

Scope of a Physician's Duty When Counselling Patients on Smoking Cessation^{*}

I Introduction

Tobacco-related disease is generally regarded as the greatest preventable threat to health facing Canadians today. As such, intervention to assist smokers in quitting may be the most significant contribution that a physician can make to the health of patients. Yet studies and anecdotal evidence indicate that many physicians do not counsel their smoking patients to quit. This raises important legal questions for the medical practitioner when diagnosing, treating and counselling patients who smoke. Physicians face potential liability if they do not take steps to advise their patients in a manner commensurate with their duty and the applicable standard of care.

For instance, despite the well-known risk factors associated with smoking, many physicians are not taking smoking histories from their patients. Some physicians may feel it is intrusive to involve themselves in a matter of lifestyle, yet most patients report that smoking cessation advice from physicians would be welcome¹. Whatever the reason, failure to take adequate measures to diagnose and counsel with respect to smoking cessation may expose the physician to legal liability for harm that results. As we point out below, under current rules of tort law the risk of a successful lawsuit is low: the causation issues facing any single plaintiff seeking damages against a physician arising out of a failure to counsel cessation indicate that plaintiffs will continue to principally pursue manufacturers of tobacco products, as well as intermediaries who have exposed them to smoke, such as employers.

Because the difficult causation issues will vary with the facts of each case, this opinion focuses upon the responsibilities of a physician when counselling patients who smoke. In particular, it focuses on the physician's legal responsibility to 'ask, advise and assist' smokers with respect to tobacco cessation.

It is impossible, within the confines of a general opinion, to anticipate every smoking-related scenario which could potentially give rise to physicians' liability. Rather this opinion will canvass the law as it relates to treating smokers and will provide some general guidelines that may assist physicians in avoiding legal consequences in certain cases. As always, a

^{*} Prepared by Bull, Housser & Tupper: Penny A. Washington, Partner, Health Care Litigation Group and Craig Jones, Tobacco Litigation Group, with the assistance of Melanie Cheesman, articulated student.

¹ B.L. Frankowski et al. "Advising Parents to Stop Smoking: Pediatricians and Parents' Attitudes" 91 *Pediatrics* 296 (February, 1993). The studies in the Frankowski article were done as the dangers of ETS were becoming widely known in the general public.

physician who has particular questions or concerns about any given patient should contact their College or seek advice from the CMPA or independent legal counsel.

II Tobacco Industry Personal Injury Litigation

It is not the purpose of this opinion to exhaustively review the history of tobacco-related litigation. However, a basic understanding of the background may be necessary to fully understand the context in which we analyze physicians' duties when treating smoking patients, and so we undertake the following brief review.

In the early 1950s, the first studies suggesting strong causal relationships between smoking and disease in smokers were published. In 1954, Liggett & Myers, RJ Reynolds and Phillip Morris, three giant US tobacco companies, were sued in separate actions. One was dismissed promptly by the court for lack of evidence; the second was won by Phillip Morris in 1963, and the third, *Pritchard v. Liggett & Myers Co.*,² dragged on for 12 years before the plaintiff, financially exhausted, dropped the action. In fact, between 100 and 150 cases were filed against tobacco companies in 1953 and 1954. Of these, only 10 went any significant distance towards trial. Four were voluntarily dismissed, three resulted in jury verdicts for the manufacturers, and three ended in summary judgment for the manufacturer³.

Further attempts by smokers to sue the tobacco industry met with similar failures throughout the 1960s and 70s; establishing a familiar pattern. Because smoking-related disease was primarily a statistical assumption⁴, plaintiffs could not prove with legal certainty that a particular company's product caused their disease. This 'causation problem' will be discussed later. Even beyond the legal obstacles, the tobacco industry's resources were virtually insurmountable by individual plaintiffs. So as one tobacco industry lawyer confirmed (circa 1988): "The aggressive posture we have taken... continues to make these cases extremely burdensome and expensive for plaintiffs' lawyers... To paraphrase General Patton, the way we won these cases was not by spending all of [RJR]'s money, but by making the other son of a bitch spend all of his." Although hundreds of cases were initiated in the US 'first wave', only a very few (perhaps 11) ever reached trial. In none of these were the plaintiffs successful.

Following the 'first wave' of litigation, there were significant advances in public health and policy. The U.S. Surgeon General's Report on tobacco was published in 1964 (the report of the U.K. Surgeon General, published in 1962 and reached similar conclusions), and contained solid scientific evidence regarding the health hazards of tobacco. Such evidence continued to mount and the causation of smoking-related diseases soon reached wide-spread scientific and medical acceptance. This was followed by legislation in the U.S. requiring warnings on cigarette packs

² 350 F. 2d 479 (3d Cir. 1965).

³ F. J. Vandall, "The legal theory and the visionaries that led to the proposed \$368.5 billion tobacco settlement" 27 *Southwestern L. R.* 473.

⁴ This is one of the ironies of causation in tobacco cases. The industry relies on the fact that disease causation has never been established in humans, though of course testing on humans would be unethical given the known dangers.

and restricting advertising.⁵ The legislation was amended in 1970 and 1984 to require stricter warnings. In Canada, the tobacco industry mounted a lobby against similar legislation and forestalled it by voluntarily agreeing to advertising restrictions and labelling requirements.

In addition U.S. tort law became increasingly familiar with product liability claims for products that were dangerous not because they were defective, but simply because they were hazardous even when manufactured as intended and used as specified (asbestos and coal dust are immediate examples). This is sometimes called strict liability, because a manufacturer of such a product could be held liable notwithstanding no negligence in its manufacture. With the development of strict liability, tort law shifted away from the requirements of foreseeability and carelessness. These developments offered renewed hope to tobacco litigants. Claims in the 'second wave' of litigation relied upon the theory of strict liability: (a) that the cigarettes failed the risk-utility test; (b) that warnings were inadequate; and (c) even with adequate warnings, the product was so dangerous that it should not have been put on the market. Despite the new claims, juries preferred to place the blame for smoking-related illnesses squarely on the smokers themselves.

By the end of the 1980s, despite overwhelming evidence that smoking caused a vast number of diseases and premature deaths, the tobacco industry's litigation record was still intact. One award was made against the Liggett group in favour of a dead woman's husband, but was later overturned on a technicality, and abandoned by the plaintiff.⁶

In 1990, a Mississippi Court ruled that smoking *was* the cause of Nathan Horton's death, but did not award damages, saying that Horton shared culpability with American Tobacco because he chose to smoke. This 'contributory negligence' principle, and the connected rule of 'voluntary assumption of risk', are the second line of defence for the tobacco industry in suits brought by smokers, along with the problem of proving causation already discussed.

A spate of lawsuits had been brought in several other countries as well, including England, Ireland, Finland and Australia. One Helsinki University professor of anatomy, Ismo Virtanen, who supported under oath the industry's claim that medical science has not proved that tobacco causes disease (and was well paid for his efforts), was later indicted for criminal perjury. Nonetheless, no tort action succeeded in those countries against the manufacturers.

There has only been one completed personal injury action against Canadian tobacco manufacturers.⁷ The case was dismissed on the basis that the limitation period had expired. A new class action has been launched in Ontario, and British Columbia has recently passed a statute to facilitate suits against the industry, and has itself launched an action under it; at least one B.C. class action is being prepared by Vancouver counsel as this opinion is being written. Ontario has announced that it intends to pursue legal action against the tobacco industry in the

⁵ 1965 U.S. *Federal Cigarette Labeling and Advertising Act*.

⁶ *Cipollone v Liggett Group* 501 U.S. 504 (1992).

⁷ *Perron v R.J.R. MacDonald* (October 7, 1996, B.C.C.A.).

US courts, using the powerful RICO law there, although technical and procedural bars may restrict Canadian provinces' rights to seek relief in America.

Massive changes occurred in the 1990s, when revelations of previously secret tobacco industry documents⁸ have led to more creative lawsuits based on the industry's campaign of deception. As of this writing, five individual smokers' suits have so far been successful at trial, and have led to damage awards. Three were reversed on review by higher courts, and the other two, large jury awards made in 1999 in California⁹ and Oregon¹⁰, await appeal.

Also very recently, two class action suits have been successfully brought to trial. On July 7th, 1999, a Florida Jury found the tobacco industry liable for damages that could run into the hundreds of billions of dollars¹¹. However, damages have yet to be assessed, and the class could still be decertified on appeal. Earlier, stewardesses had settled out of court for around \$349 million (US), for damages caused by environmental tobacco smoke in aircraft¹². As a result of this nascent wave of trial successes, many commentators believe that the tide has turned in personal injury suits against the tobacco industry in favour of the plaintiffs.

Certainly the most successful anti-tobacco litigation yet launched has been the so called 'third wave' lawsuits filed by various states for, among other things, the recovery of health care benefits paid to smokers. This litigation, which spread to encompass nearly every state in the US, eventually resulted in a handful of individual settlements before the final, global \$206 billion dollar (US) settlement was announced last year. As noted, B.C. has launched a similar suit in its own courts, and Ontario is seeking to pursue one before an American judge. Because the litigation in these state lawsuits is not based on personal injury principles, it is not relevant to the discussion here.

Care must be taken when applying the reasoning applied in any of the cases against the tobacco industry, as the relationship between smoker (or non-smoker) and cigarette manufacturer is distinct from that between a physician and a patient. Because it is the latter relationship with which we are concerned here, the history referred to in this section is useful only in that provides some contextual background for this opinion. It is instructive to note that, to date, there have been no cases against physicians with respect to patients'

⁸ The documents have come to light through whistle-blowers and through the states' lawsuits filed since 1994.

⁹ *Henley v Philip Morris Inc., et al.* (February 9, 1999) Sup Ct of CA, SF Case No. 995172.

¹⁰ *Joann Williams-Branch v. Philip Morris, Inc.*, (March 30, 1999) No. 9705-03957, (Circuit Court for the County of Multnomah (Portland)).

¹¹ *Engle et al. v. R.J. Reynolds Tobacco Company, et al.* (July 7, 1999) No. 94-08273 CA-22 (Florida: 11th Judicial District).

¹² This case, brought by stewardess Norma Broin as representative plaintiff, is discussed in the companion opinion on Environmental Tobacco Smoke (ETS), hereinafter referred to as the "companion opinion".

smoking. To understand why this is so it is necessary to review the requirements of the law of negligence.

III The Basic Principles of Negligence: A Physician's Duty and Standard of Care

Cases involving a failure to diagnose, or a failure to advise of medical risks, can be assessed under three legal 'causes of action': breach of contract, negligence, and breach of fiduciary duty. Practically speaking, however, a physician's duties in contract are the same as his or her duty of care in negligence law. While the argument could be made that a physician also owes a fiduciary duty, particularly to minor patients, such a duty would be largely superseded child-protection statutes. At any rate, Canadian courts have lately expressed a clear preference to view cases of physician malpractice as incidents of alleged negligence¹³. This opinion will therefore be generally confined to that perspective.

It is trite law to say that a physician owes a duty of care to a patient. That duty arises upon the formation of the doctor-patient relationship and has many facets: the duty to exercise care in attending upon the patient; in diagnosing, advising and treating the patient; in making referrals; and in obtaining informed consent. If a patient alleges negligence on the part of the physician, the patient will be required to prove that:

- a. at the material time the physician owed a duty of care to the patient,
- b. the physician breached the duty of care by failing to maintain the requisite standard of care owed to the patient, and
- c. the patient suffered an injury or loss which was both factually and reasonably foreseeably caused by the acts or omissions of the physician.

(a) Duty of Care

i. Reasonable Foreseeability

A physician's duty of care will be said to exist only where the event giving rise to the harm suffered by the patient was a reasonably foreseeable consequence of such acts or omissions. For example, where the injuries of a patient are the result of a reckless impulse on the part of the

¹³ Per MacLachlan J. in *Arndt v. Smith*, [1997] 2 S.C.R. 539 at para. 38, rejecting an application of fiduciary law:

...I would reject the alternative approach of fiduciary obligation proposed by the respondent... I see no reason to depart from the approach which considers the failure of a physician to advise of medical risks under the law of negligence relating to duty of care, absent special circumstances like fraudulent misrepresentation or abuse of power for an unprofessional end: see *Reibel v. Hughes*, *supra*; *Norberg v. Wynrib*...

patient which could not reasonably have been foreseen, the attending physician will not be said to have owed a duty of care to prevent the injury.¹⁴

ii. Duty to Diagnose

A physician owes a duty to exercise reasonable care, skill and judgment with respect to all medical care and treatment of patients. When a court is assessing the extent of this duty, a physician will only be held to the standard of a reasonable physician of like training, qualifications and experience. In making a diagnosis, a physician must exercise reasonable care, skill, and judgment.¹⁵ The physician must, if possible, take a complete history of the patient,¹⁶ conduct a proper examination,¹⁷ order any necessary tests,¹⁸ and consult with or make a referral to colleagues where appropriate.¹⁹ Where sufficient information is not obtained from the patient, an examination is cursory or incomplete, or necessary diagnostic tests are not performed, the physician is likely to be held liable in negligence for a faulty diagnosis. The duty to exercise reasonable care in diagnosis means that practitioners cannot rely only on what they are told by patients, but must make any reasonable inquiries.

iii. Continuing Duty

In a number of cases in the United States, courts have held that doctors may have a continuing duty to disclose risks to patients and former patients. For example, in the California case of *Tresemmer v. Barke*,²⁰ a doctor was held liable for failing to recall a former patient to advise her of newly discovered dangers associated with the use of an I.U.D. which he had inserted for her. Many U.S. courts have since imposed liability in similar or analogous circumstances.

In the recent *Hollis v. Dow Corning Corp.*²¹ case, the Supreme Court of Canada drew a close parallel between the manufacturer's duty to warn and the doctrine of informed consent in the medical context. This decision makes it feasible for courts to conclude that a physician's

¹⁴ See *University Hospital Board v. Lepine* (1966), 57 W.W.R. 5 (S.C.C.).

¹⁵ *Reibel v. Hughes* (1980), 114 D.L.R. (3d) 1 (S.C.C.); *Laferrriere v. Lawson* (1991), 78 D.L.R. (4th) 609 (S.C.C.).

¹⁶ "It is a doctor's duty to take a careful and thorough history, but that need not always amount to a cross-examination": *Lankenau v. Dutton* (1986), 37 C.C.L.T. 213 (B.C.S.C.) aff'd (1991), 7 C.C.L.T. (2d) 42 (B.C.C.A.), leave to appeal to S.C.C. refused [1991] 6 W.W.R. lxvii (note) (S.C.C.).

¹⁷ See, for example, *Law Estate v. Simice* (1994), 21 C.C.L.T. (2d) 228 (B.C.S.C.) aff'd [1996] 4 W.W.R. 672 (B.C.C.A.).

¹⁸ See, for example, *Trainor v. Knickle*, [1996] P.E.I.J. No. 55 (QL) (S.C.).

¹⁹ *Joshi (Guardian ad litem of) v. Woolley* (1995), 4 B.C.L.R. (3d) 208 (S.C.).

²⁰ 86 Cal. App. 3d 656 (1978).

²¹ (1995), 129 D.L.R. (4th) 609 (S.C.C.).

duty of disclosure to patients is a continuing one. The concept of a continuing duty could perhaps be extended to include a duty to disclose new findings with respect to the harmful effects of smoking and/or various cessation methods. Certainly, it is now well established that the duty of disclosure is not confined to risks, but extends to other material information which a reasonable patient would want to have. In particular, in a treatment context, the patient must be informed of any available alternatives to the treatment being proposed, as well as the material risks associated with those alternatives.²² The duty to disclose available alternatives²³ is especially important where these are more conservative, and involve fewer risks, than the treatment which is being proposed.²⁴

In some Ontario cases the scope of this duty has been interpreted quite narrowly. For example, in *Bonnell v. Moddel*,²⁵ Justice Griffiths was of the view that the duty to disclose alternatives should be limited to cases where in the opinion of the doctor the alternative procedures offer some advantage and are reasonably likely to achieve a beneficial result. A similar view was expressed by the trial judge in *Bucknam v. Kostiuk*,²⁶ and has been adopted in a number of recent Ontario cases.²⁷

Even where the patient succeeds in proving that the physician was negligent in failing to disclose the material risks of a treatment, in many cases the claim is dismissed for lack of causation: the patient is unable to prove that a reasonable person in his or her position would have declined the treatment if properly informed of the risks. However, where the physician's negligence lies in failing to disclose the existence of alternative procedures or treatment, especially if these alternatives involve fewer risks to the patient, the decided cases indicate that the patient is much more likely to succeed in establishing causation.²⁸

²² *Archibald v. Kuntz*, [1994] B.C.J. No. 199 (QL) (S.C.).

²³ Whether the doctor must also inform the patient of the alternatives which are *not* available, because of cost containment policies, is discussed in E. Picard & G. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3d (Toronto: Carswell, 1996) at section 4(a)(ii).

²⁴ Even before the Supreme Court's decision in *Reibel v. Hughes*, (1980), 114 D.L.R. (3d) 1 (S.C.C.), there was case law supporting the view that if a procedure can be done under both general or local anaesthetic, the anaesthetist has a duty to inform the patient of this so as to give the patient the opportunity of deciding which method to follow: *Gorback v. Ting*, [1974] 5 W.W.R. 606 (Man. Q.B.); *Kangas v. Parker*, [1976] 5 W.W.R. 25 (Sask. Q.B.), aff'd [1978] 5 W.W.R. 667 (C.A.).

²⁵ [1987] O.J. No. 97 (QL) (H.C.).

²⁶ (1983), 44 O.R. (2d) 102 (H.C.). In affirming the trial judgment the Court of Appeal offered no view on this issue - [1986], 55 O.R. (2d) 187 (C.A.).

²⁷ *Ferron v. Yadav*, [1990] O.J. No. 473 (QL) (H.C.); *Goluch v. Kucey*, [1991] O.J. No. 1725 (QL) (H.C.); *Trottier v. O'Neil*, [1993] O.J. No. 1553 (QL) (Gen. Div). See also *Kowalchuk v. Adduri* (1995), 104 Man. R. (2d) 37 at 66 (Q.B.), affirmed (1997) 123 Man. R. (2d) 148.

²⁸ E. Picard & G. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3d (Toronto: Carswell, 1996) at 130.

iv. Duty to Third Parties

There are two, quite distinct, situations in which the physician's duty to warn can be said to extend to third parties. The first broad category of a physician's duty to third parties concerns advising third parties directly at risk such as may be required, for example, where a seropositive patient refuses to inform his or her sexual partners of the risk of infection with HIV.²⁹ The second general category relates to a physician's duty to warn the *patient* of the possible effects of his or her behaviour on third parties.

Because these duties to third parties relate more closely to the issue of environmental tobacco smoke ("ETS") exposure, they are discussed more fully in our accompanying opinion on that question. However, the same principles are not without relevance when discussing cessation counselling. Should a doctor not counsel a patient to quit, and should a third party be harmed by the continued smoking, these principles in theory could operate to grant an avenue of relief to the injured third party. Under the current law respecting proof of causation, however, a successful lawsuit would be unlikely.

v. Duty to Children

An issue closely tied to a physician's standard of care when treating a child is the determination of legal capacity. In the legal literature, a minor's capacity is typically discussed in the context of consent or refusal of treatment. Whether a child is deemed to have legal capacity will in turn influence the physician's duty to inform and consult the child's parents.

Some provinces have a statutory age of consent to medical treatment. In British Columbia,³⁰ a minor³¹ may give an effective consent to health care if the health care provider is satisfied that (1) the minor understands the nature and consequences and the reasonably foreseeable benefits and risks of the treatment, and (2) the treatment is in the minor's best interests.³² Despite some uncertainty in the past Canadian law is now fairly clear. Regardless of age, a child is capable of consenting (or refusing consent) if he or she is able to appreciate the nature and purpose of the treatment and the consequences of giving or refusing consent.³³ If

²⁹ See, for example, *Pittman Estate v. Bain* (1994), 112 D.L.R. (4th) 257 (Ont. Gen. Div.).

³⁰ *Infants Act*, R.S.B.C. 1979, c. 196, s. 16 [re-en. 1992, c. 77, s. 2]. In *Ney v. Canada (Attorney General)*, [1993] 6 W.W.R. 135 at 144 (B.C.S.C.), this section was held to codify the common law, and its constitutional validity was upheld.

³¹ The age of majority in British Columbia is 19: *Age of Majority Act*, R.S.B.C. 1979, c. 5, s. 1.

³² The effectiveness of the consent is dependent only on the health care provider concluding (presumably on reasonable grounds) that these two conditions are satisfied, regardless of whether they are in fact satisfied: see *Ney v. Canada (Attorney General)*, *supra*, note 4 at 142. In this respect the legislation affords greater protection from liability than does the common law. Note also the comments of the Court in *Ney* (at 142-143) as to the factors which are relevant in determining whether proposed health care is in the infant's "best interests".

the child has this capacity, the child's consent is both necessary and sufficient; the parents' consent is not required, nor can they override the child's decision.

It is evident from the case law that the test of capacity is a highly functional one, and its application will vary from child to child and from procedure to procedure. For example, a 12-year-old may have capacity to consent to relatively minor medical procedures but not to more complex ones.³⁴ Likewise, one 12-year-old may have capacity to consent while another may not, depending on their respective levels of maturity and understanding. The assessment is a subjective one. The doctor (and ultimately, if necessary, the court) must decide whether *this* particular child is capable of consenting to *this* particular procedure, having regard to the age, maturity and understanding of the child and the nature and complexity of the procedure.

It follows that when counselling a child who smokes, careful attention must be paid to his or her capacity. The same principles which govern capacity to consent or refuse consent would also apply to the capacity to waive³⁵. A discussion of the physician's duty with respect to the treatment of younger children who smoke is beyond the scope of this paper, and will be very fact-sensitive. Mature adolescents who have a wide capacity with respect to medical treatment will be treated in the same way as adults for the purposes of this opinion.

vi. Expectant Mothers

Although in Canadian law, an unborn child is not a legal 'person', upon birth a child may accrue rights retroactively, as it were, from the prenatal period³⁶. Subject to the common law bar against suing its mother, which we will discuss in this section, a child may sue a person whose negligence or other tortious conduct caused him or her damage while in the womb.

As the Supreme Court of Canada noted in the *D.F.G.* case (which determined that the state had no right to intervene to protect an unborn child from the harm of the mother's glue-sniffing addiction), the courts of other common law jurisdictions have restricted the child's right to sue his or her mother for prenatal injuries to cases involving motor vehicle

³³ G. Sharpe, *The Law and Medicine in Canada*, 2d ed. (Toronto: Butterworths, 1987) at 69.

³⁴ See, for example, *Re A. (a child)*, [1993] F.L.C. 92-402 (Aust. Fam. Ct.), in which the Court's authorization was sought for a sex reassignment from female to male for a 14-year-old child. The Court held that although the child understood the nature of the medical problem and the proposed solution, he did not have sufficient capacity and maturity to fully appreciate all aspects of the matter and to be able to assess objectively the various options available to him, and thus he could not give a valid consent.

³⁵ See discussion on waiver, s. III(d)i below.

³⁶ *Winnipeg Child and Family Services (Northwest Area) v. D.F.G.* [1997] 3 S.C.R. 925 (S.C.C.) at paras. 7 to 15.

accidents³⁷. The Supreme Court of Canada was not willing to go even that far, declaring that a general bar exists protecting mothers from lawsuits by their children for pre-natal injuries³⁸, whether incurred as a result of negligent driving or pre-natal smoking and drinking.

The extent to which this bar may operate to protect *physicians* is difficult to ascertain. Certainly, the extension of liability from accidents to ‘lifestyle choices’ is one that the courts have been unwilling to take. Hoyt J.A. in *Dobson* raised the

...spectre of mothers being sued by their children for various activities or lifestyle choices, such as smoking, drinking and the taking or refusal of medication, during pregnancy that injure the child, with the result that mothers will be unable to control their own bodies and make autonomous choices.³⁹

The Supreme Court of Canada concurred:

There is no authority in Canada, England or Australia for the proposition that a mother can be sued for negligent behaviour relating to lifestyle choices made during pregnancy. To recognize a duty of care in such situations would constitute yet another marked extension of the common law which would affect a large segment of society. It follows that the Court must approach the issue with great caution⁴⁰.

In *Dobson*, the caution of the Court was manifest:

Is [a pregnant woman] to be liable in tort for failing to regulate her diet to provide the best nutrients for the foetus? Is she to be required to abstain from smoking and all alcoholic beverages? Should she be found liable for failing to abstain from strenuous exercise or unprotected sexual activity to protect her foetus? Must she undertake frequent safety checks of her premises in order to avoid falling and causing injury to the foetus? There is no rational and principled limit to the types of claims which may be brought if such a tortious duty of care were imposed upon pregnant women.⁴¹

Yet it is questionable whether the same caution is necessary as a matter of policy with respect to physicians’ liability for failing to adequately treat the mother. While courts may be loathe to

³⁷ *Dobson (Litigation Guardian of) v. Dobson* (1997), 148 D.L.R. (4th) 332 (N.B.C.A.); *Lynch v. Lynch* (1991), 25 N.S.W.L.R. 411 (C.A.). The Supreme Court of Canada’s judgment in *Dobson* was released on July 9, 1999 (see *infra*).

³⁸ *Dobson (Guardian ad litem of) v. Dobson* (July 9, 1999) File No.: 26152 (S.C.C.).

³⁹ *Dobson*, (N.B.C.A.) *supra* at p. 336.

⁴⁰ *D.F.G.*, *supra* at para. 34.

⁴¹ *Dobson* (S.C.C.) *supra* at para. 28.

hold mothers responsible for pre-natal injuries, they have shown no such reluctance with third parties. This was first determined in Canada in a civil law context in *Montreal Tramways v. Léveillé*⁴², where Lamont, J. said:

To the Company's contention that an unborn child being merely a part of its mother had no separate existence and, therefore, could not maintain an action under article 1053 C.C., the answer, in my opinion, is that, although the child was not actually born at the time the Company by its fault created the conditions which brought about the deformity of its feet, yet, under the civil law, it is deemed to be so if for its advantage. Therefore when it was subsequently born alive and viable it was clothed with all the rights of action which it would have had if actually in existence at the date of the accident. The wrongful act of the Company produced its damage on the birth of the child and the right of action was then complete.

However, the full impact of *Dobson* on cases of physicians' negligence is impossible to predict with anything approaching certainty. It may be argued that, because the Supreme Court has determined that an expectant mother has no legal duty toward her unborn child, the physician should be held 100% liable for harm caused by both mother and physician, under existing rules of joint and several liability. Conversely, a physician might argue on public policy grounds that to disallow contribution from a mother who also played a role in causing the harm (as when, for instance, the physician failed to properly counsel but the mother ignored other warnings about pre-natal smoking) is manifestly unfair, and should act as a bar to the child's action.

In practice, though, such a case would be rare indeed. The mother's role is still relevant to the issue of causation; the child must not only prove that his or her injuries were caused by maternal smoking, but also that, on the balance of probabilities, counselling by the physician would likely have caused the mother to quit. Short of modifications to the rules respecting causation (discussed later) this hurdle will be a high one indeed.

Regardless of how these legal questions are eventually answered, nothing in this section, or indeed the *Dobson* case, affects the standards expected of the physician. It remains true that the most effective way to avoid an award of damages is to practice consistently in accordance with the appropriate standard of care, and it is that issue to which we now turn.

(b) The Standard of Care

Once the patient has established that a duty of care existed, the patient must prove that there was a breach of that duty: that the required standard of care was not met by the practitioner. Most of the jurisprudence discusses the standard of care owed by physicians to their patients in the context of treatment; however, the standard is just as high when physicians perform an examination or reach a diagnosis. How is the required standard of care defined?

⁴² [1933] S.C.R. 456 at p. 463-65.

Generally, a physician is expected to act in the same way as a reasonable physician with comparable training would act in the same circumstances; that is, the physician must meet the standard of care of a “reasonably competent practitioner”.⁴³ Accordingly, primary care physicians will be required in law to meet the standard of care of a reasonably competent general practitioner as of the date of examination or treatment. Expert evidence of the standard must be adduced before the court unless the alleged error is so obvious that a lay person can determine that the practice or conduct was negligent without the necessity of resorting to expert evidence. Failure to meet the standard may result in a court finding against the physician for professional negligence.

i. Duty to keep abreast of current scientific knowledge

The requisite standard of care owed by a physician to a patient necessarily relates to a specific point in time. In particular, the standard of care evolves with the development of knowledge in the scientific community and in the profession. Physicians must respond to changing circumstances and keep up with new developments since the standard of care is determined with reference to knowledge the health practitioner *ought reasonably to have had* at the material time, namely, at the time when the alleged negligence occurred.⁴⁴

For example, in *ter Neuzen v. Korn* (“*ter Neuzen*”),⁴⁵ a recent case before the Supreme Court of Canada, this principle was applied in the context of artificial insemination procedure. The patient in *ter Neuzen* participated in the defendant physician’s artificial insemination program for a period of four years at a time when such participation was not considered to put anyone at risk of contracting the human immunodeficiency virus (“HIV”). Accordingly, the patient received no warnings from the attending physician about the risk of HIV infection. Although the patient was later found to have been infected by HIV during the course of the program, her negligence claim was dismissed by the Court since the physician complied with the standard procedure at the pertinent time and could not reasonably have been expected either to have discontinued the program or to have warned her of the risk.

It should be noted, however, that in some circumstances the fact that the health professional met the requisite standard of care will not provide protection from a negligence claim. This will be the case where the court finds that the standard practice itself is negligent in that it fails to adopt “obvious and reasonable precautions which are readily apparent to the ordinary [person]”.⁴⁶ Therefore, to reach any conclusions with respect to a physician’s standard of care as it relates to smoking cessation counselling, it would be necessary to determine both the current state of

⁴³ *Wilson v. Swanson*, [1956] S.C.R. 804. See also *Crits v. Sylvester* (1956), 1 D.L.R. (2d) 502, affirmed [1956] S.C.R. 991.

⁴⁴ See W.C.J. Meredith, *Malpractice Liability of Doctors and Hospitals* (Toronto: Carswell, 1956); E.I. Picard & G.B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3rd ed. (Toronto: Carswell, 1996).

⁴⁵ [1995] 3 S.C.R. 674.

⁴⁶ See *Girard v. General Hospital of Port Arthur*, June 27, 1997, File No. 2332/91.

knowledge of the scientific and medical communities and the state of knowledge of the average person.

(c) Injury and Causation

It is not sufficient that the patient or third party establish that a duty of care existed and that the standard of care was not met by the physician. For a negligence action to be successful, the injured party must also prove that he or she suffered an injury which was caused by the practitioner's acts or omissions. This requirement is two-fold: the practitioner's conduct must have caused the injury on a balance of probabilities, and the injury must be sufficiently proximate to the breach of duty.

i. Factual Causation

Recent decisions of the Supreme Court of Canada have settled the issue of proof of causation of patient injuries arising from a physician's negligence, although the mechanics of application of these principles in individual cases may still be somewhat controversial. In *Snell v. Farrell*, the Court rejected the notion that a Plaintiff must prove with scientific certainty that negligence caused the plaintiff's injuries. The Court upheld the traditional tort law test that a plaintiff must still prove causation of injuries according to the civil standard of a balance of probabilities⁴⁷. The Court also held that in certain circumstances, the evidence may justify an inference of causation where it is apparent that the negligence may have materially contributed to the development of an injury. In *Lawson v. LaFerriere*⁴⁸, the Supreme Court of Canada stated that there is no compensation for injuries based upon loss of a chance, i.e., where it is only possible that an injury flowed from the negligence or where, absent the negligence, there was a chance that the risk of injury may have been averted.⁴⁹

In *Rothwell v. Ray*⁵⁰, the Ontario Court of Appeal provided clarification of the plaintiff's burden in proving causation, especially where there may be controversy underlying the issue of scientific

⁴⁷ Recent medical negligence decisions have applied the "robust and pragmatic" approach to causation adopted by the Supreme Court in *Snell v. Farrell* (1990), 72 D.L.R. (4th) 289. See *Dann (Litigation Guardian of) v. Chiavaro* (30 May 1996), Docket No. 2854/88, [1996] O.J. No. 1912 (Q.L.) (Gen. Div.); *Joyal v. Starreveld* (1996), 37 Alta. L.R. (3d) 19 (Q.B.); *Briffett v. Gander & District Hospital Board* (1992), 326 A.P.R. 271 (Nfld. T.D.) aff'd (1996), 428 A.P.R. 271 (C.A.).

⁴⁸ [1991] 1 S.C.R. 541.

⁴⁹ The 'loss of chance' analysis eventually rejected in *Lawson* was a Franco-Belgian idea employed in Quebec because of its similar civil law system. The reasoning employed by the Supreme Court confirmed that the rules of causation are the same in Quebec as in common law jurisdictions. The court held that, if the 'loss of chance' produced *real damage* (i.e., if a cancer patient lost his chance at a cure via misdiagnosis and suffered mentally as a result), then the *damage* (i.e. the mental distress) could be compensated for. Conversely, if all that was lost was a 'chance', the court was in no position to 'pro-rate' an award based on that lost chance, unless the chance rose to the level of likelihood on the balance of probabilities.

⁵⁰ (1990) 76 D.L.R. (4th) 280.

causation, as is the case with many smoking-related diseases. In that case, the Court held that the plaintiff must meet both a general and specific test of causation. In the former, there must be evidence proving on a balance of probability that the event flowing from the alleged negligence *can* cause the injury complained of. Only if this onus is met, does the Court go on to consider the second test of whether the negligence alleged *did* cause the injury complained of in the particular case.

However, in a recent decision of the Newfoundland Court of Appeal⁵¹ the Court held that negligence may be found “if the evidence adduced is such that, in the absence of evidence to the contrary, a reasonable inference can be made that the tortious acts of the defendant substantially contributed to the injury”.⁵²

Nonetheless, a patient who seeks to sue a physician for not providing smoking cessation counselling, and who demonstrates that the physician has not met the expected standard of care, will further have to demonstrate on the balance of probabilities that, had the advice been given, he or she would have quit, and further still that, following the cessation, the disease or damage would not have occurred. These remain very substantial factual hurdles.

ii. Proximity

The requirement of proximity is based on the general principle of negligence law that a defendant is only liable for those injuries which were a reasonably foreseeable result of the defendant’s acts or omissions. “Reasonably foreseeable” injuries in this context have been defined as including those consequences which would occur to the mind of any reasonable physician, which he or she would not brush aside as far-fetched.⁵³

iii. Speculative Injuries

Courts are increasingly being asked to deal with “speculative” injuries, where exposure to toxic substances such as those in tobacco smoke has created the *possibility* of some future disease such as cancer. Compensation for such injuries that cannot be proved at the time of trial has been provided on the basis of increased risk of cancer, fear of cancer and future disease risk coupled with some present harm.

On the present state of tort law in Canada, plaintiffs must prove on a balance of probabilities that the physician’s negligence *did* cause some injury to the plaintiff. In the absence of such proof, a

⁵¹ *Taylor v. Hogan* (1994), 370 A.P.R. 37 appeal allowed with respect to amount of damages [1998] N.J. No. 14.

⁵² *Ibid.* at 50. The Supreme Court of Canada has held that, where damage has both tortious and non-tortious causes, the tortfeasor is liable for all the damage that results; the amount cannot be reduced by the percentage contributed by non-tortious activity: *Athey v. Leonati* [1996] 3 S.C.R. 458.

⁵³ See, for example, *Zamparo v. Brisson*, (1981) 120 D.L.R. (3d) 545 (Ont. C.A.); *Leonard v. Knott*, [1980] 1 W.W.R. 673 (B.C.C.A.).

claim based entirely upon speculation or chance will fail⁵⁴. Where, however, a plaintiff establishes that a physician's negligence has caused some injury, a Court may award damages on the basis of future events or complications, the occurrence of which does not meet the threshold test of probability, where such future events are a reasonable or substantial possibility. Canadian courts have not, however, gone as far as their American counterparts in awarding compensation on the basis of a possibility of future occurrence.

Some American courts have provided compensation for increased risk of cancer upon proof of a reasonable medical certainty that the disease will result,⁵⁵ while others have implied a willingness to award damages for future risk of cancer based on a showing of a greater than 50 percent probability of developing the disease.⁵⁶ Other American courts appear more willing to award damages, at least against manufacturers, for a present fear of future cancer developing than for the risk of developing such a disease. Under this head of damages, a plaintiff may be required to show that: (a) there is a serious fear of cancer; (b) the fear was caused by exposure to some substance for which the defendant is responsible; and (c) the fear of contracting cancer because of such exposure is reasonable (i.e. there is a scientifically valid basis to conclude that the risk is substantial).⁵⁷ Finally, some courts have validated an approach closely akin to a traditional emotional distress analysis, holding that when a plaintiff can demonstrate some existing harm from a defendant's actions, damages for increased risk of cancer are available. For example, in the asbestos realm, it has been held that a plaintiff could recover for future risks that "reasonably are to be expected to follow, so far as human knowledge can foretell".⁵⁸

(d) Contributory Negligence

Where more than one party is at fault for the patient's injuries, the doctrine of contributory negligence applies. Legislation in each province and territory permits the court to determine the degree of responsibility of each party for the injury.⁵⁹ In the context of medical treatment, patients have certain responsibilities including a duty to provide information,⁶⁰ to follow

⁵⁴ See *Lawson v. Laferrriere*, supra.

⁵⁵ See, for example, *Sterling v. Velsicol Chemical Corp.*, 855 F.2d 1188, 1204 (6th Cir. 1988).

⁵⁶ R.L. Eshelman, "Speculative Damages and Toxic Torts: Good Intentions Make Bad Law" (1999) 41(5) *For the Defense* 17 at 21, discussing *Hagerty v. L&L Marine Services, Inc.*, 788 F.2d 315 (5th Cir. 1986).

⁵⁷ See *Deleski v. Roymark Industries, Inc.*, 819 F.2d 377 (3d Cir. 1987); see also *Adams v. Johns-Manville Sales Corp.*, 783 F.2d 589 (5th Cir. 1986).

⁵⁸ See *Anderson v. W.R. Grace & Co.*, 628 F.Supp. 1219 (D.Mass. 1986). We are not aware of any cases in which this principle has been extended to physicians' negligence.

⁵⁹ See, for example, *Negligence Act*, R.S.O. 1990, c. N.1.

⁶⁰ See *Leadbetter v. Brand* (1980), 37 N.S.R. (2d) 581 (T.D.). Duty in this sense is not used as the source for an independent tort (i.e. a physician can't sue a patient because the patient fails to meet the duty), but rather as the source for a finding of contributory negligence. This 'duty', in other words, is owed by the patient to him- or herself.

instructions,⁶¹ and generally to act in their own best interests.⁶² In their interactions with physicians they are expected to meet the standard of care of a reasonable patient. If they do not, and the breach of this standard is the factual and proximate cause of their injuries, they are contributorily negligent.

This is to say that the competent adult patient remains autonomous, and generally preserves the right to exercise his or her will even to the point of self-harm. A physician could not be held liable simply because the patient rejected the advice given so long as the patient's choice is a reasonably informed one. The physician need not ensure that the patient's choice is rational or reasonable.

i. Effect of a waiver

The ability of patients to waive their right to information was acknowledged by Chief Justice Laskin in *Reibl v. Hughes*,⁶³ where he stated that

It is, of course, possible that a particular patient may waive aside any question of risks and be quite prepared to submit to the surgery or treatment, whatever they be. Such a situation presents no difficulty.⁶⁴

However, a waiver must be initiated by the patient and should be acceptable only where the patient is truly declining an explanation. There must be evidence of an express waiver in circumstances where, from the patient's perspective, the doctor was willing to provide an explanation. An express waiver may absolve the physician of further intervention (either in the form of warnings in an 'informed consent' case, or by extension in the 'treatment refusal' of a smoker).

It follows that a physician should not force cessation method information on a smoking patient where he or she expressly waives the right to receive any such information. However, where a patient does waive the right to be informed, the physician's documentation of the discussion may be very important, as it may be years before a claim arises. If patients, having been appropriately advised, refuse treatment, then they may be found wholly responsible for their own condition or contributorily negligent, depending on the circumstances.

⁶¹ See *Crossman v. Stewart* (1977), 5 C.C.L.T. 45 (B.C.S.C.).

⁶² *Moore v. Large* (1932), 46 B.C.R. 179 at 183 (C.A.).

⁶³ (1980), 114 D.L.R. (3d) 1 (S.C.C.).

⁶⁴ *Ibid.* at 13. See also *Pittman Estate v. Bain* (1994), 112 D.L.R. (4th) 257, additional reasons at (1994), 112 D.L.R. (4th) 482, further additional reasons at (1994), 112 D.L.R. (4th) 494, further additional reasons at (1994), 35 C.P.C. (3d) 67 (Ont. Gen. Div.).

IV Legal Characterization of the Smoker/Physician Relationship

(a) The Effect of Public Knowledge on the Duty to Disclose

An important factor in the determination of a duty to disclose is the extent to which the information to be disclosed is known to the general public. It has been suggested that although the general population is aware of many of the risks of smoking, the severity and frequency of occurrence of smoking-related diseases fails to be fully appreciated.

Setting aside the issue of whether members of the public can be taken to know of the dangers inherent in smoking, it is less likely that a court would find that smokers had an adequate degree of knowledge with respect to available cessation methods and their rates of success.

(b) The Effect of Addiction on the Duty to Disclose

Smokers are generally addicted to nicotine. This addiction is not in itself necessarily harmful; it is of course the method that the addict uses to satisfy the addiction, i.e. burning tobacco (usually) in cigarettes, that causes the harm. So while addiction to nicotine is recognized as a disease, the necessity for treatment arises from the fact that, if left untreated, nicotine addiction will frequently lead to subsequent diseases that may prove very harmful and are frequently fatal.

The harms of smoking have been widely noted in the scientific literature since 1954, and at least since the 1960s a general consensus has arisen among physicians that smoking causes lung and heart disease. It is generally accepted today that smoking is the leading cause of preventable premature mortality and morbidity in North America, and kills tens of thousands of Canadians each year.

It is not the purpose of this opinion to catalogue the diseases which have either been proven to be caused by smoking or are strongly linked with it. The unambiguous threat presented by smoking is such that the requirement that smoking cessation advice be offered by physicians exists independent of whether or not a patient is suffering from or showing signs of smoking-related illness.

There are some unique characteristics of tobacco addiction that must be considered when determining the standard of care. Because tobacco use is increasingly unpopular, and may even be considered to reflect poorly on one's character, patients may under-report their smoking. There is now evidence emerging to suggest that parents may under-report the degree to which they are exposing their children to smoke, and that a high percentage of pregnant women who tell

their doctors that they have quit smoking have in fact not.⁶⁵ Even among pregnant women who quit smoking, the majority restart after giving birth⁶⁶. These factors complicate the physician-patient relationship, and indicate that the physician's vigilance when dealing with 'ever-smokers' (ie those who either smoke or have in the past), should be ongoing.

(c) Duty to Disclose Risks and to Counsel on Cessation Methods

We have not found a case in any common law jurisdiction relating directly to a physician's duty of care with respect to disclosure of the risks of continued smoking nor cases relating to a physician's duty to discuss various cessation methods. Therefore, we must argue by analogy from related litigation.

i. Analogy: Informed Refusal

In the California case of *Truman v. Thomas*,⁶⁷ a 30 year old woman died of cervical cancer. For 6 years her family physician had recommended that she undergo a pap smear test, but she had continually postponed doing so. The physician did not explain to her the risks of ignoring this recommendation. The California Supreme Court held that the physician had a duty to explain these risks, and was negligent in failing to do so. The Court stated that a physician must provide all material information which a reasonable person in the patient's position would regard as significant, including the risks of forgoing the recommended treatment. This case illustrates a situation where, although the decision ultimately rested with the patient, the physician had a duty to fully explain the consequences of failing to undergo the treatment. It also provides some indication about the effect of "general public knowledge" on a physician's duty to disclose.

Although there have, from time to time, been suggestions that the doctrine of informed refusal does not exist in Canadian law,⁶⁸ the principle that a doctor is under a duty to inform the patient of the risks of declining treatment is, in fact, well established. For example, in *Reibl v. Hughes*,⁶⁹ Chief Justice Laskin stated that what "is under consideration here is the patient's right to know what risks are involved in undergoing *or foregoing* certain surgery or treatment" [emphasis added]. Likewise, in its recent decision in *Hollis v. Dow Corning*

⁶⁵ Prof. Judith Lumley, from La Trobe University's Centre for Mothers and Children's Health, reported to a conference of the Australian Medical Association that urine tests reveal that up to 49 percent of women who said they had stopped smoking during pregnancy lied: Sarah Dent, "Butt out for babies", *Herald Sun* 05/25/99.

⁶⁶ B.L. Frankowski et al. "Advising Parents to Stop Smoking: Pediatricians and Parents' Attitudes" 91 *Pediatrics* 296 (February, 1993).

⁶⁷ 165 Cal. Rptr. 308 (1980).

⁶⁸ See, for example, *Malette v. Shulman* (1990), 67 D.L.R. (4th) 321 (Ont. C.A.).

⁶⁹ *Reibl v. Hughes*, (1980), 114 D.L.R. (3d) 1 (S.C.C.) at 13.

Corp.,⁷⁰ the Supreme Court of Canada noted that the doctrine of informed consent “dictates that every individual has a right to know what risks are involved in undergoing or *foregoing* medical treatment and a concomitant right to make meaningful decisions based on a full understanding of those risks” [emphasis added].⁷¹

ii. *Analogy: Alcohol and Drug Addiction Cases*

An examination of the law as it relates to a physician’s duty of care where the patient is addicted to drugs or alcohol will provide useful analogies from which to predict the movement of jurisprudence with respect to patients addicted to smoking.

In addition, drug and alcohol cases will provide insight into the duty of disclosure as it relates to pregnant women. For example, in the case of *Winnipeg Child and Family Services (Northwest Area) v. D.F.G.*,⁷² the Supreme Court of Canada discussed the rights of the mother versus those of the unborn foetus in the context of a pregnant woman addicted to glue sniffing. Cases addressing issues surrounding Fetal Alcohol Syndrome or “FAS” will also be of use. Do the same principles and considerations apply when the addiction is to smoking? Is a physician required to fully inform a pregnant woman of all material risks to the baby caused by “passive” smoking?

V Smoking Cessation

(a) The Benefits of Cessation

The benefits of smoking cessation are well established, and were first comprehensively summarized in the 1990 *Surgeon General’s Report*. That report found that, for instance, “persons who quit smoking before age 50 have one-half the risk of dying in the next 15 years compared to continuing smokers”⁷³. The report goes on to say that:

⁷⁰ *Hollis v. Dow Corning Corp.*, [1995] 4 S.C.R. 634 at para. 24.

⁷¹ See also *Davisdon v. British Columbia*, [1996] 1 W.W.R. 137 (B.C.S.C.), in which the plaintiff sued two ambulance attendants, alleging that they were negligent in failing to inform him of the risks involved in his refusal to be taken to hospital following a fall and head injury. The Court dismissed the claim, holding that the ambulance attendants were not negligent having regard to all the circumstances, and in particular, the fact that (1) the attendants did inform the plaintiff that it would be advisable for him to go to hospital and be examined by a doctor, (2) the risk of choosing not to do so must have been apparent to the plaintiff, and (3) the ambulance attendants were not doctors and thus were not qualified to offer advice as to the specific risks of not seeking immediate medical attention.

⁷² [1997] 3 S.C.R. 925, [1997] S.C.J. No. 96.

⁷³ U.S. Dept. of Health and Human Services, *The Health Benefits of Smoking Cessation: a report of the Surgeon General* (Rockville, MD: CDC, 1990) at p. v.

Many smokers who have already developed smoking-related disease or symptoms may be less motivated to quit because of a belief that the damage is already done. For the same reason, physicians may be less motivated to advise these patients to quit. However, the evidence reviewed in the Report shows that smoking cessation yields important health benefits to those who already suffer from smoking-related illnesses.

So, it appears that both healthy and symptomatic patients benefit significantly from smoking cessation.

From a legal point of view, smoking cessation can be viewed as a treatment with a very high success rate. Legally this will bear on issues of causation, as it would have to be argued on the facts of each case whether, had the physician's advice been given and acted upon, the patient would still have suffered the tobacco-related harm for which relief was sought.

(b) Smoking Cessation Aids

i. *Physicians' Cessation Counselling*

There is little doubt that physicians' counselling plays an important role in the decision of smokers to quit. Studies indicating that a doctor's advice increases patient cessation rates has been widely available since the late 1980s⁷⁴, and were summarized in a 1990 *Surgeon General's Report*⁷⁵.

The Surgeon General also noted that the frequency of smoking cessation counselling from physicians had increased several-fold between 1964 and 1987⁷⁶. Nonetheless, many physicians report that they are "unprepared for, and unsuccessful in, treating patients addicted to nicotine"⁷⁷; Several authorities have cited lack of physician confidence as a major hurdle in the anti-smoking battle; others report that they do not have the time to provide an adequate cessation program.

⁷⁴TJ Glynn, MW Manley, TF Pechacek, "Physician-initiated smoking cessation program: The National Cancer Institute Trials" in Engstrom et al. (eds) *Advances in Cancer Control: Screening and Prevention Research*. (New York, Wiley-Liss, Inc., 1990), pp. 11-25; TE Kottke, RN Battista, GH Defries GH, ML Brekke "Attributes of successful smoking cessation interventions in medical practice. A meta-analysis of 39 controlled trials" *JAMA* 25:2882-2889, May 20, 1988; JL Schwartz, *Review and Evaluation of Smoking Cessation Methods: United States and Canada, 1978-1985* U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, NIH Publication No. 87-2940, April 1987.

⁷⁵US Department of Health and Human Services *The Health Benefits of Smoking Cessation: A report of the Surgeon General, 1990* (Rockville, MD: CDC, 1990).

⁷⁶ *Supra* at p. 609.

⁷⁷ MC Fiore, RP Epps and MW Manly, "A missed opportunity: teaching medical students to help their patients successfully quit smoking" (Column) *JAMA* 271:624 (February 23, 1994).

The end result, as summarized by the US Centers for Disease Control, is that only half the smokers who see a doctor have ever been urged to quit⁷⁸.

There is also evidence that even somewhat perfunctory counselling by physicians may assist patients in quitting⁷⁹. In a meta-analysis of 56 studies on the topic, cessation rates of 10.7% were found for those receiving less than 3 minutes of counselling, 12.1% for those receiving between 3 and 10 minutes, and 18.7% for those receiving over 10 minutes⁸⁰.

ii. Quit Smoking Programs and Groups

It has been widely acknowledged that group or individual counselling sessions are an effective aid to cessation. It is not difficult for a physician to become familiar with the programs and groups offered in his or her area⁸¹.

Aversive smoking, which involves multiple sessions in which a client smokes intensively to the point of discomfort, was judged effective by the AHCPR/CDC panel, providing it was accompanied by sufficient screening and medical supervision. The effectiveness of other methods including hypnosis, acupuncture and antidepressant drugs was not sufficiently supported in the literature reviewed at that time.

iii. Nicotine Replacement Therapy

Because smoking is used principally as a method of nicotine delivery, one method of cessation therapy has naturally been to replace the nicotine without necessitating smoking. This is most frequently done by the nicotine patch or nicotine gum, both of which were once prescribed but are now available without a prescription. Other delivery methods such as nasal sprays have proven to be effective, but are still available by prescription only.

It has been demonstrated that nicotine replacement therapy, particularly through the use of the nicotine patch, has proven successful when assisting patients to quit. However, it is important to note that studies indicate that any cessation program is aided by physician counselling.

⁷⁸ US Department of Health and Human Services, "Physician and other health-care professional counseling of smokers to quit – United States 1991" *MMWR* 42(44):854-857.

⁷⁹ "Effectiveness in disease and injury prevention, public health focus: effectiveness of smoking control strategies - United States" (Periodical Report) *Cancer Weekly* Sept 14, 1992.

⁸⁰ MC Fiore, DW Wetter, WC Bailey et al. *Smoking Cessation Clinical Practice Guideline* (Rockville, MD., Agency for Health Service, US Dept of Health and Human Services, 1996). Also published in *JAMA* 1996; 275(16):1270-1280.

⁸¹ See for instance the National Clearinghouse on Tobacco and Health: *Smoking Cessation Programs: An Inventory of Self-Help and Group Programs.*, Minister of Supply and Services, Canada, 1994 (Catalogue No. H39-296-1994).

The medical community has embraced nicotine replacement therapy. The Ontario Medical Association recommends NRT even for pregnant patients and even though such an application is in violation of Health Canada regulations. The *Toronto Star* recently quoted Dr. Ted Boadway of the OMA as suggesting that “Many of these recommendations are considered radical.... [but] [n]icotine replacement therapy is incredibly safe”⁸².

iv. *Bupropion hydrochloride (Zyban)*

Zyban was developed as an antidepressant, and is now prescribed in lower doses as a smoking cessation aid. The effectiveness of *Zyban* as an aid to smoking cessation was demonstrated in two placebo-controlled, double-blind studies. In one study, *Zyban* was compared to placebo; in the second study, *Zyban* was evaluated versus placebo, a nicotine patch (*Habitrol*), and in combination with the patch. In both studies, all patients received brief individual smoking cessation counselling.

In the study involving the patch, patients treated with *Zyban* had significantly higher 4-week quit rates than those treated with the patch. Patients treated with the combination of *Zyban* and the patch had significantly higher quit rates than those treated with the patch alone. Quit rates with combination therapy, while higher, were not statistically significantly higher than quit rates with *Zyban* alone. The 4-week quit rates from this second study were 23% for placebo; 36% for the patch; 49% for *Zyban* and 58% for *Zyban* and the patch⁸³.

(c) A Brief Survey of Published Guidelines

Some of the major health care agencies and associations recommending routine tobacco use cessation counselling include the American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, the American Cancer Society, the American College of Obstetricians and Gynecologists, the American Heart of Association, the American Lung Association, the National Cancer Institute, the American Medical Association, the American Dental Association, the National Institutes of Health, the U.S. Preventive Services Task Force, the Canadian Council on Smoking and Health (now the Canadian Council on Tobacco Control), the Canadian Task Force on the Periodic Health Examination (now the Canadian Task Force on the Preventive Health Care), and the Agency for Health Care Policy and Research.

A comprehensive review of cessation counselling was undertaken in the mid-1990s by the US Centers for Disease Control (CDC) and the Agency for Health Care Policy and Research (AHCPR), who convened an expert panel of 19 physicians and health education professions to review the scientific literature and develop guidelines for physician administered cessation

⁸² *Toronto Star*, July 1, 1999.

⁸³ Source: Glaxo-Wellcome, Inc.

programs that were effective. The results were then peer reviewed by 71 experts from various disciplines, and the guidelines were published⁸⁴.

The panel found that the effectiveness of cessation interventions were directly related to their intensity and duration, with four to seven counselling sessions deemed to be most effective. The guidelines for primary care physicians included the following recommendations⁸⁵:

1. Every person who smokes should be offered smoking cessation treatment at every office visit.
2. Clinicians should ask about and record the tobacco-use status of every patient.
3. Cessation treatment even as brief as 3 minutes a visit is effective.
4. The more intense the treatment, the more effective it is in producing long-term abstinence from tobacco.
5. Nicotine replacement therapy (nicotine patches or gum), social support, and skills training are effective components of smoking cessation treatment.
6. Health care systems should be modified to routinely identify and intervene with all tobacco users at every visit.

The American College of Preventive Medicine has recently published the following guidelines⁸⁶:

Clinicians should provide tobacco use cessation counseling at every clinical encounter. The counseling should be personal, medically oriented, clear, and strong. Nonsmokers may be encouraged to remain abstinent. Patients who use tobacco products may be identified through office and medical record systems, such as including smoking status as part of the vital signs. Or using a stamp on the front of the patient record identifying the patient as a smoker. Tobacco users may be counseled on the health effects of tobacco use, and may receive personal advice and encouragement to quit at every visit.

Recommendations regarding NRT may be offered. Specific recommendations include:

- (1) Tobacco usage history should be obtained at all patient visits.
- (2) Nonsmokers, especially children and adolescents, should be encouraged not to start.
- (3) Office and medical record systems to identify patients who use tobacco should be employed.
- (4) Physicians and other office staff should advise all tobacco users to quit.
- (5) Physicians and other office staff should identify and assist smokers who are willing to quit.

⁸⁴ Fiore et al., *supra*.

⁸⁵ *Helping Smokers Quit: A Guide for Primary Care Clinicians*. Clinical Practice Guideline, Number 18. AHCPR Publication No. 96-0693, April 1996. Agency for Health Care Policy and Research, Rockville, MD. <http://www.ahcpr.gov/clinic/smokepcc.htm>

⁸⁶ VJ Kattapong et al., "Tobacco-Cessation patient counseling: American College of Preventive Medicine practice policy statement" *Am J Prev Med* 1998 Aug;15(2):160-2

- (6) Physicians and other office staff should provide motivational interventions for smokers who are not willing to quit.

The Institute for Clinical Systems Integration has published a guideline for its members which includes a diagnostic chart as a suggested guideline for cessation intervention⁸⁷; it heavily emphasizes the need for consistent and repeated intervention when treating smokers or indeed former smokers.

Canadian medical organizations have not individually been as outspoken as their US counterparts when it comes to instructing physicians on cessation counselling; rather, they have co-operated to endorse a uniform cessation program.

In October of 1991, the Canadian Consensus on Physician Intervention in Smoking and Health, held under the auspices of the Canadian Council on Smoking and Health (now the Canadian Council on Tobacco Control), identified concerns that led to the advent of the *Guide Your Patients to a Smoke Free Future* (SFF) program. This program was developed based on three basic steps for counselling, called the "Three A's of Smoking Intervention" (ask, advise and assist). The program is now available to physicians across Canada. Current figures show that over 9,000 Canadian physicians have been trained to date in the program⁸⁸.

SFF is a program of the Canadian Council on Smoking and Health that is endorsed by the College of Family Physicians of Canada, the Canadian Medical Association, the Heart and Stroke Foundation of Canada, and The Lung Association, and is recommended by the Canadian Cancer Society.

Similarly, the Canadian Task Force on Preventive Health Care developed guidelines in 1994 after reviewing the relevant studies on the effectiveness of the (then available) cessation therapies. Their conclusions stressed the support for physician cessation counselling:

[Recommendation grade [**A, B, C, D, E**] and level of evidence [I, II-1, II-2, II-3, III] are indicated after each recommendation. Citations in support of individual recommendations are identified in the guideline text⁸⁹.]

- There is good evidence to support smoking cessation counselling by physicians for all patients who smoke [**A, I**]. Nicotine replacement therapy may be offered as an adjunct [**A, I**].

⁸⁷ LI Solberg et al. "Tobacco use prevention and cessation for adults and mature adolescents" (ICSI 1998) www.icsi.org. ICSI provides guidelines for its member clinics in the United States; we have not reproduced the chart here out of respect for copyright; it may be ordered from the ICSI website.

⁸⁸ *Guide Your Patients to a Smoke-Free Future*, Canadian Council for Tobacco Control (CCTC): www.cctc.ca/sff/index.htm.

⁸⁹ For instance, A, I is the highest recommendation with the strongest supporting evidence. For a complete explanation of the grading of recommendations and evidence, see www.ctfphc.org/ctfphc&methods.htm.

- There is fair evidence to support referral to validated smoking cessation programs after cessation counselling [**B**, I].
- There is fair evidence to support counselling of children and adolescents to prevent smoking initiation [**B**, I, III].
- There is insufficient evidence to evaluate counselling to reduce exposure to ETS [C, I, II-3], but it may be helpful to include during cessation counselling.⁹⁰

VI. Summary and Legal opinion

In our opinion, Canadian courts would likely find that a physician who does not routinely counsel smoking patients on cessation is not meeting the requisite standard of care. Whether such a finding would result in a successful claim for damages would depend on whether the individual plaintiff could overcome the significant causation hurdles discussed earlier in this opinion.

Based on the scientific literature reviewed, physicians ought to be aware that:

- Tobacco use poses a risk, and perhaps the most serious risk, to a smoking patient's health.
- Exposure to environmental tobacco smoke (ETS) may cause a wide range of ailments in adults and particularly in children (see companion opinion on ETS).
- Smoking cessation advice from physicians is both generally welcome and frequently effective.
- Smoking cessation aids such as nicotine replacement therapy and Zyban substantially increase the patient's chances of successfully quitting.

Although a precise 'threshold date' at which physicians ought to first have been aware of the above matters is impossible to ascertain without the benefit of the first legal decisions on topic, it is safe to say that at least since 1990 physicians may reasonably be expected to be aware of the literature linking smoking cessation with physicians' advice and cessation aids. Since at least 1993⁹¹, physicians may reasonably have been expected to be aware of the literature linking ETS with disease in non-smokers.

⁹⁰ Taylor MC and Dingle JL. "Prevention of tobacco-caused disease" In: Canadian Task Force on the Periodic Health Examination. *Canadian Guide to Clinical Preventive Health Care*. Ottawa: Health Canada, 1994; 500-11.

⁹¹ We believe that the 'threshold date' for certain diseases may be deemed as early as the mid-1980s. See the discussion in Part IV, and also the survey of medical literature in Appendix A, of our accompanying opinion on ETS.

Physicians have an ongoing responsibility to keep up with current scientific and medical opinion regarding the harms of smoking and cessation techniques, and to incorporate such knowledge in their diagnosis and treatment of patients as the area develops.

In our opinion, from our review of the case law and medical literature, a court is likely to conclude that in order to meet the current standard of care:

- Physicians should routinely take smoking histories from all patients.
- Physicians should inquire of ‘ever-smokers’, at nearly every visit, the current status of their smoking or cessation.
- Physicians should counsel smoking cessation at every visit of a smoker, unless explicitly told not to do so by the patient.
- Physicians should inform all smoking patients of current cessation aids including nicotine replacement therapy and *Zyban*.
- Physicians should inform parents about the health hazards of passive smoking. If the physician believes that others may be in danger from ETS exposure (particularly children), the physician should take the steps outlined in the companion opinion.
- Physicians should inform expecting parents of the dangers to the child and counsel cessation in the pre-natal period.

As with any patient intervention, it is recommended that physicians document smoking-related advice and cessation counselling given to patients, and in particular, any waiver by the patient of such counselling.