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Consent to Treatment

CONSENT TO TREATMENT

By LORNE ELKIN ROZOVSKY*

This article attempts to deal with the legal aspects of consent to treatment as they affect the daily practicalities of hospital and medical practice.

Despite the ever popular box office topics of abortion, medical malpractice and moment of death, "consent to treatment" remains of burning interest to the health care industry. This is despite the fact that there are relatively few legal suits arising in this area. Hospital administrators and physicians are continually concerned about whether their treatment of patients has been in their words "legal". This concern probably stems from the differing orientations of the health care industry and the legal world. Whereas the latter focuses on the rights of individuals; the former concentrates upon the needs of individuals as determined by its own standards. The patient is not normally a participant in the decision-making process as regards treatment. The rights of the patient and the needs of the patient are not always the same, and it is the act of consenting to treatment which links the two. The health care worker, whether he be administrator, physician or nurse knows that his whole function is based on this exercise of the patient's rights. Needless to say, in an industry such as the health care field where questioning and challenging on a case-to-case basis are not a part of every day life, the entire subject matter of consent to treatment may be regarded as a threat to traditionally unquestioned authority.

The concern over consent to treatment also arises from the fact that hospitals, as opposed to practitioners' offices, are traditionally systems oriented. Efficient hospital administrators attempt to fit consent to treatment within an efficient system. This is usually done through the "consent form". What administrators, physicians and nurses fail to appreciate is the fact that the mere signing of a form does not necessarily make the proposed treatment "legal". They do not appreciate that the consent form is merely evidence of the patient having consented. The manner in which the consent is obtained may have far more bearing on whether the consent is valid than the actual signing of a form.

There is also some feeling in the health care industry, particularly in that branch mainly concerned with physicians, that consent to treatment concerns the physician almost exclusively. This completely disregards the development of the health care 'team' located in the hospital which is treating the patient. While the physician is a member of this team, many of the personnel who are presently treating and interfering with the patient's integrity are not physicians. With the usual exception of the physician, the hospital is vicariously responsible for the members of the team who are its employees.

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If the American trend is followed in Canada,¹ the hospital may be primarily responsible for the treatment of the patient. Consent to treatment is thus a matter of concern for the hospital as well as for the physician alone.²

Assault and Battery

Regardless of whether these two torts are considered as one combined tort or separately, it is clear that the effect of them is that an action arises when one person intentionally applies force to the person or body of another without the latter's consent or some other lawful reason. Such an action arises no matter how trivial the touching may be, regardless of any harm that may have been caused and regardless of whether or not the person doing the touching was angry or hostile.³ It is clear therefore that almost everything which a hospital employee or a physician does to a patient could constitute assault and battery, or in common parlance, assault. It is also clear that one of the essential elements in establishing the tort of assault is that there was no justification for the touching or that the patient did not consent to the touching.

From a realistic point of view, if there were no damages and the touching of the patient was minor and part of the general treatment, it is probable that an assault action would not be taken, or that it would be thrown out of court as an abuse of the court's process.⁴

Despite the fact that lack of consent is a constituent element of the tort of assault and battery, the matter is sometimes handled by the courts and by plaintiffs' counsel as a negligence problem. However, it should be noted that when lack of consent is discussed in negligence terms, it is usually described as negligence in failing to obtain consent; either by failing to properly inform the patient,⁵ negligence in failing to warn the patient of the risks involved in the medical procedure,⁶ or negligence in going beyond the patient's instructions.⁷ The removal of more body tissue than was necessary has also been discussed in terms of negligence rather than in terms of assault and battery or a touching outside the consent of the patient.⁸ Most Canadian cases, however, deal with the matter strictly as one of assault and battery or trespass to the person. Consent to treatment cases usually arise as a result of the

¹ *Darling v. Charleston Memorial Hospital* (1965), 33 Ill. (2d) 326, 211 N.E. (2d) 253.

² See T. L. Fisher, *Patient Consent Form* (1971), Canadian Hospital, Vol. 48, No. 1, Jan. 1971, at 34; and L. E. Rozovsky, *Consent to Investigative Operative or Treatment Procedures* (1972), Canadian Hospital, Vol. 49, No. 7, (July, 1972) at 48.

³ Salmond, *The Law of Torts* (15th ed. London: Sweet & Maxwell, 1969) at 157; J. G. Fleming, *The Law of Torts* (2nd ed. Sydney: Law Book Co. of Australasia, 1961) at 26.

⁴ *Burk v. S.*, (1951-2), 4 W.W.R. (N.S.) 520 (B.C.S.C.).

⁵ *Kenny v. Lockwood*, [1932] 1 D.L.R. 507 (Ont. C.A.).

⁶ *Male v. Hopmans* (1967), 64 D.L.R. (2d) 105, [1967] 2 O.R. 457 (Ont. C.A.). Suit for negligence dismissed.

⁷ *Boase v. Paul*, [1931] 1 D.L.R. 562 (Ont. S.C.).

⁸ *Wilson v. Swanson*, [1956] S.C.R. 804; 5 D.L.R. (2d) 113 (S.C.C.).

intentional acts of physicians or hospital employees, intention being a constituent element of the tort of trespass;⁹ whereas negligence is unintentional.¹⁰

The distinction is important usually because of limitation periods. Most provinces in Canada have in their medical or hospital statutes special limitation periods for actions against both physicians and hospitals, as well as employees of the latter.¹¹ In some cases, the limitation may be included in the provincial Limitation of Actions Act.¹² The categorization of the tort as assault or as negligence is important where the limitation period is different depending upon the categorization. Most provinces frame their special limitation periods in terms of "negligence in the admission, care, treatment or discharge of a patient" for hospitals,¹³ whereas Saskatchewan sets specific limitation periods for all actions brought against hospitals.¹⁴ The latter would of course include assault and battery, and therefore any concern about categorization of the tort would not be based on limitations. A similar problem arises with respect to actions against physicians where limitations sections are often based on "negligence or malpractice". These actions would not appear to include a claim for assault and battery. In the case of physicians, these sections are sometimes included under provincial medical acts and sometimes under Limitation of Actions Acts. While there is not always a discrepancy in the limitation period depending upon the categorization of the tort, this possibility should be kept in mind and appropriate statutes examined.¹⁵

The second reason for concern as to the categorization of a tort arising from lack of consent is that to prove assault and battery no injuries are required whereas such proof is required in any suit based on negligence.¹⁶

The third reason for concern over categorization concerns hospitals only and not physicians since malpractice insurance policies of hospitals usually cover "negligence in the administration of any medical, surgical or

⁹ See, *supra*, note 3, Salmond. Also J. J. Atrens, "International Interference with the Person" in A. M. Linden, ed., *Studies in Canadian Tort Law* (Toronto: Butterworths, 1968) at 378.

¹⁰ S. R. Speller, *Law Relating to Hospitals and Kindred Institutions* (4th ed. London: H. R. Lewis, 1965) at 98; Also *Winn v. Alexander*, [1940] 3 D.L.R. 778, [1940] O.W.N. 238.

¹¹ Hospital Act, R.S.B.C. 1960, c. 178, s. 36; The Limitation of Actions Act, R.S.A. 1970, c. 209, s. 56; *The Hospital Standards Act*, R.S.S. 1965, c. 265, s. 14; *The Public Hospitals Act*, R.S.O. 1970, c. 378, s. 37; Public Hospitals Act, S.N.B. 1966, c. 22, s. 17; Public Hospitals Act, R.S.N.S. 1967, c. 249, s. 15; The Hospitals Act, S.P.E.I. 1959, c. 16, s. 15; The Hospital Act, S.N., 1971 no. 81, s. 37. See also limitations for actions against physicians: The Limitation of Actions Act, R.S.A. 1970, c. 209, s. 55; Medical Act, R.S.B.C. 1960, c. 239, s. 82 and S.B.C. 1066, c. 26, s. 48; Medical Act, R.S.M. 1970, c. M90, s. 43; The Newfoundland Medical Board (Amendment) Act, S.N. 1959, No. 11, s. 2; Limitation of Actions Act, R.S.N.S. 1967, c. 168, s. 2; *The Medical Act*, R.S.O. 1970, c. 268, s. 48; The P.E.I. Medical Act, S.P.E.I. 1952, c. 31, s. 31; *The Medical Profession Act*, R.S.S. 1965, c. 303, s. 55; *Medical Profession Ordinance*, R.O.Y.T. 1958, c. 73, s. 10.

¹² E.g. Limitations of Actions Act, R.S.N.S. 1967, c. 168, s. 2(1)(d).

¹³ B.C., Alta., Ont., N.S., N.B., P.E.I., P.E.I. & Nfld.

¹⁴ *The Hospital Standards Act*, R.S.S. 1965, c. 265, s. 14.

¹⁵ See J. S. Williams, *Limitation of Actions in Canada* (Toronto: Butterworths, 1972) at 232.

¹⁶ In *Mulloy v. Hop Sang*, [1935] 1 W.W.R. 714 (Alta. A.D.) the injury to the patient was not as a result of the trespass and damages were awarded *per se*.

hospital treatment" which would leave the hospital uninsured for assault if a court were to interpret the policy strictly. Such a distinction does not concern physicians individually since most physicians in Canada are members of the Canadian Medical Protective Association, a mutual defence association and not an insurance company.¹⁷

A fourth concern over categorization is that if an action is categorized as assault and battery, medical testimony may not be permitted to illustrate acceptable medical practice since the standard with which the procedure was performed becomes irrelevant.¹⁸ The fact that an operation was necessary and that it was performed satisfactorily is no defence to an action based on trespass to the person.¹⁹

Consent to Treatment

There is much confusion among many of the personnel of the health care industry in relation to the distinction between consent to treatment and the consent form. It is often not recognized by the layman that the signing of a consent form merely evidences that the person has consented and that the evidence could be obtained through witnesses who either heard or saw the patient consent. Such consent may be expressed by the patient in writing or orally or it may be implied from what the patient has said or written or from some action he has taken. Once proven, the manner in which the patient consented is irrelevant.²⁰

While it was clear at common law that no amount of professional skill could justify the substitution of the will of the surgeon for that of his patient²¹ and that, generally speaking, a patient was required to give his basic and fundamental consent to the general nature of treatment to be conducted,²² the remedy for failure to abide by this principle was strictly by way of civil action. However, some provincial legislatures have now superimposed a statutory requirement on the common law. An Ontario regulation under the Public Hospitals Act, for instance,²³ states that no surgical operation shall be performed on a patient unless a consent in writing for the performance of the operation has been signed by the patient; or, if the patient is unable to sign by reason of mental or physical disability, the spouse, one of the next of kin or parent of the patient; or the parent or guardian of the patient if the patient is unmarried and under 18 years of age. Saskatchewan,²⁴ New Brunswick²⁵ and Quebec²⁶ have similar provisions. While reinforcing the common law,

¹⁷ 23, 668 members in 1971 (C.M.P.A. 71st Annual Report, June, 1971).

¹⁸ See P. V. Coffey, *Surgery Without Consent* (1965), 29 Albany L. R. 342.

¹⁹ *Mulloy v. Hop Sang*, *supra*, note 16.

²⁰ W. C. J. Meredith, Q.C., *Malpractice Liability of Doctors and Hospitals* (Toronto: Carswell, 1956) at 141-42; Speller, *supra*, note 10, at 98.

²¹ *Brannan v. Parsonnet* (1912), 83 N.J.L.R. 20 at 26.

²² *Male v. Hopmans*, (1965) 54 D.L.R. (2d) 592 at 595; [1966] 1 O.R. 647 (Ont. H.C.) aff'd by (1967), 64 D.L.R. (2d) 105, [1967] 2 O.R. 457 (Ont. C.A.).

²³ R.R.O. 1960, Reg. 523, s. 42.

²⁴ S. Reg. 13/71, s. 51.

²⁵ N.B. Reg. 66-47, s. 40.

²⁶ 3.2.1.8 of Reg. under Health and Social Services Act, S.Q. 1971, c. 48 from Quebec Official Gazette, May 27, 1972.

they also add certainty to particular vacuum areas in so far as health and hospital workers are concerned.

Criteria for a Valid Consent

Five criteria must be met to establish a good defence to a suit for assault and battery by a physician or hospital employee.

1. *Voluntary Consent.*

The patient consenting to the touching of his person must consent in a free and voluntary manner. He must be in a position to choose between consent and refusal without any feeling of constraint.²⁷ Similarly a consent given under compulsion or duress or obtained by fraudulent misrepresentation is invalid.²⁸ The patient must also be in a condition so as to physically and mentally be able to consent voluntarily. A Quebec case rejected the defence of consent where it was obtained following the giving of a sedative and was given in words of defeat, exhaustion and abandonment of willpower.²⁹

2. *Informed Consent.*

Unlike decisions of American courts which have attempted to define very strict, subjective or objective tests with regard to informing a patient,³⁰ Canadian courts seem to have described the duty to inform the patient in much more general terms — that is to be honest in fact and to express an honest belief. The Ontario Court of Appeal has held that the surgeon, in informing the patient, should not be judged as if he had warranted a perfect cure nor be found derelict in his duty on any meticulous criticism of his language.³¹ There is no necessity for a physician to explain in detail the actual medical techniques being used as long as the nature of the treatment is fully understood.³² However, Canadian courts seem to lean towards the subjective test in that the information given to the patient depends upon the condition and the mentality of that particular patient. For instance, the Ontario Court of Appeal, in dealing with lack of consent as a negligence matter, held that it was not negligent to fail to warn a patient of a grave possibility of hearing loss where, owing to the condition of the patient, the physician could not have hoped to make clear the bewildering alternatives to the treatment and the patient could not have made any intelligent choice at all.³³ In that case, the risk of hearing loss was 20 to 30%. In an earlier

²⁷ *Bowater v. Rowley Regis Corp.*, [1944] K.B. 476; also *Latter v. Braddell* (1881), 5 L.J.Q.B. 448.

²⁸ See, *supra*, note 20 at 142.

²⁹ *Beausoleil v. Soeurs de la Charité* (1964), 53 D.L.R. (2d) 65, [1965] Que. Q.B. 37.

³⁰ M. Oppenheim, *Informed Consent to Medical Treatment* (1962), 65 Clev. Mar. L. Rev. 249.

³¹ *Kenny v. Lockwood*, *supra*, note 5.

³² *Johnston v. Wellesley Hospital*, [1971] 2 O.R. 103 (Ont. S.C.).

³³ See *supra*, note 22 in the Court of Appeal.

case, the same Court held that it was not necessary to disclose to a patient before an operation those dangers which are inseparable from any operation such as death under an anaesthetic, the danger of infection, of tetanus, of gas gangrene or gangrene.³⁴ It has also been recognized that to inform the patient to too great an extent may in fact be detrimental to the patient's condition.³⁵

3. *Consent to Act Performed.*

While on the one hand the patient must give his fundamental consent to the general nature of the treatment,³⁶ on the other hand the consent must not be so general as to be meaningless.³⁷ The touching of the body or the medical or surgical treatment proposed must relate as closely as possible to that which the person has consented to. The courts have stayed away from very specific consents requiring a detailed informing of the patient and a corresponding detailed consent to same.³⁸

The major problem in this area is the extent to which the surgeon can go within the realm of the consent given. It is clear that an operation cannot be performed which is different from that which is consented to.³⁹ The British Columbia Supreme Court awarded a plaintiff \$3,000 for the tying of her fallopian tubes during a cesarean section, which was performed with the consent of the plaintiff. The Court found that while it was certainly advisable to tie the tubes, an emergency did not exist and therefore it was not necessary to take such a step at that time. The law is clear that an operation without consent on the basis of convenience is not acceptable.⁴⁰

On the other hand, the courts have gone quite far in extending the scope of consent in order to allow for the physician's exercise of judgment. For example, the Quebec Superior Court dismissed an action brought against a physician who had removed a patient's ovaries without consent. No negligence was alleged, and the physician did not decide to remove the ovaries until he had begun an appendectomy operation. Since the consent was for an operation which would put an end to the patient's troubles, consent to the removal of the ovaries was implied.⁴¹

The same Court in dealing with the same problem nine years later found for the defendant on the basis that he had done what was proper to remove the complaint of which the patient had complained. She had consented to an operation to remove this complaint. An additional factor was that her ovaries were already sterile.⁴² Both these cases relied heavily on Common Law deci-

³⁴ *Kenny v. Lockwood*, *supra*, note 5.

³⁵ See *supra*, note 22 in the Court of Appeal.

³⁶ See *supra*, note 22 in the High Court.

³⁷ See *supra*, note 10 at 99.

³⁸ *Johnston v. Wellesley Hospital*, *supra*, note 32.

³⁹ See *Valdez v. Percy*, 38 Cal. Ap. (2d) 485.

⁴⁰ *Murray v. McMurchy*, [1949] 1 W.W.R. 989; [1949] 2 D.L.R. 442.

⁴¹ *Caron v. Gagnon* (1930), 68 C.S. 155.

⁴² *E. v. M.* (1939), 77 C.S. 298.

sions. An early Manitoba case dealt with lack of consent as a negligence problem. There a physician who was employed to remove a tumor also removed the womb, the ovaries and the fallopian tubes. The action was dismissed on the basis that it was good medical practice to do this especially since the ovaries and the fallopian tubes were useless once the womb had been removed. Furthermore, because the action was brought on the grounds of negligence, the patient was unable to show that her condition was as a result of the alleged negligence.⁴³

In certain cases, the patient has made a very specific request to the physician to carry out a certain procedure. Any deviation from this procedure can result in liability.

In the famous *Mulloy v. Hop Sang* case,⁴⁴ the physician was employed to temporarily repair an injured hand and not to amputate it. The physician amputated and was found liable for trespass. In an earlier decision, the Ontario Supreme Court found a dentist liable for extracting 12 teeth instead of the one requested by the patient. Again, while the claim was based on assault and battery, the Court considered it as a negligence problem.⁴⁵

In another Quebec case, it was decided that the physician could change techniques without getting the patient's permission to do so. In *Lafreniere v. Hopital Maisonneuve*,⁴⁶ the Court, relying on an earlier British Columbia Supreme Court decision,⁴⁷ held that it was permissible for the physician to give a general anaesthetic rather than to continue to give locals. As the only master of his work, he would have been at fault in not giving anaesthesia regardless of the type. This may appear to be in conflict with the *Beausoleil* case⁴⁸ but there, the patient expressly forbade the giving of a spinal anaesthetic. The instructions were very specific and were reversed only after the patient was sedated.

As a result of these decisions, it has become the practice to request patients to consent to additional or alternative operative measures that may be found either necessary or immediately necessary.⁴⁹ While this recognizes that the operation or procedure might be extended, it does not allow for a completely different operation to take place, something which would not have been even remotely contemplated by the patient.

4. *Consent to a Particular Person Touching.*

When a person consents to being touched (a touching which without such consent would be assault) there is an implication that the consent is also to a particular person doing the touching. As a result, it has also become

⁴³ *Bennett v. C.* (1907-8), 7 W.L.R. 740 (Man.).

⁴⁴ [1935] 1 W.W.R. 714 (Alta. A.D.).

⁴⁵ *Boase v. Paul*, *supra*, note 7.

⁴⁶ [1963] Que. C.S. 467.

⁴⁷ *Burk v. S.*, *supra*, note 4.

⁴⁸ *Beausoleil v. Soeurs de la Charite*, *supra*, note 29.

⁴⁹ See *supra*, note 20 at 148. Also *supra*, note 2 and *Consent to Treatment* (London: Medical Defence Union, 1968) at 10.

common practice to have patients recognize that no assurance has been given that an operation will be performed by a particular surgeon.⁵⁰ While such a clause certainly assists in avoiding problems, the Ontario High Court in *Villeneuve v. Sisters of St. Joseph*⁵¹ held that the authority given to one physician to do an operation gave that physician implied authority to engage another to do the anaesthesia. The Court reasoned that the plaintiffs, as intelligent persons, could not have been unaware that the operation involved anaesthetic and that this would be given by someone other than the physician initially employed. A similar situation arose in British Columbia where the Court concluded that it would not be reasonable to expect the physician employed to do the anaesthetic and the operation.⁵²

5. *The Patient Must be Capable of Consenting.*

Basically only adults have the legal capacity to consent to treatment. While this capacity arose traditionally at age 21, various provinces have altered this age by changing the age of majority or by enacting specific provisions as outlined above implying that capacity arises at a lesser age. Once a person has reached adulthood, that person and only that person has the power to consent to a touching of his own body. While this has been modified slightly by legislation as noted above, consent or authorization taken from other persons does not replace the necessity for consent from the patient. If a patient is not mentally capable of consenting for one reason or another, and he is not in an emergency state, nor under guardianship, in the absence of legislation, there is no person who can stand in his place for the purposes of consent.

The traditional view that persons who have not reached their majority do not ordinarily have the legal capacity to consent unless they have been specifically given such capacity by legislation was liberalized somewhat by the Ontario Court of King's Bench in the 1910 case, *Booth v. Toronto General Hospital*⁵³ in which a 19 year old though "not of the highest intelligence" consented to an operation. The Court stated that while he had not reached his majority he was capable of taking care of himself and of doing a man's work and therefore it was not necessary to consult his parents. The recognition that minors can be capable of consenting at law when they are emancipated from their parents causes certain practical difficulties for hospital personnel, particularly at the lower administrative levels, since decisions to operate in necessary but non-emergency cases must usually be made in a very limited space of time and often under a certain amount of stress. The lack of precise guidelines and of legislation specifically lowering the age limit causes much uncertainty. Admitting clerks cannot truly be expected to carry out investigations as to whether or not a child is emancipated, especially in cases where the parents cannot be found. A more difficult problem arises with patients under psychiatric care. Many people equate mental illness with a

⁵⁰ See *supra*, note 49.

⁵¹ [1971] 2 O.R. 593.

⁵² *Burk v. S.*, *supra*, note 4.

⁵³ *Booth v. Toronto General Hospital* (1910), 17 O.W.R. 118.

lack of capability. This is neither true in law nor in psychiatry. Canadian mental health legislation by and large creates a vacuum in the matter of consent to treatment, especially where the patient in a psychiatric hospital must be transferred to a general hospital for non-emergency treatment and where such person has not been declared legally incompetent.

Public trustees are not usually given power over the person of a patient but over his estate only. Thus consent cannot be given by this official. Similarly mental health legislation usually does not give the director or administrator of a mental hospital the power of guardianship over the person of his patients. Guardianship proceedings, especially for relatively minor medical matters, are costly and time consuming, and this gap in Canadian mental health legislation should be filled. Until that time however, consent is often obtained from relatives or from hospital administrators — not as a substitute for the consent of the patient but to estop the relatives from taking action against the hospital and the physician. Given the attitude of the Canadian courts in the area of consent to treatment, one wonders whether a court would in fact be very sympathetic to a suit for assault and battery where hospital and medical officials have acted reasonably and fairly and for the benefit of the patient.

Other groups which concern health care workers are married men and women, prisoners, the blind, the deaf, the illiterate and non-English speaking persons. While the rights of a husband over his wife's body (or vice versa) can be disputed at length and are beyond the scope of this article, one must recognize that there is no requirement at Common Law for consent from a patient's spouse. However it is advisable, particularly in the area of sexual relations and reproductive capabilities, to obtain consent on the ground that such an operation would affect the non-patient spouse's marital rights. Such a procedure requires the consent of the spouse not as a substitute for that of the patient but in addition to it.⁵⁴ It should be noted that consent must be obtained from prisoners unless there is a statutory provision to the contrary. Without such authority even a court cannot order a procedure as simple as a medical examination of a prisoner without his consent.⁵⁵

The blind, the deaf, the illiterate and non-English speaking patients cause certain problems simply because of the difficulty of informing these patients of what they are consenting to and the reliance by many health institutions on written forms, without making provision for consent to be obtained in a manner conducive to the capabilities of the patient. Hospitals and physicians should make provisions to obtain consent in a way that allows such patients the full exercise of their rights.

Forbidden Touching

The mere fact that a person requires medical attention does not give the health care workers confronting him the right to treat him over his objections. No consent can be implied from his condition, and once it has been proven that he has specifically refused to give consent, there is no defence to a suit

⁵⁴ See discussion in *Best v. Samuel Fox and Co. Ltd.*, [1954] 2 All E.R. 394.

⁵⁵ *Agnew v. Johnson*, 13 Cox C.C. 625.

for assault. Such was the case in *Mulloy v. Hop Sang*.⁵⁶ The patient in that case specifically told the physician that his hand was not to be amputated. The physician said that he would be governed by the conditions found when the anaesthetic had been administered, and he assumed that by not receiving an answer from the patient he could proceed as he pleased. Because the patient was a foreigner, the Court found that he did not understand what the physician had said and that if he had, since he already had given specific instructions, he would have refused. Thus the Court would not imply consent from his failure to answer the physician's remark. The *Beausoleil* case⁵⁷ was also a case of forbidden touching. Such cases usually arise with Jehovah Witness patients since their refusal to accept blood transfusions brings them into direct confrontation with the orientation and mentality of the health care industry.⁵⁸

Emergencies

The one major exception in which consent to treatment is not required is in the case of an emergency. An emergency may arise on the initial contact with the patient or during treatment of the patient. 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.⁵⁹ 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.⁶⁰

Experiments

The usual principles of consent apply to experimental medical procedures. However, because the risk may be far greater and because in many cases there is no benefit to the patient, the patient must be informed to a much greater degree than he would ordinarily. The possibility of an adverse psychological reaction is no excuse for not doing this. In *Halushka v. University of Saskatchewan*,⁶¹ the Saskatchewan Court of Appeal held that the duty to inform is as great if not greater than in ordinary medical cases and that there can be no exceptions as in ordinary medical practice. The researcher does not have to balance the probable effect of lack of treatment with the effect of the information on the patient. Furthermore, the Court stated that the undisclosed or unrepresented facts need not concern matters which directly cause the ultimate damage if they are of a nature which might influence the judgment upon which the consent is based.

⁵⁶ [1935] 1 W.W.R. 714 (Alta. A.D.).

⁵⁷ (1964), 53 D.L.R. (2d) 65, [1965] Que. Q.B. 37.

⁵⁸ L. E. Rozovsky, *Blood (Part I): Jehovah Witnesses & The Law*, Canadian Hospital, Mar. 1971.

⁵⁹ *Marshall v. Curry*, [1933] 3 D.L.R. 261 (N.S.S.C.).

⁶⁰ *Mulloy v. Hop Sang*, *supra*, note 16.

⁶¹ (1965), 53 D.L.R. (2d) 436.

The Consent Form

Hospitals, physicians and nurses are constantly asking when the law requires them to use a consent form. Since it is the consent which is required and not the signed form, the simple answer would be never except where provincial legislation requires it. It must be explained to them that the consent form commonly used in hospitals and by physicians is merely evidence that the patient has consented and that in itself it is not foolproof. If the form in which it is written or the manner in which it is signed or the circumstances under which it is signed are not in conformity with the facts or with the legal requirements of the particular situation, it can be overthrown.

Despite the fact that one need not prove damages in assault and battery cases, it is more likely that a patient will sue on grounds of assault and battery, perhaps in addition to negligence, where injury has in fact occurred. Since written evidence collected at the time of the event is usually more reliable than the memory of a witness, it would be best to obtain such written evidence in cases which carry a greater risk of injury to the patient. In all other cases the patient is less likely to sue, or if he were to sue without having suffered damages, the courts would probably regard it as an abuse of the court's process or award only nominal damages, especially where the hospital and physicians have acted fairly and reasonably. These are the legal risks which must be outlined by the solicitor to his hospital or medical clients. The extent of the protection desired is strictly an administrative and medical decision. Needless to say, the best protection would be to have a consent form signed in cases of all touchings of all patients. Considering the practical effects however, the operations of the hospital would grind to a halt.

Conclusion

While it is clear that Canadian courts have accepted the right of the patient to refuse treatment and have balanced this right with the desirable goal of the health care industry to care for the needs of a patient, there is often considerable disturbance when a patient does exercise his rights to refuse treatment. Mr. Justice Knowles speaking in the Saskatchewan Court of King's Bench in 1929⁶² expressed his frustration over a patient who had refused to consent to a necessary operation and was, as a result, experiencing an agonizing wait for death.

His Lordship said:

Three months ago the medical men knew this would all happen, but according to our present legislation, or lack of legislation, they were helpless. The poor immigrant, through ignorance or foolhardiness, or both, forbade them putting forth the hand which would have saved his life. Should not society protect such a man from his own foolishness?

⁶² *Masny v. Carter-Halls-Aldinger Co. Ltd.*, [1929] 3 W.W.R. 741 at 745.

