Malette v. *Shulman*: The Requiremeut of Conseut iu Medical Emergencies

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1. Introduction

Intuition is a useful guide in law, and we should be suspicious of judgements which defy it. *Malette* v. *Shulman*[1] is one such judgement. In awarding $20,000 against the defendant for, in effect, saving the life of the plaintiff, the decision is open to serious objections.

2. The Facts

On June 30, 1979, the defendant, Dr. Shulman, a general practitioner, was on duty as the Kirkland Lake and District Hospital emergency officer when the plaintiff, Mrs. Malette, was brought into the emergency room. She was unconscious and in critical condition as a result of a motor vehicle accident that had already claimed the life of her husband. "The plaintiff presented to Dr. Shulman in a very dramatic manner with large quantities of blood visible including a trail on the floor from ambulance to emergency room as well as on walls, stretcher and nurses' uniforms."[2] The patient was in or entering shock and was semi-conscious and incoherent. "Her nose appeared to be completely severed. Her face, which was flattened and balloon shaped with eyes swollen closed and mouth distorted open, was detached from the skull....the plaintiff was vomiting blood."[3] Medical experts concluded that "on the generally accepted trauma chart injury severity scale the plaintiff's case was assigned a value of 29 which categorized the plaintiff in a 50% mortality rate with full appropriate treatment."[4] That afternoon

*I would like to thank Professor Gordon Bale of Queen's University for comments and criticism of an earlier draft. Responsibility for the views expressed in this paper remains, of course, my own.

[1](1987), 63 O.R. (2d) 243, 43 C.C.L.T. 62 (H.C.) [hereinafter *Malette* cited to O.R.].

[2]*Ibid.* at 245.

[3]*Ibid.*

[4]*Ibid.* at 257.

and into the small hours of the next morning Dr. Shulman demonstrated exemplary professional skill in saving the life of the plaintiff. This according to the expert witnesses relied on by the judge at trial, who "unreservedly supported every aspect of Dr. Shulman's treatment procedure" and commended him for having done "a great deal in a short time."[5]

This case is legally noteworthy because Mrs. Malette was a Jehovah's Witness, and because she carried with her a card expressly ruling out blood transfusions under any circumstances. Dr. Shulman became aware of this card before giving her any blood transfusions. However, Mrs. Malette's condition continued to deteriorate even after treatment with non-blood alternatives. When Dr. Shulman decided it was clear that blood transfusions were necessary to save Mrs. Malette's life, he went ahead and gave them,[6] feeling that he could not rely on the authority of such a card in a life and death situation. At trial, Donnelly J. of the Ontario Supreme Court, sitting without a jury, awarded damages of $20,000 against Dr. Shulman for battery, having decided that Dr. Shulman was wrong in doubting that the card continued to represent Mrs. Malette's true wishes.

We must be surprised that a doctor could be found liable for saving a life, and before we rationalize the award too quickly on the basis of lack of consent, we should note that the behavior of Dr. Shulman bears none of the arrogance that we associate with medical battery. Donnelly J. notes that "Dr. Shulman was not...seeking an excuse to circumvent the card and, through medical arrogance, to usurp the decision-making process in favour of his superior rights. There was no intransigent, defiant, refusal to accept instructions in order to force treatment. Nor was there an intentional violation of, nor a gesture of contempt for, the plaintiff's religious beliefs."[7] Rather, there was "an honest attempt to deal with a complex medical, legal and ethical problem."[8] This case is morally distinguishable from the usual medical battery cases, and we should expect it to be legally distinguishable as well.

3. Negligence, Malice, Religious Discriminatiou & Conspiracy

The most important and contentious issue in this case is the finding of battery on which the damages were based. However, the plaintiff sued for negligence, conspiracy and battery against Dr. Shulman, the hopsital, the hospital's executive director and the nurses involved. All the allegations

[5]*Ibid.* at 264.

[6]Dr. Shulman "hung" the blood himself, by order of the hospital administrators, who wished to insulate themselves from responsibility for this decision.

[7]*Supra*, note 1 at 273.

[8]*Ibid.*

except that of battery against Dr. Shulman were found to be groundless and I will not review their disposal.

4. Battery: Damages

The first and most obvious objection to the decision concerns the award of damages. Donnelly J. finds punitive damages to be inappropriate, and indeed he declines to award costs to the successful plaintiff. The award of $20,000 was based on general damages founded on mental distress. However, the plaintiff continues to be "recognized and accepted in her religious community as being without fault. Nor does she regard her eternal salvation as being compromised."[9] There is no evidence of any physical manifestation of such distress, simply the plaintiff's evidence that she feels "very, very dirty."[10] This judgement therefore, directly challenges the general rule that claims for mental distress must be predicated on physical manifestations of mental harm, or on conduct which is outrageous.[11] Neither is the case here, and no reasons were advanced for not conforming to the general rule.

It might be said that the award could be justified on the basis of an affront to the plaintiff's dignitary interest, as would be the case, for instance, if a woman were abused while under anaesthetic.[12] However, whether a dignitary interest or an expanded notion of mental distress serves as the basis for damages, it is fundamental in assessing damages that the damage flow from the alleged tortious act. In awarding damages, one cannot compare Mrs. Malette's present mental state to what it would have been had there been no accident. That would be appropriate in assessing damages against whoever caused the accident. Rather, for our purposes, one must compare her present mental state to what it would have been had Dr. Shulman not given her blood. While Mrs. Malette may feel sullied and distressed, had the action complained of not been committed, she would not be alive and unsullied, but most probably, dead and unsullied.[13] Life itself, as well as

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[9]*Ibid.*

[10]*Ibid.*

[11]See J.G. Fleming, *The Law of Torts*, 7th ed. (Sydney: Law Book, 1987) at 32.

[12]*Ibid.* at 23.

[13]Appropriate treatment was found to include administration of blood transfusions. Thus, if the plaintiff had a fifty per cent chance of living with full appropriate treatment, she would presumably have had even a lesser chance of surviving without blood transfusions. Certainly Dr. Shulman, found to be a competent doctor, believed she would have died without blood. It would be conceivable to base the award on the chance that Mrs. Malette would have lived without treatment, but evidence would then be required to determine what that chance was, and to show that it was not negligible. Moreover, the amount awarded would have had to have been reduced in proportion to the probability that Mrs. Malette would have died without the transfusion. As no such evidence was discussed by Donnelly J. in awarding damages, and as no calculations were made, it is evident that he did not base his award on this argument.

mental distress, resulted from the doctor's actions, which clearly make this situation distinct from that of battery perpetrated against an anaesthetized victim. The difficulty of justifying damages in such a situation is illustrated by analogy with "wrongful life" cases that have come before American courts. There, it has been noted that "whether it is better never to have been born at all than to have been born even with gross deficiencies is a mystery more properly to be left to the philosophers and theologans. Surely the law can assert no competence to resolve the issue, particularly in view of the uniformly high value which the law and mankind has placed on human life, rather than its absence."[14] It is implausible that either mental discomfort or dignitary interests are to be given greater weight than gross physical deficiencies. Less abstractly, one commentator noted: "[i]f plaintiff prevails, the result is a formal judicial declaration that it would have been better if plaintiff had not been born."[15] Here, the result is a formal judicial decision that Mrs. Malette is $20,000 dollars worse off than if she were dead. Surely this is an absurd result.[16]

That the damages awarded were excessive seems clear.[17] There is also, however, a strong argument that Dr. Shulman should not have been found liable at all.

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[14]*Becker* v. *Schwartz*, 46 N.Y. 2d 401 at 411, 413 N.Y.S. 2d 895 at 900, 386 N.E. 2d 807 at 812 (1978), quoted in *Siemieniec* v. *Lutheran General Hospital*, 117 Ill. 2d 230, 512 N.E. 2d 691 at 698 (1987).

[15]P.J. Kelley, "Wrongful life, Wrongful Birth, and Justice in Tort Law" (1979) 4 Wash. U.L.Q. 919 at 942.

[16]There have been wrongful life cases in which damage awards have been made, even though such awards depart from general principles of tort law. This is widely recognized, indeed sometimes explicitly acknowledged, even at the time that damages are awarded. See, *e.g.*, *Procanik* v. *Cillo*, 97 N.J. 339, 478 A. 2d 755 (1984), in which the majority, responding to the dissenting comment of Schreiber J. that the court is not justified in "discarding" the usual principles of awarding damages (478 A. 2d at 773), says that "we seek only to respond to the call of the living for help in bearing the burden of their affliction" (478 A. 2d at 763). While such sympathy may sometimes justify departure from usual principles — but see *Siemeniec*, 512 N.E. 2d at 700-701 for critical comment — the analogy with Mrs. Malette's situation is not perfect, and it is incongrous to apply such a humanitarian plea to compensate for "damages" which would not even be actionable in most contexts.

[17]This is strengthened by the fact that Donnelly J seemed to consider the participation of Mrs. Malette's daughter as decisive in dismissing "speculative frailties" as to the validity of the card. On her arrival at the hospital (after transfusions had already been started), the daughter confirmed the card as recent, and insisted that her mother not be given any more blood. In fact, the daughter's participation only confirms what we have accepted, that Mrs. Malette publicly announced her determination to refuse blood. It does not shed any more light on the question of what she would have done when actually faced with the prospect of death. If the daughter's confirmation of the card was a decisive factor, then the award of any but nominal damages becomes completely untenable. The "refusal" would have been valid only after blood had already been given, and Dr. Shulman would have been liable only for the damage caused by giving additional blood. This damage must be minimal.

5. Presence of Consent

At first glance, this case would seem to turn on whether "the card" actually constituted a valid refusal to undergo a blood transfusion, subject, as it was, to the following objections presented by the defendant: (1) that it might not represent the plaintiff's current intent (the card was signed but not dated), (2) that it might not have been intended to apply in life threatening circumstances, or (3) that it might have been signed as the result of religious peer pressure. On the facts, Donnelly J. found that "there is no basis in evidence to indicate that the card may not represent the current intention and instruction of the card holder," and that "Dr. Shulman's doubt about the validity of the card, although honest, was not rationally founded on the evidence before him."[18] However, in *In re Estate of Dorone*,[19] a case with facts analagous to those in *Malette*, the Supreme Court of Pennsylvania decided that "nothing less than a fully conscious contemporaneous decision by *the patient* will be sufficient to override evidence of medical necessity",[20] citing the same objections to relying on the card as were raised by the defendant.

If we accept Donnelly J.'s finding, the Pennsylvania decision seems overly broad, allowing a doctor to proceed in a situation in which there is no rational doubt as to the patient's wishes. I will argue that the result in *Dorone* is preferable because Donnelly J. failed to draw an important distinction — between a rational doubt and a reasonable one. I will also argue that the requirement for valid consent given in *Dorone* is indeed overly broad, as it might allow, and even require, that a doctor proceed when there is no *reasonable* doubt as to the patient's wishes. In the balance of this paper, I will examine the principles in issue, and attempt to clarify the requirements for consent in emergency situations.

6. "Informed Refnsal"

I will first consider the novel argument forwarded by the defendant, that the concept of informed consent should be extended to a right of "informed refusal". It was argued that Dr. Shulman was obliged in law to advise the patient of the risks attendant upon refusing treatment, and to satisfy himself that such refusal was based on a clear understanding of those risks, before considering the refusal valid.

This argument is conceptually seductive since it attacks the always blurred line between acts of commission and omission. However, as Don-

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[18]*Supra*, note 1 at 268.

[19]*In re Estate of Dorone*, 502 A. 2d 1271 (1985), *aff'd* 534 A. 2d 452 (1987).

[20]534 A. 2d at 455 (original emphasis).

nelly J. points out, refusal cannot be so easily assimilated into consent, if only because a doctor is not open to liability for a refusal by the patient to accept treatment. No doctor could be successfully sued for not having been able to convince his patient of the advisability of a given procedure; conversely, in a normal consulting-room situation, no doctor could be justified in operating in the face of a patient's refusal, merely because the doctor felt, for one reason or another, that the patient had not properly understood the procedure. "[The] right to refuse treatment is not premised on an understanding of the risks involved," said Donnelly J., but rather it is "an inherent component of the supremacy of the patient's right over his own body."[21] In other words, our society has not yet accepted the level of paternalism required to support a doctrine of informed refusal, which would allow a doctor to proceed in the face of an express refusal of consent by the patient.

The judgement of the Supreme Court in *Reibl* v. *Hughes*,[22] the leading case on informed consent, may help clarify the flaw in this analogy. *Reibl* established that liability for battery turned on whether there was consent (except where there was deceit as to the nature of the act), and not on whether consent was "informed". If the consent is found not to have been informed, then the physician may be liable in negligence, but not in battery. As with consent, so with refusal; in other words, liability for battery must turn on whether there was a refusal, not on whether it was informed. "Informed refusal" could plausibly be invoked only in a negligence action, in which, for instance, a patient refused the most effective treatment because of a doctor's inadequate explanation of the options.

7. Consent in Emergencies

The argument as it developed, concentrating on the validity of the card and on the concept of "informed refusal", almost completely missed an essential feature of the case. It was an emergency situation. Donnelly J.'s decision is based on the proposition that "the treating doctor avoids liability for battery only with a valid consent".[23] This is not the case: emergencies are an exception, and until we have thoroughly explored the implications of this exception, even the question of the validity of the card is of secondary importance.

Donnelly J. himself quotes many sources to the effect that consent is not required in emergencies. For instance, in Ontario, *The Public Hospitals Act* provides that "where the surgeon believes that delay caused by obtaining the consent would endanger the life or a limb or vital organ of the patient

[21] *Supra*, note 1 at 272.
[22] [1980] 2 S.C.R. 880, 114 D.L.R. (3d) 2 [hereinafter *Reibl* cited to S.C.R.].
[23] *Supra*, note 1 at 272.

or out-patient, as the case may be...no consent is necessary...."[24] He also cites *Parmley* v. *Parmley and Yule*[25] in which Mr. Justice Estey of the Supreme Court of Canada stated: "[t]here are times under circumstances of emergency when both doctors and dentists must exercise their professional skill and ability without the consent which is required in the ordinary case." Generally, the authorities do not say that the consent is implied, but that it is simply not necessary. The clearest statement of this comes in the case of *Marshall* v. *Curry*,[26] in which Chief Justice Chisholm of the Nova Scotia Supreme Court stated: "I think it better, instead of resorting to a fiction, to put consent altogether out of the case, where a great emergency which could not be anticipated arises, and to rule that it is the surgeon's duty to act in order to save the life or preserve the health of the patient; and that in the honest execution of that duty he should not be exposed to legal liability."[27]

Even those cases dealing not with emergency situations, but with informed consent in non-emergency situations, recognize this limitation. Although the oft-quoted words of Cardozo J. in *Schloendorff* v. *Society of New York Hospital*,[28] that "every human being of adult years and sound mind has a right to determine what shall be done with his own body...",[29] are the definitive statement of principle on which the consent doctrine is based, the statement is qualified as not appropriate "in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained."[30] In *Hopp* v. *Lepp*,[31] used by Donnelly J. as authority for the proposition that "the treating doctor avoids liability for battery only with a valid consent",[32] "any question of emergency or mental incompetency...is expressly left aside."[33] As well, in *Reibl*, Laskin C.J.C. held that "actions of battery in respect of surgical or other medical treatment should be confined to cases where...there has been no consent at all or where, *emergency situations aside*, surgery or treatment has been performed or given beyond that to which there was consent".[34]

We see, then, that the doctrine that consent is not required in emergency situations is coeval with the doctrine of consent itself, and is acknowledged

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[24]R.S.O. 1980, c. 410, s. 50(d).

[25][1945] S.C.R. 635 at 646, [1945] 4 D.L.R. 81 at 89, quoted in *Malette, supra*, note 1 at 269.

[26]60 C.C.C. 136, [1933] 3 D.L.R. 260 (N.S.S.C.) [hereinafter *Marshall* cited to D.L.R.].

[27]*Ibid.* at 275, quoted in *Malette, supra*, note 1 at 269.

[28]211 N.Y. 125, 105 N.E. 92 (1914).

[29]105 N.E. at 93.

[30]*Ibid.*

[31][1980] 2 S.C.R. 192, 112 D.L.R. (3d) 67 [hereinafter *Hopp* cited to S.C.R.].

[32]*Supra*, note 1 at 272.

[33]*Supra*, note 31 at 196.

[34]*Supra*, note 22 at 890-91 (emphasis added).

as such regularly. The present case presents an apparent conflict between established principles, and we should not prefer one principle over another without due consideration of the reasons behind them.

The most obvious explanation why consent is not required in emergency situations is that consent is impossible to obtain. In other words, the issue of emergency only arises if consent is absent. Moreover, if we have consent — or refusal — the existence of an emergency is irrelevant. Many judgements implicitly or explicitly adopt this rationale for the emergency doctrine, and this is undoubtedly the approach taken by Mr. Justice Donnelly. After citing the above passages from *Marshall* and *Parmley* v. *Parmley*, he dismisses them by saying: "[a] special standard exists in emergency situations predicated on the impossibility of obtaining valid consent because of [the] grave condition and the urgent necessity for treatment to protect life and health."[35] However, the caselaw does not explicitly hold that this is the *only* reason, and to accept impossibility as the only reason blindly prejudges the case — and wrongly so if we can find independent reasons for not requiring consent in emergencies. It is true that this doctrine arose in cases where it was not possible to obtain consent. But this is a good reason for thinking that the reasons, as enunciated in those cases, may not be complete, since with one obvious reason before the courts, there was no need to look for further justification. To do justice in novel situations, however, we should not discard good reasons underlying principles of common law, merely because a particular reason had not occurred to the judge who first enunciated the principle.

8. The Reasonable Person

To discover other reasons for not requiring consent in emergencies, we may ask ourselves how was it that Dr. Shulman, certainly a competent doctor, and presumably not markedly irrational, could come to a conclusion which was judged "not rationally founded". Donnelly J. provides us with an answer. He says: "Dr. Shulman was confronted by profound imponderables with no time for reflection. There was no established precedent upon which to rely. The subject-matter in issue was controversial, emotional and related to life and death decisions."[36] The fact that this was a life and death emergency was adverted to in the *post facto* court-room analysis, but it seems to have received little consideration. Perhaps Dr. Shulman's opinion as to the validity of the card was not rationally founded on the evidence, but in the circumstances, could we expect it to be? Even if a reasonable person would retrospectively have concluded that Mrs. Malette would not

[35] *Supra*, note 1 at 270.
[36] *Ibid.* at 275.

have wanted blood, can we believe that most reasonable people would have come to that conclusion at that time, when faced with this "dilemma of dreadful finality"?[37]

We may compare the reasonableness of Dr. Shulman's legal judgement in this situation with that of judges in similar circumstances. Apart from the case of *Dorone*, at least sixteen[38] American cases have been reported which deal not with an undated card, but with conscious and immediate refusal by patients (only two of whom were found not to have been fully competent) to accept blood. In eleven of these cases, the justices who made the life or death decision ruled that transfusions be given despite the patients' wishes. Some of these cases may be plausibly distinguished because the patient was pregnant, or the mother of a dependant child, or possibly *non compos mentis*. Nonetheless, the judgements in emergency cases, where the judge had to make a decision at the patient's bedside, are revealing as to their true motivations: "The final, and compelling, reason for granting the emergency writ was that a life hung in the balance";[39] "Therefore, this Court... 'determined to act on the side of life' in the pending emergency.";[40] "since death would likely follow unless a transfusion was authorized...";[41] "I could not let her die!"[42] It seems likely that the so-called distinguishing factors are not so much reasons as excuses for choosing life over death in emergency situations.

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[37]*Ibid.* at 267.

[38](1) Cases involving parents. (i) Application for order to allow transfusion granted in first instance: *Application of President and Board of Directors of Georgetown College*, 331 F. 2d 1000 (1964), *rehearing en banc denied*, 331 F. 2d 1010 (1964), *cert. den.*, 377 U.S. 978 (patient possibly *non compos mentis*); *Hamilton* v. *McAuliffe*, 353 A. 2d 634 (1976); *Powell* v. *Columbian Presbyterian Medical Centre*, 49 Misc. 2d 215, 267 N.Y.S. 2d 450 (1964); *Crouse Irving Memorial Hosp.* v. *Paddock*, 127 Misc. 2d 101, 485 N.Y.S. 2d 443 (1985); *Mercy Hosp. Inc.* v. *Jackson*, 510 A. 2d 562 (1986); *Wons* v. *Public Health Trust of Dade County*, 500 So. 2d 679 (1987) (order granted in first instance, reversed on appeal, despite the fact that transfusion had already been made). (ii) Application to allow transfusion denied in first instance, reversed on appeal: *Raleigh Fitkin-Paul Memorial Hosp.* v. *Anderson*, 201 A. 2d 537 (1964), *cert. den.* 377 U.S. 985.(2) Cases not involving parents. (i) Order to allow transfusion denied in first instance: *In re Osborne*, 294 A. 2d 372 (1972); *Erickson* v. *Dilgard*, 44 Misc. 2d 27, 252 N.Y.S. 2d 705 (1962); *In re Melideo*, 88 Misc. 2d 974, 390 N.Y.S. 2d 523 (1976); *St. Mary's Hosp.* v. *Ramsey*, 465 So. 2d 666 (1985). (ii) Order to allow transfusion allowed in first instance, reversed on appeal: *In Brooks' Estate*, 32 Ill. 2d 361, 205 N.E. 2d 435 (1965); *In re Brown*, 478 So. 2d 1033 (1985); *Homes* v. *Silver Cross Memorial Hosp.*, 340 F.S. 125 (1972) (motion to dismiss complaint for having ordered transfusion denied). (iii) Order granted in first instance: *U.S.* v. *George*, 239 F.S. 752 (1965); *John F. Kennedy Mem. Hosp.* v. *Heston*, 42 N.J. 421, 279 A. 2d 670 (1971) (patient may not have expressed conscious refusal of blood, but decision is clear that, in the circumstances, the order would have been made even if she had).

[39]*Application of Georgetown College*, 331 F. 2d at 1010.

[40]*U.S.* v. *George*, 239 F.S. at 754.

[41]*Hamilton*, 353 A. 2d at 635.

[42]*Powell*, 267 N.Y.S. 2d at 452.

While a number of cases affirm the right of a competent patient to refuse blood, two cases stand for the opposite proposition.[43] And as we are not searching for authority, what is perhaps more instructive is that, at first instance, the decisions were five to four in favour of allowing the transfusion — even for patients without dependent children. Perhaps the only lesson we can draw is that it is very difficult to make a life and death decision when the results will be felt within hours. Only in the clearest of circumstances, with time for reflection, will a judge decline to allow a transfusion, and even then he or she may sometimes balk.

We see that judges, whose profession is balancing competing claims, regularly order blood transfusions, even after discussion with competent patients who refuse to assent. In so doing, judges make emotionally laden statements. Such statements are not an aberration, but are quite normal in the circumstances. Some impairment of judgement in an emergency is not an idiosyncratic or self-induced phenomenon (like inebriation), but rather part of the make-up of even the most reasonable people.

If we can understand a lapse by a judge in making legal decisions of such finality under pressing time constraints, should we not be even more understanding in the case of a doctor, who is already preoccupied with critical medical decisions and not professionally trained to make legal decisions? Doctors are trained to react medically in an emergency, and so to demand good medical judgement in such situations is reasonable. To demand simultaneously a judicial decision about a complex legal and ethical question is not. In a case of self-defence, where justifiable fear might similarly cloud one's judgement, it is said that one need not judge with nicety the force of one's blow; why then is Dr. Shulman required to judge with nicety the legal issues he faced? Shortly put, there is no human standard by which we can say that Dr. Shulman "should have known better". Dr. Shulman's decision may, in hindsight, have been irrational, but it was not unreasonable.

The strongest reply to this would be to say that this is not an action for negligence, and that what is at issue is not whether the defendant fell below any standard, but whether there was a refusal of consent, which is simply a question of fact. Yet the law has progressed from the days of strict liability. Professor Williams tells us, in the case of *Stanley* v. *Powell*,[44] that "the tort of trespass was placed securely on the basis of fault."[45] In the usual

[43]*U.S.* v. *George*, 239 F.S. 752, and *Kennedy Mem. Hosp.* v. *Heston*, 279 A. 2d 670.

[44](1890), [1891] 1 Q.B. 86.

[45]G. Williams & B.A. Hepple, *Foundations of Tort*, (London: Butterworths, 1976) at 47. Note that this is clearly not a case in which the modern risk-sharing justification for strict liability is applicable.

battery cases, issues of reasonableness do not arise because the fault is found in the intention itself. Without begging the question we cannot say the same in the present case. Despite similarities of contact and consent, we must recognize that the intention and the duty of a physician to help his or her patient create a substantial difference between medical treatment and a fistfight. The Supreme Court implicitly recognized this in *Reibl*, finding that the action of battery is not appropriate in a medical context, except when egregious breaches of duty by the physician are involved.

In any case, the requirement of consent is already enmeshed in questions of reasonableness. The leading case on what constitutes consent, *O'Brien* v. *Cunard SS. Co.*,[46] held as follows: "in determining whether the act was lawful or unlawful, the surgeon's conduct must be considered in connection with the surrounding circumstances."[47] In other words, this "matter of fact" question of consent reduces to the question of how reasonable persons would conduct themselves in like circumstances. It is an artificial and arbitrary sort of objectivity which would ignore those aspects of the circumstances tending to obscure the doctor's legal judgement and simply assume that he can make his decision in what the court deems a completely rational manner. While of necessity we judge in hindsight, when we apply the standard of the reasonable person, we are asking what a reasonable person would have done at the time, not what he or she would have done in hindsight.

It may be objected that this argument leads to the conclusion that in certain situations there is no "matter of fact" as to whether there is consent, because reasonable people would not be able to make competent judgements. Hence, the usual "reasonable person" standard must be modified, even arbitrarily, so as not to allow this conclusion. This argument reinforces the view being urged in this paper. Recall that we are trying to determine what good reasons there might be for accepting a liberal interpretation of the doctrine that emergencies should be an exception to the requirement of consent. That it allows us to remain consistent with precedent rather than tampering with the reasonable person standard is one such reason; that reasonable people cannot decide whether consent is present is another.

To explain the rule that consent is not required in medical emergencies, as founded only on the impossibility of obtaining consent, is, in a sense, not to explain it at all. This reasoning gives no guidance in the crucial question of how to decide whether there has been legally sufficient consent. To answer this question by saying that consent or refusal is present if a reasonable person would so determine in hindsight, is an arbitrary departure

[46]154 Mass. 272, 28 N.E. 266 (1891).
[47]*O'Brien*, 28 N.E. at 266.

from the reasonable person standard used in non-emergency cases. It also results in the drawing of an arbitrary line which would brand as an intentional tortfeasor a doctor who was behaving reasonably in the circumstances. This line of reasoning goes against both the trend of modern tort law and the thrust of the Supreme Court decision in *Reibl.*

An alternative, prompted by the above discussion, is to view this rule simply as a crystallization of the requirement that people act reasonably in their relations with others, rather than as an exception to the usual requirement of consent. This approach grounds the rule (that consent is not required in emergencies) in fundamental principles of tort law, and provides a useful context for discussion as to what constitutes "consent" or "emergency" in various fact situations. To accept this interpretation would not require disrupting precedent, as all possible respect for the wishes of the patient is naturally part of what is meant by reasonable behavior. Indeed, it echoes the view that a surgeon may perform an unauthorized procedure if he discovers an unforseen problem in the course of an operation, only if it would be "unreasonable" and not merely "more convenient" not to do so.[48]

9. Public Policy

Of course, the courts do not simply apply the reasonable person standard; they also, in part, set it. It is therefore necessary to ask not only whether a doctor faced with a major emergency is in any position to make a good judgement as to whether there has been a valid consent or refusal, but also whether, as a matter of policy, we wish him to try.

Donnelly J. says that the correct choice in this case is so difficult to determine that "the final answer will not be known until this litigation runs its full course."[49] What if the final answer is that the card was open to valid doubt? Can we countenance a legal system that insists doctors come to certain conclusions on such difficult questions in emergency situations when a judge cannot do so in the peace of the courtroom? This demand is not only unreasonable, it is impossible in situations where the time for reflection will let death, rather than the facts, decide the issue.

As the results of this case become more widely known, doctors may begin to hesitate in similar circumstances — when, for instance, someone is thought to be a Jehovah's Witness but has no card. Even if the doctor would have been vindicated in the end, his knowledge that he must not

[48]*See, Murray* v. *McMurehy*, [1949] 1 W.W.R. 989, [1949] 2 D.L.R. 442 (B.C.S.C.). Of course this point is largely moot today, as modern release forms generally authorize any procedure the surgeon finds advisable.

[49]*Supra*, note 1 at 275.

only use his best judgement in the circumstnaces, but also arrive at the legally correct conclusion or face liability, could cause a delay in acting, a delay which could cost the life of someone who would have not objected to the transfusion. This concern is graphically illustrated in at least one case, in which an infant died because of the delay in giving a transfusion occasioned by the necessity of getting a court order to allow the transfusion in the face of the parent's objections.[50]

Another point of policy raised in several of the American cases is well stated in *Kennedy Memorial Hospital* v. *Heston*.[51] The Supreme Court of New Jersey noted that "the medical and nursing professions are consecrated to preserving life. That is their professional creed. To them, the failure to use a simple, established procedure in the circumstances of this case would be malpractice, however the law may characterize that failure in light of the patient's private convictions. The hospital and its staff should not be required to decide whether the patient is or continues to be competent, or whether the release tendered by the patient or a member of his family will protect the hospital from civil responsibility. The hospital could hardly avoid the problem by compelling the removal of a dying patient...."[52] Mrs. Malette may have felt "very dirty" after surviving her ordeal, but how would Dr. Shulman have felt if he let her die? The medical ethic creates moral imperatives which may well be felt as strongly as religious ones, and we should not belittle the importance of these values merely because they are labelled secular. We see then that there are good reasons, both in law and public policy, for not requiring consent in certain emergency situations. These reasons are independent of the impossibility of obtaining consent. The question is now clearly one of balancing this principle with the right to control one's body. To do this, we must consider the strength of this right.

10. Right of Refusal

Mr. Justice Cardozo's famous statement of the right of an adult to determine what shall be done with her body was strong, but not categorical. To elevate it to a position of absolute supremacy is a device of rhetoric which conceals a radical position which the law, as the practical forum of moral balancing, must avoid. Theoretical objections to such absolutism are reinforced by legal and societal decisions which demonstrate that, as a practical matter, society has long entrenched restrictions on a person's control over her body.

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[50] *Wolfe* v. *Robinson* (1961), [1962] 1 O.R. 132, 31 D.L.R. (2d) 233 (C.A.).

[51] Also in *Georgetown College*, 331 F. 2d at 1009, and *U.S.* v. *George*, 239 F.S. at 754.

[52] *John F. Kennedy Mem. Hosp.* v. *Heston*, 279 A. 2d 670 at 673 (1971).

For instance, the American precedents in Jehovah's Witness cases have indicated that concern for the well-being of a young or unborn child is grounds for ordering blood transfusions against the patient's will. Another obvious case of balancing rights and duties arises in the context of abortion. Despite the claim that a woman has a right to do as she wishes with her body, there is no question of simply dismissing the argument of anti-abortionists on this basis alone. In *R.* v. *Morgentaler*, the Ontario Court of Appeal, specifically referring to Mr. Justice Cardozo's remark, commented that "even such fundamental rights are not absolute."[53]

Suicide is a third example. While it has recently been removed from the *Criminal Code*, the common law has long held that one's right over one's body does not extend to taking one's own life. While a suicide attempt is at least as powerful an indication of the patient's intentions towards her own body as "the card" is in *Malette*, a doctor will not be held liable for preventing a suicide, and in some circumstances may be under a duty to do so, even in jurisdictions where suicide is no longer an offence.[54]

A final example are drug offences, which are crimes notwithstanding that they prevent a person of adult years from doing with her body as she sees fit. These simple examples make it clear that Justice Cardozo was only setting forth a right which must always be considered, not one which must always triumph.

11. Sanctity of Life

A common thread running through these examples is the following: in situations involving life and death, society is most ready to restrict a person's right to control her body. This reflects a presumption in favour of the sanctity of life which exists both in law and in society at large. While there are a number of possible reasons for preferring death to life, and Donnelly J. lists "patriotism in war, duty by law enforcement officers, protection of the life of a spouse, son or daughter, death before dishonour, death before loss of liberty, or religious martyrdom",[55] we note that those who act on such beliefs are usually considered heros or martyrs. The use of such encomiums suggests that the mass of humanity does not fall into these categories. In two American cases, the court found that the patient did not object to life-saving transfusions, but simply did not want to authorize them. We see that if Dr. Shulman erred in doubting the card, it was not an arbitrary error, but one based on the widespread presumption in favour of life. Society's bias in this

[53](1985), 52 O.R. (2d) 353 at 377, 22 D.L.R. (4th) 641 at 655.

[54]*See*, Skegg, *Law, Ethics and Medicine* (Oxford: Oxford University Press, 1984) at 110-12, 155-57.

[55]*Supra*, note 1 at 272.

respect suggests that we not presume that someones wishes to be a martyr, except in the face of the clearest of evidence.

This is emphasized in the American case of *In Re Osborne*,[56] the most widely reported case upholding the right, in certain circumstances, of a competent adult to refuse a blood transfusion on religious grounds. The language used in defining the right to refuse blood is cautious and restrictive. The court in *Osborne* stressed the importance of a meeting with the patient, by a judge, in order to make the best possible assessment of the patient's wishes. The court also noted that "where the patient is comatose, or suffering impairment of capacity for choice, it may be better to give weight to the known instinct for survival which can, in a critical situation, alter previously held convictions."[57] Although the court affirmed a right to refuse blood, it also recommended procedural and presumptive safeguards to make sure that any error is made in favour of preserving life. A broad interpretation of the emergency exemption from the consent requirement is similarily biased.

12. Rights of Jehovah's Witnesses

What of the rights of Jehovah's Witnesses and others who may wish to refuse certain forms of medical treatment? Do they have no rights in emergencies, so that a doctor may proceed with treatment even in the face of a conscious and competent refusal? Besides the unpalatability of such a conclusion, such an exemption inevitably leads to disputes over categorization. It could be said that I have only shifted the question from "What is consent?" to "What is an emergency?"

However, I have not been arguing that the exemption from the consent requirement in emergency situations should be an absolute rule. Rather, it should be viewed as based on a requirement of reasonableness. We might then say that an emergency is a situation in which it is unreasonable to expect a doctor to fully weigh the issues of consent; the doctor should do whatever it is reasonable to do. This is not intended to be facetious. Rather, it emphasizes that what is at issue is reasonable behavior, not definitions of words. The concepts of emergency and consent will be the focus of the debate, but they must be defined with regard to what is reasonable in the given context.

The meaning of "reasonable" is itself highly dependent on context. In a society in which life was the ultimate good, there would never be any doubt as to the reasonableness of administering life-saving treatment. But

[56]294 A. 2d at 373.
[57]*Ibid.* at 374.

I fully agree, for reasons given by Donnelly J and others,[58] that adult Jehovah's Witnesses have the right to refuse life saving blood transfusions for religious reasons, and that they continue to have this right in emergencies. I prefer to characterize the issue not as about the right to refuse treatment, but about the possibility of communicating this refusal.

13. Reasonableness in Emergencies

Communication is not simply a matter of words, but of context as well. A shared language is the most obvious requirement for effective communication, but accompanying actions, and the immediate and social contexts, can all affect the message. For instance, in *U.S.* v. *George*[59] a patient refused to authorize a transfusion. A judge called to the bedside explained that even if he signed the authorizing order, the patient could still prevent the transfusion by simply placing his hand over the area where the needle was to be inserted, and force or restraint would not be used to administer the transfusion. The patient indicated that if the order was signed, his conscience would be clear and he would not resist the transfusion in any way. Had he refused the transfusion? It was apparent that the patient did not want to die, nor did he want a transfusion. What is communicated by such contradictory messages? It is too simplistic to say that the patient refused because his answer to the direct question was "no".

In the present case, the communication problem arose not because the patient had not done everything she could to make her wishes known, but because the message was a difficult one to transmit. "You must be joking" is a common, and often correct, response to a claim which deviates widely from what is normal or expected. More than a simple statement would be required for most people to convince us that she or he could run a four minute mile, or would pay ten thousand dollars for an antique tea-cup. Mrs. Malette was not joking, but Dr. Shulman's reliance on a societal presumption in favour of life in deciding that the card did not communicate a desire to die before accepting a transfusion, but was rather a sign of solidarity with her co-religionists, is a normal use of context in communication. More effort is required to communicate such an unusual message, and the emergency made further explanation impossible. "Consent" and "emergency" are interrelated terms not susceptible of independent definition.

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[58]See R. Kouri, "Blood Transfusions, Jehovah's Witnesses and the Rule of Inviolability of the Human Body" (1974) 5 R.D.U.S. 156. I have cited American cases which suggest that the interest of the state in insuring that a child has a mother is sufficient to override a refusal of consent, in order to illustrate the difficulty of making judgements in such difficult cases. I am not endorsing these cases but rather I suggest that they stretch to the limit, if not beyond, justification for such state interference.

[59]239 F.S. 752.

14. Effective Refusal

The most objectionable aspect of the argument so far advanced, certainly to a Jehovah's Witness, is that it allows no form or card which would unchallengeably constitute a valid refusal in emergency situations. But "valid refusal" is a somewhat misleading phrase. All a legally valid refusal would assure is that a Jehovah's Witness could sue successfully. It would take a practically effective refusal to insure that no blood transfusion took place, which presumably is the aim of the Jehovah's Witnesses. I suggest that a legally valid refusal, and a practically effective refusal, should coincide.

How do we decide what should be reasonably effective? Since context is so important, any strict and easily applied rule would be tidy, but would likely be unreasonableness in the face of novel situations. In *Dorone*, the Superior Court of Pennsylvania recognized this. It held that whether the evidence that the patient would refuse a transfusion was of such quality that the court should not allow the transfusion, was "not an abstract question, it can only be answered in the context of the particular facts that confronted the court."[60] The court was willing to consider all circumstances surrounding the card and the religious beliefs of the signer before making its decision. Moreover, the Court did not state that a card in conjunction with such evidence could never be sufficient grounds for not ordering a transfusion. Unfortunately, on appeal, the Supreme Court of Pennsylvania said that in an emergency "nothing less than a fully conscious contemporaneous decision *by the patient* will be sufficient to override evidence of medical necessity".[61]

To see how this rule might be too inflexible, consider alternate means by which Jehovah's Witnesses might communicate their wishes. If a pregnant Jehovah's Witness anticipated difficulties at birth, she might discuss at length with her doctor the firmess of her objection to transfusions. If an emergency did arise during the delivery, the doctor should not be excused for not respecting her wishes, even if the patient were unconscious. In a small community a group of Jehovah's Witnesses might go to the local hospital and explain personally the firmness of their religious objections to blood transfusions. If soon afterwards a member of this group were brought in, unconscious but carrying a card, as was Mrs. Malette, we might reasonably require that no blood be given.[62] To require a conscious contempo-

[60]502 A.2d at 1275.

[61]534 A.2d at 455 (original emphasis).

[62]This should also prevent the hospital administration from shirking responsibility for making the decision. We might well require more sensitivity from the administration when faced with a refusal of transfusion, since the administration would be burdened neither with making an immediate medical decision, nor with intimate involvement with the patient.

raneous refusal would create a divergence between what we reasonably believe to be the true wishes of the patient, and the legally effective wishes, thereby not only allowing the doctor to proceed when she should not, but exposing her to liability for not doing so.[63] We should also recognize that in a more ambiguous situation, as in this case or *Dorone*, there is no one reasonable decision. If it is reasonable to make a mistake in determining the true wishes of the patient, it could not be less reasonable to decide correctly.

To give legal force to a specific type of refusal card, would separate legal validity from effectiveness in a slightly different way. It would favour the Jehovah's Witnesses at the risk of being unreasonable to the doctor, as in the present case. And while it would theoretically prevent future transfusions by acting as a deterrent, in practice, it would at most lead to a generalized fear of legal consequences, which would most likely both prevent action in cases where it was demanded and not prevent transfusions in cases where the refusal was legally valid.

It may be said that this is always a problem with the deterrent role of tort law, and that a sharp and somewhat arbitrary line is always drawn by the courts. In this case, however, we are not drawing distinctions between reckless behavior and unacceptably reckless behavior, in which a blunderbuss deterrent will not do much harm. Rather, we are dealing with different judgements of how best to behave in the face of strong and conflicting demands. To condemn marginally acceptable behavior is very different from second-guessing choices based on values lauded by society and by the health care system. A pressing case is needed before the courts should discourage these values. That no such case is present in medical emergencies is emphasized by the difficulty of ascribing damages. There is no obvious suffering which cries out for compensation, thereby buttressing a weak deterrence argument, as is the case in the wrongful life claims.

15. The Final Balance

In this paper, I have argued that consent is not required for a doctor to treat a patient in a medical emergency, and that this exemption should be seen not as an exemption from the general rule based on the impossibility of obtaining consent, but as a crystallization of the general principle that

[63]Fear of liability in such circumstances is not entirely fanciful; see *Randolph* v. *City of New York*, 501 N.Y.S. 2d 837, which reversed the trial judgement for malpractice against a doctor who did not give blood to a patient who had refused consent to a transfusion (the patient died as a result). The possibility of liability does not arise from not administering medically indicated treatment that the patient would not consent to, but from the possibility that the patient might not have legally refused consent.

people must act reasonably in their relations with others. This view does not involve changing the present law, and would not dictate a different result in any of the established medical consent cases. It is simply an elucidation of a well-established principle which applies *prima facie* in the present case.

Reasonableness must include respect for the wishes of the patient and of her right to refuse treatment. However, in a pressing emergency, such as that faced by Dr. Shulman, it seems clearly unreasonable, especially in view of the reaction of judges when faced with conscious and contemporaneous refusals, to ask a doctor to overcome training and instinct to rely on a refusal card, even if it would seem in retrospect to represent the true wishes of the patient. On the other hand, to go beyond the circumstances of this case and set forth a general rule as to what constitutes a valid refusal, runs the risk of hampering the reasonable exercise of the physician's judgement by fear of malpractice liability on the one hand, and battery on the other.

The problem which has arisen in *Malette* is a result of a basic conflict between the values of the Jehovah's Witnesses, who do not wish blood transfusions, and those of the community as a whole, which systematically insists on the importance of life. The system should accommodate both views as far as possible, but there comes a point when basic values clash irreconcilably. The decision of Donnelly J. implicitly tries to have it both ways, making a scapegoat of Dr. Shulman in the process. Instead, we should recognize the conflict, and if it is indeed irreconcilable in some circumstances, we must decide in favour of life.

As a matter of policy, we do not want doctors hesitating in the emergency room through fear of the law, and as a matter of justice, we must not punish someone for making a difficult and honest choice, especially when the "error" was to save a life. The final paragraph of the decision in *Application of President and Directors of Georgetown College*, in which the judge himself faced the same dilemma as Dr. Shulman, recognizes these considerations. Perhaps if Donnelly J. also had had to make the crucial decision, and not simply pass judgement on it afterward, his decision would have read similarly:

> The final and compelling reason for granting the writ was that a life hung in the balance. There was no time for research and reflection. Death could have mooted the cause in a matter of minutes, if action were not taken to preserve the status quo. To refuse to act, only to find later that the law required action, was a risk I was unwilling to accept. I determined to act on the side of life.[64]

[64]331 F.2d at 1009-1010.