Malette v. Shulman et al.

Indexed as: Malette v. Shulman
(Ont. H.C.J.)

63 O.R. (2d) 243
[1987] O.J. No. 1180

ONTARIO
High Court of Justice
Donnelly J.
December 21, 1987.

Professions -- Physicians and surgeons -- Consent to treatment -- Unconscious patient carrying card declaring her to be Jehovah's Witness and refusing consent to blood transfusions -- Physician administering blood liable for damages for battery.

Damages -- Personal injuries -- Non-pecuniary loss -- Quantum -- Blood administered against express wishes of Jehovah's Witness -- $20,000 awarded for mental distress.

The plaintiff was unconscious after an automobile accident. The defendant physician administered blood to her, though informed of a card in her purse declaring that she was a Jehovah's Witness and desiring that no blood should be administered to her in any circumstances.

In an action for damages, held, the defendant was guilty of battery and the plaintiff was entitled to damages for mental distress of $20,000.

Cases referred to

Rogin v. Shannon (1986), 37 C.C.L.T. 181; Marshall v. Curry,

[1933] 3 D.L.R. 260, 60 C.C.C. 136; Parmley v. Parmley and Yule, [1945] 4 D.L.R. 81, [1945] S.C.R. 635; Reibl v. Hughes (1980), 114 D.L.R. (3d) 1, [1980] 2 S.C.R. 880, 14 C.C.L.T. 1, 33 N.R. 361; Videto v. Kennedy (1981), 33 O.R. (2d) 497, 125 D.L.R. (3d) 127, 17 C.C.L.T. 307; Hopp v. Lepp (1980), 112 D.L.R. (3d) 67, [1980] 2 S.C.R. 192, [1980] 4 W.W.R. 645, 22 A.R. 361, 13 C.C.L.T. 66, 32 N.R. 145; R. v. Big M Drug Mart Ltd. (1985), 18 D.L.R. (4th) 321, 18 C.C.C. (3d) 385, [1985] 1 S.C.R. 295, [1985] 3 W.W.R. 481, 60 A.R. 161, 37 Alta. L.R. (2d) 97, 85 C.L.L.C. Paragraph14-023, 13 C.R.R. 64, 58 N.R. 81

Statutes referred to

Canadian Charter of Rights and Freedoms
Public Hospitals Act, R.S.O. 1980, c. 410

Rules and regulations referred to

R.R.O. 1980, Reg. 865 (Public Hospitals Act), s. 50

ACTION for damages for negligence and battery.

W. Glen How, Q.C., for plaintiff.

Michael E. Royce, for defendant, Dr. D.L. Shulman.

DONNELLY J.:--

INTRODUCTION

The plaintiff, one of Jehovah's Witnesses, claims damages alleging that the administration of blood transfusions to her constituted negligence and assault based on religious discrimination and conspiracy.

The defendants are the hospital, T.M. McAnulty its executive director, Dr. D.L. Shulman and four nurses.

The third and fourth party proceedings were resolved before trial.

Dr. D.L. Shulman, graduated in medicine in 1973, interned in family practice for one year at Dalhousie and thereby qualified as a member of the Canadian College of Family Practitioners. Thereafter he trained for nine months at McMaster as an anaesthetist. In July, 1976, he opened a family practice as a general practitioner in Kirkland Lake where he served two or three shifts per week in the emergency department of the local hospital.

FACTS

About 13:15 hours on June 30, 1979, the plaintiff, a 57-year-old housewife, was a passenger in, and her husband was the operator of, a motor vehicle involved in a head-on collision with a truck resulting in injury to the plaintiff and the immediate death of her husband. Gerald Blanchard, an employee of a car dealership near the accident site and an elder of the local Jehovah's Witnesses congregation, attended the plaintiff while she was still seated in the vehicle at the accident scene. He described a "trickle of blood" from her facial injuries to the upper part of her white suit. He observed no other blood on her person, in the car or on the ground. Police Officer Brian Clarke arrived at 13:20 hours and observed that the plaintiff had facial injuries with some bleeding. Gary Hodgins, an ambulance attendant, also arrived at 13:20 hours. His only recollection of the incident was seeing the plaintiff seated in her vehicle. By reconstruction from his ambulance report, he gave evidence of sustained external bleeding with no serious blood loss in the five minute ambulance trip to hospital.

On arrival at Kirkland and District Hospital emergency department about 13:30 hours the plaintiff was received by the defendants, Registered Nurses Johnson and Matijek (Matijah). Dr. Shulman, who was on duty as hospital casualty officer, was called from a cardiac case in the emergency department and within a few minutes examined Mrs. Malette. Thereafter he

attended her almost constantly in hospital as well as during her air ambulance flight to Toronto.

The plaintiff was "shockey" in appearance, semi-conscious, not responding to verbal stimuli (her native language was French), moaning, groaning and uttering no coherent sounds. Nurses Johnson and Matijek noted a steady, constant stream of severe bleeding from her nose and mouth which they described as "too quick and too bright red" to be normal. Nurse Hannah, who was called from the intensive care unit to assist, observed that the plaintiff was semi-conscious and bleeding profusely. The blood was "too bright" and she concluded that this was arterial blood.

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. This abundance of blood was recorded in Dr. Shulman's admission record dictated almost contemporaneously at 14:30 hours and in his discharge summary dictated about six weeks later.

At the emergency department the plaintiff was found to have:

(1) Severe facial lacerations. 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. There were obvious multiple fractures of facial bones with a constant stream of blood from the area of nose and mouth. The plaintiff was vomiting blood.

(2) Indications of abdominal injuries, with the plaintiff holding her left flank. Her abdomen was tender with fullness of the upper left central chest. Bruising was observed in the area of the iliac crest.

(3) Pale, cold and clammy skin.

Immediately and regularly the plaintiff's vital signs were taken. They were initially recorded in the nursing notes at blood pressure 150/90 and pulse rate 90. I accept the nurses'

evidence that these vital signs were carefully monitored at regular intervals of 5, 15 or 30 minutes and that Dr. Shulman was kept current with the results although, because of concern for and attention to the patient, those results were not always recorded in the nursing notes as usual practice would indicate.

Dr. Shulman concluded that the patient suffered from incipient shock resulting from blood loss and he was concerned about the risk of falling blood pressure. The immediate treatment was by the standard therapy of replenishing blood loss with intravenous glucose followed immediately at 13:45 hours by Ringer's Lactate, a clear volume expander, administered in both arms by large bore intravenous.

About 14:00 hours Dr. Shulman anterior packed the plaintiff's nose with plain gauze followed by a second anterior packing, both of which did little to stop the blood flow. The laceration about her eye was sutured. Her respiration was relatively normal and oxygen was administered by face mask.

Since the patient was unable to speak, Nurse Johnson checked the purse which accompanied the plaintiff to hospital and about 13:45 hours to 14:00 hours found a Jehovah's Witness card signed but bearing neither date nor witness signature. Although in French, it was promptly translated. The card read as follows:

The parties have agreed upon the following translation:

This information was communicated by the nursing staff to the hospital executive director, the defendant McAnulty, who discussed the issue with the hospital chief of staff, Dr. Middlemiss. Mr. McAnulty concluded that the administration of blood, as a medical decision, was Dr. Shulman's responsibility. He directed that if Dr. Shulman decided to administer blood, it should be "hung" by the doctor, not by the hospital staff and that the staff should co-operate with the doctor. He further specifically directed that Dr. Shulman be advised of the contents of the card.

Nurse Johnson, as directed by her nursing supervisor, on three separate occasions in the presence of Nurses Hannah and Matijek, while Dr. Shulman was attending the plaintiff in the emergency room, advised Dr. Shulman of the presence and contents of the card. This advice was recorded on the emergency department chart. Although he did not specifically look at the card as he was attending the plaintiff, Dr. Shulman did acknowledge that he was advised of and understood the purport of the card prior to blood being administered at 15:20 hours. He acknowledged that he assumed it to be Mrs. Malette's card and signature.

Between 13:50 hours and 15:00 hours the patient received three litres of Ringer's Lactate.

At 14:15 hours Dr. Shulman consulted Dr. Dakin, a general and orthopaedic surgeon on duty in the hospital. Dr. Dakin was informed of the available partial history relating to a high-energy, head-on car crash with a fatality and of the plaintiff's substantial facial and other injuries and blood loss.

At 15:00 hours Dr. Dakin examined the patient noting the level of consciousness. Although she was unable to respond verbally and her eyes were swollen closed, he had the impression that she was aware of his presence. The obvious facial injuries were associated with substantial swelling. The face was quite unstable. The abdomen was distended with bruising at the iliac crest. There were indications of chest pain. The bright bleeding continued in spite of the nasal pack. The systolic blood pressure was barely 100. The pulse rate was slow from blood loss suggestive of some stimulation slowing the heart rate, mainly through the vagus system.

Dr. Dakin concluded that there had been a major significant force to the face and abdomen with considerable potential for crush, blood loss, and damage to the vagus system. He found the patient's airway and ventilation to be sufficient. He was very much concerned about potential damage to the heart and great blood vessels, abdominal injury and relieving possible pressure on the brain. The swelling was indicative of risk of other

potential damage as bleeding sources contributing to the stomach blood. He was of the opinion that it was vital to maintain blood volume to avoid irreversible shock. The extent and nature of the fractures being as yet undetermined, immediate intubating or posterior nasal packing involving passing a catheter through the airway was contra-indicated because of the risk of any such insertion in the vital areas of the brain and spinal cord. The patient's general condition was too unstable to permit any further attempt at posterior nasal packing in an effort to staunch the blood flow.

On Dr. Dakin's order the patient was transferred to the X-ray department for X-rays of skull, pelvis and chest. These X-rays revealed a normal cervical spine and minor rib fractures.

Before the X-rays were satisfactorily completed the plaintiff's condition deteriorated, with systolic blood pressure dropping to the 50 - 40 range. Respiration was becoming increasingly distressed and the level of consciousness was dropping. This was a demonstration of increasing signs of hypovolemic shock. She continued to bleed profusely and was becoming critically ill.

The laboratory report on the crossing and matching of blood was now available. Dr. Shulman made the decision to administer blood and he did so personally, "hanging" two units of blood simultaneously at 15:20 hours while the plaintiff was still in the X-ray room.

At 15:50 hours, because of her deteriorating condition, the plaintiff was transferred to the intensive care unit with its monitored life-support systems. She continued "shockey" with further significant drop in heart rate and blood pressure. She was semi-conscious to stuporous -- although Nurse Winters (now Blea) described her as "lucid and rational" in the limited sense that she was able to respond to commands such as "turn over".

At 16:15 hours, having determined by X-ray results that there was no gross abnormality of the cervical spine, an endo-tracheal tube (from mouth to trachea attached to a

respirator) was inserted to protect her breathing.

At 16:30 hours Dr. Shulman made an unsuccessful attempt at posterior nasal packing by passage of a Foley catheter with an attached balloon to be inflated to produce a block by direct pressure on bleeding areas.

At 17:30 hours, under a local anaesthetic only, Dr. Dakin performed a mini-laparotomy involving insertion of a tube into the abdomen to check for significant abdominal bleeding. The patient was in a depressed level of consciousness and was unresponsive to pain.

At 18:00 hours a bronchostomy was performed to check by direct visualization or bleeding in order to rule out concern with respect to the abdominal cavity. Again the patient was unresponsive to marked pain stimuli.

Celine Bisson, daughter of the plaintiff, was advised of the accident about 15:00 hours by police and immediately telephoned her sister Paulette Doucet. They discussed the question of administration of blood. Mrs. Bisson drove from Timmins, arriving at the hospital about 18:00 - 18:30 hours. She immediately spoke to Nurse Winters, objecting to the administration of blood. Mrs. Bisson refused to sign an authorization to give blood. About 19:00 hours, with her husband Hubert Bisson and Mr. Blanchard the local church elder, she saw Dr. Shulman and informed him that the plaintiff was her mother and that they were both Jehovah's Witnesses. She expressed her conviction that her mother wanted no blood and also that she did not want blood. A biblical justification was attempted by her. She mentioned a second medical opinion, alternative bloodless treatment and a transfer to hospital in Toronto. Dr. Shulman was quoted by her as saying "Don't you care if your mother dies? You will be responsible. I am in charge. I am responsible and I will give blood". According to her, Dr. Shulman "could not stand them" and walked out.

At 19:00 hours Mrs. Bisson signed "A Consent to Treatment and a Release of Liability Form" specifically prohibiting blood transfusions. Nurse Winters told her that because it was the

July 1st holiday week-end the hospital administrator was unavailable to discuss the problem. According to Mrs. Bisson, 15 or 20 minutes later, Dr. Shulman returned and threw the release on the desk indicating that it was of no value and that the blood would continue. She did not see Dr. Shulman again. About midnight the nursing staff informed her that her mother was being transferred to hospital in Toronto.

Dr. Shulman had a limited recollection of the interview with Mrs. Bisson. He thought that had a second opinion been requested, he would have advised that the patient had already been seen by Dr. Dakin and another doctor at the hospital. He had no recollection of the second meeting with Mrs. Bisson and asserts that he had no intention to be unavailable or to walk out of any meeting. He knew that Mrs. Bisson did not want blood for her mother and that she had signed the qualified release. Dr. Shulman indicated that he would have been happy to turn the patient over to some other doctor as it was a difficult case. He continued because that was his ethical responsibility.

Mrs. Bisson did not further pursue her unhappiness with the medical treatment nor did she retain another doctor although Mr. Blanchard, who accompanied her, was a local businessman and knew area doctors sympathetic to Jehovah's Witnesses.

Hubert Bisson visited the plaintiff in the intensive care unit and asked in French if she wanted blood, directing her to indicate her response by squeezing his hand. Mrs. Malette testified that she recalls the incident. By hand signal Mrs. Malette indicated "no blood". Nurse Winters, although present, did not understand what was said. Hubert Bisson told her what had happened. Dr. Shulman was not informed about this incident.

At 18:10 hours the results of the mini-laparotomy and bronchostomy being negative, attention was turned to the most obvious bleeding site in the area of the nose. About 19:00 hours Dr. Dakin consulted a ear, nose and throat resident at Toronto General Hospital who suggested that the external carotid artery be tied off below the jaw, a procedure which Dr. Dakin considered to be beyond his competence involving risk of compromising brain circulation. This procedure was not carried

out and instead between 18:15 hours and 18:30 hours there was another unsuccessful attempt at posterior nasal packing after which the anterior packing was replaced. Bleeding and the blood transfusions continued.

About 19:30 to 20:00 hours the plaintiff's condition stabilized somewhat with improving blood pressure, level of consciousness and skin condition.

About 23:20 hours Dr. Shulman again consulted Dr. Dakin, and together they inserted the Foley catheter so that the balloon was in place as posterior nasal packing. Dr. Dakin described feeling crepitation in the process. He regarded the procedure as only partially successful with no significant change in bleeding.

About 00:20 hours on July 1st, Dr. Dakin examined the plaintiff for the last time. He was then, and remains now, strongly of the belief that the patient suffered from hypovolemic shock.

About 02:20 hours the patient, accompanied by Dr. Shulman and two nurses, was taken by air ambulance to Toronto General Hospital, arriving at about 04:30 hours. The blood transfusions were discontinued there. On August 11th she was discharged from Toronto General Hospital.

NEGLIGENCE

Was the medical management of the plaintiff negligent irrespective of her status as a Jehovah's Witness?

With respect to the standard of care applicable to medical doctors in the discharge of their professional duties and with respect to the burden of proof resting upon a plaintiff in this type of action, the authorities which I accept and apply are assembled by Anderson J. in Rogin v. Shannon (1986), 37 C.C.L.T. 181 at pp. 187-9:

> Dealing first with the standard of care I would refer, as many other Judges situated as I am have done over the years,

to the judgment of the Ontario Court of Appeal in Crits v. Sylvester, a report of which is in [1956] O.R. 132, 1 D.L.R. (2d) 502 [affirmed [1956] S.C.R. 991, 5 D.L.R. (2d) 601 (S.C.C.)]. The particular references for which I wish to have regard are found commencing at p. 143 [O.R.] of the judgment. Schroeder J.A. speaking for the Court has this to say:

"The legal principles involved are plain enough but it is not always easy to apply them to particular circumstances. Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required of him than one who does not profess to be so qualified by special training and ability."

Further on the same page he says:

"In approaching a problem such as this it is well for a Court to caution itself, as was done by Denning L.J. in Roe v. Minister of Health et al.; Woolley v. Same, [1954] 2 Q.B. 66 at 83, [1954] 2 All E.R. 131, where that learned jurist stated: 'It is so easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought always to be on our guard against it, especially in cases against hospitals and doctors.' "

And on the following page:

"But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point,

but we must not condemn as negligence that which is only a misadventure."

In Gent v. Wilson, [1956] O.R. 257 at 265, 2 D.L.R. (2d) 160, we have from the same learned Justice of Appeal the following:

"Each case must, of course, depend upon its own particular facts. If a physician has rendered treatment in a manner which is in conformity with the standard and recognized practice followed by the members of his profession, unless that practice is demonstrably unsafe or dangerous, that fact affords cogent evidence that he has exercised that reasonable degree of care and skill which may be required of him."

And in the penultimate sentence of his judgment:

"Nothing is to be imputed to the defendant that is not clearly proved against him. Post hoc, ergo propter hoc, has no place in our law."

The final reference which I wish to make on this subject is to Wilson v. Swanson, [1956] S.C.R. 804, 5 D.L.R. (2d) 113 (S.C.C.) the judgment of Rand J:

"An error in judgment has long been distinguished from an act of unskilfulness or carelessness or due to lack of knowledge. Although universally-accepted procedures must be observed, they furnish little or no assistance in resolving such a predicament as faced the surgeon here. In such a situation a decision must be made without delay based on limited known and unknown factors; and the honest and intelligent exercise of judgment has long been recognized as satisfying the professional obligation."

Turning to the onus of proof; I take as a brief and accurate statement that which is found in the judgment of my brother Hollingworth in Suitter v. Blake-Knox, Ont. H.C., No. 6838/79, August 1, 1985, as yet unreported, to the following effect:

"To succeed the plaintiffs must persuade me on the balance of evidence or, as it is sometimes called, the balance of probabilities two things: First, that the anesthetist and/or the surgeons were guilty of errors of professional judgment of such a character to constitute a breach of their duty of care toward her. That is to say baldly, that they were negligent. And secondly, there must be a nexus of causation. That is to say, the negligence must have resulted in the brain damage."

Mr. Justice Anderson further stated in Rogin v. Shannon at pp. 190-1:

Before turning to the disposition of the case as against the defendant McCormick, I should say a word about the expert evidence adduced by the plaintiff and on behalf of the defendant doctors respectively.

Called on behalf of the plaintiff was Dr. Peter LeWitt, a neurologist who is associated with the Department of Neurology at Lafayette Clinic in Detroit. His credentials as a neurologist appear to be eminently respectable and he has an impressive list of publications to his credit. Objection was taken to the admissibility of his evidence, objection on behalf of the defendant doctors, upon the premise that it was not competent for the purpose of establishing a standard of care. That submission was based upon the premise that he is a neurologist and the standard of care with which I am concerned is that of a general physician or a general surgeon. I rule that his evidence was admissible because there were obviously neurological questions involved in the case as to which he, as a neurologist, would be competent to express an opinion.

The position taken by counsel for the defendant doctors was in substance renewed in the final argument, in the form of a submission that his evidence cannot be taken as giving evidence of the standard of care to be expected in the circumstances of Dr. DeMarco or Dr. McCormick, a general physician working in an emergency room and a general surgeon respectively. The submission was that his perspective is that

of a specialist in neurology and that any standard of care which he offered or any criticism which he offered of the performance of the defendant doctors would inevitably be coloured and determined by his specialty.

I think there is much force in that argument. As establishing a standard of care I think his evidence is not of much assistance.

Called on behalf of the defendant doctors was Dr. Barr, a neurosurgeon associated with the staff of Victoria Hospital in London, Ontario. That hospital serves a large area for the treatment of patients having traumatic head injuries. His practice involves treatment of a large number of paediatric cases. His evidence, taken as a whole, asserts no criticism of the conduct of DeMarco and McCormick.

At first blush it might appear that the same objection could be taken to the evidence of Dr. Barr as that which I have described as having been taken with respect to the evidence of Dr. LeWitt. But I have concluded that that is not so; that it cannot be effectively taken. There is a difference, an essential difference, between expressing a standard of care and criticism of a physician or physicians for failing to come up to that standard and approval of the specific conduct in the circumstances of the physician or physicians.

If the conduct of DeMarco and McCormick in diagnosis and treatment of a head injury is deemed appropriate by a neurosurgeon it must surely, by necessary inference, meet the standards which would be required of a physician or surgeon who did not have that specialty.

To assist the court in determining the proper standard of care required of a general practitioner on duty as casualty officer in a primary care hospital, the plaintiff called:

(1) Dr. Philip R. Roen, a urologist teaching and practising at New York City in the speciality of the diagnosis and treatment of conditions of the male genito-urinary system.

(2) Dr. William H. Pogue of West Hartford, Connecticut, a specialist in haematology.

(3) Dr. John M. Thomas of Nanaimo, British Columbia, a specialist in obstetrics and gynaecology with substantial experience in the management of low haemoglobin and hypovolemic shock.

(4) Dr. Gonzalo Perales of Thunder Bay, a specialist in general and vascular surgery with trauma being a special interest and a large component of his practice.

The fundamental premise of those doctors was that there had been no excessive blood loss and bleeding had substantially stopped on arrival at the hospital emergency department. They were of the opinion that the following symptoms were inconsistent with massive blood loss:

(1) Haemoglobin, blood pressure and pulse levels, although a cause of concern, were not alarmingly low.

(2) The initial elevated blood pressure later falling was consistent with early pain and anxiety following trauma.

(3) Oxygen levels as determined by blood-gas testing did not indicate a blood transfusion.

(4) In a classic presentation of hypovolemia the pulse rate is weak or thready and usually elevated. This pulse rate was low.

(5) The nursing notations by Nurse Winters indicated the plaintiff was "rational and lucid" in the intensive care unit.

(6) There is no notation by Dr. Shulman of a diagnosis of hypovolemia.

(7) When the patient did not respond to infusion of fluids and blood, Dr. Shulman should have recognized that this was not hypovolemic shock. He should have considered that the underlying cause of the slow pulse was vagal reaction

precipitated by the accident and should have tested accordingly.

The plaintiff's medical evidence was that Dr. Shulman fell into diagnostic error and resulting from that diagnosis, into treatment errors as follows:

Diagnostic error

By failing to recognize that there was no gross bleeding, Dr. Shulman erred in concluding that the plaintiff suffered from hypovolemic shock at the hospital emergency department.

Treatment errors

(1) The infusion of blood was not indicated, there being no extensive blood loss and hence no significant degree of shock. The patient would have responded to conservative alternative treatment with minimal fluid and no blood being added.

(2) The rapid infusion of blood following the Ringer's Lactate overloaded the circulatory system diluting natural clotting factors, dislodging clotting and distending blood vessels, thereby causing continued or new bleeding. This treatment was excessive, inappropriate and achieved no benefit for the patient.

(3) If there was additional bleeding in the emergency department, there should have been prompt posterior nasal packing with the Foley catheter.

(4) The face mask administration of oxygen was inadequate and the endo-tracheal tube should have been in place to improve and protect breathing before 16:15 hours.

(5) The patient should have been sedated to promptly alleviate pain and render management easier.

(6) Failure to recognize the underlying cause of the slow heart rate as vagal stimulation and accordingly failure to test the heart rate by medicating with atropine.

(7) Dr. Thomas also was of the opinion that blood pressure should not be fully restored. He agreed that most doctors would do so but in his view this is an error in modern medicine which would result in further bleeding.

(8) Dr. Thomas was apprehensive that the excessive infusion of blood could overload the heart and congest the lungs.

Dr. Shulman's diagnosis and treatment programme were reviewed on behalf of the defence by Dr. Bruce Rowat and Dr. Peter Lane. Dr. Rowat is and has been the clinical director of emergency services at Toronto General Hospital since 1977, working two shifts per week in that department. He is an associate professor of emergency medicine at the University of Toronto. Dr. Lane is the clinical director, department of emergency services, and the head emergency physician, regional trauma unit, at the Sunnybrook Medical Centre. He has practised in the field of emergency medicine since completing his emergency medicine residency at Queen's University in 1979. He is also an associate professor, department of surgery, at the University of Toronto.

Drs. Rowat and Lane dealt with the objections to diagnosis and treatment made by the plaintiff's doctors as follows:

Diagnostic error

Hypovolemic shock is diagnosed on the basis of an over-all clinical impression. They agree with Dr. Shulman's diagnosis of the plaintiff's condition as hypovolemic shock based on the patient's presentation with the following important symptoms: Substantial bleeding; skin cold and clammy with perspiration; extremities cold indicating reduced blood supply; consciousness depressed; reduced blood pressure, and obvious substantial facial injuries.

The pulse rate being low rather than increased, did not rule out hypovolemic shock. Dr. Rowat was of the opinion that any statement that this was not hypovolemic shock was nonsense.

Regarding Dr. Shulman's failure to note the diagnosis of hypovolemic shock in the emergency room records, those symptoms do not appear until the body has lost about 30% of its fluid by volume. This would not likely occur by arrival at hospital emergency within 15 minutes of injury but the symptoms did start to manifest at 14:30 hours.

Treatment errors

(1) When in X-ray, the plaintiff's blood pressure fell precipitously to 50 systolic, indicating a failure to respond to the Ringer's Lactate management of the major blood loss. This treatment was clearly inadequate and in the opinion of Dr. Rowat and Dr. Lane, in accordance with standard medical care, blood therapy was required. They agreed that the necessity for blood therapy is based on a very broad and general consensus among all disciplines and specialities in the profession.

(2) Drs. Rowat and Lane agree that there was no indication that too much fluid or blood was administered and further confirmed that in their opinions the quantity of blood was appropriate.

(3) With respect to posterior nasal packing to further control bleeding, the massive trauma to the facial structures to the extent of a Le Fort III fracture carried the potential that those structures were displaced or unstable, and a further potential for fracture of the cribriform plate (the thinnest portion of the skull being the area of the floor of the brain behind the palate) in close proximity to the massive external injuries, a misdirected catheter or endo-tracheal tube may disrupt the brain or spinal cord. Therefore X-rays of face, skull and cervical spine were critical in order that the treating doctor could first determine the extent of the injuries and the status of the spine and of the cribriform plate to avoid risk of paralysis or death. Thereafter, when the patient stabilized, posterior packing should be undertaken. As well, with disruption of facial anatomy, the catheter insertion carries the risk of causing further bleeding and an effective block by the balloon is less probable.

(4) The considerations applicable to the posterior nasal

packing also applied to intubating and it was appropriate to postpone this to 16:15 hours even though further swelling may occur.

(5) Analgesics or "pain killers" such as morphine do not assist in the management of shock induced by blood loss and may mask symptoms and also render the patient unconscious thereby creating communication difficulties. Such treatment may also dilate the peripheral blood vessels and thereby may precipitously and significantly drop blood pressure. The patient did not initially require such relief because of her level of consciousness. Dr. Shulman did authorize their administration as it became necessary.

(6) With regard to the diagnostic suggestion by Dr. Pogue that the slow pulse rate was due to vagal stimulation, Dr. Lane was of the opinion that the probable cause was injury or contusion to the heart. The high energy collision with paradoxical sternum and associated ribs render this as a valid consideration. As well the slow heart rate could be caused by heart disease consistent with the plaintiff's stated age of 57 years, routine medication for angina or blood pressure, or the stress of major trauma. He was of the opinion that it was unlikely that a vagal response produced the slow heart rate.

(7) With respect to restoring blood pressure to a lower than normal level, Drs. Lane and Rowat confirm that it is standard medical practice to restore haemo-dynamic parameters and it was quite appropriate to restore over-all blood volume. The therapy of keeping blood volume and pressure low should be rejected as simply prolonging the hypovolemia and risking impairment of circulation to tissues.

(8) Drs. Lane and Rowat confirm that according to hospital charts and records the potential dangers of excessive infusion of fluids did not develop to any clinically significant degree.

In order to evaluate Dr. Shulman's care, apart from the plaintiff's specific objections, they regarded it as necessary and proper to put themselves in the doctor's position at the time and not to be wise with the lucidity of hindsight. In so

doing they 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.

Both agree that Dr. Shulman assessed and treated in accordance with A.B.C. protocol applied in major trauma cases (Airways, Breathing, Circulation), directing his attention immediately to:

Airways -- No initial intervention was indicated respecting the movement of air.

Breathing -- Air entry was initially good on both sides and when oxygen by face mask was administered no other immediate treatment was indicated.

Circulation -- There was evidence of extensive bleeding indicating that volume should be replaced. This was expeditiously assessed and blood loss was vigorously replaced according to standard medical teaching and practice by two large bore intravenous lines, one in each arm. Glucose and water were quickly and appropriately changed to Ringer's Lactate which is an appropriate solution.

Having identified the immediate life threatening considerations, it was appropriate to initially attempt to control bleeding by anterior nasal packing.

It was appropriate that Dr. Shulman as casualty officer should consult Dr. Dakin, the surgeon, and follow his advice.

X-rays were also necessary because the paradoxical breathing which developed in the area of sternum indicated double fractures of the same ribs with portions floating. The heart was directly behind that injured area. There was also external evidence of injury in the pelvic area particularly at the iliac crest in the area of the large abdominal vessels.

Because of the instability that developed in X-ray the transfer to the intensive care unit with its monitoring systems

was appropriate.

When Dr. Shulman and Dr. Dakin continued to be perplexed as to the source of blood they conducted the mini-laparotomy as standard surgical practice. As well the bronchostomy was quite reasonable once the patient was intubated.

At 18:30 hours the further attempt at posterior nasal packing was timed as a matter of medical judgment and was then appropriate as the patient was stabilizing. The discontinuance of the attempt was sound because it was relatively contra-indicated by the low blood pressure and pulse and the patient's over-all status which was still somewhat compromised.

The decision to transfer from a primary care to a tertiary care hospital was appropriate once the patient was stabilized and the airway was secured by the ventilator. It was appropriate that the patient, especially with the Le Fort III facial fracture, be sent on to an area of more expertise. Transfer is recommended on a casualty scale of 15. This injury scaled at 29.

By 23:30 hours the blood pressure was somewhat stabilized. The transfer to Toronto was upcoming and because of the inherent difficulties of surgery during flight a further attempt at posterior packing was definitely indicated.

Blood loss

Although the material facts are substantially free of dispute, a factual determination must be made respecting the evidence of bleeding.

The conclusion by the plaintiff's expert medical witnesses that there had not been much bleeding and that it was essentially stopped on hospital arrival was based on the following analysis of the trial evidence and hospital records:

(1) Witnesses Blanchard, Clarke and Hodgins gave evidence consistent with no gross bleeding before hospital arrival.

(2) Nurse Hannah's nursing note of a blood clot at the patient's nose with blood oozing around it.

(3) The absence of reference to profuse bleeding in nursing charts.
(4) Cross-examination of the emergency department nurses and Dr. Shulman challenging their evidence at trial of substantial bleeding.

(5) Blood pressure and pulse rate at the emergency department were only slightly elevated and so were consistent with pain and anxiety and ruled out any significant bleeding.

(6) The patient did not respond to rapid infusions of fluid -- although this was qualified, as Dr. Thomas agreed, by the possibility that the patient was losing fluid at about the same rate.

The evidence supporting excessive bleeding was:

(1) Dr. Shulman's admission history indicating profuse bleeding from the outset, referring to bleeding from both nostrils and throat, loss of one litre of blood in one hour and vomiting of old and new blood. The plaintiff's doctors expressed reservations as to the accuracy of that record, preferring the nursing notes which they described as "contemporaneous" although made at most an hour prior to Dr. Shulman's dictation of the admission history. The suggestion was made during the course of the trial by the plaintiff's lead counsel that the doctor had prepared hospital records in consultation with his solicitor in contemplation of this action. That allegation was totally unsupported.

(2) Dr. Dakin's consultation record dictated at 15:00 hours noting that the patient was obviously grossly shocked and urgently needed blood to survive.

(3) Dr. Wolfe's consultation report.

(4) The severe facial injuries involving lacerations and obvious fractures.

(5) The evidence of Dr. Shulman regarding the dramatic presentation of the plaintiff in emergency with an abundance of blood.

(6) The nurses' evidence of profuse bleeding.

Helen Blanchard and Alice Bourgeois, members of the local Jehovah's Witnesses congregation, sat with the plaintiff through the course of the evening to comfort her. They described extensive bleeding from the eyes, nose, ears and mouth (this, at a time when blood was being transfused).

The doctors attending the plaintiff were in a far superior position to assess bleeding than those doctors later reading hospital charts and records. I find no reason not to accept the evidence of Drs. Shulman and Dakin and of the nurses regarding blood loss. I was impressed by the sincerity, candour and professional manner of all of those witnesses and I found their evidence to be credible and reliable. The suggestion that their evidence regarding blood loss was in any way contrived or exaggerated was unwarranted. I find that there had been profuse bleeding with substantial blood loss as described by Dr. Shulman and the nurses. This bleeding continued until late that evening.

The opinions of and conclusions by Drs. Pogue and Thomas were premised on there being no substantial blood loss and this casts grave doubt on the validity of their theories.

Standard of care

To determine the standard of practice to be reasonably expected of the defendant doctor, the evidence of independent expert medical witnesses must be considered in light of:

(1) the relevance of their training, experience and specialty to the medical issues before the court;

(2) any reason for the witness to be less than impartial;

(3) whether the standard of care propounded reflects the standard of the great majority of medical practitioners in the field in question, and

(4) whether that testimony appears credible and persuasive compared and contrasted with the other expert testimony at the trial.

Dr. Roen's experience in the basic management of patients with blood loss, hypovolemic shock, and falling haemoglobin is substantial. He had little or no primary responsibility for facial injuries and has never carried out posterior nasal packing with a Foley catheter in a trauma case. He had limited emergency medicine experience never having acted as a casualty officer carrying out general medical functions in the emergency department. He has a special interest and expertise in surgery without blood transfusions (bloodless surgery), particularly for Jehovah's Witnesses, having authored an article "Extensive Urological Surgery Without Blood Transfusion". He sets a standard with respect to the avoidance of blood transfusions not reasonably to be expected of a general practitioner. His evidence is of limited use in establishing the standard to be reasonably expected of Dr. Shulman.

Dr. Pogue had hospital emergency experience from 1971 to 1974 and intensive care unit experience from 1974 to 1976, but very little such experience thereafter. As a haematologist he has special training and experience in matters of blood clotting and transfusions. He admitted to being more conservative in and to setting a higher standard for administering blood transfusions than most physicians. ("Mine is a better standard".) As well his wife is a Jehovah's Witness and he attends meetings with her and as a result he has a special interest in Jehovah's Witnesses. In Dr. Pogue's opinion transfusions are administered too casually and are too fashionable. As a result of his special interest in Jehovah's Witnesses, his specialist qualification and his higher standard, his testimony is accordingly of limited use in establishing the standard to be reasonably expected of Dr. Shulman.

Dr. Thomas' experience as an emergency department casualty officer was very limited and was all prior to 1980. Dr. Thomas is a Jehovah's Witness and admits to an approach different from the medical profession generally. He states, "I am convinced blood transfusions are harmful". Fifty per cent of his patients are Jehovah's Witnesses. He is adverse to transfusions based on his faith as a Jehovah's Witness, his own practice and experience, and his view of scientific evidence with respect to risks and benefits. Since 1971 he has made a specialty of "bloodless surgery". He therefore has a great deal more experience in bloodless surgery than would a general practitioner and therefore is of less guidance in establishing the standard of Dr. Shulman.

Because of Dr. Perales' interest and extensive experience in emergency medicine, his evidence is relevant in setting the standard for Dr. Shulman. Dr. Perales has a special interest in bloodless surgery. Fifteen or twenty per cent of his patients are Jehovah's Witnesses. He conceded that he is more inclined than most doctors to avoid blood transfusions. He regards blood transfusions as living organisms requiring the patient's consent much as in the nature of an organ transplant. He advises his patients of the risks and benefits of blood transfusions and he is more inclined to alternative treatment. Dr. Perales has a very high standard because of his specialist's training and his special interest in emergency and trauma medicine and bloodless surgery. His standards on when blood ought to be transfused are different from the majority of the medical profession. This limits the value of his evidence in establishing the standard applicable to Dr. Shulman.

All of the doctors called by the plaintiff were responsible, serious professionals of obvious sincerity and deserving great respect with much to offer in the field of bloodless medicine, but because of their varying specialties and shared special interest in "bloodless" medicine, no unfairly high standard should be set for Dr. Shulman as a general practitioner.

Dr. Shulman's opinion at trial that this was hypovolemic shock and that the vagal effects did not influence the clinical course was based on the patient's history, his clinical

examination, the vital signs and the fact that his diagnosis and therapy did benefit the plaintiff.

There is substantial support for Dr. Shulman in the evidence of Dr. Dakin who, as a surgeon, had more expertise in emergency matters and who was personally involved in assessing the plaintiff. He agrees with every step taken by Dr. Shulman throughout the case. Dr. Dakin not only confirmed the diagnosis but underscored the urgency of the blood transfusion. Dr. Shulman as a general practitioner requested this consultation and was entitled to rely substantially on the surgeon's opinion.

Of the doctors who testified, the five with significant emergency medicine experience (Drs. Perales, Rowat, Lane, Shulman and Dakin), agree that at some stage the diagnosis of hypovolemic shock was correct and that administration of fluid followed by blood, if the blood pressure does not significantly improve, is standard treatment. The remaining three (Drs. Roen, Thomas and Pogue) who had limited expertise or experience in emergency medicine share the view that the diagnosis was wrong.

Dr. Pogue concedes that if this was hypovolemic shock, it was treated as many doctors would treat. The original transfusion would be Ringer's Lactate. On failure to respond to the large volume at a rapid rate, the question of blood transfusion would then be a medical judgment. Where there is a legitimate difference of diagnostic opinion with significant bleeding in an emergency, blood would probably be routinely administered.

Dr. Roen agreed that the symptoms of hypovolemic shock are low blood pressure, cold perspiration, extremities feeling cold, reduced level of consciousness and a faint thready pulse. He acknowledges that both doctors who examined and treated the patient concluded that this was hypovolemic shock and they treated accordingly. He was further of the opinion that in cases of significant bleeding involving hypovolemic shock associated with volume decrease in circulatory blood, consideration must be given to the risk of circulatory collapse, hepatitis, kidney shut-down, acquired immune deficiency syndrome and also to the patient's wishes.

Circulatory collapse is a high priority. If bleeding continues, fluid should be administered, preferably Ringer's Lactate. This is done while time is required to cross and match blood.

Dr. Thomas agreed that both Dr. Shulman and Dr. Dakin concluded that this was hypovolemic shock and treated appropriately as generally accepted by the medical profession. They followed that standard of practice because, according to Dr. Thomas, "they did not know any better".

Dr. Perales confirmed that hypovolemic shock and vagal response are not mutually exclusive. With substantial blood loss and reduced levels of consciousness it is necessary to assess the quantity and lost fluid must be restored and bleeding stopped.

Drs. Rowat and Lane are eminently qualified and experienced senior emergency department physicians practising as well as supervising and teaching in the emergency specialty. Their testimony is relevant and is of great assistance in establishing the proper medical standard of care because on a daily basis they deal with problems similar to that presented by the plaintiff. Neither doctor has any special interest in the subject-matter of this case. They are independent with no alignment with either of the competing interests. Both gave testimony impartially and with candour. I found that testimony to be of the highest order and the evidence of Drs. Rowat and Lane is accepted. Both agree that Dr. Shulman's diagnosis, treatment and procedures met the proper standards and that he followed the proper priorities. They share the view that he did a great deal in a short time. Taken as a whole their evidence asserts no criticism of Dr. Shulman. Drs. Rowat and Lane unreservedly support every aspect of Dr. Shulman's treatment procedure. That approval is compelling evidence because it follows that having met the standard of the specialists, Dr. Shulman must have met the standard for a general practitioner.

I accept the defendants' evidence that the proper treatment and standard practice in cases of hypovolemia requires administration of a volume expander such as Ringer's Lactate while blood is being crossed and matched. If the patient does

not respond with significantly increased blood pressure this is followed by transfusions of blood to carry essential oxygen to tissues and to remove waste products to prevent damage to vital organs.

I further find that the head and facial injuries were so serious and as yet unknown prior to X-rays that it was not yet appropriate to attempt to stop the internal bleeding by including posterior nasal packing with a Foley catheter. That inability to control bleeding led inevitably to hypovolemic shock, which was required to be kept in manageable bounds until the extent of the injuries was determined and the patient's condition stabilized sufficiently to permit further nasal packing.

It follows that no negligence can be discerned in the diagnostic procedures. That diagnosis was followed by the proper treatment programme which was carried out in a competent, careful and conscientious manner. All the evidence fairly viewed supports a finding of reasonable compliance with the standard of care required. There is no evidence from which negligence can properly be found or inferred.

The plaintiff has failed to discharge the burden of proving on a balance of probabilities negligent medical care.

NURSES JOHNSON, HANNAH, WINTERS AND MATIJEK

There was no evidence called to establish a nursing standard of care against which alleged breaches of duty may be measured. The nurses followed the instructions of the doctors and there was not the slightest suggestion in evidence that they were other than prompt and efficient in the discharge of their professional duties. Their performance throughout was responsible and competent. Any deviation from a perfect standard of charting vital signs was not negligence and was not a proximate cause of any damage which the plaintiff may have suffered. I can find no fault or negligence on the part of any of the nurses.

THE HOSPITAL AND T.M. MCANULTY

Dr. Shulman was an independent contractor and not a hospital employee and so the hospital has no vicarious liability for conduct by Dr. Shulman. The actions of the hospital and its executive director in leaving the medical decision to Dr. Shulman, in not obstructing him, and in co-operating in the care of the patient constituted a reasonable response. There was no evidence of negligence with respect to the hospital or its executive director, Mr. McAnulty. Based on the conclusions which I have reached, the action in negligence against those two defendants fails.

MALICE, RELIGIOUS DISCRIMINATION AND CONSPIRACY

The plaintiff alleges that Dr. Shulman harboured malice against Jehovah's Witnesses and conspired with the other defendants to administer blood in violation of the plaintiff's religious duty to abstain from blood. Plaintiff's counsel suggested, in examination of witnesses and by material filed, that there was discrimination against and intolerance of Jehovah's Witnesses by a segment of the medical profession. He alleged this to be a specific incident of such oppressive attitude and conduct. Under that relevancy umbrella he led the Koykka and Blanchard evidence.

Koykka

After sustaining a throat larceration in a chain saw accident in 1979, Mr. Koykka was treated by Dr. Shulman at the Kirkland Hospital Emergency Department. As a Jehovah's Witness he refused blood. Dr. Shulman discussed the advisability of blood separately with Mrs. Koykka and with her 16-year-old son. He did in each case mention the possibility of death if blood was not given. The doctor gave evidence that although he considered death an unlikely event, he wanted to determine if the family supported the patient's instruction.

Dr. Shulman was the anaesthetist for Mr. Koykka's surgical procedure and administered no blood. It would have been his responsibility to do so if blood had been required. Dr. Shulman attended Mr. Koykka for several days' post-operative care in

the hospital. The topic of blood was not raised and there was no indication of resentment regarding his treatment, advice, discussions or tactics.

Blanchard

Mrs. Blanchard attended the Kirkland Hospital in January, 1977, for the birth of her third child -- her first by Caesarian section. As a Jehovah's Witness she declined blood. Dr. Shulman inquired whether blood should be administered if necessary to avoid death. Mrs. Blanchard found this discussion upsetting but maintained her refusal. Dr. Shulman was the anaesthetist during the operative procedure. The patient lost one-and-a-half litres of blood and her blood pressure dropped to 55 systolic. Had she not refused blood as a Jehovah's Witness, Dr. Shulman would have given blood. However, none was administered. Dr. Shulman testified that he had no intent to give blood because he was satisfied with her "informed" refusal. Dr. Shulman indicates that Mrs. Blanchard's surgical procedure was not an unusual event. In consequence, he had no specific recollection of the discussions but he was certain that he had no reason to attempt to dissuade her from refusing blood. He regarded it as appropriate to clarify the instruction but he neither had reason to, nor was he attempting to intimidate, be spiteful or to transfer blame as was suggested to him in cross-examination. The recollections of Mrs. Blanchard and the Koykkas of these events of ten years ago or seven-and-one-half years ago may be coloured by annoyance or upset over the fact that any discussion of potential death lacks somewhat in delicacy and is forceful to some extent.

Regarding the conversations with Mrs. Bisson, both Dr. Shulman and Mrs. Bisson apparently had strong beliefs and this conversation may have been somewhat strenuous dealing with the vital issues of life and religion. Dr. Shulman says that at that stage he was confronted with the fundamental problem of the "informed rejection" and that it would have been very sad for Mrs. Malette, having had the blood, to have it discontinued and thereby receive no benefit. He regarded her as still being very critically ill.

The conversations may have been abrupt, insensitive and lacking in communication skills (there was evidence that Dr. Shulman's manner had brought nurses to tears on other occasions). There was no indication of any underlying malice or ill-will in his dealings with the Koykkas, the Blanchards, Mrs. Malette or Jehovah's Witnesses generally. The incidents do demonstrate that Dr. Shulman was aware of and tried to comply with his ethical duty to inform the patient of the risks he believed to be involved and further that he complied with firm informed refusals to accept blood.

Aside from the Koykka and Blanchard incidents, Dr. Shulman had limited experience with Jehovah's Witnesses, one family being his patients for three to four years as well as one other occasional patient. He also had dealt with Jehovah's Witnesses in isolated incidents while on hospital emergency duty.

The doctors and nurses who gave evidence knew of no reputation by Dr. Shulman for animosity against Jehovah's Witnesses. No evidence was led, no admissions were made and no inference can be drawn that the doctor harboured any such animosity.

With respect to the alleged conspiracy by the hospital to administer blood, Dr. Shulman made a medical decision to give blood. The hospital's decision was to not actively oppose, otherwise the patient may have been gravely endangered. The hospital took reasonable care to ensure that Dr. Shulman was aware of the card and its contents. It permitted him to hang the blood but did not participate.

There was simply no evidence whatever of a medical or hospital conspiracy to violate the religious rights of Jehovah's Witnesses. There was an abject failure of any evidence of malice, ill-will, improper motive or conspiracy on the part of the hospital, Dr. Shulman or any of the other defendants and that claim is dismissed as against all defendants.

BATTERY

Dr. Shulman, on being confronted by an unconscious patient in a life threatening situation in whose possession was found a card refusing blood as a Jehovah's Witness, faced a dilemma of dreadful finality. An immediate decision was required, either to follow the instruction given by the card or to administer the blood transfusion which he regarded as medically essential. He squarely faced the fundamental issue of the conflict between the patient's right over her own body and society's interest in preserving life.

Dr. Shulman acknowledged an awareness of the patient's right to make a decision against a certain treatment in favour of alternative treatment and of his ethical obligation to abide by that decision. However, upon considering the validity of the card, he was not reasonably satisfied that it constituted an adequate instruction because there was no evidence that: (1) it represented the plaintiff's current intent; (2) the instruction applied to the present life threatening circumstances, and (3) at the time the plaintiff made the decision and signed the card she was fully informed of risks of refusal of treatment and accordingly that this was a rational and informed decision.

Since there was a "shadow of a doubt" regarding "informed" rejection of treatment, Dr. Shulman regarded himself as obliged to treat to the best of his ability and administered blood.

Even if information of the finger-squeezing episode with Hubert Bisson had been relayed to Dr. Shulman, it would have been of minimal if any value in resolving the underlying problem. The patient's head injuries and her level of consciousness were such as to render any decision, particularly one dealing with life and death, suspect. Failure by Nurse Winter to inform Dr. Shulman of the incident was not negligence. Further, the status of the "card" is not elevated by Mrs. Bisson's oral instructions or written "substitute'' consent. Although the daughter is a devout Jehovah's Witness this is not a guide to the strengths of the beliefs and objections of the mother.

The "card" was subject to attack by the defence on the basis of its inherent frailties -- that it may have been signed

because of religious peer pressure, under medical misinformation, not in contemplation of life threatening circumstances, or that it may not represent current instructions.

It was further argued on behalf of Dr. Shulman that the relatives' participation compounds the problem by adding further uncertainties, such as: is the relative the closest relative in blood; speaking for a unanimous consensus amongst the relatives; competent to give lawful consent; capable of understanding the risks, and devoid of self-interest?

Mrs. Bisson's participation has the effect of rendering unlikely these speculative frailties. It confirms the card and signature as her mother's, her mother's current status as a Jehovah's Witness and her mother's wish not to have blood. It raises nothing inconsistent with the card representing the mother's current intent applying to life threatening situations. The card itself presents a clear, concise statement, essentially stating, "As a Jehovah's Witness, I refuse blood". That message is unqualified. It does not exempt life threatening perils. On the face of the card, its message is seen to be rooted in religious conviction. Its obvious purpose as a card is as protection to speak in circumstances where the card carrier cannot (presumably because of illness or injury). There is no basis in evidence to indicate that the card may not represent the current intention and instruction of the card holder.

I, therefore, find that the card is a written declaration of a valid position which the card carrier may legitimately take in imposing a written restriction on her contract with the doctor. Dr. Shulman's doubt about the validity of the card, although honest, was not rationally founded on the evidence before him. Accordingly, but for the issue of informed refusal, there was no rationally founded basis for the doctor to ignore that restriction.

Informed refusal

A conscious, rational patient is entitled to refuse any

medical treatment and the doctor must comply, no matter how ill advised he may believe that instruction to be. The doctor lawfully invades the patient's body for the purpose of treatment only after he has fully communicated to the patient the risks of treatment and the patient makes the affirmative decision, premised on a reasonable appreciation and awareness of the risks, to permit that treatment for his body. Otherwise such treatment is a battery with liability consequences.

Section 50 of R.R.O. 1980, Reg. 865, under the Public Hospitals Act, R.S.O. 1980, c. 410, provides as follows:

> 50. No surgical operation shall be performed on a patient or an out-patient unless a consent in writing for the performance of the operation has been signed by,
>
> . . . . .
>
> (c) the spouse or a parent, guardian or next-of-kin of the patient or out-patient, as the case may be, where the patient or out-patient is unable to consent in writing by reason of mental or physical disability,
>
> but where the surgeon believes that delay caused by obtaining the consent would endanger the life or a limb or vital organ of the patient or out-patient, as the case may be,
>
> (d) the consent is not necessary; and
>
> (e) the surgeon shall write and sign a statement that a delay would endanger the life or a limb or a vital organ, as the case may be, of the patient or out-patient.

Where immediate medical treatment is necessary to preserve the life or health of the patient who is unable to express consent by reason of lack of consciousness or extreme illness, then it is not battery for the doctor to proceed with treatment in the absence of the patient's consent. Marshall v. Curry, [1933] 3 D.L.R. 260, 60 C.C.C. 136, where Chief Justice Chisholm of the Nova Scotia Supreme Court stated at p. 275:

> I think it is 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.

This principle was confirmed by Parmley v. Parmley and Yule, [1945] 4 D.L.R. 81, [1945] S.C.R. 635, where Mr. Justice Estey of the Supreme Court of Canada stated at p. 89:

> There 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. Upon such occasions great latitude may be given to the doctor or the dentist.

A special standard exists in emergency situations predicated on the impossibility of obtaining valid consent because of grave condition and the urgent necessity for treatment to protect life and health. This is recognized by text writers as follows:

Picard, Legal Liability of Doctors and Hospitals in Canada, 2nd ed. (1984), at p. 45:

> A person may be unable to give consent due to unconsciousness or extreme illness. In such circumstances a doctor is justified in proceeding without the patient's consent, subject to a number of restrictions.

> While the legal basis for substituting the doctor's decision for that of the patient has been debated by academics, Canadian judges have taken a realistic approach. Refusing to strain the law to find consent, the courts have recognized that sometimes a doctor may proceed without consent.

Rozovsky, "Consent to Treatment", Vol. 11, No. 1, Osgoode Hall L.J. 103 (1973), at p. 112:

> The one major exception in which consent to treatment is not required is in the case of an emergency ... To proceed without consent, it must be shown that it was not possible to obtain the patient's consent (assuming him to be an adult and of sound mind) and that the procedure was immediately necessary to preserve the health and life of the patient. It is not enough that it would be better or more convenient to proceed with a particular procedure at the time. It must be necessary to proceed at the time without consent.

In cases of informed consent there is an objective standard by which the physician must disclose not only the risks of the procedure but also all information which a reasonable person in the position of the patient would require. The law of informed consent is generally well established by Reibl v. Hughes (1980), 114 D.L.R. (3d) 1, [1980] 2 S.C.R. 880, 14 C.C.L.T. 1, and by Videto v. Kennedy (1981), 33 O.R. (2d) 497, 125 D.L.R. (3d) 127, 17 C.C.L.T. 307.

Chief Justice Howland in Videto v. Kennedy states at pp. 502-3 O.R., pp. 132-4 D.L.R.:

> As Cardozo J. said in Schloendorff v. Society of New York Hospital (1914), 105 N.E. 92 at p. 93: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body ...". It is necessary to consider what was the nature and extent of the duty of disclosure by the appellant. A patient's consent will only protect a surgeon against liability if the patient has been sufficiently informed so that the patient could make the choice whether or not to submit to the surgery. The basic duty of a surgeon is to disclose all material risks attending the surgery which is recommended. The responsibility was stated by Laskin C.J.C. in delivering the judgment of the Supreme Court of Canada in Reibl v. Hughes, supra, at pp. 884-5 S.C.R., p. 5 D.L.R., as follows:
>
> "It is now undoubted that the relationship between surgeon and patient gives rise to a duty of the surgeon to make disclosure to the patient of what I would call all material risks attending the surgery which is recommended. The scope

of the duty of disclosure was considered in Hopp v. Lepp, [1980] 2 S.C.R. 192, at p. 210, where it was generalized as follows:

" 'In summary, the decided cases appear to indicate that, in obtaining the consent of a patient for the performance upon him of a surgical operation, a surgeon, generally, should answer any specific questions posed by the patient as to the risks involved and should, without being questioned, disclose to him the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation. However, having said that, it should be added that the scope of the duty of disclosure and whether or not it has been breached are matters which must be decided in relation to the circumstances of each particular case.' "

"The Court in Hopp v. Lepp, supra, also pointed out that even if a certain risk is a mere possibility which ordinarily need not be disclosed, yet if its occurrence carries serious consequences, as for example, paralysis or even death, it should be regarded as a material risk requiring disclosure."

The Supreme Court of Canada analysed this responsibility in greater depth and its conclusions may be summarized as follows:

1. The question of whether a risk is material and whether there has been a breach of the duty of disclosure are not to be determined solely by the professional standards of the medical profession at the time. The professional standards are a factor to be considered.

2. The duty of disclosure also embraces what the surgeon knows or should know that the patient deems relevant to the patient's decision whether or not to undergo the operation. If the patient asks specific questions about the operation, then the patient is entitled to be given reasonable answers to such questions. In addition to expert medical evidence, other evidence, including evidence from the patient or from members of the patient's family is to be considered. In Reibl

v. Hughes, supra, at p. 894 S.C.R., p. 12 D.L.R., Laskin C.J.C. stated:

"The patient may have expressed certain concerns to the doctor and the latter is obliged to meet them in a reasonable way. What the doctor knows or should know that the particular patient deems relevant to a decision whether to undergo prescribed treatment goes equally to his duty of disclosure as do the material risks recognized as a matter of required medical knowledge."

3. A risk which is a mere possibility ordinarily does not have to be disclosed, but if its occurrence may result in serious consequences, such as paralysis or even death, then it should be treated as a material risk and should be disclosed.

4. The patient is entitled to be given an explanation as to the nature of the operation and its gravity.

5. Subject to the above requirements, the dangers inherent in any operation such as the dangers of the anaesthetic, or the risks of infection, do not have to be disclosed.

6. The scope of the duty of disclosure and whether it has been breached must be decided in relation to the circumstances of each case.

7. The emotional condition of the patient and the patient's apprehension and reluctance to undergo the operation may in certain cases justify the surgeon in withholding or generalizing information as to which he would otherwise be required to be more specific.

8. The question of whether a particular risk is a material risk is a matter for the trier of fact. It is also for the trier of fact to determine whether there has been a breach of the duty of disclosure.

The defence contended that the doctrine of informed consent should be extended to informed refusal on the following

analysis. Since there is an obligation on the doctor recommending treatment to advise as to the risks, it must logically follow there is a higher duty where the patient proposes a course of action that the doctor believes to be prejudicial. Thus Dr. Shulman was obliged in law to advise the refusing patient of the attendant risks. Only then could he be satisfied that the refusal was based on a proper understanding of risks. There was no opportunity to fulfil his obligation to ensure there was an opportunity for an informed choice and so he was not bound by the refusal of treatment.

No case has been cited supporting this concept of informed refusal of treatment. Accordingly, I proceed without the benefit of authority and rely upon the following analysis. The principle underlying the doctrine of informed consent finds its roots in the patient's well recognized right to self determination of his body. The patient has the right to decide what, if anything, will be done to his body: Hopp v. Lepp (1980), 112 D.L.R. (3d) 67, [1980] 2 S.C.R. 192, [1980] 4 W.W.R. 645. The treating doctor avoids liability for battery only with a valid consent. To be valid that consent must be informed. Hence the need for the doctor to explain risks. The doctor is legally and ethically obliged to treat within the confines of that consent. The same liability considerations do not apply to a patient's refusal to accept treatment. In that instance the doctor is not exposed to a claim in battery. The right to refuse treatment is an inherent component of the supremacy of the patient's right over his own body. That right to refuse treatment is not premised on an understanding of the risks of refusal.

However sacred life may be, fair social comment admits that certain aspects of life are properly held to be more important than life itself. Such proud and honourable motivations are long entrenched in society, whether it be for 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. Refusal of medical treatment on religious grounds is such a value. The right to freedom of religion is not challenged although the facts of this case pre-date the Canadian Charter of Rights and

Freedoms and the Charter does not operate retroactively. Chief Justice Dixon states in R. v. Big M Drug Mart Ltd. (1985), 18 D.L.R. (4th) 321 at p. 353, 18 C.C.C. (3d) 385, [1985] 1 S.C.R. 295 at p. 336:

> Freedom of religion
>
> A truly free society is one which can accommodate a wide variety of beliefs, diversity of tastes and pursuits, customs and codes of conduct. A free society is one which aims at equality with respect to the enjoyment of fundamental freedoms and I say this without any reliance upon s. 15 of the Charter. Freedom must surely be founded in respect for the inherent dignity and the inviolable rights of the human person. The essence of the concept of freedom of religion is the right to entertain such religious beliefs as a person chooses, the right to declare religious beliefs openly and without fear of hindrance or reprisal, and the right to manifest belief by worship and practice or by teaching and dissemination. But the concept means more than that.

If objection to treatment is on a religious basis, this does not permit the scrutiny of "reasonableness" which is a transitory standard dependent on the norms of the day. If the objection has its basis in religion, it is more apt to crystallize in life threatening situations.

The doctrine of informed consent does not extend to informed refusal. The written direction contained in the card was not properly disregarded on the basis that circumstances prohibited verification of that decision as an informed choice. The card constituted a valid restriction of Dr. Shulman's right to treat the patient and the administration of blood by Dr. Shulman did constitute battery.

DAMAGES

Punitive damages

Counsel for the plaintiff in his closing submissions asks for an award for punitive damages. No such relief was specifically

sought in the pleadings although they are framed in language which could support such a claim. Amendment was neither sought nor made.

Dr. Shulman was not, as urged on behalf of the plaintiff, seeking an excuse to circumvent the card and through medical arrogance to usurp the decision-making process in favour of his superior rights. This was no intransigent, defiant, refusal to accept instructions in order to force treatment. Nor was it an intentional violation of, nor a gesture of contempt for, the plaintiff's religious beliefs.

The absence of malice, religious prejudice and improper motive are manifest. It was simply an honest attempt to deal with a complex medical, legal and ethical problem. The state of the pleadings is immaterial. This is not a case for punitive damages.

General damages

There was no evidence that the treatment given delayed the plaintiff's recovery, endangered her life or caused any bodily harm. That treatment may well have been responsible for saving her life. The plaintiff's damages arise solely because she was given blood contrary to her religious beliefs.

Because she was unconscious and did not consent to administration of blood, she is recognized and accepted in her religious community as being without fault. Nor does she regard her eternal salvation as being compromised.

Accordingly her damages are limited to mental distress. She described severe emotional and mental upset. "Very, very dirty", as if her privacy had been invaded and her body violated akin to sexual assault, was her description of her feelings and sensations on becoming aware of what had happened. Her evidence was that these feelings continued to the date of this trial so that "some days I don't feel like living".

There was no evidence of medical, psychiatric or other professional assessment counselling, treatment or therapy.

There was no taint of subterfuge, guile or deceit in her evidence and I accept her description of her reaction to this ordeal as being truthful, accurate and reliable.

The fair and proper assessment of the plaintiff's general damage is difficult. The lack of corroboration is not fatal to her claim. Corroborative evidence as well as verifying often enables a depth of understanding of the loss to be compensated. That element is lacking in this case. The suggestion was made that her mental distress would have resulted from her grievous injuries including loss of her eyesight. This was unsupportable on the evidence. The plaintiff sustained damage. On a balance of probabilities, the proximate cause of that damage was demonstrated to be the infusion of blood. Although the damages are mental and emotional and hence difficult to demonstrate, they are none the less compensible and are substantial. No submissions were made regarding quantum of damage. I have concluded that a fair quantification of this loss is an assessment of $20,000 for general damages.

COSTS

(1) The plaintiff's statement of claim alleges

in paragraph 12

(Dr. Shulman)

> ... motivated by animosity toward the plaintiff and her beliefs as one of Jehovah's Witnesses determined to assault the helpless plaintiff by forcing the prohibited treatment (blood) on her in defiance of her instructions. Such action of the defendant Shulman was intended to violate her bodily privacy and to force upon her a violation of her belief in the sanctity of blood.

in paragraph 15

> The only reason such treatment (blood) was imposed was as a gesture of contempt toward the plaintiff to satisfy the medical arrogance and religious animosity of defendant

Shulman.

(2) The suggestion was made on behalf of the plaintiff during the course of the trial that the defendant Shulman had prepared the hospital records in consultation with his solicitor in contemplation of this action.

(3) The defendants, including Dr. Shulman, were accused in cross-examination of deliberately exaggerating their evidence relating to the amount of blood loss.

All of those allegations which substantially prolonged the trial were totally unsupportable by the evidence. 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. The final answer will not be known until this litigation runs its full course.

Dr. Shulman acted promptly, professionally and was well motivated throughout. His decision to administer blood was an honest exercise of professional judgment. Such unsuccessful allegations against him should bear substantial consequences.

For those reasons there will be no order as to costs.

PREJUDGMENT INTEREST

No claim for prejudgment interest was made in the pleadings and no amendment was sought. There will be no prejudgment interest.

The plaintiff will therefore have judgment for damages for battery in the amount of $20,000 against the defendant Dr. D.L. Shulman only.

Judgment for plaintiff.