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François Lareau
8 December 2011

APPENDIX "CODE-10"

BRIEF

Canadian
Medical
Association

Brief to the House of Commons Sub-Committee of the Standing Committee on Justice and the Solicitor General on the Recodification of the General Part of the Canadian Criminal Code

Submitted by
The Canadian Medical Association
Ottawa, Ontario
October 19, 1992

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To provide leadership for physicians and to promote the highest standard of health and health care for Canadians.
Jouer un rôle de chef de file auprès des médecins et promouvoir les normes les plus élevées de santé et de soins de santé pour les Canadiens.

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I INTRODUCTION

The proposed recodification of the General Part of the *Criminal Code* (*Code*) aims to make the *Code* simpler, clearer and more readily understandable by all Canadians and to bring the *Code* up to date so that it applies to Canadian society today. The General Part of the *Criminal Code* will set principles and rules that will apply to all offence creating sections.

The science and practice of medicine and Canadian society have changed considerably since the introduction of the original *Code* in 1893. While the *Code* has proved remarkably flexible in accommodating many of these changes there remain theoretical and practical difficulties in applying the principles of the *Code* to the context of medical practice today.

Advances in the science of medicine have been dramatic in the past 100 years. Invasive surgery, transplantation, transfusion, systematic research and mechanisms to save, sustain and prolong life are some of the practices of today that were not contemplated when the original *Code* was drafted.

Canadian society has also changed since the *Code's* inception. One significant change is the emphasis on and predominance of individual rights and freedoms. This is reflected in the Canadian Constitution by the recent addition of the *Canadian Charter of Rights and Freedoms*, in federal and provincial human rights legislation and in court decisions; it is also reflected in the changed nature of the physician-patient relationship where decisions are now made jointly between physician and patient rather than by the physician alone.

These changes have contributed to a tension between the apparent requirements of the criminal law and medical practices that are considered appropriate and desirable. The changes have also raised difficult questions as to what constitutes appropriate conduct in a particular medical context.

The Canadian Medical Association (CMA) represents more than 46,000 or 80% of physicians across the land and all ten provincial and two territorial medical associations are represented on the Board of Directors and at the General Council of the Association. The CMA is pleased to have this opportunity to participate in the process of developing a criminal law which meets the needs of Canadian society today by bringing the major concerns of physicians to the Sub-Committee of the Standing Committee on Justice and the Solicitor General.

Canadian physicians are primarily interested in ensuring that the new General Part of the *Criminal Code*:

- explicitly recognizes medical practice as a legitimate sphere of activity, distinct from the wrongs that the criminal law seeks to address;
- clarifies the ambiguities in the current law particularly with respect to the obligations of physicians in the initiation and cessation of treatment; and,
- addresses differences in the clinical and criminal law definition of death.

The CMA will address these issues in turn. The first section of each issue will discuss the difficulties posed by the current criminal law. This will be followed by a discussion and critique of the recommendations contained in a number of publications of the Law Reform Commission of Canada (a list of all documents referred to is appended to this brief), including the recommendations of the Framework Document,[1] and the recommendations of the CMA. The final section for each issue will contain conclusions and will reiterate the recommendations of the CMA. These recommendations are general in nature since there is no draft legislation to comment on. It is hoped and anticipated that the CMA will have the opportunity to continue to participate in the process that results in the *Code's* recodification, particularly with respect to commenting on proposed legislation.

II ISSUES FOR CANADIAN PHYSICIANS

A) EXEMPTION FROM CRIMINAL LIABILITY

1) *THE CURRENT CONTEXT*

The criminal law condemns violations of bodily integrity by making it an offence to intentionally, recklessly or negligently, kill, cause bodily harm or assault another person. Only in the case of assault does the consent of a person transform what would be culpable conduct into conduct that is not contrary to criminal law.

The outcomes that criminal law seeks to condemn are sometimes also the unintended or intended outcomes of medical practice. Many of the activities of physicians involve a *risk* of death or bodily harm to patients. Although never the intended outcome, physicians will embark on a course of action in the knowledge that such a risk exists and may materialize. Sometimes such a risk does materialize and unintended death or bodily harm ensues. In addition, the nature of medical practice often involves activities that are physically intrusive. These can range from

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[1] Working document of the Sub-Committee on Justice and the Solicitor General, *Towards a New General Part of the Criminal Code of Canada.*

touching a patient to highly invasive surgery. The intended outcome of any of these activities is the benefit of the patient. However, as well as benefiting the patient, the more intrusive practices will also cause unavoidable bodily harm. Finally, practices such as the donation of tissues and organs and experimentation may produce both intended and unintended outcomes. While these practices are clearly beneficial to individual recipients of donations and to the population that benefits as a result of research, the individual donating or participating in research cannot always be said to have physically benefited from participating in such activities.

Since it is a criminal offence to engage in conduct that may or does cause bodily harm, and since it is not a defence to claim that the "victim" consented to the conduct, a large sphere of activity engaged in by physicians potentially and theoretically contravenes the *Code*.

There is a clear distinction between the conduct the criminal law condemns and the conduct of physicians. The criminal law is concerned with objectional conduct and antisocial acts whereas the conduct of physicians is encouraged and receives public sanction in light of the ends that are attained. This distinction is currently recognized both implicitly and explicitly. Implicit recognition is evidenced by the absence of criminal actions against physicians. Explicit recognition can be found in sections 45 and 216 of the current *Code*.

Section 45 provides:

- Every one is protected from criminal responsibility for performing a surgical operation on any person for the benefit of that person if

    (a) the operation is performed with reasonable care and skill; and

    (b) it is reasonable to perform the operation, having regard to the state of health of the person at the time the operation is performed and to all the circumstances of the case.

Section 216 provides:

- Every one who undertakes to administer surgical or medical treatment to another person or to do any other lawful act that may endanger the life of another person is, except in cases of necessity, under a legal duty to have and to use reasonable knowledge, skill and care in so doing.

The standard of conduct expected of physicians is not without scrutiny. The criminal law operates to prohibit undesirable practices and conduct. However, in general, the practice of medicine is monitored and regulated through the civil law system and by professional licensing and regulatory authorities.

The difficulties with the current regime are twofold. First, the implicit recognition of the distinction between medical practice and conduct that the criminal law seeks to condemn results

in uncertainty as to which conduct is permitted and under what circumstances. These difficulties have been recognized in a number of the works of the Law Reform Commission of Canada and recommendations have been made as to an appropriate resolution. In light of this, failure to address these difficulties explicitly may be construed as a decision to define as criminal, activities that are currently implicitly recognized as legitimate.

Second, while the provisions contained in the current *Code* have provided physicians with some protection from criminal responsibility, the provisions are too narrow in scope to clearly apply to medical practice today. Section 45 of the *Code* has been found by the courts to apply only to surgery.[2] However, there are many practices other than surgery that may result in death or bodily harm. There are other practices that are accepted as legitimate even though they do not benefit the person who is the subject of the practice. In addition, there is some doubt as to the scope of the defence contained in section 45. It has been suggested by the Law Reform Commission that the defence may only be available in situations of necessity or emergency.[3]

Two of the stated objectives of the recodification are to clarify the law and to update the law so that it applies to society today. These objectives will be served by incorporating provisions that appropriately resolve the difficulties outlined above.

2) *RECOMMENDATIONS OF THE LAW REFORM COMMISSION OF CANADA*

Two works of the Law Reform Commission of Canada were devoted to medical treatment and the criminal law: Working Paper 26, Medical Treatment and Criminal Law[4] and Report 28, Some Aspects of Medical Treatment and Criminal Law[5]. Both of these works recognize the problems discussed above and make specific recommendations as to their resolution. The overall recommendations of the Law Reform Commission of Canada, based on numerous works produced over a span of approximately twenty years, are contained in Report 31, Recodifying the Criminal Law[6]. This report also addresses and contains recommendations about the problems identified above. The Framework Document does not consider or make recommendations on this matter. The CMA considers this to be a serious omission.

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[2] *Morgentaler v. R.* (1975), 20 C.C.C. (2d) 449 (S.C.C.)

[3] Law Reform Commission of Canada, Working Paper 26, Medical Treatment and the Criminal Law (1980) at 39.

[4] (1980).

[5] (1986).

[6] (1987).

The recommendations contained in these works cover five distinct topics. These are:

a) Distinguishing between conduct the criminal law seeks to condemn and the conduct of physicians engaged in the practice of medicine.

b) Defining medical treatment

c) Addressing the relevance of patient consent

d) Specifying the standard of conduct required in order for such conduct to be lawful

e) Providing for practices that are considered non-therapeutic, for example organ and tissue donation and experimentation.

The recommendations of the Commission, a comment on the recommendations and the recommendations of the CMA will be considered in turn for each of these topics.

a) **Distinctions between conduct the criminal law seeks to condemn and the conduct of physicians engaged in the practice of medicine.**

i) Recommendations of the Commission

In Working Paper 26 the Commission recommended:

- that the administration of treatment continue to be regulated by the *Criminal Code* but be distinguished from certain other acts of application of force which are considered to be criminal;

- that treatment ... [be] considered as *prima facie* legal

In Report 28 the Commission noted:

- Some form of regulation of medical treatment within the *Criminal Code* is essential. This is implicit in the existing legislation, as the provisions of sections 19, 45 and 198 on the one hand legalize what would otherwise fall under the heading of assault, and on the other set out general criteria governing the legality of this type of procedure.

- The final form which the regulation of medical treatment may take in the new Canadian Criminal Code is still to be determined. It will probably only be settled once the substance and form of other provisions governing offences against the person are determined.

The Commission went on to recommend:

- That all the offences against the person currently contained in the *Criminal Code* be retained, subject to the necessary technical modifications of substance and form, and that provision be made for redefining the rules regarding medical treatment;

- That the new legislation on the subject be drafted so as to separate medical treatment from other forms of violation of the integrity of the person and to recognize that the former is *prima facie* legal.

In Report 31 the Commission distinguished between two types of assault: assault by touching or hurting and assault by harming. Consent would constitute a defence for the former type of assault but not for the latter. (The current *Code* makes similar distinctions.) To avoid making many medical practices criminal, the Commission recommended that the offence of assault by harming, committed purposely or recklessly, not apply to the administration of treatment.[7]

ii) Comment

Working Paper 26 and Report 28 both recommend making a distinction between medical practice and conduct the criminal law seeks to condemn. Both reports recommend that the criminal law should continue to have some application to medical practitioners. The vehicle chosen to accomplish this is, with the caveats discussed below, to recognize medical practice as *prima facie* legal. This recommendation probably codifies what is currently implicit in practice. If medical treatment were recognized as *prima facie* legal this would mean that there would be a rebuttable presumption that conduct was lawful. If a physician were charged with an offence such a provision could be raised in defence. The defence could be defeated, however, if it were established that the circumstances were such that the presumption of legality is rebutted. The circumstances that would warrant a rebuttal of the presumption are not specified in the recommendations. Consequently, if these recommendations were followed, it would be left to the courts to outline when the defence is available and when it is not. As a result there would be no certainty as to what constituted acceptable conduct and what constituted unacceptable conduct. Such uncertainty should be avoided if possible and the preferred approach would be a provision that is clear as to what is required of conduct in order for it to be recognized as legal.

The recommendation contained in Report 31 takes a different approach: an offence creating section is deemed not to apply to medical treatment provided conduct has complied with other requirements of the exemption section (these requirements are discussed below). This recommendation successfully addresses the problem of the *Code*'s apparent prohibition of the more invasive medical practices as a result of its prohibition of severe violations of the body notwithstanding consent. The principal difficulty with this recommendation is the limited nature

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[7] Page 62.

of its scope. As discussed above, there are a number of offence creating sections that have potential application to medical practice, including those that relate to killing and assault. However, Report 31 does not recommend an exception if conduct has resulted in death rather than bodily harm or, in the case of assault by touching or hurting, if consent has not been given.

The current criminal law protects physicians from criminal liability in cases of the intended or unintended outcome of bodily harm and the unintended outcome of death, provided conduct has complied with stipulated standards. Although Report 31 contains an exemption in the offence sections relating to causing death, this exemption is restricted to palliative care and would not, therefore, be generally available. Since many medical treatments have a known risk of death and since treatments are proceeded with in full knowledge of this risk, which at times materializes, it is important that an exemption also be provided to protect physicians from liability in the event of the unintended outcome of death.

The exemption also does not apply to the less serious form of assault (assault by touching or hurting). Consent is the key to the lawfulness of conduct in this context. In the medical context, however, there are times when consent cannot be obtained. A patient may be unconscious and unable to consent. The patient may be a child and lack the capacity to give consent. The patient may be an adult who temporarily or permanently lacks the capacity to give consent. In these circumstances if the lawfulness of conduct is determined by consent and there is not an appropriate exemption in the case of medical treatment, then any medical treatment given would constitute an assault.

This discussion illustrates that many of the *Code*'s provisions that protect bodily integrity are problematic when applied in the medical context. A recodified Special Part of the *Code* is unlikely to change this. Since the problem is generally applicable it is appropriate to address it in the General Part of the *Code*.

iii) Recommendation of the CMA

CMA RECOMMENDS THAT:

THE GENERAL PART OF THE CRIMINAL CODE CONTAIN A PROVISION THAT LEGITIMIZES THE PROVISION OF MEDICAL TREATMENT AND THAT SUCH A PROVISION BE GENERALLY APPLICABLE.

b) Definition of medical treatment

If medical treatment is to be recognized as legitimate then it is important to establish which activities are considered to be included within the definition.

i) Recommendations of the Commission

In Working Paper 26 the Commission recommended:

- that the concept of treatment be recognized for the purposes of the *Criminal Code* as a process oriented towards the therapeutic alteration of individual health condition resulting from disease, illness, disability or disorder.

In Report 31 the Commission did not make specific recommendations as to the definition of treatment. However, in commenting on its recommendation that medical treatment be exempted from the offence creating section of assault by harming, the Commission noted:

- Medical treatment .... is to be understood in a broad sense, as recommended in Working Paper 26 .... to cover not only surgical and dental treatment but also procedures taken for the purpose of diagnosis, prevention of disease, prevention of pregnancy or as ancillary to treatment.

ii) Comment

The intent of the recommendation and comment is to give a sufficiently broad definition of medical treatment which is in keeping with a common understanding of this term within the health care context. The Commission did not recommend including organ and tissue donation or experimentation within this broad definition and Working Paper 26 would have excluded procedures such as birth control from the definition since it classified them as non-therapeutic interventions for social purposes. The inclusion, in Report 31, of the prevention of pregnancy as a medical treatment would appear to the CMA to be a correct one. Working Paper 26 also recognizes "care" as an element of treatment and defines care to be "the maintenance of a person's physical and mental condition to avoid and preserve basic comfort and functions". The recommendation made in the Working Paper focuses on "therapeutic alteration" and may not, therefore, adequately capture the inclusion of care. A definition of medical treatment should include care in order to cover those situations where patients require care even though their condition cannot be therapeutically altered; this is particularly necessary in the case of terminally ill patients receiving palliative care.

The definition of medical treatment should be broad enough to incorporate what is generally accepted as the scope of practice of qualified physicians engaged in promoting the well-being of their patients and, particularly in the case of physicians practising in the public health field, of society. The definition should also be dynamic rather than static, to allow a sufficient degree of flexibility to incorporate new practices.

iii) Recommendation of the CMA

THE CMA RECOMMENDS THAT:

MEDICAL TREATMENT BE GIVEN A SUFFICIENTLY BROAD DEFINITION THAT IS DYNAMIC AND INCORPORATES THOSE PRACTICES THAT ARE GENERALLY ACCEPTED AS WITHIN THE SCOPE OF PRACTICE OF A QUALIFIED PHYSICIAN, INCLUDING THE PROVISION OF CARE AND PUBLIC HEALTH MEASURES.

c) Relevance of patient consent

i) Recommendations of the Commission

All three documents contain provisions that would require a patient's consent to be a pre-condition of any exception or distinction made.

In Working Paper 26 the Commission recommended:

- that individual consent continue to be recognized as one of the essential conditions of the legality of the administration of treatment;
- that what constitutes a legally valid consent to treatment, for the purposes of the criminal law, be determined according to the standards evolved by case law;
- that treatment not be administered without the consent of the individual treated, unless there is or has already been a finding of incompetence or another specific exception recognized by law;
- that the judicial finding of incompetence be made by a Superior, a District or a County Court;
- that decisions regarding non-therapeutic interventions on incompetents be made by a provincial board established for this purpose;
- that the right of a competent adult to refuse treatment be specifically recognized by the *Criminal Code*;
- that treatment shall not be administered against an individual's refusal unless there is a finding of incompetence or an exception recognized by law;
- that treatment can legally be administered to an individual without the necessity of obtaining his consent, in a situation of emergency, where that individual is incapable or unable to express his consent;

- that the right of a competent individual to refuse treatment in a situation of emergency be recognized.

In Report 28 the Commission states that, "the new *Criminal Code* should attempt to achieve greater clarity as regards consent, and in particular as to the legal effect of consent by the "victim" to a violation of the integrity of his person. To achieve this objective the Commission makes the following recommendations:

- that except in emergency cases, the patient's consent be a prerequisite to the legality of medical treatment. Where the patient is unable to communicate, the consent of a third party as defined by provincial law should be obtained;

- that the patient's consent be a prerequisite to the legality of human experimentation. Further the risk incurred should not be out of proportion to the benefit that may be expected and should not constitute a serious threat to the person's life or health;

- that consent may only be regarded as valid if it is free and informed, the exact meaning of these concepts to be determined by the courts in each particular case.

In Report 31 the Commission also recommended that the offence creating section not apply "to the administration of treatment with the patient's informed consent".

ii) Comment

In the criminal law context, consent is relevant for two distinct reasons. The first is that the general policy of the criminal law is to make severe violations of bodily integrity an offence notwithstanding the consent of the "victim". (As discussed above, this presents an obstacle in the case of the provision of medical treatment.) The second is that in protecting bodily integrity the general policy of the criminal law is to condemn all unwarranted invasions of the body which would clearly include invasions that are perpetrated against the victim's will. In the context under consideration, the application of the criminal law to medical practice, the objective is to remove obstacles that would appear to penalize desirable action and to ensure that in doing so the criminal law continues to give overall protection to bodily integrity by prohibiting undesirable conduct. In addressing this the Commission has made recommendations that remove the obstacles but retain the patient's consent as a necessary condition of legality. The Commission addresses a number of issues relevant to the topic of consent: consent in the case of the competent person, consent in the case of the incompetent person, consent in the case of

non-therapeutic procedures and the emergency situation. The issue of consent in the case of non-therapeutic procedures will be discussed below under II(A)(2e) Provisions for non-therapeutic practices. The recommendations of the Commission on each of the other issues are as follows:

♦ **Consent in the Case of the Competent Person**

All recommendations insist on the consent of a competent patient as a prerequisite to the legality of medical treatment. The principal difference among the recommendations is the standard of consent that the criminal law should require. Working Paper 26 recommends that this standard be left to the courts to be determined, whereas Reports 28 and 31 recommend a more rigorous standard by introducing the civil law concept of "informed consent".

In civil and criminal law, consent will, under certain circumstances, be considered to be invalid if it is not "freely" given. The circumstances that the law classically recognizes as sufficient to invalidate consent include obtaining it by threat, force, fraud, duress and when the person consented was incompetent. In the medical context the law recognizes that the consent of a competent patient is a prerequisite to both the civil and the criminal legality of treatment. In civil law, if the consent of a patient has not been given then a patient would have an action in battery against the offending physician. From a legal perspective, an action in battery is to be preferred to an action in negligence because the former is more readily proved and monetary damages are awarded irrespective of a showing of physical harm. An action in battery will be successful if it is proved that there was a wrongful touching, that is, a touching without consent. The issue of consent, then, is a vital component of this action, particularly when the person who is claiming that a battery occurred had appeared to give consent. In such circumstances the claimant will attempt to establish that consent was not "freely" given. Before the Supreme Court of Canada's decision in *Reibl v. Hughes*[8] there was some attempt to establish that a failure to disclose sufficient information (particularly the risk of an adverse outcome) to a patient about a particular medical treatment would constitute circumstances that were sufficient to invalidate consent. If this attempt had been successful a claimant would have been able to successfully sue a physician regardless of the outcome of a particular medical treatment. The Supreme Court rejected this approach. Instead, the Supreme Court restricted actions in battery to "cases where surgery or treatment has been performed or given to which there has been no consent at all or where, emergency situations aside, surgery or treatment has been performed or given beyond that to which there was consent."[9] In so far as the appropriate disclosure of information was concerned, the Court recognized that a physician has a duty of disclosure and failure to make proper disclosure would give rise to an action in negligence. The Court went one step further

[8] (1980), 14 CCLT.

[9] *Id*, at 13.

to recognize the complexity of decision-making in the medical context and shaped an unique action that accommodated this complexity. In order to successfully establish that a physician has breached his/her duty of disclosure a claimant must establish:

- that an undisclosed risk of treatment materialized and damage occurred;
- that if a reasonable person in the patient's particular circumstances had known of the risk s/he would not have consented to the procedure.

The term "informed consent" is most frequently associated with the duty of disclosure and an action in negligence based on a breach of the duty. The general use of the term can have the unfortunate result of "collapsing" two obligations of a physician: the obligation to disclose information and the obligation to obtain consent. Failure to recognize these two obligations as distinct can also result in the erroneous conclusion that if there has been an insufficient disclosure of risks and alternatives there has been no consent - precisely the result that the Supreme Court of Canada avoided.

While consent and the disclosure of information are related in the sense that the requirements imposed by law protect the right of a patient to determine what should be done with his/her body, the mechanisms that the civil law uses to protect this right in the medical context are significantly different.

If the duty to disclose information were specifically made a prerequisite to the legality (in the criminal sense) of medical treatment the result would be the imposition of a considerably higher duty on physicians than is currently imposed. An exemption clause (or similar vehicle) that contained such a requirement would have the potential effect of criminalizing conduct irrespective of the outcome of treatment. For example, if a physician failed to disclose a known risk of a surgical procedure, the exemption would be inoperative. If the exemption is inoperative then the surgery would be illegal conduct even if it was a complete success and no adverse outcome was suffered.

The civil law requirements of proof in an action based on a breach of the duty of disclosure incorporate the complexities of medical decision-making. The criminal law should clearly do no less than this. Moreover, any consent requirement should reflect the criminal law's general concern to prohibit only objectionable conduct that has a certain degree of gravity and seriousness to warrant criminal sanction.

♦ The Incompetent Patient

Report 31 fails to distinguish between competent patients and incompetent patients; however, both Working Paper 26 and Report 28 do make a distinction. Since the process of decision-making leading to a treatment decision differs for these two groups of patients, a distinction is appropriate. Unlike competent patients, incompetent patients are unable to indicate what an appropriate decision should be by exercising their right to consent to or reject a proposed treatment. An exemption clause that failed to take account of the incompetent patient but that required patient consent as a prerequisite to the legality of medical treatment might prevent incompetent patients from receiving the medical treatment that they should have.

The recommendations of the Commission cover two issues: the determination of incompetence and the appropriate decision-making process for incompetent patients.

With respect to the determination of incompetence, Working Paper 26 requires that a court find a person to be incompetent before s\he is considered to be an incompetent patient. While such a requirement would help to ensure that competent patients are not erroneously treated as incompetent, the mechanism chosen to attain this is onerous (and probably costly) and provides limited safeguards in the case of patients who are in fact incompetent but for whom no court has pronounced on their incompetency. Would the consent of such a patient be valid? In addition, the requirement suggests that the issue of incompetency is black and white. In practice, a person may be competent to make certain treatment decisions but incompetent to make others. In other cases a person's incompetence may be temporal: there may be times during the day when the person is sufficiently lucid to understand a therapeutic plan, its possibilities and consequences and to convey his/her willingness to accept the plan. Finally, the recommendations appear to have overlooked the large group of people who are technically incompetent: children. In the case of most children their competency to make treatment decisions develops as they get older. The point at which children become competent to make medical decisions is the subject of debate; however, there is general agreement that young children are not competent to make medical decisions. The recommendations of the Working Paper would appear to require a finding of incompetence in any child before treatment decisions could be made on the child's behalf. The recommendation would impose a regime of decision-making that is, particularly in the case of children, significantly different from the one currently in place. Since incompetency is subject to change, the recommendation would, in practice, also entail repeated trips to a court to have competency determined.

With respect to the appropriate decision-making process for an incompetent patient, Working Paper 26 makes no specific recommendations and Report 28 would require the consent of a third party as recognized by provincial law to permit treatments to proceed (this requirement is imposed when the patient is unable to communicate consent and it is assumed that this is when the patient is incompetent). In considering this issue, regard must be had to the physician's primary ethical obligation to his/her patient and to the fact that few provincial or territorial jurisdictions make express provisions for decision making authority regarding the treatment and care of incompetent people. In practice, the treatment decision that is aimed for is the one that is best for the patient, and a number of people, including the physician and other health-care providers, may be involved in the process of decision-making. These people would include the recognized legal guardian of the patient where one exists, spouses or partners of the patient, and in some instances close acquaintances of the patient. Making any decision that is in the best interests of another person is notoriously difficult. Although there will be objective criteria to consider, there will also be subjective elements to the decision, which makes a clear or obvious answer in all cases an elusive objective. This is so in the medical context just as it is in other spheres of human activity that require decision making on behalf of another. Of particular concern in this process is to accord the incompetent patient safeguards, in light of their vulnerability, which will guard against abuses. Thus, while certain people will be recognized as having a *prima facie* right to make treatment decisions for an incompetent patient (for

example, parents for children), there is also a recognition that if the decision made appears to be contrary to the patient's interests there will be some mechanism available to challenge the decision and to ensure that the patient does receive the treatment and care that is appropriate in the circumstances. If there is disagreement about the appropriate decision to be made for the patient, the nucleus of the disagreement, from the physician's perspective, is generally that the anticipated benefits of a proposed course of care or treatment appear to clearly outweigh any burdens imposed on the patient. In such circumstances a physician would be expected and in some instances required to take steps to protect the patient. The protections accorded children in provincial and territorial child welfare legislation are examples of the expectations of decision-makers when making a decision for an incompetent person.[10] To ensure that incompetent patients are given appropriate treatment and care it is important that physicians retain their traditional advocacy role for their patients and maintain an entitlement to challenge treatment decisions that appear contrary to their patient's interests.

Some incompetent patients were once competent. Some of these patients may have expressed their wishes as to appropriate treatment decisions in the event of their incompetency. The expression of their wishes may have been in writing or orally. There is a growing acknowledgement that these wishes should be respected and acted on provided they are clear and sufficiently current to be contemplative of advances in medicine. The CMA's policy on Advance Directives, which is appended to this brief, gives these wishes such recognition.

♦ The Emergency Situation

Only Report 31 fails to provide for the emergency situation. Working Paper 28 incorporates the emergency under "other exceptions recognized by law" and Report 26 makes explicit provisions for the emergency. The difficulty with the recommendation contained in Report 26 is that it may recommend that when a patient is unable to communicate (which often occurs in an emergency situation), the consent of a third party should be obtained. If this is the recommendation, it is problematic for two reasons. The first is that the nature of the emergency may be such that there will not be time to obtain the consent of a third party. Since the exception to the need to obtain consent has developed as a pragmatic response to circumstances where treatment is necessary to preserve health or save life, requirements that impede treatment in emergency situations would undermine the rationale for the exception. The second reason is that the exception has been narrowly circumscribed by the law to ensure that only treatments that are necessary are performed in an emergency. Other treatments are delayed until either the patient is competent to make his/her own decision or, if the patient is incompetent, an appropriate decision-making process is undertaken. In the emergency context, a third party should have no greater power with respect to appropriate treatment decisions than that currently provided to the physician. One instance that might usefully include the views of a third party is when it is known by that party that the particular patient would refuse specific forms of treatment, notwithstanding the clear benefits of preserving health or saving life.

[10] See also *Re Eve* [1986] 2 S.C.R. 388.

A physician has a recognized right to provide treatment to a patient without the patient's consent in an emergency situation[11]. This is a limited right which permits a physician to perform procedures that are necessary to preserve health or save life when a patient is unable, due to unconsciousness or extreme illness, to consent to the treatment. The recognition of this right should be preserved in the criminal law context by excepting any consent requirements in emergency situations. If the right is to be circumscribed further, by adding a requirement as to third party consent, then provision should be made to ensure that this requirement does not have the effect of delaying necessary treatment and jeopardizing health or life. If the right is to be circumscribed by recognizing a person's right to reject certain forms of care in emergency situations, then again this should not impose unreasonable obligations on physicians or other health-care providers that would delay the receipt of necessary treatments in emergency situations.

iii) Recommendations of the CMA

THE CMA RECOMMENDS THAT:

ANY EXEMPTION PROVISION MAKE A DISTINCTION BETWEEN PATIENT CONSENT IN THE CRIMINAL LAW CONTEXT AND PATIENT CONSENT IN THE CIVIL LAW CONTEXT;

THAT THE CIVIL DUTY TO DISCLOSE NOT BE INTRODUCED INTO THE CRIMINAL LAW AS A PRECONDITION TO THE LEGALITY OF TREATMENT;

THAT ANY PROVISION WITH RESPECT TO CONSENT TAKE INTO ACCOUNT THOSE PATIENTS WHO ARE INCOMPETENT;

THAT THE WISHES OF A PATIENT MADE WHEN COMPETENT BE APPLICABLE WHEN THE PATIENT IS INCOMPETENT UNLESS THERE ARE REASONABLE GROUNDS FOR NOT FOLLOWING THESE WISHES;

THAT ANY PROVISION WITH RESPECT TO CONSENT TAKE INTO ACCOUNT THE EMERGENCY SITUATION.

[11]E.I. Picard, Legal Liability of Doctors and Hospitals in Canada (2nd Edition) 45 (1984).

d) Specification of standard of conduct considered lawful

i) Recommendations of the Commission

Report 31 makes the exemption from criminal liability conditional on the treatment provided, "the risk of harm [is] not disproportionate to the expected benefits". Report 28 recommended that:

- in general, the existing rules on the reasonableness of medical procedures and the standard required for penalizing abuses be maintained.

The intent of this recommendation is to retain the current understanding that in the medical context the criminal law exercises control by penalizing actions that, taken as a whole, are unreasonable.[12]

Working Paper 26 recommended:

- that the acceptable minimum standard required from a qualified person in the administration of treatment be the knowledge, skill and care of a competent similarly qualified person performing the same act in similar circumstances;

- that the standard of reasonable knowledge, care and skill recommended above apply also in emergency situations, taking in [sic] consideration the particular circumstances of the case;

- that the acceptable minimum standard for the unqualified person in the administration of treatment be that of the reasonable, ordinary person and not that of the qualified person;

- that where a person holds himself out as having certain qualifications and where the public or the individual treated rely on these qualifications, that person be judged according to the standard of the qualified person he represented himself to be;

- that the *Criminal Code* make separate provisions for the general duty of reasonable knowledge, care and skill in the performance of dangerous acts and for the duty of reasonable knowledge, care and skill, in the administration of treatment by qualified professionals;

- that the duty of reasonable knowledge, care and skill apply upon the undertaking of the administration of treatment.

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[12] See pages 6-7, and the commentary on recommendation 6 at page 16.

In making this recommendation the Commission recognized that the legality of medical treatment depends on the assumption that it is performed "with an acceptable level of skill, knowledge and care".[13] The Commission goes on to note that this is currently expressly provided for in the *Criminal Code* (ss. 45 and 216) and is the basis "of the wrongful act in criminal negligence". In recommending the use of the word "competent" it was the intent of the Commission to hold a physician to the same standard as similarly situated members of the profession. This would, in the Commission's opinion, impart a degree of flexibility to provide for distinctions between specialists and general practitioners and the standard required when experimental or innovative therapies are utilized.

ii) Comment

In considering these recommendations, care must be taken to distinguish between the standard of conduct required by a physician in the civil law context and the standard of conduct required in the criminal law context. The criminal law should reflect the qualitative difference between wrongful acts in civil law where liability follows if a professional has not acted in accordance with the standard of a reasonable physician in similar circumstances and criminal law which requires a marked departure from the standard of conduct required in similar circumstances. The current *Code* provisions make this distinction clear and provide some flexibility with the general requirement of reasonableness in the particular circumstances.

iii) Recommendations of the CMA

THE CMA RECOMMENDS THAT:

ANY PROVISION THAT IMPOSES A STANDARD OF CONDUCT MAKE A DISTINCTION BETWEEN THE STANDARD IN THE CRIMINAL LAW CONTEXT AND THE STANDARD IN THE CIVIL LAW CONTEXT.

e) Provisions for non-therapeutic practices

i) Recommendations of the Commission

Report 31 contains no recommendations on this subject.

In Working Paper 26 the Commission recommended:

- that treatment and non-therapeutic interventions be distinguished by the criminal law, the former being considered as *prima facie* legal;

[13] at 74.

- that the provisions of the *Criminal Code* apply to non-therapeutic interventions as for any other acts involving the application of force and wounding, but that a defence be available to prevent certain of them from constituting a criminal offence;

- that decisions regarding non-therapeutic interventions on incompetents be made by a provincial board established for this purpose.

In Report 28 the Commission recommended:

- That the patient's consent be a prerequisite to the legality of human experimentation. Further, the risk incurred should not be out of proportion to the benefit that may be expected and should not constitute a serious threat to the person's life or health.

Two further documents of the Commission have particular relevance to this issue: Working Paper 66, Procurement and Transfer of Human Tissues and Organs, and Working Paper 61, Biomedical Experimentation Involving Human Subjects. In Working Paper 66 the Commission made the following recommendations concerning live organ and tissue donation:

- The provision of a safe and adequate, just and efficient, tissue transfer and supply system should be a common national goal of law and public policy.

- The development and reform of laws affecting tissue transfer and replacement regimes should be based on principles of

  - autonomy, inviolability and integrity of the human body;

  - altruism and encouraged voluntarism;

  - gratuity and universality;

  - preserving and protecting life; and

  - respecting the dying, the dead and their families.

- The existing model for living donor tissue and organ transfer, which is premised on free and informed consent and a requirement that the risk of harms incurred not be disproportionate to expected benefits in medical intervention, should generally be maintained.

- The *Criminal Code* should be amended by the addition of a provision that excludes, from offences against bodily integrity, those cases of human tissue and organ donation in which the donor's free and informed consent is properly obtained and the risk of harms incurred is not disproportionate to the expected benefits.

- Tissue procurement from those persons who are incompetent to consent to donation should be regarded as lawful, when there has been a case-by-case determination by an independent third party (for example, court, review board, ombudsman and so forth) to ensure that the following conditions have been met:

  - the donation of bone marrow and non-regenerative tissue is restricted to donors and recipients in the same family;

  - all reasonable, potential procurement and medical treatment alternatives have been exhausted;

  - the procedure does not involve any serious risks to the donor;

  - the risk of harms incurred is not disproportionate to the expected benefits;

  - the legal guardian's consent has been obtained; and

  - where possible, the potential donor's consent has been obtained, and his or her refusal is always to be respected.

Working Paper 61 made the following recommendations concerning non-therapeutic experimentation:

- Non-therapeutic biomedical experimentation should be considered legal and permissible under criminal law where:

  - the subject's free and informed consent has been properly obtained; and

  - there is an acceptable ratio between the risks incurred by the subject and the benefits expected to result from the experiment.

- Experimentation should be considered legal, even where the subject has been deceived, where,

  - there are no other means of achieving the research goal;

  - the experimentation involves no risk to the subject;

  - no information is withheld which could cause the subject to refuse to participate;

  - the research is of major scientific value; and

  - it is possible to debrief the subjects and inform them why deception was necessary once the research has been completed.

- The *Criminal Code* should be amended by the addition of a provision which excludes from offences against bodily integrity those cases of non-therapeutic biomedical experimentation in which free and informed consent is properly obtained and the risks incurred are not disproportionate to expected benefits.
- Clause 7(3)(a) of the Commission's Report 31 .... should be amended to read as follows:

  - 7(3) Exceptions.

  - (a) Medical Procedure. Clauses 7(2)(a) and 7(2)(b) do not apply to medical procedures performed with the subject's free and informed consent, for therapeutic purposes or for the purposes of scientific experimentation, where the risks involved are not disproportionate to the expected benefits.

- The Commission recommends that the legality of non-therapeutic biomedical experimentation involving children should be recognized in a general federal statute on experimentation provided that all the following conditions are met:

  - the research is of major scientific importance and it is not possible to properly conduct it using adult subjects capable of giving consent;

  - the research is in close, direct relation to infantile diseases or pathologies;

  - the experiment does not involve any serious risks for the child;

  - the consent of a person having parental authority and of an independent third party (a judge, an ombudsman or the child's lawyer) is obtained; and

  - where possible, the consent of the child should be obtained. Moreover, whatever the child's age, his refusal should always be respected.

- The legality of non-therapeutic biomedical experimentation on mentally deficient persons should be recognized, in a general federal statute on experimentation, provided the following conditions are met:

  - the research is of major scientific importance and it is not possible to properly conduct it using adult subjects capable of giving consent;

  - the research is in close, direct relation to the subject's mental illness or deficiency;

  - the research does not involve any serious risks for the subject;

- the consent of the incompetent person's representative and of an independent third party (a judge, an ombudsman or the incompetent person's lawyer) is obtained; and

- where possible, the incompetent person's consent is to be obtained, and his refusal is always to be respected.

ii) Comment

Working Paper 26 makes a distinction between therapeutic procedures, which would include experimentation for therapeutic purposes, and other invasive procedures which would include non-therapeutic experimentation and live organ and tissue donation. Report 28 focuses on experimentation generally, which would presumably include therapeutic experimentation. Working Paper 26 contains recommendations on live organ and tissue donation and Working Paper 61 contains recommendations that relate to non-therapeutic experimentation. There is some indication in these documents that the non-therapeutic practices of experimentation and live organ and tissue donation should be permitted and that the *Code* should make express provisions to ensure that they are permitted under certain conditions.

In a previous section of this brief the definition of medical treatment was discussed. It was noted that certain procedures are generally accepted to be within the scope of practice of a qualified physician even though they are not necessarily therapeutic. The provision of palliative care and birth control are two examples. An adequate definition of medical treatment would ensure that such procedures are not subject to the same requirements as non-therapeutic interventions such as experimentation and donation. One useful distinction between those practices that are properly included within the definition of medical treatment and those that are not pertains to the subject of the benefit. Generally speaking, if the subject of the benefit is the patient undergoing the procedure then the procedure may be more appropriately incorporated under the definition of medical treatment, whereas if the population in general benefits from the procedure then it may be more appropriately incorporated under the definition of non-therapeutic intervention. There will be some exceptions to this; public health measures are a clear example of such an exception.

In considering this topic it is important to determine whether it is appropriate to distinguish between treatments that may be experimental or innovative and non-therapeutic experimentation. Such a distinction is recognized in the case law.[14] The former is more appropriately recognized as medical treatment since the ends that are sought are the provision of medical care to the person receiving the experimental or innovative therapy. Non-therapeutic experimentation, however, aims to provide general benefit to the population by increasing scientific knowledge but will not necessarily provide a benefit to the person who is the subject of the research.

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[14] See for example, *Cyderman v. Ringrose*, [1978] 3 W.W.R. 481 (Alta. C.A.); *Zimmer v. Ringrose* (1981), 28 A.R. 69 (C.A.).

In considering these practices, considerable emphasis is placed on the need for full disclosure of information to the subject before consent is obtained. In the criminal law context, if non-therapeutic practices are to be permitted, thought must be given to the level of disclosure required and to whether the disclosure requirements should vary between therapeutic experimentation and non-therapeutic experimentation.

In addition, consideration must be given to the acceptability of the participation of incompetent people, both adults and children, in all of these practices and the required standards that should pertain. Working Paper 61 does not recommend making provisions in the *Code* for non-therapeutic experimentation on incompetent people although recommendations are made to permit such experimentation under certain circumstances. Working Paper 66 does not make specific recommendations concerning amendments to the *Code* but does make provision for organ and tissue donation in the case of incompetent people. If the legality of these practices is to be recognized, the *Code* should make these distinctions.

Within this context, some thought should also be given to additional requirements for special population groups who may be more susceptible to being coerced to participate in experimentation. "Captive" populations, that is those who are involuntarily detained in penal institutions, would be an example of such a special population. Working Paper 61 acknowledges this problem, and finds it necessary to study the matter further before reaching any position. Finally, the Commission often uses a risk/benefit analysis to place some obligations on the person who is undertaking the non-therapeutic practice or experimentation. The difficulty with such an analysis is that in the experimental context the risks and benefits of a particular practice will not always be clear or readily ascertainable; in fact the research itself may help to establish these factors. In the case of live tissue and organ donation and non-therapeutic experimentation, the risk/benefit analysis (as it applies to the donor) would not be a useful determinate of the appropriateness of facilitating the donation: the risks would generally clearly outweigh any medical benefit.

iii) Recommendations of the CMA

THE CMA RECOMMENDS THAT:

EXPRESS PROVISIONS BE MADE IN THE GENERAL PART OF THE CRIMINAL CODE TO RECOGNIZE AS LEGITIMATE LIVE ORGAN AND TISSUE DONATION AND MEDICAL EXPERIMENTATION.

B) THE OBLIGATIONS OF PHYSICIANS WITH RESPECT TO BEGINNING, CONTINUING AND CEASING TREATMENT

1) *THE CURRENT CONTEXT*

Physicians work to preserve and promote health and prevent death. The criminal law, too, seeks to protect health and life. Difficulties arise when the law appears to require a physician to act to preserve and promote health or prevent death in circumstances where such action may be inappropriate.

Physicians recognize that there are limits to their obligations to preserve and promote health and prevent death. It is generally accepted that a competent patient has the right to reject any treatment recommended even though that patient's decision would appear to compromise his/her health or life.

When the patient's condition is such that death is both imminent and inevitable, aggressive and intrusive therapies are not necessarily in the interests of the patient. In working Paper 28, *Euthanasia, Aiding Suicide and Cessation of Treatment*, the Commission commented:

- The question of whether to terminate or not to initiate treatment arises particularly in two very specific contexts. ... The first context is that of the terminally ill patient, namely one who has reached the stage where the administration of therapeutic care has become medically useless to bring about eventual recovery or even effective control of the disease. Beyond this point, the patient's interest lies in the alleviation, as far as possible, of the physical and mental suffering of the terminal phase. As many of the doctors whom we have consulted have confirmed, the patient's needs change once he realizes with certainty that recovery is impossible and that death has become inevitable. Basically, what the patient then requires is effective control of his symptoms and the chance to live what remains of his life as comfortably as possible. For some, it is also important that the passage from life to death take place with dignity and lucidity and that surgical or other forms of intervention which are mutilating or perceived as degrading be avoided. The decision to discontinue a form of treatment perceived as useless and potentially degrading is often made on the suggestion of the patient.

These sentiments are reflected in the CMA position on the *Resuscitation of the Terminally Ill*, a copy of which is appended to this brief.

A further problem that arises in this context in particular is the administration of treatments that relieve pain but which may also have the effect of hastening death. It is generally accepted that appropriate pain relief is a humane response to the suffering that may be endured in the terminal phase.

In the case of incompetent patients, the problems are more difficult. Unless the incompetent patient was competent at one time, and did during that time express the wish as to the treatments s/he would accept or reject in a given context, the appropriate decision must be ascertained by reference to what is in the patient's best interest. Of a particularly troubling nature are patients who have suffered upper brain death and exist in a "permanent vegetative state" and patients whose principal condition is terminal and death is imminent but who have other conditions which could be treated, for example, pneumonia. What decision would be in these patient's best interest?

The provisions of the current *Criminal Code* do not adequately address these questions and appear to require a physician to provide treatments in situations where it would be desirable not to initiate treatment or to cease its provision. Two recent decisions of the Quebec courts illustrate the difficulties with the current *Code*[15].

Section 14 of the *Code* provides:

- No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.

Section 241 of the *Code* provides:

- Every one who

  a) counsels a person to commit suicide, or

  b) aids or abets a person to commit suicide,

  whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

Both of these sections contain a strong protection of life and limit the autonomy of an individual to make decisions concerning the termination of his/her own life. In the medical context, however, these provisions are in conflict with the recognition that a competent patient has the right to make decisions concerning what will be done to his/her body even if such a decision results in his/her death. They are also problematic in situations where the condition is terminal and death is imminent and measures that might prolong life are not always implemented in the interests of the patient.

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[15] See, *Nancy B. v. Hotel-Dieu de Quebec et al.* (1992), 86 D.L.R. (4th) 385 (Que. Sup. Ct.) and *Manoir de la Point Bleu (1978) Inc. v. Robert Corbeil et al.* (Justice Gontran Rouleau, Jan. 22, 1992, Que. Sup. Ct.)

Section 215 of the *Code* provides:

> (1) Every one is under a legal duty ...
>
> (c) to provide necessaries of life to a person under his charge if that person
>
> (i) is unable, by reason of detention, age, illness, mental disorder or other cause, to withdraw himself from that charge, and
>
> (ii) is unable to provide himself with necessaries of life.
>
> (2) Every one commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse, the proof of which lies on him, to perform that duty, if ...
>
> (b) with respect to a duty imposed by paragraph 1(c), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.

Section 217 of the *Code* provides:

- Every one who undertakes to do an act is under a legal duty to do it if an omission to do the act is or may be dangerous to life.

These sections, too, appear to place a strong obligation on a physician to provide treatment that may be inappropriate in the circumstances.

Section 245 of the *Code* provides:

- Every one who administers or causes to be administered to any person or causes any person to take poison or any other destructive or noxious thing is guilty of an indictable offence ...

This section, along with the general prohibitions against causing death or bodily harm, raise questions about the legitimacy of treatments that have the secondary effect of, in particular, hastening death.

2) *RECOMMENDATIONS OF THE LAW REFORM COMMISSION OF CANADA*

Recommendations concerning these issues are contained in a number of documents of the Commission. In addition to the documents noted above, two others are of particular importance: Working Paper 28, Euthanasia, Aiding Suicide and Cessation of Treatment[16] and Report 20, Euthanasia, Aiding Suicide and Cessation of Treatment[17]. The recommendations contained in these documents, comments on these recommendations and the recommendations of the CMA are considered under the following topics:

a) Competent patients: initiation and cessation of treatment

b) Incompetent patients: initiation and cessation of treatment

c) Medically/therapeutically useless treatment

d) The treatment and care of terminally ill patients

a) Competent patients: initiation and cessation of treatment

i) Recommendations of the Law Reform Commission

The main theme of the Commission's recommendations on this topic is the provision of a statement that would make it clear that a competent patient has the right to reject treatment and require that it cease and that the *Criminal Code*'s provisions do not require a physician to violate this right.

The Framework Document considers two issues that are relevant to this topic. The first concerns the *Code*'s provision that consent to death is no defence. The second concerns the Code's provision of a medical treatment exception for the Code's provisions that make certain omissions culpable.

In considering the provision that consent to death is no defence, the following issues are raised for consideration:

- should the provision be extended to be applicable to causing bodily harm?
- should the provision be retained in the new General Part, or should the issue of consent to the infliction of bodily injury and/or death be dealt with in specific sections of the *Code*?

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[16] (1982)

[17] (1983)

In considering the medical treatment exception, the following issues are raised:

- Should there be a provision in the General Part which states that there is no duty to continue treatment which is therapeutically useless or to which the person does not consent?

- If the answer ... is "yes", a) should the term "therapeutically useless" be defined? and b) should the requirements of consent be defined more specifically?

Working Paper 28 concluded that:

- the law should recognize the competent patient's wishes and respect them as regards the cessation or non-initiation of treatment;

- the law should recognize that the prolonging of life is not an absolute value in itself and that therefore a physician does not act illegally when he fails to take measures to achieve this end, if these measures are ... contrary to the patient's wishes or interests;

- the law should recognize that a physician who continues to treat a patient against his wishes is subject to the provisions of the *Criminal Code*;

and recommended that the *Criminal Code* be amended by adding the following provision:

- Nothing in sections 14,[18] 45,[19] 198[20] and 199[21] of the *Criminal Code* shall be interpreted as requiring a physician

    (a) to continue to administer or to undertake medical treatment against the clearly expressed wishes of the person for whom such treatment is intended

Report 20 makes the same recommendation but also includes section 229 which makes it an offence to administer a noxious thing or poison.

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[18] Consent to death is no defence.

[19] Protection from liability when performing a surgical operation.

[20] The duty to use reasonable knowledge and skill when undertaking to administer surgical or medical treatment.

[21] The general duty to continue an act that has been undertaken if failure to do so might be dangerous to life.

Working Paper 26 recommended:

- that individual consent continue to be recognized as one of the essential conditions of the legality of the administration of treatment;

- that treatment not be administered without the consent of the individual treated, unless there is or has already been a finding of incompetence or another specific exception recognized by law;

- that the right of a competent adult to refuse treatment be specifically recognized by the *Criminal Code*;

- that treatment not be administered against an individual's refusal unless there is a finding of incompetence or an exception recognized by law.

Report 28 recommended:

- That the ambiguity created by the provisions of section 199 of the present *Criminal Code* be resolved, and that the *Criminal Code* provide for the right of any competent person to refuse medical treatment or to ask for its suspension or termination, and that therefore no one shall be required to provide it against the patient's wishes.

Report 31 recommended the provision of a medical treatment exception in relation to the duty imposed to provide necessaries to anyone under his care and to carry out an undertaking given or assumed, which would state:

- No one has a duty to provide or continue medical treatment ... for which informed consent is expressly refused or withdrawn.

ii) Comment

There appears to be consensus on the need to make provisions that make it clear that a physician is not obligated to initiate treatment to which a patient does not consent and should cease treatment that the patient no longer consents to. The recommendations contained in Report 31 and the context of discussion in the Framework Document place the medical treatment exception in the section that stipulates when failure to act (omissions) will constitute an offence. In the criminal law context only acts (rather than omissions) will generally result in criminal liability except where there are specific provisions that make certain omissions culpable. While non-initiation of treatment might be properly classified as an omission, the cessation of treatment cannot be. In view of the general applicability of the principle, the medical treatment exception should be made to apply generally, rather than to be restrictively applied in the case of omissions. The recommendations contained in other reports of the Commission appear to try to accomplish this by referring to sections of the *Code* that would appear to require a physician to treat a patient contrary to that patient's wishes. In doing this, it is important to ensure that

all sections that are relevant, including the section that states that consent to death is no defence and the section that relates to suicide, are included. An appropriate way of accomplishing this would be to make a general statement in the General Part that relates to the whole *Criminal Code*.

The CMA *Code of Ethics* also recognizes these principles and states:

- An ethical physician will recognize that a patient has the right to accept or reject ... any medical care recommended.

The CMA position on the Resuscitation of the Terminally Ill also recognizes the principle and states:

- Competent patients have the right to make decisions about their treatment.

One matter that should be addressed is the extent to which a competent patient's wishes will be applicable in the event of incompetency. With a growing awareness in the public and health care professionals of vehicles such as the advance directive (living will) it is important to clarify the status of a competent patient's wishes as they apply to that person when s/he is incompetent. The CMA policy on Advance Directives endorses the use of such vehicles and states that a physician should honour them unless there are reasonable grounds for not doing so. Working Paper 28 suggests that the wishes of a patient, made in the course of discussion with a physician, relative or friend or contained in a letter or document such as a living will, should be respected.[22]

The recommendations of the Commission focus on medical treatment. The definition of medical treatment will help to clarify what is encompassed by this term. However, consideration must also be given to measures that are taken to provide nutrition, hydration, oxygen and warmth to patients who are unable to provide these to themselves. The means taken to provide these substances are ones that are conventionally considered medical interventions; however, the substances themselves are more in the nature of basic necessities rather than therapies. The few court judgements that have considered this matter appear to indicate that there is no duty to provide these measures to a person under one's care if that person rejects their provision or requires that their provision be ceased.[23] In practice it is difficult to distinguish between the provision of therapies and the provision of necessities; both are needed to sustain the health and life of the patient. Since physicians will be instrumental in providing these necessities, it is important that the General Part contain a clear statement as to a patient's right to refuse their provision.

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[22] at 61.

[23] *Supra* note 15; see also *A.-G. of B.C. et al. v. Astaforoff and A.-G. of Canada* (1983), 35 C.R. (3d) 69 (B.C.S.C.)

iii) Recommendations of the CMA

THE CMA RECOMMENDS THAT THE GENERAL PART CONTAIN PROVISIONS THAT:

CLARIFY THAT A PHYSICIAN HAS NO OBLIGATION TO INITIATE OR CONTINUE TREATMENTS TO WHICH A COMPETENT PATIENT DOES NOT CONSENT;

RECOGNIZE THAT A COMPETENT PATIENT'S WISHES WILL BE APPLICABLE UPON HIS/HER INCOMPETENCY AND SHOULD BE FOLLOWED UNLESS THERE ARE REASONABLE GROUNDS FOR NOT DOING SO.

b) Incompetent patients: initiation and cessation of treatment

i) Recommendations of the Law Reform Commission

The Framework Document makes no specific recommendations in regard to incompetent patients. However, in the medical treatment exception provision the question posed also relates to whether there is a duty to provide therapeutically useless treatment. This is discussed under the next topic; however, it does have some application to the initiation and cessation of treatment for incompetent patients. Working Paper 31 addresses this matter in a similar way. Working Paper 28 and Reports 20 and 28 all contain provisions which attempt to provide protection to incompetent patients that would guard against abusing their vulnerability and yet permit the non-initiation or cessation of treatment in circumstances where providing the treatment would prolong the dying process.

Working Paper 28 defines an incompetent patient as, "anyone who, because of infancy, temporary or permanent unconsciousness or some other handicap, is unable to express his wishes, make an informed decision, or exercise choice". In this document the Commission states:

- ...law should strenuously avoid and forbid any form of discrimination against any such persons. Insistence on heroic but useless measures is no more justified for the incompetent patient than it is for the competent. In other words, an individual's incapacity should not serve as a basis or pretext for denying him the fundamental right or opportunity available to the competent patient to exercise choice. It would be regrettable and absurd if, because a person is incompetent, his attending physician were legally obliged to continue or to undertake useless treatment and required to prolong his patient's suffering to no avail. It would be unthinkable that a person should lose his right to die with dignity as soon as one becomes incapable of expressing wishes.

- ...the law must recognize what is now a medical and scientific reality. It must admit that the cessation or non-initiation of treatment which offers no chance of success is *a good decision and one based on sound medical practice*. Treatment is a measure designed to help the patient recover from his illness, to halt its progress at least temporarily or to relieve its symptoms. It is selected and administered in an effort to protect or to extend life.

The Commission goes on to discuss the fact that a competent patient is able to consider options and make choices on the basis of information provided and may, in rare cases, "choose to have his life artificially maintained, or to prolong his agony or suffering." The Commission stated:

- However, in the case of the incompetent patient, it is neither legally required nor sound medical practice to transpose the general situation to an exceptional one and to assume that, because the person is incompetent, he would have chosen to have his life artificially maintained, his agony prolonged or his suffering extended. Hence, the law must recognize that even in the case of an incompetent person, the cessation or non-initiation of medical treatment may objectively constitute good medical practice and should not be subject to criminal sanctions.

In considering how decisions to not initiate or to cease treatment for incompetent patient should be made, the Commission considered three options:

- To leave the decision to the judgement of the physician, recognizing that the physician would seek expert advice as required and involve the family and next-of-kin in the decision making process;

- To "judicialize" the decision making process. There are a number of ways of accomplishing this end, from requiring that treatment decisions for an incompetent patient be made by a court or administrative agency, to utilizing a hospital committee to make decisions or to set guidelines for treatment decisions, or to require that two physicians participate in the decision.

- To leave the decision to the family, next-of-kin or representative of the patient.

The Commission noted difficulties with all processes. It rejected the "judicialization" model as being impractical and also as making a decision-making process that should be based on consensus into one that is confrontational. The Commission noted, however, that if there were clear disagreements between the physician and the family then judicial decision may be appropriate, because there is a conflict concerning what constitutes the patient's best interests. The Commission also rejected the next-of-kin option even though it appeared, at first sight, to be the better one because it can be assumed that generally these people will have the patient's best interests at heart and may be able to assess subjective elements. The Commission noted two objections. The first is that this option imposes an unreasonable burden on the family which may result in feelings of guilt. The second is that in order to provide the incompetent patient

with as much protection as possible the decision must be surrounded with as much objectivity as possible. It favoured the first option, that of leaving the decision to the ultimate judgement of the physician. The Commission noted that physicians would still be subject to scrutiny for the decisions they make and, if the law in this difficult area were clarified, they would no longer continue aggressive therapies out of fear of legal consequences.

In this context, the Commission distinguishes between the non-initiation or cessation of treatment "because it offers no reasonable hope of improvement and merely prolongs the dying process rather than life itself" and treatment that "is not undertaken or continued only because the prognosis of the incompetent patient does not measure up to the "accepted norm". The Commission was keen to ensure that decisions not to initiate or to cease treatment were not made *because* the patient was incompetent but because the incompetent patient has a condition that has irreversibly initiated the dying process.

The Commission reached the following conclusions:

- the law should clearly state that a physician acts legally when he decides to terminate or not to initiate treatment which is useless or which no longer offers reasonable hope, unless the patient has expressed his wishes to the contrary;

- the law should recognize that the prolonging of life is not an absolute value in itself and that therefore a physician does not act illegally when he fails to take measures to achieve this end, if these measures are useless or contrary to the patient's wishes or interests;

- the law should recognize that the incapacity of a person to express his wishes is not a sufficient reason to oblige a physician to administer useless treatment for the purpose of prolonging his life;

- the law should recognize that in the case of an unconscious or incompetent patient, a physician incurs no criminal responsibility by terminating treatment which has become useless.

The Commission recommended amending the *Code* by the addition of the following:

- Nothing in sections 14, 45, 198, and 199 of the *Criminal Code* shall be interpreted as requiring a physician ...

  (b) to continue to administer or to undertake medical treatment, when such treatment is medically useless and is not in the best interests of the person for whom it is intended, except in accordance with the clearly expressed wishes of this person.

Report 20 essentially concurs in the findings contained in Working Paper 28. Having considered submissions on the recommendations in Working Paper 28 the Commission recommended the following addition to the *Criminal Code*:

- Nothing in sections 14, 45, 198, 199 and 229 shall be interpreted as requiring a physician...

  (b) to continue to administer or undertake medical treatment, when such treatment has become therapeutically useless in the circumstances and is not in the best interests of the person for whom it is intended.

The term "therapeutically useless" is used due to the number of complaints that were received concerning the pejorative connotation of the term "medically useless treatment" which was thought to imply that it was general practice to provide extraordinary treatment or to "overtreat". The use of the word "therapeutically" is defined by the Commission to mean, "the intention is therapeutic when the aim is to treat the patient for the purpose of curing or ameliorating his condition".

Report 28 made the following recommendations:

- That whether in the case of an incompetent or competent person, a physician cannot be held criminally liable if he decides to suspend or not to commence treatment which has no further therapeutic value and is not in the patient's best interests.

Working Paper 26 addresses the matter of incompetent patients but is concerned primarily with the finding of incompetence and the administration of treatment to incompetent patients without the necessity of consent. The Working Paper, in its text, does recognize that treatment decisions are generally made in the best interests of incompetent patients and states:

- Traditionally, the family has decided. This should still be so in the case of therapeutic treatment where the best interest of the incompetent patient is pursued. However, it is increasingly suggested that the family may express interests which may not always adequately represent the best interests of the incompetent, especially with regard to non-therapeutic interventions. While family interests must be outweighed only by compelling interests, the proper forum for so deciding must objectively weigh all considerations with predominant emphasis on the best interests of the incompetent individual. Recent cases on the cessation of therapy administered to comatose patients have recommended either a committee or a court as the appropriate forum. While both procedures have been the focus of considerable debate, the Commission favours the use of administrative boards.

ii) Comment

The gist of many of the Commission's recommendations is that an incompetent patient should be no worse off with regard to treatment decisions concerning the non-initiation of treatment or its cessation than a competent patient. While treatment should not be denied or terminated on the basis of a value judgement concerning the "worth" of an incompetent person, it should neither be initiated or continued when to do so would prolong the dying process with the result of extending suffering. To clarify a physician's obligations in this regard the Commission made recommendations as to appropriate amendments to the *Criminal Code*. Since many of the *Criminal Code*'s provisions are concerned with unlawfully causing another person's death, a provision in the General Part of the *Criminal Code* that applied generally would help clarify these matters.

In terms of the appropriate decision-making process for incompetent patients, in Report 20, the Commission acknowledges that in many cases provincial law makes specific requirements which aim to protect the vulnerable. However, since a physician would likely be the person to be charged with an offence, the Commission still considered it appropriate, in the criminal context, to leave final responsibility to the physician. Other recommendations of the Commission would impose more formal requirements when decisions are made concerning incompetent patients. Any recommended process should recognize the physician's expertise in medical matters and also the physician's special role with respect to promoting his/her patient's welfare. The process should also provide a practical way of reaching effective decisions without compromising the patient's welfare.

The CMA *Code of Ethics* recognizes the primary obligation the physician has to his/her patient and the first principle in the *Code* states:

- Consider first the well-being of the patient.

iii) Recommendations of CMA

THE CMA RECOMMENDS THAT THE GENERAL PART CONTAIN PROVISIONS THAT:

RECOGNIZE THAT PHYSICIANS HAVE NO OBLIGATION TO INITIATE AND MAY CEASE TREATMENTS THAT ARE OR HAVE BECOME THERAPEUTICALLY FUTILE AND THAT SUCH A PROVISION APPLY TO COMPETENT AND INCOMPETENT PATIENTS;

RECOGNIZE THE PHYSICIAN'S RESPONSIBILITY TO ADVOCATE FOR THE BEST INTERESTS OF AN INCOMPETENT PATIENT.

c) Medically/therapeutically futile treatment

i) Recommendations of the Law Reform Commission

The Framework Document asks whether there should be a provision in the General Part which states that there is no duty to provide therapeutically useless treatment and if so, whether this term should be defined.

In Report 28 the Commission recommended:

- That whether in the case of an incompetent or a competent person, a physician cannot be held criminally liable if he decides to suspend or not to commence treatment which has no further therapeutic value and is not in the patient's best interests.

In Working Paper 28 the Commission concluded that:

- the law should clearly state that a physician acts legally when he decides to terminate or not to initiate treatment which is useless or which no longer offers reasonable hope, unless the patient has expressed his wishes to the contrary;

- the law should recognize that the prolonging of life is not an absolute value in itself and that therefore a physician does not act illegally when he fails to take measures to achieve this end, if these measures are useless or contrary to the patient's wishes or interests.

The Commission went on to recommend that the *Code* be amended as follows:

- Nothing in sections 14, 45, 198 and 199 of the Criminal Code shall be interpreted as requiring a physician...

  to continue to administer or to undertake medical treatment, when such treatment is medically useless and is not in the best interests of the person for whom it is intended, except in accordance with the clearly expressed wishes of this person.

Report 20 basically concurs with these recommendations. Another section of the *Code* is added to the exception and "except in accordance with the clearly expressed wishes of this person" is deleted from the exception.

The Commission notes that the word "therapeutically" is used "in its ordinary sense, that is, the intention is therapeutic when the aim is to treat the patient for the purpose of curing or ameliorating his condition."

The Commission recognizes that while a treatment may be therapeutically futile, its provision may be justified on other grounds. An example given is where a patient wishes time to put affairs in order or to see a relative. These would be factors to be considered in the patient's best interests.

The Commission gave the following examples of when treatment could be considered to be therapeutically futile:

- when artificial ventilation is continued for a patient whose cerebral functions have already undergone irreversible cessation;
- when dispensing antibiotics to treat pneumonia will prolong the agony of death;
- performing surgery to correct a newborn's deformity when the infant can not survive his other medical problems.

The discussion above in section IIB(2)(b), the initiation and cessation of treatment for incompetent patients, is also relevant here.

ii) Comment

As has been discussed above, the Commission wanted to distinguish between treatments that are useful because they serve a therapeutic purpose and those that are not. In making recommendations on this subject the Commission focused on the patient as a whole rather than on isolated conditions the patient may have. In circumstances where the patient has a terminal illness and the patient's death is imminent, no treatments serve a therapeutic purpose because they will not reverse the underlying condition but will only prolong the dying process and extend suffering. In the case of incompetent patients the Commission was relatively consistent in its recommendations, recognizing that therapeutically futile treatments need not be dispensed by a physician. The Commission was less consistent in the case of competent patients. Some of the Commission's recommendations would leave to the patient the final decision as to whether or not a treatment should be initiated or ceased. Other recommendations acknowledged that there may be reasons why a competent patient may wish to receive treatments that extend the dying process but suggested that these considerations should factor into making a decision that is in the best interests of the particular patient. These recommendations were made partly in response to concerns that making specific provisions as to the competent patient's right to make decisions concerning the provision of therapeutically futile treatments may lead to the conclusion that physicians are required to provide treatments that are counter-indicated.

The CMA *Code of Ethics*, in discussing the dying patient, states:

- An ethical physician will allow death to occur with dignity and comfort when death of the body appears to be inevitable;
- An ethical physician may support the body when clinical death of the brain has occurred, but need not prolong life by unusual or heroic means.

The CMA's policy on the Resuscitation of the Terminally Ill also states the following:

- Advances in medical technology are providing health care workers with increasingly sophisticated methods of resuscitation. Although interventions with these devices are often life-saving, health care professionals frequently feel uncertain when deciding to resuscitate a patient for whom such an intervention would not appear beneficial, in that it would prolong the dying process rather than extend life.

- It is recognized that there are conditions of ill health and inevitable death for which an instruction on the order sheet signed by the attending physician that there should be "no resuscitation" is appropriate and ethically acceptable. It is also recognized that it is the patient's right to accept or refuse treatment.

This policy recognizes that competent patients have the right to make decisions about their treatment. The policy also requires that when a competent patient requests that an order not to resuscitate be rescinded, this request should be implemented immediately. In the case of incompetent patients, the policy recommends that decisions be made in close consultation with appropriate members of the patient's family and with other health professionals involved in the care of the patient.

The policy requires an assessment of the patient's condition to ascertain:

- the irreversibility of the patient's condition and/or the irreparability of the damage it has done;

- the length of time that it can be expected that the patient will live without intervention;

- the consequences of the "no resuscitation" order - that it may lead to the death of the patient before the time the physician has estimated.

In considering this issue, the CMA is of the opinion that the term "therapeutically futile" most accurately captures the determination that is made with respect to the benefits a particular treatment can offer the patient when account is taken of the overall condition of the patient.

Patients who are in a persistent vegetative state are not as clearly addressed by the Commission's recommendations. These patients have a condition that is incurable, their upper brain has ceased to function and they require medical intervention to provide necessaries. Their underlying condition is not, however, necessarily terminal.

iii) Recommendations of CMA

THE CMA RECOMMENDS THAT THE GENERAL PART OF THE CRIMINAL CODE:

RECOGNIZE THAT PHYSICIANS HAVE NO OBLIGATION TO INITIATE AND MAY CEASE TREATMENTS THAT ARE OR HAVE BECOME THERAPEUTICALLY FUTILE, AND THAT SUCH A PROVISION APPLY TO COMPETENT AND INCOMPETENT PATIENTS.

d) The treatment and care of terminally ill patients

i) Recommendations of the Law Reform Commission

Many of the issues concerning the treatment and care of terminally ill patients have been discussed. One issue that has been raised in a number of the Commission's works is the provision of palliative care. The difficulty is that in some instances appropriate treatments that will relieve suffering may also hasten the death of the patient. The Framework Document does not address this issue. In Report 31 the Commission provides the following exception to the homicide provisions:

- Palliative Care. Clauses 6(1) to 6(5) [crimes against life, including furthering suicide] do not apply to the administration of palliative care appropriate in the circumstances for the control or elimination of a person's pain and suffering even if such care shortens his life expectancy, unless the patient refuses such care.

Working Paper 28 recommended:

- Nothing in sections 14, 45, 198 and 199 of the *Criminal Code* shall be interpreted as preventing a physician from undertaking or ceasing to administer palliative care and measures intended to eliminate or to relieve the suffering of a person for the sole reason that such care or measures are likely to shorten the life expectancy of this person.

Report 20 recommended that:

- Nothing in sections 14, 45, 198, 199 and 229 shall be interpreted as preventing a physician from undertaking or obliging him to cease administering appropriate palliative care intended to eliminate or to relieve the suffering of a person, for the sole reason that such care or measures are likely to shorten the life expectancy of this person.

Report 28 recommended:

- that there be a provision in the *Criminal Code* stating that the administration of palliative care is not subject to any legal penalty when it is done for the person's benefit, even if it has the effect of reducing his life expectancy.

ii) Comment

Although there is consensus on the desirability of ensuring that appropriate palliative care is available to a patient, even if the measures result in reducing the patient's life expectancy, there is some disagreement as to which sections of the *Criminal Code* would restrict a physician's ability to render this care. Report 31 concentrates on the homicide provisions, including the provisions relating to assisted suicide. Report 20 and Working Paper 28 do not make any provisions for these sections; they concentrate on the sections that provide that consent to death is no defence, the duties of physicians when engaged in surgical procedures, the duties of physicians with respect to patients in their care and, in the case of Report 20, the administering of a noxious or poisonous substance. Report 28 appears to make a recommendation that would be generally applicable.

The CMA policy on the Resuscitation of the Terminally Ill provides:

- Palliative care to alleviate the mental and physical discomfort of the patient should be provided at all times.

iii) Recommendation of CMA

THE CMA RECOMMENDS THAT THE GENERAL PART CONTAIN A PROVISION THAT:

ENSURES THAT PALLIATIVE MEASURES ARE NOT DENIED PATIENTS ON THE GROUNDS THAT ADMINISTERING THESE MEASURES MAY ENTAIL A RISK OF HASTENING THE PATIENT'S DEATH.

C) THE DEFINITION OF DEATH

1) *THE CURRENT CONTEXT*

One technical problem that arises for physicians is the difference between the criminal law's definition of death and the accepted clinical definition of death. Physicians accept that death has occurred when there is an irreversible cessation of circulatory and respiratory functions. However, physicians also accept that death has occurred when there has been an irreversible cessation of brain functions even though the heart continues to beat while a patient is on a respirator. This understanding is reflected in the CMA Position on *Guidelines for the Diagnosis of Brain Death*, which is appended to this brief.

The criminal law has traditionally accepted that death has occurred when there is an irreversible cessation of circulatory and respiratory functions. However, there is some recognition in the case law that brain death may be a suitable definition of death.[24] The case law also indicates that there may be a distinction between the definition of death in the clinical setting and the definition of death for criminal law purposes.[25]

This difference is of particular concern when the organs from cadavers are used for transplantation. Brain dead cadavers are the primary source of such organs. In order to maintain the organs in a condition that will be suitable for transplantation, the cadaver may be maintained on a respirator until the organs are removed. If the criminal law definition of death applied in the medical context, physicians would effectively be removing vital organs from a live person, a practice that would clearly be contrary to law.

In addition, when brain death has occurred, all forms of life support may be removed. Once the means of life support have been removed, the circulatory and respiratory systems will cease to function. The decision, in this case, is not made in the best interest of the patient as in the circumstances discussed in previous sections; it is made because the patient is dead. However, technically, if the criminal law's definition were applicable, a physician would be ceasing a treatment before the patient's death, which leads to the patient's death.

This is a theoretical rather than a practical problem, since physicians are not charged with offenses when they proceed according to accepted clinical criteria and practice.

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[24] *R. v. Kitching and Adams* (1976), 32 C.C.C. (2nd) 159 (Man. C.A.).

[25] *R. v. Green*, June 27, 1988, Justice Wood, Vernon B.C. (B.C.S.C.).

2) *RECOMMENDATIONS OF THE LAW REFORM COMMISSION OF CANADA*

i) Recommendations of the Commission

The Commission has produced two documents on this topic: Working Paper 23[26] and Report 15[27], both entitled, Criteria for the Determination of Death.

Report 15 recommended:

- That the Parliament of Canada adopt the following text:

  - A person is dead when an irreversible cessation of all that person's brain functions has occurred.

  - The cessation of brain functions can be determined by the prolonged absence of spontaneous cardiac and respiratory functions.

  - When the determination of the absence of cardiac and respiratory functions is made impossible by the use of artificial means of support, the cessation of the brain functions may be determined by any means recognized by the ordinary standards of current medical practice.

The recommendations of Report 15 are very similar to this, and vary only by the insertion of the word "irreversible" before the word "cessation" in paragraphs two and three.

A more recent working paper of the Commission also addresses this topic. Working Paper 66, Procurement and Transfer of Human Tissues and Organs, recommended that:

- The "irreversible cessation of all brain functions" standard, proposed by the Commission ten years ago in Report 15, should not be modified to facilitate organ procurement from dying anencephalic infants or other patients who do not meet the whole-brain-death standard.

ii) Comment

Although the distinction between the criminal law definition of death and the clinically accepted definition vary, this has not proved to be a problem in practice. However, since one objective of the current recodification is to bring the *Code* up-to-date it would be helpful to have a definition of death in the General Part which reflects current understanding.

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[26] (1979)

[27] (1981)

iii) Recommendation of the CMA

The CMA, therefore, recommends:

THAT DEATH BE DEFINED IN TERMS OF THE IRREVERSIBLE CESSATION OF BRAIN FUNCTION AND/OR IN TERMS OF THE PROLONGED ABSENCE OF CARDIAC AND RESPIRATORY FUNCTIONS.

III CONCLUSIONS AND SUMMARY OF RECOMMENDATIONS

A) EXEMPTION FROM CRIMINAL LIABILITY

The Law Reform Commission, among others, has recognized that there is a distinction between the conduct the criminal law seeks to condemn and the normal professional conduct of physicians. It has been pointed out that the *Criminal Code* does not clearly provide for this distinction particularly in sections that criminalize conduct that causes death or serious bodily harm and to which the consent of the "victim" is not a defence. Other practices that physicians are involved in are also problematic in the criminal law context, in particular, non-therapeutic practices such as live tissue and organ donation and non-therapeutic research.
The CMA, therefore, recommends that:

WITH RESPECT TO THE LEGALITY OF MEDICAL TREATMENT:

THE GENERAL PART OF THE CRIMINAL CODE CONTAIN A PROVISION THAT LEGITIMIZES THE PROVISION OF MEDICAL TREATMENT AND THAT SUCH A PROVISION BE GENERALLY APPLICABLE.

WITH RESPECT TO THE DEFINITION OF MEDICAL TREATMENT:

MEDICAL TREATMENT BE GIVEN A SUFFICIENTLY BROAD DEFINITION THAT IS DYNAMIC AND INCORPORATES THOSE PRACTICES THAT ARE GENERALLY ACCEPTED AS WITHIN THE SCOPE OF PRACTICE OF A QUALIFIED PHYSICIAN, INCLUDING THE PROVISION OF CARE AND PUBLIC HEALTH MEASURES.

WITH RESPECT TO PATIENT CONSENT:

ANY EXEMPTION PROVISION MAKE A DISTINCTION BETWEEN PATIENT CONSENT IN THE CRIMINAL CONTEXT AND PATIENT CONSENT IN THE CIVIL LAW CONTEXT;

THE CIVIL DUTY TO DISCLOSE NOT BE INTRODUCED INTO THE CRIMINAL LAW AS A PRECONDITION TO THE LEGALITY OF TREATMENT;

ANY PROVISION WITH RESPECT TO CONSENT TAKE INTO ACCOUNT THOSE PATIENTS WHO ARE INCOMPETENT;

THE WISHES OF A PATIENT MADE WHEN COMPETENT BE APPLICABLE WHEN THE PATIENT IS INCOMPETENT UNLESS THERE ARE REASONABLE GROUNDS FOR NOT FOLLOWING THESE WISHES;

ANY PROVISION WITH RESPECT TO CONSENT TAKE INTO ACCOUNT THE EMERGENCY SITUATION.

WITH RESPECT TO THE STANDARD OF CONDUCT:

ANY PROVISION THAT IMPOSES A STANDARD OF CONDUCT MAKE A DISTINCTION BETWEEN THE STANDARD IN THE CRIMINAL LAW CONTEXT AND THE STANDARD IN THE CIVIL LAW CONTEXT.

WITH RESPECT TO NON-THERAPEUTIC INTERVENTIONS:

EXPRESS PROVISIONS BE MADE IN THE GENERAL PART OF THE CRIMINAL CODE THAT RECOGNIZE AS LEGITIMATE LIVE ORGAN AND TISSUE DONATION AND MEDICAL EXPERIMENTATION.

B) THE OBLIGATIONS OF PHYSICIANS WITH RESPECT TO BEGINNING, CONTINUING AND CEASING TREATMENT

The Commission leaves little doubt that a competent patient should be entitled to reject the initiation of treatment and require that treatment be ceased. It is also clear that the *Criminal Code* be amended to ensure that this right is recognized and respected. The Commission also recognizes the need to ensure that an incompetent patient is not prejudiced as a result of his/her incompetency. The incompetent patient should not be subjected to treatments that competent patients would generally reject. The incompetent patient must be protected from abuses of his/her vulnerability. The Commission is less consistent on the appropriate decision-maker in

the case of treatments that have become therapeutically futile (in the sense described above). There is a clear uneasiness in removing, from the competent patient, the right to be the ultimate decision-maker with respect to treatments, that while therapeutically futile, prolong the dying process. Finally, the Commission makes a number of recommendations pertaining to the need to address palliative care measures in the *Criminal Code* and to ensure that patients receive appropriate relief from their suffering even when such relief hastens their death.

In making its recommendations, the Commission was not consistent in identifying which sections of the *Code* are problematic in relation to the physicians obligations concerning the initiation and cessation of treatment.

The CMA, therefore, recommends that the General Part contain provisions that:

CLARIFY THAT A PHYSICIAN HAS NO OBLIGATION TO INITIATE OR CONTINUE TREATMENTS TO WHICH A COMPETENT PATIENT DOES NOT CONSENT;

RECOGNIZE THAT A COMPETENT PATIENT'S WISHES WILL BE APPLICABLE UPON HIS/HER INCOMPETENCY AND SHOULD BE FOLLOWED UNLESS THERE ARE REASONABLE GROUNDS FOR NOT DOING SO;

RECOGNIZE THE PHYSICIAN'S RESPONSIBILITY TO ADVOCATE FOR THE BEST INTERESTS OF AN INCOMPETENT PATIENT;

RECOGNIZE THAT PHYSICIANS HAVE NO OBLIGATION TO INITIATE AND MAY CEASE TREATMENTS THAT ARE OR HAVE BECOME THERAPEUTICALLY FUTILE AND THAT SUCH A PROVISION APPLY TO COMPETENT AND INCOMPETENT PATIENTS;

ENSURE THAT PALLIATIVE MEASURES ARE NOT DENIED PATIENTS ON THE GROUNDS THAT ADMINISTERING THESE MEASURES MAY ENTAIL A RISK OF HASTENING THE PATIENT'S DEATH.

C) THE DEFINITION OF DEATH

Although the distinction between the criminal law definition of death and the clinically accepted definition vary, this has not proved to be a problem in practice. However, since one objective of the current recodification is to bring the *Code* up-to-date it would be helpful to have a definition of death in the General Part which reflects current understanding.

The CMA, therefore, recommends:

THAT DEATH BE DEFINED IN TERMS OF THE IRREVERSIBLE CESSATION OF BRAIN FUNCTION AND/OR IN TERMS OF THE PROLONGED ABSENCE OF CARDIAC AND RESPIRATORY FUNCTIONS.