any proceeding other than a criminal proceeding, needs to be satisfied in accordance with the civil standard of a ‘balance of probabilities’.

Furthermore, cases involving inquiries and inquests have given direction on this point to presiding officials. Generally the guidance has been to indicate that protective phraseology should be adopted. Wording such as ‘the evidence suggests’ is recommended in order to avoid making a finding that leads directly to a conclusion of culpability. I have therefore attempted to do so wherever such phraseology is warranted.

MEDICAL STANDARDS COMMITTEES AND PRIVILEGE

During the course of these proceedings, it became apparent that some of the issues under review had been considered by medical standards committees established by the HSC, as well as by the Manitoba College of Physicians and Surgeons.

Medical standards committees enjoy some immunity from having to reveal their proceedings pursuant to section 9 of the *Manitoba Evidence Act*. That provision states:

Evidence as to proceedings of hospital committee, etc., not compellable

9(1) A witness in any legal proceeding, whether a party thereto or not, is excused from answering any question as to any proceedings before, or producing any report, statement, memorandum, recommendation, document, or information of, or made by, a committee to which this subsection applies and that is used in the course of, or arising out of, any study, research, or program carried on by a hospital or any such committee for the purpose of medical education or improvement in medical or hospital care or practice.

Application of subsec. (1)

9(2) Subsection (1) applies to all of the committees hereinafter mentioned; namely:

- (a) a standards committee appointed under section 26 of The Hospitals Act;
- (b) a research committee of a hospital;
- (c) a medical staff committee established for the purpose of studying or evaluating medical practice in a hospital; and
- (d) a medical research committee recognized by the Minister of Health and approved for the purpose of this section by a regulation made by him.

Application of *The Regulations Act*

9(3) *The Regulations Act* applies to a regulation made under clause (2)(d).

Exception

9(4) Subsection (1) does not apply to original medical and hospital records pertaining to a patient.

Members of committee, etc., not excused generally

9(5) Notwithstanding that a witness in any legal proceeding is or has been a member of, or has participated in the activities of, or has made a report, statement, memorandum, or recommendation to, or has provided information to, a committee to which subsection (1) applies, he is not, subject to subsection (1), excused from answering any question or producing any document that he is otherwise bound to answer or produce.

Definitions

9(6) In this section

“**legal proceeding**” in addition to having the meaning given to that expression under section 1, includes an action or proceeding for the imposition of punishment by fine, penalty, or imprisonment to enforce any regulation made under an Act of the Legislature and any proceeding before any tribunal, board, or commission;

“**witness**” in addition to the ordinary meaning thereof, includes every person who, in the course of a legal proceeding, is examined *viva voce* for discovery or is cross-examined upon an affidavit made by him, or answers any interrogatories or makes an affidavit as to documents, or is called upon to answer any question or produce any document, whether under oath or not.

Protection from liability

10 Neither

(a) the disclosure of any information or of any document or anything therein, or the submission of any report, statement, memorandum, or recommendation, to any committee to which subsection 9(1) applies, for the purpose of its being used in the course of any study, research, or program carried on by a hospital or any such committee for the purpose of medical education or improvement in medical or hospital care or practice; nor

(b) the disclosure of any information, or of any document or anything therein, that arises out of any such study, research, or program;

raises or creates any liability on the part of the person making the disclosure or submission.

Counsel for some of the families wished to ask some of the members of those standards committees questions about committee proceedings. A considerable amount of time was devoted to argument, and in January 1998, a decision was rendered on the issue. Essentially I ruled that an inquest judge had authority to inquire into proceedings of medical standards committees if their proceedings are relevant to the issues being inquired into. However, I declined to make any such inquiries in view of the lateness of the motion, and the fact that much of the relevant evidence could be otherwise obtained. That decision is filed as part of the record of these proceedings.

IN CAMERA PROCEEDINGS

During the course of hearings some of the witnesses or their counsel asked that certain evidence be heard *in camera*. Provision for doing so is found in section 31 of the *Fatality Inquiries Act*.

Inquest open

31(1) Subject to subsection (2), an inquest under this Act shall be open to the public.

***In camera* inquest**

31(2) Where a provincial judge charged with conducting an inquest is of the opinion that testimony to be given or other evidence to be introduced at the inquest includes matters that

- (a) involve public security;
- (b) are of such a personal nature that, having regard to the circumstances, the privacy of a person would be unreasonably breached; or
- (c) relate to professional activities that, having regard to the circumstances, the professional reputation of an individual would be damaged unjustifiably;

the judge may, on application, order that the inquest or a part of the inquest be conducted *in camera*.

Factors for *in camera* inquest

31(3) For the purposes of subsection (2), a provincial judge shall consider the following matters:

- (a) the nature of the personal interests or of the professional activities that may be adversely affected by testimony heard or evidence introduced at the inquest;
- (b) whether disclosure of all or part of the diagnosis or medical records of the deceased or disclosure of a report of a medical examiner
 - (i) would result in injury or harm to the mental or physical welfare of a third party,
 - (ii) would be prejudicial to the interests of a person not involved in the inquest,
 - (iii) has the approval or consent of the legal representative of the deceased; and
- (c) whether conducting the inquest *in camera* would be
 - (i) in the interests of justice, or
 - (ii) injurious to the public interest generally.

Application for *in camera* inquest

31(4) A person who

- (a) is a Crown attorney or other officer or counsel appointed by the minister to act for the Crown;
- (b) is a member of the family of the deceased;
- (c) is the legal representative of the deceased;
- (d) may be adversely affected, personally or professionally, by evidence given at the inquest; or
- (e) is declared by a provincial judge, on application, to be an interested party;

may apply to a provincial judge for an order that an inquest or part of an inquest be conducted *in camera*.

Application *in camera*

31(5) An application under subsection (4) shall be made *in camera*.

Decision final

31(6) An order made under subsection (2) is final and is not subject to judicial review or appeal.

No disclosure of *in camera* evidence

31(7) Subject to subsection 33(2), where an inquest or part of an inquest is conducted *in camera* pursuant to an order made under subsection (2), no person shall disclose or cause to be disclosed to another person testimony heard or evidence introduced *in camera*.

In my opinion, there was merit to the applications made on the grounds set out in the legislation, and from time to time, *in camera* hearings occurred. I have decided that much of the evidence rendered in the *in camera* proceedings need not to be discussed or disclosed in this report. However, even where some of that evidence has been disclosed and discussed, the order made at the time of the *in camera* applications forbidding disclosure of the evidence revealed during those hearings remains in effect. In particular information that might identify children other than those who died in 1994, and whose cases were investigated as part of these proceedings, is not to be disclosed.

DISCLOSURE

In October 1995, hearings were conducted into the question of the disclosure of documents relating to the matters under investigation by this inquest that were in the possession of the Province of Manitoba and the HSC. Disclosure was directed to be made, but for the most part, both the HSC and the Province had voluntarily disclosed a great deal of material. That disclosure resulted in several volumes of documents being marked as exhibits in these proceedings.

Despite the disclosure that was made, it became apparent that there continued to be materials that were in the possession of some of the parties, particularly the HSC, that had not been disclosed as ordered. A considerable amount of material was discovered as the proceedings went on and the witnesses testified. Personal notes, hospital data, memos and correspondence, minutes of meetings and briefing documents were discovered even after disclosure had been ordered. It is conceivable that not every document bearing on the issues under examination was discovered and disclosed during the proceedings. With an institution the size of the HSC and the Department of Health, such an event is entirely possible. However I am satisfied that every effort was made to provide what materials were known to exist, and that any non-disclosure was inadvertent. For that reason I concluded that while any failure to disclose was a cause for concern, it was not enough for any sanctions to be considered.

Despite the lateness of some disclosure, and the fact that not all of the relevant materials may have been provided to the Inquest in a timely manner or at all, the evidence disclosed enough about the events that happened surrounding the program, and in particular the events of 1994, that the facts as they occurred were readily determinable.

THE TAKING OF EVIDENCE

On December 6, 1995, the evidence was heard of Dr. Cameron Ward, a pediatric cardiologist who worked at the Children's Hospital during 1994. Ward had been involved in the care of some of the 12 children, and had held a position with the Variety Children's Heart Centre in 1994. A special hearing was convened in December 1995, as Ward was about to leave Canada for another position in Australia.

The bulk of the evidence, however, began on March 5, 1996. Hearings were held throughout 1996, 1997 and 1998. In total, more than 80 witnesses testified during more than 285 days of hearings over a period of almost three years. Close to 50,000 pages of transcript evidence were produced, and hundreds of documents, eventually exceeding 10,000 pages of material, were filed as exhibits in these proceedings. This is the Final Report of the Inquest.