Disentangling "Informed Consent"

*Hilary Young**

The legal concept of "informed consent" to medical treatment is often confusing to students and lawyers alike. This is in part because there is no single legal concept of informed consent. In law, the term relates to two different legal obligations. One is the fundamental and general obligation not to touch people without their consent. The other is an obligation specific to health practitioners to provide their patients with relevant information. Using the term "informed consent" to refer to either is misleading because it suggests the need, within a single legal rule, for both information and permission. However, depending on which legal obligation is at issue, only information or permission is likely to be relevant.

This article disentangles the meanings of informed consent to help people better understand the relevant law. But the issue is not only one of doctrinal clarity: there are potential and actual negative consequences of confusing the issues, and these are explored. Thus, while the term informed consent is likely to remain ingrained, it is important to understand which obligation is at issue in a given case so that the law can be applied and developed in a way that protects the relevant interests at stake.

* Professor in the Faculty of Law at the University of New Brunswick. This article is dedicated to her students, who continue to inspire her research. She also wishes to thank Nathan Hood for his valuable research assistance.

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Introduction

Most law students and all students of the health care professions encounter the concept of "informed consent" to medical treatment. It relates to some of the most important ethical and legal obligations that health practitioners owe their patients. Yet my Torts and Health Law students often find the legal issues confusing. Their confusion stems in large part from the fact that informed consent is not one concept in tort law, but (at least) two, related to different legal wrongs, and for each, the label informed consent is misleading.

Students are not the only ones who confuse the concepts. *Malette v Shulman* (*Malette*) states that "to be valid, . . . consent must be informed",[1] and Ontario's *Health Care Consent Act* (*HCCA*) states that "the elements required for consent to treatment" include that "consent must be informed".[2] But these statements are both incorrect: as this article demonstrates, the validity of consent does *not* depend on whether it is informed. Although I am not the first to note the confusion,[3] it persists.

The law is essentially this: one must give permission to being touched, or else the contact constitutes the legal wrong of battery. The same is true of medical touching: consent is required. This has nothing to do with information. The issue is consent in the sense of permission, not *informed* consent. At the same time, health practitioners owe a separate legal duty to provide material information to their patients. This implicates the law of negligence. It has very little to do with consent. By disentangling these concepts, students, health professionals, lawyers, judges, and legislators can better understand the relevant

1. [1987] OJ No 1180 (HCJ) at para 115, 1987 CanLII 4096 (ONSC) [*Malette*].

2. *Health Care Consent Act*, *1996*, SO 1996, c 2, Schedule A, s 11(1) [*HCCA*].

3. See e.g. *Reibl v Hughes*, [1980] 2 SCR 880 [*Reibl*] at 888–89, 1980 CanLII 23 (SCC); Katrine Del Villar et al, "Does a Refusal of Treatment need to be Informed? Towards a Resolution of the Current Confusion in English, Canadian and Australian Common Law" (2024) 16:1 McGill JL & Health 61 at 113.

legal obligations that health professionals owe to their patients regarding consent and information.[4] This will help ensure that the law appropriately protects the interests at stake.

Following this introduction, which asserts the existence of doctrinal confusion related to informed consent, the article begins by reviewing the law of battery and showing that whether information is provided is largely irrelevant to that tort—both at common law and under health care consent statutes such as the *HCCA*. It then reviews the law of negligence as it relates to informed consent: here, the sufficiency of information is highly relevant, but consent is not. Again, the article demonstrates this both for the common law and the *HCCA*. Following this description of the law, the article discusses why the doctrinal confusion matters. It does so by identifying potential and actual consequences of conflating the battery and negligence issues. The problem is not simply one of doctrinal precision; the confusion has sometimes influenced the development of the law itself. For example, the mistaken belief that consent to treatment must be informed to be valid has led the Supreme Court of Canada to conclude that there are affirmative rights to certain forms of life support. It therefore matters that we keep the doctrines distinct as the law continues to evolve.

I. Informed Consent in the Law of Battery

With very few exceptions, people may decide whether others may touch them, and unwanted touching is unlawful. The ancient common law tort of battery protects this fundamental interest in bodily autonomy.[5] The interest is broad: the relevant touching need not be harmful to be unlawful.[6] So long as the contact is direct and non-trivial, the law of battery is engaged.[7] However, such touching is defensible if it is without fault[8]—that is, unintentional and not negligent—or if it is consented to.[9]

4. While the law of informed consent also implicates professional obligations, enforceable in administrative law by regulatory bodies, fiduciary obligations, and even criminal law, this article focuses on tort law, which is what we usually mean when we refer to the law of informed consent.

5. See e.g. *Non-Marine Underwriters, Lloyd's of London v Scalera*, 2000 SCC 24 at paras 10, 15 [*Non-Marine Underwriters*].

6. See *Malette*, *supra* note 1, discussed below. See also Allen M Linden et al, *Canadian Tort Law*, 12th ed (Toronto: LexisNexis, 2022) at s 2.03.

7. *Non-Marine Underwriters*, *supra* note 5 at paras 4–5 (adopts the directness approach with lack of intent a defence). The same case at para 16 states that the touching need not be injurious, only non-trivial.

8. *Ibid* at paras 4–5.

9. This is not meant to be an exhaustive list of defences. Legal authority, for example, is also a defence to battery.

The tort of battery applies in the same way to medical treatment as to other kinds of touching; health practitioners have no special privilege to touch their patients without permission.[10] Thus, any medical intervention involving non-trivial physical contact is battery unless it is consented to.

For example, in *Malette*, it was battery to provide a medically necessary blood transfusion to a woman of the Jehovah's Witness faith who had refused consent to having blood transfusions. Ms. Malette was in a car accident and arrived at the hospital unconscious and needing a blood transfusion. A card in her wallet indicated that for reasons of faith, she refused blood transfusions under any circumstances. Dr. Shulman was acting in good faith and was unclear whether the card in Ms. Malette's wallet was sufficient refusal in the circumstances. He gave the transfusion and thereby saved his patient's life. However, the courts concluded that the refusal was valid; therefore, proceeding with the transfusion was a profound interference with Ms. Malette's bodily autonomy and a battery. Ms. Malette was entitled to refuse to be touched, even when her life was at risk.[11]

The role of consent in the law of battery is therefore to serve as a defence where someone has given permission to be touched. So far, I have said nothing about information or being informed. While patients must be told what form of physical contact is being proposed, so that they may agree to it (or not), the sufficiency of information is otherwise effectively irrelevant to consent as a defence to battery. Notwithstanding the quotes from *Malette* and the *HCCA* in the opening paragraphs of this article, consent is not invalid if it is not informed, either at common law or according to health care consent statutes such as Ontario's *HCCA*. Ms. Malette's refusal was arguably not informed, since Dr. Shulman had no opportunity to discuss risks and benefits of a blood transfusion, but it was still legally valid.

The common law has been clear since 1980 that a lack of information does not affect the validity of consent as a defence to battery. The Supreme Court of Canada resolved this issue in *Reibl v Hughes* (*Reibl*).[12] In that case, Mr. Reibl had agreed to undergo a procedure to remove an occlusion from his left carotid artery. The procedure carried a significant risk of stroke, and Mr. Reibl did suffer a stroke as a result. He was insufficiently informed of the risks and the Court accepted that had he been properly informed, he would not have agreed to the procedure. He alleged both negligence and battery for failing to inform. The battery claim was premised on the idea that his physician's failure to inform of risks should invalidate the consent that Mr. Reibl provided

10. Linden et al, *supra* note 6 at s 2.06(1)(b). One exception relates to emergency treatment. See *HCCA*, *supra* note 2, s 25.

11. *Malette*, *supra* note 1. This decision was upheld on appeal in *Malette v Shulman*, 1990 CanLII 6868 (ONCA). See also Linden et al, *supra* note 6 at 2.03.

12. *Reibl*, *supra* note 3.

to the procedure. If consent were invalidated, no defence to battery would apply, and the law would treat the procedure as having been done without Mr. Reibl's permission.

The Supreme Court of Canada rejected the battery claim. Acknowledging the doctrinal confusion, the majority stated:

> The popularization of the term "informed consent" for what is, in essence, a duty of disclosure of certain risks of surgery or therapy appears to have had some influence in the retention of battery as a ground of liability, even in cases where there was express consent to such treatment and the surgeon or therapist did not go beyond that to which consent was given. It would be better to abandon the term when it tends to confuse battery and negligence.[13]

The Court went on to hold that the sufficiency of information provided is not relevant to the validity of consent in the battery context. This was in large part because negating freely given consent where it is based on insufficient information is "incompatible with the elements of the cause of action in battery".[14] Battery focuses on intentional and unconsented to "invasions of one's bodily security".[15] A failure to inform of risks may be a serious breach of legal and ethical obligations, but it is not akin to unwanted touching. *Reibl* therefore holds that a failure to inform is a negligence issue, and battery applies only where there was no consent for the relevant physical contact.

I said that information is *effectively* irrelevant to battery. In fact, there are two very narrow contexts in which misinformation or a lack of information are relevant to consent to battery. First, it may be that a patient was not informed about the nature of the intervention. It follows that they cannot have agreed to that intervention. The battery issue is not the failure to inform, but the fact that no consent was obtained for the specific physical contact at issue.

Disputes can sometimes arise as to whether what was proposed was sufficiently described, so that it could be said that the patient gave permission to that intervention. For example, in *Brushett v Cowan* (*Brushett*),[16] the plaintiff broke her leg at the site of a bone biopsy performed by the defendant, Dr. Cowan. He performed the bone biopsy to try to diagnose the cause of pain and abnormalities in Ms. Brushett's leg. Dr. Cowan obtained explicit consent for a diagnostic *muscle* biopsy, as well as "to such further or alternative

13. *Ibid* at 888–89.

14. *Ibid* at 890.

15. *Ibid*.

16. 1987 CanLII 5214 (NLSC) [*Brushett* SC]; *Brushett v Cowan*, 1990 CanLII 6513 (NLCA).

measures as may be found to be necessary during the course of the operation".[17] While performing the muscle biopsy, Dr. Cowan noted an irregularity on the bone and biopsied it as well. When Ms. Brushett was later injured due to the bone biopsy, she claimed she did not consent to it, and it was therefore a battery.

One issue was whether this general permission for "such further or alternative measures" was specific enough to constitute consent to a bone biopsy. If not, and there were no other source of consent for the bone biopsy, there would be battery.

The trial judge and the Court of Appeal of Newfoundland and Labrador disagreed. The trial judge found that such vague words could not ground permission for the bone biopsy.[18] However, the majority at the Court of Appeal overturned on this point. Noting that a consent form is not the sole source of permission, the Court referred to the multiple consultations between the plaintiff and defendant aimed at diagnosing the problem with Ms. Brushett's leg. The consent form had to be understood in this context, such that Ms. Brushett was found to have implicitly consented to the bone biopsy. The battery claim therefore failed. While the battery issue arguably turned on the sufficiency of information Dr. Cowan provided, the issue for the courts was not whether consent was informed, but whether it could be said that Ms. Brushett consented to a bone biopsy at all.

A second way in which misinformation or a lack of information is relevant to consent in battery is that the defence of consent may be vitiated (that is, rendered legally ineffective) if it is obtained by fraud. The Supreme Court of Canada said in *Reibl*: "[U]nless there has been misrepresentation or fraud to secure consent to the treatment, a failure to disclose the attendant risks, however serious, should go to negligence rather than to battery".[19] Such fraud has sometimes been said to mean deliberate "misrepresentations made for the purpose of obtaining consent".[20] But more is required: the fraud must go to the "nature and quality of the act".[21] In other words, the very nature of what is being agreed to must be misrepresented, not just "collateral" facts. Thus, deliberately downplaying risks somewhat, in order to secure consent, would presumably not vitiate consent because the patient is still agreeing

17. *Brushett* SC, *supra* note 16 at para 1.

18. Ibid at paras 17–19.

19. *Reibl*, *supra* note 3 at 891–92.

20. *Kita v Braig*, 1992 CanLII 1421 (BCCA) at para 12.

21. Philip H Solomon et al, *Cases and Materials on the Law of Torts*, 11th ed (Toronto: Thomson Reuters, 2023) at 210.

to the touching in question, even if they are unaware of the risks.[22] The question is less "did the physician deliberately misrepresent?" and more, "was the relevant touching agreed to?"

Much has been written about where the line should be drawn between misrepresentations that will vitiate consent and those that will not: when does a misrepresentation so mislead the patient that it should be said the patient did not actually consent to the relevant contact?[23] For example, in a criminal case[24] that pre-dated *Reibl*, the Court of Appeal for Ontario was divided as to whether it vitiated consent to misrepresent oneself to be a physician in order to obtain consent to conducting intimate physical exams. The majority said this went to the nature and quality of the act, such that consent was vitiated, while the dissenting judge said the misrepresentation was not one going to the nature and quality of the act, so consent was valid.[25]

A non-medical example relates to whether not disclosing one's HIV status vitiates consent to sexual contact. Failing to disclose this information can create a risk of serious bodily harm and that can be enough to vitiate consent to sexual intercourse. The Supreme Court of Canada has held that failure to disclose one's HIV status vitiates consent to sexual intercourse unless there was no meaningful risk of transmission, because of both a low viral load and wearing a condom.[26] The case law around the kinds of health risks that will justify vitiating consent is controversial and somewhat unpredictable.[27]

22. I draw this conclusion by analogy to circumstances that will vitiate consent to battery in both medical and non-medical contexts. For the medical, see *Regina v Maurantonio*, 65 DLR (2d) 674, 1967 CanLII 317 (ONCA) [*Maurantonio*], discussed in the next paragraph. For the non-medical, consider that lying about one's marital status in order to convince someone to have sex does not vitiate consent to engaging in sex, even though it is a deliberate misrepresentation: *R v Tebbs*, 2022 ONSC 4325. (While one might assume criminal cases are irrelevant to the question of battery, in fact the criminal law has driven much of tort law regarding when consent will be vitiated. See Solomon et al, *supra* note 21 at 210, where the authors note that the approach to vitiating consent to battery is similar to the approach in criminal assault cases, though this should not necessarily be the case. See also Margaret A Somerville, "Structuring the Issues in Informed Consent" (1981) 26:4 McGill LJ 740 at 743.)

23. See e.g. Somerville, *supra* note 22.

24. See note 22 for the relevance of criminal cases.

25. *Maurantonio*, *supra* note 22.

26. *R v Mabior*, 2012 SCC 47.

27. See e.g. *R v Hutchinson*, 2014 SCC 19 and *R v Kirkpatrick*, 2022 SCC 33.

It is beyond the scope of this article to address precisely when a misrepresentation will vitiate consent to medical treatment.[28] The point is that only in rare and often egregious circumstances will a failure to inform be relevant to the law of battery. Even then, it is not the failure to inform per se that vitiates consent but that fact that because of this failure, the patient cannot be said to have agreed to the relevant procedure at all—to the "nature and quality of the act", as it is often phrased. The issue is still consent, in the sense of agreement, not *informed* consent.

So far, I have been discussing the common law. But perhaps the situation is different under consent and capacity legislation such as the *HCCA*.[29] This legislation was enacted to provide consistent rules regarding consent in the medical context and to promote autonomous decision-making.[30] The plain meaning of section 11(1) of that *Act* is that consent must be informed to be valid: "[T]he elements required for consent to treatment" include that "[t]he consent must be informed".[31] Yet there are several reasons why this plain meaning must be rejected. This provision, and similar ones in other provinces' statutes, must be understood to codify the common law of battery—and, as we shall see, negligence—in this respect.

First, the *HCCA* would presumably have to be explicit to make such a significant change to the ancient and fundamental tort of battery. It would have to say that going forward, in the medical context only, a failure to inform constitutes battery—even where permission was given—if it was not informed. It does not say this. Indeed, one of the problems with the *HCCA* is that it does not refer to existing causes of action at all: the words "negligence" and "battery" do not appear. So, when it says consent must be informed, the *HCCA* does not specify whether this is in relation to battery, negligence, or both. Nor does it create a new cause of action that its broad consent rule applies to.

Second, had it intended to change the law of battery, Ontario's legislature presumably would have set out *what kinds* of failures to inform vitiate consent. Under the *HCCA*, material information must be provided.[32]

28. It is also beyond the scope of this article to settle the normative question of whether and when a lack of information *should* vitiate consent. However, I think it makes sense to leave the sufficiency of information largely out of the battery question. Although informed decision-making is important, these are good reasons for not too readily limiting a person's ability to decide whether they may be touched. See e.g. *Norberg v Wynrib*, [1992] 2 SCR 226, 1992 CanLII 65 (SCC).

29. In addition to the *HCCA*, see BC's *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181, especially ss 1, 6; PEI's *Consent to Treatment and Health Care Directives Act*, RSPEI 1988, c C-17.2, ss 1, 6; and the Yukon's *Care Consent Act*, SY 2003, c 21, Sch B, ss 3–5.

30. *HCCA*, *supra* note 2, s 1.

31. *Ibid*, s 11(1).

32. *Ibid*, s 11(3).

That encompasses a wide range of information regarding risks and alternatives. As we have seen, in the common law of battery, consent freely given is rarely vitiated. If the legislature had intended to create new grounds for vitiating consent to battery in the *HCCA*, it would presumably have excluded minor failures to inform, or perhaps adopted the common law approach of vitiating consent where there is fraud going to the nature and quality of the act. It was surely not the legislature's intent to vitiate consent for *any* failure to provide material information, such as where a risk was mentioned but its likelihood of occurring was accidentally misstated. There is no precedent for such an approach, nor would it be defensible as a matter of policy.

Perhaps most convincingly, the courts and Ontario's Consent and Capacity Board—the administrative tribunal which adjudicates consent and capacity matters—have not interpreted the *HCCA* as grounding a claim in battery where consent is insufficiently informed. There are no Ontario cases of which I am aware (nor cases in other provinces under similar statutes) in which a failure to provide sufficient information led to liability in battery. Indeed, the Consent and Capacity Board has said that the *HCCA* intended to codify the common law requirement of informed consent.[33]

The *HCCA*'s requirement of *informed* consent (that is, the obligation to provide material information) relates to negligence, not battery. Thus, for example, in *Denman v Radovanovic* (*Denman*), the issue was stated to be informed consent and related to whether the defendant physician had provided the patient with sufficient information about the risks of an embolization procedure.[34] The plaintiff agreed to the procedure and suffered a traumatic brain injury as a result. The plaintiff argued he would not have agreed had he been made aware of the risks of the procedure and of deferring any treatment. The informed consent issue was assessed based both on the common law and section 11(3) of the *HCCA*, which sets out what kinds of information must be provided. The Ontario Superior Court of Justice found the information provided to be insufficient and therefore proceeded with the other elements of negligence, such as whether harm was caused as a result. There was no issue as to whether the plaintiff actually consented—he did. And therefore there was no liability in battery—only in negligence. Indeed, the word battery does not occur in the case.

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33. *JEP (Re)*, 2017 CanLII 49299 at 29 (ONCCB): "The *HCCA* codified the common law principle of requiring that consent be informed (S11 *HCCA*)"; *AC (Re)*, 2013 CanLII 48963 at 27 (ONCCB). A more nuanced view is that expressed by Robertson and Picard: "[T]he legislation does not completely replicate the common law in every respect; in some ways the statutory consent requirements are broader, and in others they are narrower, than in the common law". Gerald B Robertson and Ellen I Picard, *Legal Liability of Doctors and Hospitals in Canada*, 5th ed (Toronto: Thomson Reuters, 2017) at 67–68.

34. 2023 ONSC 1160.

The case's reference to both common law and the *HCCA* demonstrates that even since the *HCCA* came into force, courts must largely apply the common law of battery and negligence because that statute does not create a complete code, replacing these common law torts. Rather than reading the *HCCA* as new law requiring informed consent for both battery and negligence, the Court in *Denman* understood the failure to inform to be a negligence issue only, consistent with the common law since *Reibl*.

Thus, despite loose use of the word "informed" in the *HCCA*, the law is clear that informed consent in battery just means consent, in the sense of permission or agreement. This is why *Mallette* and the *HCCA* are wrong to the extent they say otherwise.

II. Informed Consent in the Law of Negligence

Information, then, relates primarily to the second legal concept that the words "informed consent" evoke. This is a legal obligation on certain health practitioners to provide patients with information that is relevant to them in making health care decisions. It is not about the act or state of consenting; it is about empowering patients to make autonomous choices.

The tort of negligence holds responsible those who cause injury through their careless or unreasonable acts. It sometimes also imposes special obligations, known as affirmative duties, on people to help, by providing warnings or information, for example.[35] One such affirmative duty requires health practitioners to provide patients with material information—that is, information a reasonable person in the patient's position would want to know in deciding whether to undergo a proposed treatment. Health practitioners must also answer any questions the patient has.[36]

Like the tort of battery, this negligence duty to provide information helps protect a right to bodily autonomy because it helps ensure that patients can make decisions about their bodies that best reflect their own values. However, the wrongdoing in a negligent failure to inform relates not to interferences with one's body, but to failing to meet one's professional obligations to provide relevant information. Further, this failure is only actionable in negligence if it causes harm: the patient must have suffered an injury while being treated which, had they been properly informed, would have been avoided because the patient (technically a reasonable person in the patient's position) would

35. These are the affirmative duties of care. For more on affirmative duties, see e.g. *Childs v Desormeaux*, 2006 SCC 18.

36. See e.g. *Hopp v Lepp*, [1980] 2 SCR 192 at 210, 1980 CanLII 14 (SCC); *Ediger v Johnston*, 2013 SCC 18 at para 55 and *HCCA*, *supra* note 2, s 11(2)–(3).

have refused the procedure.[37] This was the case in *Denman*, discussed above, where Mr. Denman would have foregone an embolization procedure, and avoided injury, had he known of the significant risks of that procedure.

Often, however, the patient would have made the same decision even if properly informed, because the proposed procedure made sense in the circumstances. If informed, the patient still would have been injured, because they still would have agreed to the procedure, and so the health practitioner is not liable in negligence, despite failing to properly inform.[38] Negligence law's protection of bodily autonomy is therefore much less direct than battery's. It only provides recourse where a failure to inform causes injury.

Material information must, of course, be provided *before* the proposed procedure is performed, or else the law could not serve its purpose of helping to ensure informed medical decision-making. For the same reason, information must be provided before a decision to undergo a procedure is made. In that sense, consent must be informed in negligence, but not battery.

But a closer analysis reveals that it is not the case that the *decision*—the agreement or consent—must be informed. The legal issue is whether the health practitioner satisfied their obligation to provide information, not whether, as a result, the decision was an informed one. This may be a fine semantic distinction, but conceptually, it is still correct to say that informed consent in negligence is not really about consent.

A health practitioner can sometimes satisfy their duty to inform in negligence even if the patient's consent is ultimately not an informed one. A health practitioner must provide or offer to provide information. That information may be rejected in the sense of the patient refusing to hear it.[39] It may be rejected in the sense of a patient refusing to believe it. It may be misunderstood.[40] None of this affects the validity of consent or the health practitioner's

37. The causation test is unique in informed consent cases, invoking what a *reasonable person* would have done rather than what the plaintiff (reasonable or otherwise) would have done. See e.g. *Arndt v Smith*, 1997 CanLII 360 (SCC) at paras 3–17. However, for the purposes of comparing battery and negligence, there is no need to delve into the modified objective approach to causation.

38. *Ibid*.

39. For the proposition that patients may waive their rights to be informed see Robertson and Picard, *supra* note 33 at 219. They add: "It is of course the patient's right to do so, but waiver should be acceptable only where the patient istruly declining an explanation".

40. For a discussion of whether the health practitioners must ensure information is understood or whether they must simply take reasonable steps to ensure it is understood, see Robertson and Picard, *supra* note 33 at 202–06. I agree with their view that the former would be impractical and inconsistent with the standard of care in negligence; the law only requires reasonable steps.

liability in negligence. So long as the health practitioner has provided, or offered to provide, material information in a way the patient will understand, their duty is met. In that sense, consent need not be informed.

Consider another example in which a physician provides a patient with incorrect information about a material aspect of a procedure. However, the patient's wife is present and she happens to be an expert in the relevant medical field. She corrects the misinformation the physician provided. The patient agrees to the procedure based on correct information, so the patient's consent is now an informed one. However, the physician has still breached their legal duty. There would be no liability in negligence because no injury would result from this breach. However, this example demonstrates that the negligence issue is not about whether consent is actually informed but about whether the practitioner provided relevant information.

The above relates to the common law of negligence. As for the *HCCA* and similar provincial health care consent statutes, I explained above why their requirement that consent be informed cannot relate to the validity of consent as a defence to battery. Might it simply mean consent must be informed for the purposes of *negligence* law? Yes, but only in the common law sense that a failure to inform is negligence if it results in injury. This has nothing to do with the presence of consent or its validity. The *HCCA* creates no new causes of action and has not been interpreted to require obligations to inform that differ significantly from those under the common law of negligence.

I pause here to note that a failure to inform, regardless of injury, may also violate professional codes of conduct and could result in disciplinary action. For example, a physician who failed to properly inform patients could be disciplined by their professional college even if no patients were injured. So too, touching a patient without permission can violate professional codes of conduct and result in discipline. Thus, in addition to the torts of battery and negligence, informed consent can implicate administrative law. In administrative law too, however, it makes sense to distinguish professional obligations to inform from those not to interfere with a patient's body without consent. They are independent ways of failing to meet obligations to patients and may warrant different responses.

Fiduciary duties may also be implicated, but courts have tended not to address health practitioners' failures to inform or to obtain consent as violating fiduciary obligations.[41]

41. For a counterexample, see *Barker v Barker*, 2022 ONCA 567 at paras 116–31.

III. The Consequences of Confusing Informed Consent Concepts

It is hopefully now clear why informed consent is not a single legal rule or doctrine. Nevertheless, the term is certainly ingrained. Surely there is no harm is in referring to informed consent, so long as everyone understands their rights and obligations. Patients must consent to being touched or else health practitioners may be liable in battery, and health practitioners must inform to avoid breaching their negligence duty. Using a single phrase for both obligations might even be helpful in continuously emphasizing the need for both permission and information. Does it matter if we conceive of this as one thing or two, especially in light of statutes like the *HCCA*, which fail to make the distinction? Often it does not matter, but sometimes it matters a great deal.

First, informed consent confuses my students. They are not alone.[42] While the mere fact of confusing students does not demand action, confusion borne of inaccuracy or unnecessary complexity should be corrected.

Second, blurring the defence to battery and the professional obligation to inform could lead to confusion over when consent is required. For battery purposes, consent is required whenever there is non-trivial physical contact. In negligence, health practitioners must provide material information in contexts both broader and narrower than non-trivial physical contact. After all, the negligence obligation relates to providing information relevant to decision-making, not to whether the patient is touched. For example, a physician must provide material information about a prescription drug that they prescribe,[43] but since there is no direct physical contact between the health practitioner and the patient, there is no need for the patient to consent.[44]

The negligence obligation is also narrower—at least under some statutes—in that material information need not be provided where the

42. For cases where summary judgment was granted, dismissing a battery claim because what was actually alleged was a failure to inform, see: *Suserski v Nurse*, 2006 CanLII 40677 (ONSC) at para 29; *Oran v Abourawi*, 2010 ONCA 567 at para 2; *Thorburn v Grimshaw,* 2024 NSSC 15 at paras 38–44. Note that these plaintiffs were all self-represented, but when I practiced law, I encountered a lawyer who tried to sue in battery for a failure to inform.

43. See e.g. *Florence v Benzaquen*, 2020 ONSC 1534 at para 38; *Lucuta v Stevens*, 2019 ONSC 1691 at para 11.

44. This is true in battery because there is no direct physical contact so no need for the defence of consent. I recognize, however, that the act of taking the drug would amount to implicit consent.

"treatment . . . poses little or no risk of harm".[45] In battery, as noted above, harm is irrelevant to liability and the threshold for non-trivial touching is low. So consent would be required for a health practitioner to place a stethoscope on a patient's chest,[46] but material information would not have to be provided in relation to this intervention.

If battery and negligence concepts are confused or conflated, it is harder to assess whether consent is required in cases such as the prescription drug example above. It is also harder to assess the consequences of failing to obtain informed consent. Is it battery not to obtain informed consent to taking a prescription drug? Presumably not, though one might assume otherwise. Does a patient need to prove an injury? Yes in negligence; no in battery. The range of damages presumably differs as well.

While there is a clear theoretical risk of confusion, I could find no cases where liability appeared to be wrongly decided because of it. For example, I found no cases under the *HCCA* where it was held that consent was not required for non-trivial medical touching because the touching "poses little or

45. For the meaning of "treatment", see *HCCA*, *supra* note 2, s 2(1)(g). Since under the *HCCA*, consent is only required for "treatment", excluding interventions with little or no risk of harm from the ambit of treatment means consent is not required for them under the *Act*. At common law, it is perhaps less obvious when the obligation to inform arises, but the concept of "material" information should inform when no information is necessary.

46. It may seem impractical or unrealistic to imagine a health practitioner obtaining consent to listening to a patient's heartbeat. However, obtaining consent need not be onerous. If a health practitioner says: "I am going to listen to your heart now, okay?" while raising a stethoscope, consent is obtained where the patient says yes or otherwise signals willingness to being touched in that way.

no risk of harm".[47] Such a finding would be consistent with the plain meaning of section 2(1)(g) of the *HCCA* but would rewrite the law of battery.

There are, however, situations where the confusion between consent in battery and informing in negligence has led to unnecessarily complex litigation and even unprincipled extensions of the law. One relates to the issue of informed refusal, while the other relates to creating entitlements to treatment that patients want but health practitioners do not want to provide.

A. Informed Refusal

If we accept that consent to treatment must be informed, but fail to distinguish between different legal obligations, two problematic things follow. First, it is hard to justify the need for informed consent but not informed refusal, which has sometimes been argued to be required.[48] By analogy to informed consent, informed refusal means that *refusals* of consent would have to be informed to be valid. This may seem plausible since, if the point is to inform decision-making, then the amount of information health practitioners must provide cannot depend on whether the decision is ultimately yes or no. If there is a right to consent, there must also be a right to refuse consent. If there is a right to be informed, it must apply regardless of whether consent is given or refused. Therefore, refusals of consent must be informed too.

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47. That said, there are cases where the Consent and Capacity Board (CCB), the administrative tribunal responsible for consent and capacity decisions under the *HCCA*, has determined its jurisdiction over a potential battery based on whether the touching was treatment that poses little or no risk of harm. It is an arguable reading of the *HCCA* that because the CCB deals with issues involving "treatment", and "treatment" is defined to exclude interventions posing little risk of harm, the CCB has no jurisdiction over medical interventions that might be batteries but that are not harmful. In *RF (Re)*, 2007 CanLII 32895 (ONCCB), the CCB held it had jurisdiction to review a patient's capacity where the treatment in question was placing a Nicoderm patch on a patient. The CCB found that there were small risks of using the patch such that the treatment did not pose "little or no risk of harm". But the implication is that had the patch posed little risk, the patient's capacity could not have been reviewed by the CCB. Along similar lines see *UH (Re)*, 2016 CanLII 98580 (ONCCB), where removing mechanical ventilation was not "treatment", engaging the CCB's jurisdiction, because it posed no risk of harm given that the patient was already dead. While the patient's death was enough to render the issue of consent moot, it is interesting that the lack of harm is being used to deny jurisdiction in a case involving a potential battery when the exception was likely included in relation to negligence, not battery. Consent is required for non-trivial touching regardless of a risk of harm and the CCB should be able to assess capacity to provide that consent.

48. See e.g. *Malette*, *supra* note 1; in the negligence context, see *Davidson v British Columbia*, 1995 CanLII 1334 (BCSC). For a general discussion, see Del Villar et al, *supra* note 3.

However, the idea of informed refusal leads to absurd consequences. As noted by Professor Siebrasse, it cannot be that a health practitioner could be liable for failing to convince a patient of the merits of a procedure that was refused. Nor could they escape liability for treating a patient who had clearly refused consent, simply because that consent had not been informed.[49] While the Court of Appeal for Ontario in *Malette* declined to speak to the issue of informed refusal, in my view the trial judge was correct in saying that the "right to refuse treatment is not premised on an understanding of the risks of refusal".[50]

The confusion arises because we conflate the right to be informed with the right not to be touched without permission. If we view these as two issues instead of one, the problem disappears. Permission and refusal are treated the same in battery: one may accept or refuse intervention *regardless* of whether information has been provided. Information is effectively irrelevant. To require that health practitioners have an opportunity to inform us before we are allowed to tell them to leave us alone would erode the fundamental rights protected by the law of battery.

Similarly, health practitioners must offer material information, but their failure to do so is a negligence issue focusing on what information should have been provided in the circumstances. That does not create a legal inability to refuse treatment unless information has been provided. Thus, the analogy between informed refusal and a right to informed (affirmative) consent falls away if we keep battery and negligence concepts distinct.

B. Entitlements to Treatment

Finally, confusion about *informed consent* has created a positive right to treatment health practitioners do not wish to provide in at least one narrow context. This example relies on the language of the *HCCA* but results from its failure to distinguish between causes of action in requiring informed consent.

Again, the starting point is that informed consent is required for treatment. In the negligence context, treatment can be defined broadly because many kinds of interventions engage the health practitioner's negligence duty to inform. We are not limited by the concept of physical interventions, which is relevant to battery but not the duty to inform. Thus, the *HCCA* defines "treatment" exceptionally broadly, to mean "anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a . . . plan of treatment".[51] Including a

49. Norman Siebrasse, "*Malette v. Shulman*: The Requirement of Consent in Medical Emergencies" (1989) 34:4 McGill LJ 1080 at 1085.

50. *Malette*, *supra* note 1 at 272.

51. *HCCA*, *supra* note 2, s 2(1) under definition of "treatment".

"plan of treatment" in the definition of treatment, for which informed consent is required, makes sense if we understand informed consent to mean the negligence duty to inform, because patients need information to create such a plan. However, if we understand informed consent to mean permission or consent, as in battery, the inclusion of a plan of treatment is nonsensical. Battery is about consenting to being touched. A plan of treatment has nothing to do with physical contact.

This definition of treatment is so broad that it includes decisions whether or not to provide an intervention at all, since that would be included in plan of treatment. Radiation therapy is treatment for cancer but so too is *refraining* from providing radiation therapy, if that is a decision made for therapeutic, palliative or other purposes noted in the *HCCA*'s definition of treatment.

If the decision not to offer radiation therapy is itself a form of treatment, and informed consent is required for treatment, then informed consent is required *not* to have radiation. The "informed" part of informed consent poses some challenges—does a health practitioner have to provide information about every possible or plausible treatment that they are not proposing to offer their patient?

But the real challenge is the "consent" part of informed consent. If we understand needing informed consent not as two distinct obligations, but as a single one where a patient must be both informed and must *consent* to treatment for consent to be valid, then one requirement can hold the other hostage. If *not* being offered radiation therapy is treatment, because it is part of a plan of treatment, then as a matter of logic, patients must consent to *not* being offered radiation therapy. A decision with only one possible outcome is no decision at all, so refusal must be possible. But if one can refuse consent to *not* being offered radiation therapy, through the magic of a double negative, one can effectively *insist* on radiation therapy being provided. Through rigid statutory interpretation, and by ignoring the relevant principles underlying the law of informed consent, we have created an entitlement to treatment that physicians are not proposing to offer.

This may seem even more hypothetical and absurd than the prospect of courts requiring informed refusal, but the Supreme Court of Canada has created an entitlement to certain forms of life support based on the logic above. In *Cuthbertson v Rasouli* (*Rasouli*),[52] doctors diagnosed Mr. Rasouli as being in a persistent vegetative state with no chance of regaining consciousness. Since there were no medical interventions that would help Mr. Rasouli regain a conscious existence, his physicians recommended withdrawing life support, and allowing him to die. Mr. Rasouli's family strongly objected, insisting that they had a right to consent to any withdrawal of life support. Phrased differently, they argued for an entitlement to

52. 2013 SCC 53.

medical treatment that physicians were not willing to provide, in the form of continued life support, based on the need for informed consent.

The Supreme Court of Canada held that Mr. Rasouli was entitled to life support that his physicians wished to withdraw, because withdrawing life support was a form of treatment, and consent is required for treatment.[52] Consent was therefore required to withdraw life support and if Mr. Rasouli's wife, who was his substitute decision-maker, refused that consent, life support would have to continue being provided. But this logic only works if you view informed consent as one concept and not two. Just as one's refusal of treatment does not have to be informed, one's right to information about a plan of treatment does not turn on consent. Consent as permission cannot create a positive right to accessing certain treatment.

I think this decision is wrong in law, but my goal is not to argue that *Rasouli* was wrongly decided. Rather, I raise *Rasouli* as an example of what can result from confusing the "consent" and "informed" parts of informed consent.[53] Under existing law, withdrawing life support would require Mr. Rasouli's doctors to provide information about the consequences of this to Mr. Rasouli's substitute decision-maker. Further, consent would be required for any non-trivial touching by the doctors—removing a ventilation tube, for example. But this does not create a positive claim to make physicians offer health care services they do not propose to provide.[54] Such an entitlement may be defensible but it cannot be found in the law of battery or in physicians' negligence duty to inform.

While the Court grounded its analysis in the language of the *HCCA*, with its broad statutory definition of treatment, I demonstrated above that the *HCCA* cannot be understood as having rewritten basic concepts of consent

53. I do not mean that the majority in *Rasouli* confused the concepts. The reasons make clear that they understood the difference between consent in battery and informing in negligence. But they relied on wording in the *HCCA* which itself conflates the concepts—presumably without intending to overwrite the fundamental common law principles of consent. By relying on a literal interpretation of the *HCCA*, the majority was able to arrive at its conclusion that the right to consent to treatment can create a positive right to treatment physicians do not propose to provide.

54. One might argue that life support cannot, in practice, be withdrawn without touching (e.g. removing a breathing tube) and therefore the law of battery means that consent is required for such removal of the tube and therefore of life support. This is known as the "treatment package" doctrine and it is addressed in detail in Hilary Young, "Why Withdrawing Life-Sustaining Treatment Should Not Require 'Rasouli Consent'" (2012) 6:2 McGill JL & Health 54 at 73–79. Regardless, the Supreme Court went further and said that even if no touching were required, treatment would have to continue to be provided, because they were relying on a definition of treatment that was not grounded in physical contact.

as a defence to battery or of the obligation on health practitioners to provide information. Such a reform of these basic principles would be necessary, in my view, to support the Supreme Court's reading of the *HCCA*.

The logic of *Rasouli* may not expand beyond that case's facts. In *Wawrzyniak v Livingstone* (*Wawrzyniak*),[55] a trial court rejected a similar argument. It held that imposing a do not resuscitate order without the consent of—and indeed, contrary to the wishes of—the patient's substitute decision-maker is not battery. It is also not negligence, so long as that decision conforms with the standard of care. In other words, the right to consent to treatment does not create a freestanding entitlement to any treatment, simply because the patient (or their substitute decision-maker) withholds consent to it being denied. The Court in *Wawrzyniak* clarified that consent is required for touching but that treatment can be legally withheld if done in accordance with professional standards.

IV. Keeping Battery and Negligence Distinct Does Not Mean the Law Cannot Evolve

I have attempted to draw a clear distinction between the battery concept of consent to treatment and the negligence obligation to inform. In so doing, my approach to battery and negligence may seem overly rigid. The law of informed consent has evolved considerably over the past half century. In addition to expanding duties to inform and rejecting paternalism,[56] the *Canadian Charter of Rights and Freedoms* has been engaged to protect the decision-making process.[57] More nuanced models of decision-making are being discussed and implemented.[58] End-of-life decision-making is especially fraught, and the law is struggling to find the right balance between patients' wishes and appropriate care. But nothing I have said means the law of battery should not evolve, or that the law of negligence appropriately addresses health practitioners' duties to inform. Several valid criticisms have been leveled at

55. 2019 ONSC 4900.

56. Therapeutic privilege, for example, has been rejected. See *Meyer Estate v Rogers* (Gen Div), 1991 CanLII 7261 (ONSC).

57. This may take the form of arguing for positive rights to treatment, as in *Auton (Guardian ad litem of) v British Columbia (Attorney General)*, 2004 SCC 78, or in striking down prohibitions on Medical Assistance in Dying, in *Carter v Canada (Attorney General)*, 2015 SCC 5.

58. For patients' preferences for different degrees of autonomy in medical decision-making, see Sophie Ludewigs et al, "Ethics of the fiduciary relationship between patient and physician: the case of informed consent" (2022) 51:1 J Medical Ethics 59 at 63.

the status quo of informed consent. For example, it has been argued that the duty on health practitioners to provide material information is so weakened by the further requirement that this failure cause injury, that the law insufficiently protects patient autonomy.[59] Others have queried whether the concept of physical contact is the right threshold for battery, and have noted difficulties in knowing what counts as physical contact.[60]

It may also seem artificial to draw a bright line between providing information and obtaining permission. We inform because it enables good decision-making. We decide because of the material implications of our decision. In this sense, informing and deciding should arguably not be separated.

This is fine as a conceptual matter but as discussed above (and notwithstanding the language of statutes like the *HCCA*) Canadian law draws these distinctions quite sharply. Further, there are least some good reasons for the law to distinguish between failures to inform and non-consensual touching. For example, doing so means we can refuse to be touched regardless of whether we have been given information (the informed refusal issue). The law can more easily protect a broad right not to be touched without permission, regardless of what discussions were had or whether there is resulting injury. Similarly, health practitioners can be required to provide material information about interventions that do not require touching, like psychotherapy or prescribing medications, because touching is not especially relevant to when the duty to inform should apply.

Nor does maintaining the battery-negligence distinction preclude expanding aspects of each concept, such as holding physicians to account where they have failed to inform, even where that failure was not a but for cause of injury. We might also expand battery's scope to treatments like psychotherapy that do not require touching but implicate psychological states. I simply suggest that such changes should happen as a result of deliberation about the doctrinal and practical consequences of such changes, rather than because we have confused a negligence issue with a battery issue.

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59. See e.g. Erin Sheley, "Rethinking Injury: The Case of Informed Consent" 2015:1 (2015) 1 BYUL Rev 63.

60. It has long been recognized that interference with a person's clothing or an object they are carrying can constitute physical contact. More controversially, some courts have recognized poisoning someone's food or moving a chair so that a person falls to the ground satisfy the physical contact requirement. See Linden et al, *supra* note 6 at s 2.03. See also e.g. Neal Hoffman, "Battery 2.0: Upgrading Offensive Contact Battery to the Digital Age" (2010) 1:2 Case W Res J Intl L 61 at 77; Lynda Collins & Heather McLeod-Kilmurray, "Toxic Battery: A Tort for our Time?" (2008) 16 Tort L Rev 131.

Conclusion

The original idea for this article was to suggest the emergence of a new tort of "lack of informed consent to medical treatment", unhinged from battery and negligence. The language of the *HCCA* and its application in *Rasouli* could be interpreted as a departure from both torts. Ultimately, however, the case law suggests no such new tort; the potential for *Rasouli* to lead to other entitlements to treatment, or for other novel applications, seems not to have materialized. Rather, what we see is doctrinal confusion borne in part of the failure of statutes like the *HCCA* to specify causes of action. Long before the *HCCA*, however, people were confusing battery and negligence issues.

This article has clarified the relevant legal concepts to help prevent confusion. The duty to inform is only owed by health practitioners to their patients. A failure to inform is generally only tortious (negligent) where an injury would have been avoided had information been provided. Negligence regarding a failure to inform also requires proving that the information withheld was *material*. The claim will often require medical expert evidence, for example as to the consequences of a procedure. The essence of the claim is that someone was injured because a health practitioner failed to provide information about material consequences of having or not having a procedure.

A lack of consent, however, leads more straightforwardly to liability. Not limited to the medical context, a person need only prove that they were touched in a non-trivial way. The defendant then bears the onus of proving, by way of defence, that the contact was consensual. In the medical context, if the contact is not consensual it is usually because there was an error (surgeon operates on the left leg instead of the right) or because consent was not obtained to the specific procedure that occurred—as was alleged in *Brushett* where, for diagnostic reasons, the physician performed a bone biopsy where only a muscle biopsy was explicitly agreed to in advance. Sometimes the failure to obtain consent is more egregious, as where a sexual battery takes place. But a failure to get permission for the contact is effectively all that is required for liability. For practical reasons, the patient rarely litigates if there is no injury, but no injury is required. Plaintiffs therefore often prefer to sue in battery than negligence.

Obtaining information and providing permission are both necessary for a patient to be able to engage in medical decision-making that reflects their values and priorities, but for different reasons. The right not to be touched without permission is ancient, broad, and subject to few exceptions. It is not specific to the health care context. The law provides significant protection against unwanted touching, even where no harm results.

The right to be informed before making a treatment decision is more recent—the norm used to be medical paternalism. It is narrow in that there is no general obligation on people to inform others of risks and benefits of their choices; affirmative duties to inform are the exception, not the rule. Such

a duty makes sense in the medical context, where practitioners have expert knowledge that patients do not have, have professional obligations to act in patients' best interests, and where important decisions must be made. Even then, the law of negligence does not concern itself with a health practitioner's failure to inform unless that failure results in injury. After all, negligence is not primarily concerned with punishment—it provides compensation for injuries caused by substandard conduct.

Although these areas of law are discrete, we see that they are confused and conflated. This is perhaps not surprising given that the consent process in health care engages both and, in a broad sense, both protect the right to bodily autonomy.

Conflating battery and negligence issues makes it harder for the law to appropriately evolve. It might suggest a physician can give you a blood transfusion you have refused, because your refusal might not have been informed. It might suggest a positive right to treatment where consent to withdraw that treatment is refused. However, neither the need for informed refusal nor a right to life support is justified by a right against unwanted touching or an entitlement to information, though a positive right to treatment might be justified on other grounds.

While the language of informed consent is too ingrained to avoid, from a legal perspective there is no such thing. Keeping the different legal issues distinct not only avoids doctrinal confusion but helps ensure that the law can develop in a way that appropriately reflects the various issues at stake.