FAITH, DEATH AND SUFFERING:
ETHICS AND THE LAW OF SUICIDE INTERVENTION

by

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A thesis submitted in conformity with the requirements
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ABSTRACT

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This work addresses the legal and ethical justification for paternalistic intervention, by physicians and other health care professionals, in patients' life-ending decisions.

Decisionally competent persons have, in general, the right to make their own treatment decisions. This principle arises from the doctrine of informed consent, which gives expression to the liberal democratic ideal of protection of personal autonomy, or self-determination. However, a conflict may arise between an apparent obligation to respect such decision, and an opposing obligation, which may seem no less compelling, to save the patient's life, thereby averting what may be a tragic and irretrievable mistake. Most suicide attempts raise a conflict of this kind, and some refusals of life-sustaining treatment are also troubling in this way.

How might such violations of autonomy be justified? For a variety of reasons, those seeking to end their own life are particularly prone to misjudgment about the likelihood of recovering an adequately satisfying life. Under conditions of suffering and dependence, it is not respect but abandonment to leave patients to their own self-determination. It is proposed then that, under certain circumstances, paternalistic intervention is justified to save life, even in the face of a patient's competent refusal of such treatment, on the basis that the person might be making a grievous and irreversible mistake.
This thesis sketches the considerations relevant to paternalistic interference in life-ending choices of this kind and proposes a framework for applying such considerations to particular end of life decisions. These principles may also be applied to provide a legal basis for intervention founded upon the common law defence of necessity. Necessity offers an appropriate and legally well grounded basis for protecting medical practitioners from civil or criminal liability for rescuing a dying person or denying a competent person the choice of death, if appropriate conditions are satisfied.
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1. INTRODUCTION

Allan’s Case

Allan, a man in his early 30's, checks himself into a modestly-priced, downtown hotel. In anticipation of what is to come next, he writes a suicide note claiming the soundness of his mind and the sincerity of his desire to die. Further, he records his instructions that he should not be stopped or his life saved and that if anyone should rescue him, they would be sued. He takes an overdose of sleeping pills and waits to die. However, prior to expiring, he is discovered in a groggy state by the chambermaid who reads the note and calls an ambulance. Upon their arrival, the ambulance attendants intubate Allan with a manual ventilator and transport him to the emergency ward of the nearest hospital.

The emergency ward team is faced with a troubling decision. The suicide note seems to evidence a fixed intention to commit suicide which seems to indicate that the ventilator should be removed and he be allowed to die. However, such a decision does not come easily. A bed is readied for him in the intensive care unit and with prompt treatment, his prospects for recovery are excellent. The situation is pressing. If no action is taken quickly, he will surely die.

What is to be done? Should the ambulance attendants, the chambermaid or any other person have acted differently? If more information is needed to make the right decision, what information? Should the ambulance personnel, emergency physician, hospital or any member of the clinical team be civilly or criminally liable for saving Allan’s life - or for failing to save it? These are questions about which the law is by no means clear.

Betty’s Case

Betty, a 21-year-old college student, has just left a party and is driving with her childhood sweetheart, now fiancé, toward his apartment. The party had been something of a celebration, as the two had just announced their engagement. Betty has been drinking,
although not excessively. The roads are icy and she is driving perhaps a little too fast. Rounding a corner, Betty loses control of the car, it crosses the highway median and slams head-on into an oncoming minivan. Driving the minivan is a 28-year-old school teacher and father of a 3-year-old son, who is driving the babysitter home after an anniversary dinner out with his wife. In the crash, the man and the babysitter are killed instantly. Both Betty and her fiancé initially survive the crash and Betty is pulled from the driver’s seat by the emergency response team and rushed to hospital. Her fiancé is bleeding profusely and firmly wedged in the crumpled wreckage of the car. He cannot be released from the car for 35 minutes and although he is placed in the ambulance, he does not survive the trip to hospital.

In hospital, Betty is alive, but badly injured. After about a day-and-a-half, Betty has fully regained consciousness. She is intubated but her prognosis is good. It is expected that the ventilator may be removed after a few days and that Betty will make a good recovery. However, writing on a pad on a clipboard, Betty directs that the ventilator be turned off. By incessant questioning, she has pretty much pieced together what happened and blames herself, and her own drinking and driving, for what has happened. She claims that she cannot forgive herself, nor does she expect that the dead man’s widow or infant child would do so. The agony of living out the rest of her life with the knowledge that she has, by her account, killed three people, including the man she loves and was about to marry, is not bearable. Betty gives an apparently competent, direct and contemporaneous direction that life-sustaining treatment be withdrawn. She asks of the medical team only that they honour her wishes respecting her own medical care.

Kenneth’s Case

At the age of ten, Kenneth was rendered a quadriplegic as a result of a diving accident. Although his mother had previously died, Kenneth’s father gave him attentive care, companionship and love for the next 21 years. Kenneth is dependent on a respirator and

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1 The facts of this story are taken from the case of Kenneth Bergstedt, see McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990).
unable to move. He is however able to read, watch television, orally operate a computer, and he occasionally receives some enjoyment from wheeling around in his wheelchair. Kenneth’s quadriplegia is acknowledged to be irreversible, although his condition is not terminal so long as he receives artificial respiration. Kenneth’s cognitive powers are not affected and it is agreed that he is competent and able to understand the nature and consequences of the decisions he makes.

At age 31, Kenneth’s father is diagnosed with terminal cancer, and over time it becomes clear that his father will not live much longer. This is, for Kenneth, a dreadful blow and he harbours great misgivings about the quality of his life after the death of his father. In addition, he fears that some mishap may occur to his ventilator, without anyone being present to correct it, and that he would suffer an agonizing death from air hunger as a result. Finally, in contemplating his future in the care of strangers, Kenneth claims that he has no encouraging expectations from life, he does not enjoy life, and is tired of suffering. Therefore, he directs that his ventilator be removed. In doing so, Kenneth understands that the virtually inevitable consequence would be his death.

Overview

These stories bring two fundamental moral, policy and legal principles into conflict. For, absent a legally valid reason, the law permits people to make decisions for themselves. Broadly speaking, respecting the choices of others is our ethical duty as well. The value of individual self-determination is well established also in the medical realm and gets its most fundamental expression in the individual right to refuse to consent to medical treatments, even those required to preserve or sustain life.

But a decision to die is troubling for a number of reasons. It is troubling for the tragic effects it can have on so many others. It is troubling for the sadness, pain, suffering and illness from which it may arise. Decisions to die are troubling too because we worry that the victim may be making a mistake - may be misjudging tragically as to the possibilities for his or her own life, even evaluated on its own terms. If a mistake is being made, it is final and irretrievable, it cannot be repaired. Sometimes, against the self-determination of the
individual, there exists an obligation, both human and medical, of beneficence, to do good for a vulnerable, suffering or desperate fellow human being. If we have obligations to help others in need, and health care professionals most certainly have strong fiduciary obligations to their patients, how is the line drawn between respecting another's right of autonomy and abandoning them?

No doubt, for some life-ending decisions, intervention in the face of a persistent and genuine decision to die would be neither required nor permitted. Equally clearly, there are circumstances in which those in a position of trust are obliged to intervene. Assuming a reasonably firm and settled decision to die, what would constitute sufficient reason to intervene or to fail to cooperate with such self-destructive choice? What sort of factors are relevant and decisive with respect to decisions of this kind?

In our law, respect for the self-determination of others is the default principle. That is, absent some legally recognized constraint, persons may do as they wish. The onus lies with one who seeks to interfere with such freedom to demonstrate that interference is legally justified. Therefore, it lies with the person who interferes to stop a suicide, or to provide life-sustaining treatment over the objections of the person, to demonstrate that such interference is appropriate on the basis of legally recognized principles.\(^2\)

The present state of the law in this regard is unsatisfactory. In its recent decisions, Canadian,\(^3\) U.S.\(^4\) and British\(^5\) courts have proclaimed the autonomy of competent persons over their own lives. Suicide is no longer a crime in any of these jurisdictions. However, judges and legislators have been hesitant to give the principle of autonomy overriding effect in such

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cases, typically citing the state’s interests in preserving life, preventing suicide, protecting innocent third parties and promoting the ethical integrity of the medical professions.

In the cases of Allan, Betty and Kenneth, the conflict between respecting individuals’ wishes concerning their own medical care and the powerful impulse to save or preserve a life is not easy to resolve. On one side, the instinct is strong that, after all, it is the individual that must live with his or her own life. It is difficult not to agree with Justice Robins, of the Ontario Court of Appeal, who writes in the case of Malette v. Shulman:

The doctrine of informed consent is plainly intended to ensure the freedom of individuals to make choices concerning their medical care. For this freedom to be meaningful, people must have the right to make choices that accord with their own values, regardless of how unwise or foolish those choices may appear to others.6

At the same time, when refusal of treatment threatens to end life, our sense of the sanctity of life is also powerful. Justice Sopinka, in the Rodriguez case wonders:

As members of a society based upon respect for the intrinsic value of human life and on the inherent dignity of every human being, can we incorporate within the Constitution, which embodies our most fundamental values, a right to terminate one’s own life in any circumstances?7

No doubt, the conflict between honouring choice and preserving life is, as a matter of policy, among the most acute that our society faces. Absolutes and simple rules will not serve. It is as unpersuasive to proclaim that a competent person may refuse any life-sustaining treatment as it is to argue that life must be preserved in every case.

The thesis proposed here is that, for medical practitioners at least, the default should be the preservation of life, when these two important values come into conflict. The considerations relevant to displacing the presumption of treatment to save or sustain life will be developed, culminating in Chapter 10. However, they are briefly encapsulated in the thesis title “Faith, Death and Suffering.” Briefly, a medical practitioner ought to be liable in battery for giving or continuing to give life-sustaining treatment to a patient, given the patient’s

6 Supra note 3 at 424.

7 Rodriguez, supra note 2 at 585.
apparently competent refusal, in any of three types of cases. Otherwise, the common law civil defence of necessity should be available for him or her to resist liability.

First, treatment refusal should be respected when the treatment itself is of a nature that administering it to the particular patient would constitute a violation of his or her deeply-held religious, cultural or personal beliefs. Second, a decision to refuse life-sustaining treatment ought to be honoured when the patient is near death, or when the process of dying has already begun. Third, such choice should be honoured when the patient is experiencing suffering which, it is reasonably believed, cannot be relieved. In other cases, notwithstanding that treatment technically constitutes a battery at common law, the practitioner should be deemed to be justified in administering treatment on the basis of necessity.

The common law civil defence of necessity, properly interpreted, expresses the common sense proposition that, in very narrow circumstances, violation of the law is justified to serve a higher purpose, or to avert a greater harm. When life-sustaining treatment is sought to be withheld or withdrawn, the value at stake is life itself and the common law has a rich tradition of valuing and protecting life.

But why would the law, or for that matter, medical practitioners or anyone else, be concerned to protect a life of which the holder of that life wishes to be free? While this is an important question, the answer to which will be developed throughout the thesis, an important aspect of the response lies in the uncertainties typically surrounding a choice to die, or to accept death. That is, the presumption that people should make their own choices, including their own medical choices, and have a right to dispose of their own life, is premised upon a number of assumptions. It is assumed first that the choice to die is adequately informed and voluntary. It assumes that the decision to die is competent in the full sense that, in making the decision, the person is not subject to cognitive or affective constraints rendering a decision less than intentional, authentic, or well-considered. If the person contemplating death believes that life holds no possibility of satisfaction, it is assumed that this judgment is realistic and likely correct. It assumes that illness or depression is not clouding the person’s ability to realistically assess his or her own prospects for a life which can become fulfilling. It assumes that the determination about the competence of the person is correct and well-founded. About
any of these matters, either the person seeking to end their life, or the person in a position to render assistance, might be mistaken or making their judgment in some misguided way.

While it would be unreasonable to require or expect an infallible judgment about all of these matters, in the context of suicide, the uncertainty and chance of error is particularly troubling. First, persons contemplating dying will usually be the victims of illness, recent disability, or personal catastrophe. In this condition, one's judgment and reason are much more likely to go astray. Second, and perhaps most important, a decision to die which is misguided or mistaken is particularly tragic because it cannot be reversed. A presumption in favour of intervention, even paternalistic intervention, is justified then on the basis both of the manifold uncertainties attending the authenticity and quality of the decision to die, and of its uncorrectable nature. After all, if a death is stopped, the attempt can be made again in future.

As a practical matter, the proposals made in this thesis will have application, at least directly, in two types of situations. First, as already noted, it is proposed that one who is sued for battery for giving life-sustaining treatment in the face of a refusal, would be entitled to invoke the defence of necessity to resist such liability in the circumstances set forth in Chapter 10. However, the same conditions will also be relevant to the determination of a court application for an order that a proposed treatment either may or may not be administered. Such court approval may quite prudently be sought in advance to confirm the legality of the proposed way of proceeding, and to shield practitioners from potential liability for treatments ultimately given or not given.

Some Limitations

Although it addresses some common issues, this thesis is not about assisted suicide or euthanasia. Roughly speaking, the heart of the assisted suicide/euthanasia debate lies in the questions whether and in what circumstances one person may help another to die. The topic of this thesis is, in some sense, a reverse question, that is, whether and under what circumstances one may intervene to stop a person from dying. However, although these are very different questions, the two issues share this much in common. Both are vitally concerned with the circumstances in which it is acceptable, or in one's own best interests, to
choose to die. Assisted suicide must be wrong at least when the person's decision to die is in some sense not acceptable or if it is formed in an insufficiently autonomous way. Clearly, in considering when intervention with a decision to die is appropriate, the same question will inevitably arise. That is, if the decision, or at least the way the decision is made, is not sufficiently autonomous, then intervention seems to be warranted. Unless one takes the view that individual choice must always be honoured, some normative assessment of the circumstances surrounding a decision to die must be made. It might be thought then that the justification for paternalistic intervention with a decision to die has much in common with the argument against medically assisted suicide. That is, just as a failure to respect a decision to die seeks to protect the person from their own unwise or ill-considered choice, prohibiting assisted suicide may seem paternalistic, justified by a perceived need to protect the person seeking to die.

However, the prohibition against assisted suicide has not been primarily justified on this basis, at least by the Supreme Courts of Canada and the United States. The Supreme Court of Canada in the Rodriguez case upheld the criminal prohibition of assisted suicide on the basis not of the protection of the particular individual seeking aid in dying. Rather, it held that the law serves to protect vulnerable others from seeking suicide as a result of the coercion or manipulation of others, or "...who might be induced in moments of weakness to commit suicide." It is for the sake of such persons, and not of those who may competently and autonomously choose to die, that the law proscribes assisted suicide. Such people's interest in having assistance in dying is in effect sacrificed for the broader social good.

Similarly, the U.S. Supreme Court in Washington v. Glucksberg found that the prohibition against assisted suicide is justified based on, among other things, the state's legitimate interest in protecting "...depressed or mentally ill persons, or those who are suffering from untreated pain, from suicidal impulses" and in "...protecting vulnerable groups - including the poor, the elderly, and disabled persons - from abuse neglect, and mistakes..."

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8 Rodriguez, supra note 2 at 595 (per Sopinka, J.)
The Court also had concerns about the potential slippery slope effects of de-criminalization of assisted suicide.

Whether these are valid arguments continues to be the subject of a lively public and academic debate. This debate will not be taken up here. Acceptance of the argument that practitioners should have a limited privilege to give life-sustaining treatments, despite the patient’s apparently competent refusal, does not commit one to either side of the assisted suicide controversy. One could support the right to assisted suicide, at least when any of the conditions of faith, death or suffering are present. Alternatively, one could consistently maintain that assisted suicide ought to remain unlawful because of concerns related to the danger of abuse of the vulnerable, or from concerns about a slippery slope. Further, one may accept or reject the core thesis of this paper without committing oneself to any position with respect to assisted suicide.

Neither does this thesis address the treatment of patients who are clearly incompetent. It does not address then life-ending decisions made on behalf of, for example, young children, the severely neurologically compromised, or permanently unconscious patients. The ethical and policy issues raised in these cases are somewhat different because the patient cannot make decisions for him or herself, a surrogate must do so. The general rule for surrogate decision-making is that of “substituted judgment,” the attempt to make, on the incompetent person’s behalf, the same decision that he or she would have made, if that were possible. The parallel situation would be one in which a surrogate decider is demanding that life-sustaining treatment be withheld or withdrawn, in circumstances which are ethically troubling to the medical practitioner(s) involved.

Making decisions for another is somewhat different from making decisions for oneself, both because the surrogate lacks privileged access to the mental states of the incompetent person, and because emotional and other non-logical factors tend to play a less important role in surrogate decision-making. Refusals of life-sustaining treatment on behalf of an incompetent person are also complicated by the question of the standard of proof needed to
show that refusal is the decision that the incompetent would have made. In any event, these differences are substantial enough that the case of incompetent refusals, or refusals on behalf of incompetent persons, will not be addressed here.

Practical Applications

The primary thrust of this thesis is the concern that medical practitioners, acting conscientiously and in good faith to preserve the life of a patient, may thereby be exposed to costly and damaging litigation. For this reason, it is proposed that the defence of necessity be available to permit practitioners to resist such liability in appropriate cases. Obviously, determining which circumstances are appropriate poses a substantial challenge. Such conditions, which establish the circumstances in which medical practitioners must respect a refusal of life-sustaining treatment, would be relevant to a court determination, in advance, as to whether treatment ought to be given. That is, in those circumstances in which the practitioner would have a valid defence of necessity, for giving treatment despite a refusal, the court should order treatment, if application is made in advance. On the other hand, where the circumstances are such that the defence of necessity should fail, that is the practitioner is obliged to honour the refusal, then in just those cases, the court should refuse to order treatment.

A Note on Usage

Throughout this thesis, I will refer to the person called upon to give or withhold treatment as a "practitioner," rather than a physician or doctor. Of course, the person in this position will typically be a medical doctor. And, the primary defendant in an action for battery for failing to honour a refusal of treatment will virtually always be the responsible physician. The term "practitioner" is used, however, for a couple of reasons. First, particularly when treatment takes place in a hospital, care will be given by a team of medical professionals, each bringing their own specialized skills, experience and training. While the

10 *Cruzan*, supra note 2.
doctor may be the one to make the final decision, it is common, and generally a good thing, that the views and expertise of other team members contribute to that decision. These other professionals include house staff, nurses, occupational and physiotherapists, social workers, pharmacists, respiratory and other technicians, and others. Second, while not the norm, it is not beyond the range of possibility that another medical professional, most likely a nurse, may be named in a lawsuit alleging unconsented treatment. The emotional burden of a decision to withdraw life-sustaining interventions is often borne most heavily by the nursing staff, and many have great difficulty caring for a patient who is deprived of treatment, for example, nutrition and hydration. In this context, it is far from impossible that a nurse or other practitioner may provide treatment contrary to the patient’s wishes.

**Brief Chapter Summaries**

The structure of the thesis is as follows: In Chapter 3, it is argued that the distinction often drawn between suicide and refusing life-sustaining treatment does not withstand scrutiny. For the purposes of the thesis then, a defence applicable to a failure to honour a refusal of treatment in respect of an underlying illness, should be treated in the same way as one in the context of an overt suicide attempt.

Chapter 4 addresses the objection that the well established medical-legal notion of competence is adequate to delineate those refusals which ought to be interfered with, from those that should not. It is argued rather that the notion is unhelpful in this context because of both practical and conceptual difficulties in determining competence. More important, particularly where the consequences of a medical choice are serious, the grounds relevant to a determination of incompetence are not the same as those relevant to the justification for intervention.

Chapter 5 sketches the available legal exceptions to the requirement of consent, most importantly the little used common law civil defence of necessity. The defence is described and its application in such cases is defended. The defence is available to justify otherwise unlawful conduct either to avert a greater harm or pursuant to a legally recognized duty which, in the circumstances, outweighs the duty to obey the particular law. Treatment to sustain life
could be such conduct.

Inasmuch as the primary objection to the application of the defence of necessity in this context is that failing to respect a refusal is an affront to the autonomy and self-determination of the individual patient, Chapter 6 describes the notion of psychological autonomy in order to provide some background to the question of the extent and limits of the value of autonomy as non-interference.

Chapter 7 builds upon a characterization of the nature of autonomous decision-making developed in the previous chapter to examine the value of autonomy, and the basis for respecting or not respecting patient choice. While autonomy is undoubtedly an important value, it is not absolute or always overriding. In particular, it has substantial limits, and in any event, autonomous decision-making may be compromised in a number of ways consistent with the person having decisional competence.

The interference defended in this thesis is fundamentally paternalistic. Chapter 8 sketches the philosophic grounding for paternalistic intervention and the conditions under which paternalistic intervention is justified. It is argued that legal paternalism is far from unknown in the common law, so it is by no means remarkable that the defence of necessity, having paternalistic effect, should be recognized.

Chapter 9 argues the case that the justification for paternalistic intervention is particularly strong where the decision is to die or accept death. It sketches the application of arguments both for and against intervention to the case of life-ending decisions.

Chapter 10 brings together all of the foregoing and proposes an operationalization of the conditions for justified paternalistic intervention. The concern is that the person making a choice to die could be mistaken. For this reason, and due to the very serious and irrevocable nature of a decision to die, or to allow death to come, the presumption should be that intervention is allowable except if any of three conditions are present. These are: faith - if the decision is to refuse treatment which is prohibited by the deeply held and persistent religious or personal beliefs of the individual; death - if the patient is anyway close to death and in the process of dying; and suffering - if the patient is experiencing unremediable suffering. If these conditions are not present, then it is reasonable to suppose that the exercise of the
practitioner's duty to preserve life, or the potential harm averted by intervention, outweighs
the harm caused by the unconsented treatment. In this way, the requirements for the defence
of necessity are satisfied.

In the next chapter, the right to refuse life-sustaining treatment in Canadian and U.S.
case law is canvassed. The law strongly presumes a right to refuse treatment, but this right
is by no means absolute. It may appear initially that paternalistic intervention to preserve life,
where such treatment has been refused, is inconsistent with the present state of the law in
Canada, the U.S. and England. However, the law of consent in each of these jurisdictions has
significant flexibility, and a privilege by medical practitioners to administer treatment, at least
in some circumstances, would be by no means a radical departure. Notwithstanding the
strength of the presumption in favour of non-interference, where health is reasonably
restorable courts have generally been hesitant to allow death to be chosen, unless the treatment
in question is highly invasive, mutilating or contrary to deeply held religious belief. Further,
the state interests in preserving life, preventing suicide and promoting the ethical integrity of
the medical professions have been accepted in the jurisprudence of both Canada and the U.S.
and have been used, at least in the U.S., to override the right to refuse treatment.
2. THE RIGHT TO DIE

Overview

In Chapter 1, three stories were told of persons who had decided that death was preferable to the life which they were leading, and who took steps to end that life. In each case, it may be imagined that the decision to die was at least reasonably well informed, voluntary and competent. Nevertheless, the feeling is strong that the individuals should not be allowed to die. This sentiment may be particularly strong in medical practitioners whose ethos and training pull strongly toward treatment and rescue. Nevertheless, treatment in the face of refusal presents significant legal peril. This is because there is a general right to refuse medical treatment, which extends even to treatments required to sustain life.\(^1\) Administering treatment in the face of a refusal may render a practitioner liable to the patient in battery.\(^2\) But if it really is the case that, at least sometimes, medical practitioners should give life-sustaining treatment, even without that patient’s consent, how and under what circumstances can such interference be justified?

It is the thesis of this work that such intervention should on some occasions be permitted. In order to lay the legal foundation for such justification, it is necessary first to canvass the existing case law with respect to the right of competent persons to refuse life-sustaining treatment.

Refusal of Life-Sustaining Treatment - Canadian Case Law

In Canada, judicial opinion concerning life-ending decision-making is sparse. The Canadian law in this regard is anchored by two recent cases: In Nancy B. v. Hotel Dieu de

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\(^1\) Malette v. Shulman, infra and Nancy B. v. Hotel Dieu de Quebec, infra.

Québec, Nancy B. was a competent 25 year old woman permanently disabled by an extreme form of Guillain Barré Syndrome, an irreversible neurological disorder rendering her incapable of unassisted breathing and virtually incapable of independent movement. She applied to the Quebec Superior Court seeking an injunction requiring the hospital, upon her request, to discontinue mechanical ventilation. In this event, she would certainly die, since her respiratory muscles had atrophied. The Court, noting that the request was freely given and informed, held that she "...is entitled to require that the respiratory support treatment being given her cease." The court held further that no crime is committed in so doing. The terms of any apparently applicable prohibition of the Criminal Code must be read in light of the common and civil law right to refuse treatment, and the relevant provisions of the Québec Civil Code. The law could not intend that a patient has the right to refuse treatment and at the same time that a physician could be legally liable for giving effect to that right. According to Mr. Justice Dufour, such legislative intent would "result in absurdities." Just a few weeks after the Nancy B. decision, Mr. Justice Rouleau, also of the Québec Superior Court, agreed that a quadriplegic resident of a long-term care institution should be permitted to die by starvation, upon his request, and without criminal sanction against the institution or its staff. While the Nancy B. and Corbeil cases were decided under applicable provisions of the Québec Civil Code, it seems clear that the general principles enunciated are applicable as well throughout the country and such litigation elsewhere would yield similar results. In particular, in reaching his decision, Justice Dufour specifically relied also on common law authorities from both Canada and the U.S.

As to the right to require that life-sustaining treatment be withheld, a decision of the

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4 Ibid. at 392.

5 Ibid. at 394.


Ontario Court of Appeal speaks in strong terms. In June of 1979, Georgette Malette, a passenger in a car driven by her husband on a highway near Kirkland Lake, Ontario, was involved in a head-on collision with a semi-trailer truck. Her husband was killed instantly and Mrs. Malette suffered very serious traumatic injuries. She was rushed to the Kirkland and District Hospital in Kirkland Lake, and was attended by David Shulman, the emergency physician on duty at the time. Mrs. Malette was unconscious, had severe head and face injuries and was bleeding profusely. The medical opinion of Dr. Shulman was that she required an urgent transfusion of blood.

However, in going through Malette's purse, a nurse discovered a card which identified her as a Jehovah's Witness and which instructed, on the basis of her religious convictions, that she be given no blood products under any circumstances. The card was signed by Mrs. Malette, but was neither dated nor witnessed. Although aware of the card and its contents, Dr. Shulman determined that Mrs. Malette's condition was such that transfusion was necessary to replace lost blood and preserve her life and health. Accordingly, he personally administered blood transfusions to her. There was no suggestion that Dr. Shulman acted other than skillfully and with due care. Mrs. Malette made a full recovery but one year later brought action against Dr. Shulman, the hospital and four nurses on duty at the time of her hospital visit. She alleged that the administration of blood transfusions had constituted an unconsented treatment - a battery - which had subjected her to religious discrimination.

At trial, although the action was dismissed as against the other defendants, Dr. Shulman was found liable in battery (and not for negligence) and ordered to pay Mrs. Malette $20,000 in damages. No order of costs was made. The Ontario Court of Appeal upheld the trial decision. Dr. Shulman had administered blood to Mrs. Malette without her consent, indeed in the face of her explicit refusal of consent. Her wishes with respect to the treatment were known to Dr. Shulman. The refusal evidenced by the Jehovah's Witness card was as effective as if, prior to passing out, Mrs. Malette had expressly instructed Dr. Shulman as to

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8 (1987), 63 O.R. (2d) 243 (H.C.)

9 Malette v. Shulman (1990), 72 O.R. (2d) 417 (C.A.)

According to these courts, the emergency exception to the requirement of consent is not available to allow a physician to disregard a patient's advance instructions. Mr. Justice Robins wrote:

The right of a person to control his or her own body is a concept that has long been recognized at common law....Thus...a medical intervention in which a doctor touches the body of a patient would constitute a battery if the patient did not consent to the intervention. Patients have the decisive role in the medical decision-making process. The right of self-determination is recognized and protected by the law.\footnote{\textit{Malette v. Shulman}, supra note 16 at 423.}

A requirement of informed \textit{consent} to treatment would be empty if it did not encompass also the right to \textit{refuse} medical treatment.

A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternate form of treatment, even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community. Regardless of the doctor's opinion, it is the patient who has the final say on whether to undergo the treatment.\footnote{\textit{Ibid.} at 424.}

As in the \textit{Nancy B.} case, the court denied that the refusal of treatment was either an act of suicide or of euthanasia. The court held further that there is no legal requirement that the refusal of life-sustaining treatment be informed. That is, it was not necessary, at least in the circumstances of this case, that Mrs. Malette have the risks and consequences of refusing blood explained to her, for her refusal to be legally effective.

Accordingly, in Canada there is clear authority for the propositions both that one may refuse to submit to any medical treatment, even if necessary to sustain one's life, and that one may require the withdrawal of such treatments. Further, one may require that treatment be withheld either concurrently or by written or verbal notice in advance. The basis for the right to be free of unwanted medical treatment lies, as found by the court in the \textit{Malette} case, in the common law of battery and the right to be free of unwanted physical interference. Justice
Cardozo, in *Schloendorff v. Society of New York Hospital* wrote the classic statement:

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.\(^\text{13}\)

The Supreme Court of Canada, in *Hopp v. Lepp*\(^\text{14}\) and *Reibl v. Hughes*\(^\text{15}\) has confirmed and described the Canadian law of informed consent, making it clear that it encompasses a right to refuse to consent to treatment. The court in *Ciarlariello v. Schacter* confirms this view:

> It should not be forgotten that every patient has a right to bodily integrity. This encompasses the right to determine what medical procedures will be accepted and the extent to which they will be accepted. Everyone has the right to decide what is to be done with one's own body. This includes the right to be free from medical treatment to which the individual does not consent. The concept of individual autonomy is fundamental to the common law.\(^\text{16}\)

There has been no judicial suggestion that this right does not extend to life-sustaining treatments, or that the *Nancy B.* or *Malette* cases were wrongly decided.

*Fleming v. Reid*\(^\text{17}\) was another decision of the Ontario Court of Appeal, concerning not life-sustaining treatments, but rather the administration, without consent, of anti-psychotic medication to involuntary patients in a psychiatric hospital. The court found that such treatment violates the rights to liberty and security of the person found in s. 7 of the *Canadian Charter of Rights and Freedoms*,\(^\text{18}\) where given in violation of a competent refusal, previously expressed. The common law right to determine what shall be done with one's own body is

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\(^{13}\) *Schloendorff v. Society of New York Hospital*, 105 N.E. 92 (N.Y.C.A. 1914) at 93.

\(^{14}\) (1980), 112 D.L.R. (3d) 67 (S.C.C.)


\(^{17}\) (1991), 4 O.R. (3d) 74.

co-extensive with the constitutional right to security of the person. However, application of the Charter requires government action which was, in the Fleming case, present because the patients were involuntarily committed to a provincial psychiatric facility on the authority of provisions of the Ontario Mental Health Act\(^9\) and whose treatment was subject to review by the Review Board established by that legislation.\(^{20}\) The activities of private doctors and of hospitals generally treating voluntary patients has been found not to be government action in the required sense and accordingly the Charter does not apply.\(^{21}\) Nevertheless, as the common law right is well established, the absence of Charter application in most cases will not be of practical significance.

A number of decisions have upheld the right to refuse potentially life-sustaining treatments. In Region 2 Hospital Corp. v. Walker,\(^{22}\) the New Brunswick Court of Appeal upheld the right of a 15-year-old Jehovah's Witness to refuse a blood transfusion, on religious grounds. Since found to be a mature minor, the patient was deemed able to take care of himself and the parens patriae jurisdiction of the court could not be employed to force treatment. Walker was authorized to refuse the blood transfusion even though the medical evidence accepted was that he would likely die without it.

In Wijngaarden v. Tzalalis,\(^{23}\) the Ontario Court of Appeal heard a motion for the stay of an order of the trial court, which had cast doubt on the genuineness of a Jehovah's Witness card directing that no blood transfusions be administered to a person seriously injured in a car accident, and ordered a transfusion. The motion was refused on the basis that the trial judge's finding that there was some doubt about the true wishes of the patient should not be disturbed. However, the denial was made only on the basis that the treating physician undertook that no

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\(^{20}\) Now the Ontario Consent and Capacity Board.


blood would be administered to the patient at any time after a competent expression of the patient’s wish not to receive blood. Finally, the British Columbia Court of Appeal decided that the Attorney-General of B.C. had no duty to force feed a hunger-striking prisoner. The Court specifically refused to decide whether prison authorities were entitled to force feed the prisoner, however, it found no basis for a duty to do so.24

**Canadian Law - Limits to the Right to Refuse Life-Sustaining Treatment**

It is acknowledged that the right to refuse life-sustaining treatments is not absolute. At least by inference, Justice Robins, in the appeal court decision in the *Malette* case, identifies four state interests which may override the individual right to self-determination.25 There are: preserving life; protecting innocent third parties; preventing suicide; and safeguarding the integrity of the medical professions. These four interests correspond to those identified by U.S. courts. The U.S. case law in this regard will be canvassed later.

For the purposes of *Malette*, the court held that the state interests in protecting innocent third parties (Mrs. Malette had no dependent minor children) and of preventing suicide, were held not to be applicable to the case. Presumably, no concern about suicide is raised since Mrs. Malette evidenced no intention to die. And, in *Nancy B.*, the court held that Nancy B. was not committing suicide since the death that would result from her refusal of treatment would not have been caused by her act, but rather by the progress of the underlying disease.26

As to the state’s interest in protecting and preserving the lives and health of its citizens, Robins writes:

> There clearly are circumstances where this interest may override the individual’s right to self-determination. For example, the state may in certain cases require that citizens submit to medical procedures in order to eliminate a health threat to the community or it may prohibit citizens from engaging in activities which are inherently dangerous to their lives. But this interest does

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25 *Supra* note 9 at 429-430.

26 *Supra* note 3 at 394.
not prevent a competent adult from refusing life-preserving medical treatment in general or blood transfusions in particular.

The state’s interest in preserving the life or health of a competent patient must generally give way to the patient’s stronger interest in directing the course of her own life.\textsuperscript{27}

The scope of this interest and the circumstances in which it \textit{would} override a competent refusal of life-sustaining treatment are not spelled out. It is not clear, for example, whether the interest is limited to addressing threats to public health (which would suggest that the concern is for innocent others) and to activities inherently dangerous to life (of course, refusals of life-sustaining treatment are, by definition, dangerous to life). Interestingly, Justice Robins argues that:

\begin{quote}
Recognition of the right to reject medical treatment cannot, in my opinion, be said to depreciate the interest of the state in life, or in the sanctity of life. Individual free choice and self-determination are themselves fundamental constituents of life. To deny individuals freedom of choice with respect to their health care can only lessen, and not enhance, the value of life.\textsuperscript{28}
\end{quote}

As to safeguarding the integrity of the medical profession, Justice Robins argues again that the state’s interest is fundamentally in line with the right to refuse treatment.

The patient’s right to determine her own medical treatment is, however, paramount to what might otherwise be the doctor’s obligation to provide needed medical care. The doctor is bound in law by the patient’s choice even though that choice may be contrary to the mandates of his own conscience and professional judgment. If patient choice were subservient to conscientious medical judgment, the right of the patient to determine her own treatment, and the doctrine of informed consent, would be rendered meaningless.\textsuperscript{29}

Accordingly, while respecting the right to refuse life-sustaining treatment was, in the circumstances of the \textit{Malette} case, found to be consistent with the ethical integrity of the medical profession, there is little guidance offered as to when respecting a refusal of treatment might \textit{not} be so consistent, and in such event, how a balance between competing personal and

\textsuperscript{27} \textit{Supra} note 9 at 429.

\textsuperscript{28} \textit{Ibid.} at 430.

\textsuperscript{29} \textit{Ibid.}
state interests may be struck. Justice Dufour, in the Nancy B. case, based his decision on s. 19.1 of the Quebec Civil Code as follows:

No person may be made to undergo care of any nature, whether for examination, specimen taking, removal of tissue, treatment or any other act, except with his consent.

In considering whether the right described by Article 19.1 is absolute, the judge quotes with approval the words of Justice Chevalier in the 1986 case of Carole Couture-Jacquet v. The Montreal Children's Hospital as follows:

This duty is almost absolute in the case of an adult patient who can discern and who is mentally and physically capable of judging all components of a problem and then making a decision which is subjective but not unreasonable.30

These words raise the possibility that a decision may be subjective but unreasonable, and that in such circumstance, the decision of a competent person may be overridden. However, the circumstances under which this negative implication may be affirmed are, at best, unclear.

Justice Dufour quotes, again with approval, an uncited lecture titled "The Right to Refuse Treatment" by Professor Jean-Louis Baudoin, now a judge of the Quebec Court of Appeal. He writes:

The ability to consent is not however absolute, but rather subject to two limitations. First, the corresponding right of others. Accordingly, an individual may not use his body in a manner which may have the effect of putting in jeopardy the life or health of others. Second, public order (policy). The law sometimes imposes limits on the right to freely do what one wishes with one's body. Accordingly, it does not allow a person to dispose inter-vivos of a part of his body which is not incapable of regeneration or, a vital organ. Subject to these two limits however, one may consider that the right to autonomy and self-determination is absolute.31

Certainly, public health considerations are well-established limitations on individual decision-making. However, it is unclear whether the second condition cited by Justice Baudoin, the "public order" condition, is meant to be restricted to the individual's disposition of his or her body or body parts. More likely, the condition concerning public order may be interpreted


31 Quoted at supra note 3 at 391.
more generally, with the disposition of body parts being an example of a broader principle. Nevertheless, two important points emerge. First, the statements as to these conditions are of sufficient generality as to give little guidance to future cases. Second, both of these conditions refer exclusively to non-paternalistic interests. That is, the conditions serve to protect either individual others, or the public good generally, but not the good of the person refusing treatment.

In the absence of a prior competent direction, where a patient is found to be incapable of giving consent, then treatment may be administered against his or her wishes, usually only with the consent of a valid surrogate decision-maker. However, superior courts may exercise parens patriae jurisdiction to order treatment in the best interests of incompetent persons. So, where Jehovah's Witness parents refused to authorize a blood transfusion for their infant daughter, the Supreme Court, exercising this jurisdiction, ordered that blood be given.

The only recent Canadian case which has held that a competent individual's right to refuse life-saving treatment was overridden by the state's interest in preserving life was the 1984 Québec Superior Court decision in Procureur Generale du Canada v. Hopital Notre Dame et Niemiec. In this case, M. Niemiec was a competent adult and illegal immigrant detained by Canadian immigration authorities awaiting deportation. He had swallowed a piece of wire and refused all medical treatment to remove the wire. He refused also to eat, claiming to prefer death to deportation. The court authorized the hospital to feed Mr. Niemiec and treat him surgically, to remove the wire, finding that he had no right to refuse treatment in this case. The court overrode his right to refuse treatment on the basis of the societal interest in preserving his life. It is not clear whether the Niemiec decision has been overridden by the later Nancy B. and Corbeil cases, but it seems that courts may be prepared to override the

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right to refuse treatment in less sympathetic or medically tragic circumstances. Accordingly, recent reported cases which approve of overriding a competent person's right to refuse treatment have typically involved some element of the larger public good, either to address a social problem like drinking and driving or to discourage attempts to manipulate the judicial or immigration systems.

In *J.M. v. S.C.W.*, a 1996 Quebec Court of Appeal decision concerning property, not health care, the court upheld a "regime of protection" taking away the appellant's right to deal with his own estate. Although found to be competent, keeping a job and generally functioning fairly well within society, he was found to be suggestible and easily influenced. Therefore, although financially comfortable because of an inheritance, the court found that he had limited capacities which, in the long run, could have led to his impoverishment largely because he was found to be susceptible to the influence of a religious sect. His sister then was ordered to retain authority over his property and estate.

At least with respect to health care, modern courts have to date been hesitant to act paternalistically to control the decision-making of a competent person. Courts have held that its inherent *parens patriae* jurisdiction does not apply to a competent person. The *J.M. W.* case shows a willingness by the Quebec Court of Appeal to intervene on an essentially paternalistic basis to protect an individual from making unwise or disastrous financial choices. It is anomalous that courts have been prepared to intervene to protect a competent person's money, but not to preserve his or her life.

**The U.S. Jurisprudence**

The U.S. experience of the right of competent persons to make life-ending decisions is decidedly richer. In *Satz v. Perlmutter*, the Florida Supreme Court addressed a question which it framed as follows:

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35 For a discussion of the *Niemiec* case, see Joan Gilmour "Withholding or Withdrawing Life Support from Adults at Common Law" (1993) 31(3) *Osgoode Hall Law Journal* 473 at 489, 495-498.

Whether a competent adult patient, with no minor dependents, suffering from a terminal illness has the constitutional right to refuse or discontinue extraordinary medical treatment where all affected family members consent.\textsuperscript{37}

Abe Perlmutter was a 73-year-old man suffering from amyotrophic lateral sclerosis (Lou Gehrig's Disease), an incurable progressive neurological disease.\textsuperscript{38} There is no cure and the normal life expectancy, from time of diagnosis, is about two years. At the time of the court hearing, Perlmutter was virtually incapable of movement and unable to breathe without a mechanical respirator. Speech was extremely difficult, requiring great effort. Even with the respirator, the prognosis for Perlmutter was death within a short time. Nevertheless, he remained alert and in command of his mental faculties and so was found to be legally competent. He sought, with the full approval of his adult family, to have the respirator removed, which, according to medical evidence, would result in death within an hour. Perlmutter was aware of the inevitable result of the removal of the ventilator and remained insistent that it be withdrawn. The Florida Supreme Court affirmed that Perlmutter was at liberty either to remain in or leave the hospital, free of the mechanical respirator if he chose, and that no person may interfere with his decision.

In 1987, Kathleen Farrell was a 37-year-old, competent, terminally ill patient, also suffering from ALS and also respirator-dependent. Mrs. Farrell told her husband that she wanted the respirator disconnected, which she was aware would result in her death. Mrs. Farrell was a fragile woman, weighing less than 100 pounds. She had no control over her hands, arms, feet or legs, and was incontinent as to bowel and bladder function. She had difficulty swallowing and was incapable of taking solid foods by mouth. She could be fed only liquids such as juice, with a syringe, by nurses who attended to her 24 hours a day. She could open and close her eyes, but was incapable of moving her head, neck or any other part of her body and had difficulty talking. When asked why she wanted to disconnect her respirator, she responded, "I'm tired of suffering." On application, the Supreme Court of

\textsuperscript{37} 379 So.2d 359 (Fla. 1980) at 359.

\textsuperscript{38} This is the same disease that afflicted Sue Rodriguez, who was the subject of the 1993 Supreme Court of Canada case on physician assisted suicide - \textit{Rodriguez v. B.C. (A.G.)}, [1993] 3 S.C.R. 519.
New Jersey acceded to her request that she be allowed to have the respirator withdrawn.  
Similarly, Martha Tune, a 71-year-old woman with terminal cancer, also dependent upon a respirator, applied for an order directing the federal veteran’s hospital in which she lived "...to remove the artificial life support from her...to permit her to die with dignity." The court complied.

However, courts have not required either that the patient be terminally ill, or even near the end of life. In 1984, William Bartling was a 70-year-old California man suffering from emphysema, chronic respiratory failure, arteriosclerosis, abdominal aneurysm, a malignant tumour of the lung, chronic acute anxiety/depression and alcoholism. Because of his lung disease, he was, like Perlmutter and Farrell, dependent on a mechanical respirator. Mr. Bartling had prepared a living will which stated in part: "If at such time the situation should arise in which there is no reasonable expectation of my recovery from extreme physical or mental disability, I direct that I be allowed to die and not be kept alive by medications, artificial means or heroic measures." He had also prepared a Durable Power of Attorney for Health Care, appointing his wife as his agent and expressing similar sentiments as those found in his living will. His legal competence was not challenged. Bartling’s condition was not terminal, his life expectancy being at least a year.

However, Bartling was a patient of the Glendale Adventist Hospital, a Christian, pro-life oriented hospital. The majority of doctors at that hospital viewed disconnecting a life-support system in such a case as inconsistent with the healing orientation of physicians. Further, they argued, disconnecting Mr. Bartling’s ventilator would be tantamount to aiding a suicide. On his application for a declaration that the respirator be removed, the court rejected both of these arguments. First, the right of Mr. Bartling to self-determination with respect to his own medical treatment is paramount to the interests of other patients, the hospital and its doctors. Further, disconnecting the ventilator would not be aiding a suicide. Rather, it would simply hasten his inevitable death by natural causes. In any event, Mr.

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Bartling's acts would not necessarily constitute suicide since the patient may not have the specific intent to die and, even if he did, to the extent that the cause of death was from natural causes, the patient did not set the death-producing agent in motion. Accordingly, the court ordered that the ventilator be disconnected and Bartling be allowed to die.\footnote{Bartling \textit{v.} Glendale Adventist Medical Center, 209 Cal. Rptr. 220 (Ct. App. 1984).}

In \textit{Lane v. Candura}, the Massachusetts appeals court refused to appoint the daughter of a 77-year-old widow, Rosaria Candura, who was suffering from gangrene in her foot and lower leg, as her legal guardian. The only substantial issue was whether Mrs. Candura was competent, and the court found that she was. In the absence of her consent to an amputation of the affected limb, that operation could not be forced on her against her will.\footnote{376 N.E.2d 1232 (Mass. Ct. App. 1978).} The result was the same in the case of Robert Quackenbush who also, according to medical evidence, required amputation of both legs due to an advanced gangrenous condition. The court accepted that Mr. Quackenbush would die within about three weeks without the amputation and that death may be averted if the operation were performed. The court found Quackenbush to be mentally competent and refused to interfere with his choice to refuse the amputation.\footnote{In \textit{re Quackenbush}, 383 A.2d 785 (N.J. Co. Ct 1978).}

A number of cases of quadriplegics have come before U.S. courts claiming the right to refuse life-sustaining treatment. For example, Elizabeth Bouvia, a 28-year-old woman afflicted with severe cerebral palsy from birth had deteriorated to the point where she was permanently bedridden. Except for a few fingers of one hand and some slight head and facial movements, she was immobile. Needless to say she was physically helpless and wholly unable to care for herself. She required assistance with feeding, washing, cleaning, turning, elimination and other bodily functions. She could do no more than lie flat in bed and would do so for the remainder of her life. She suffered also from degenerative and severely crippling arthritis, keeping her in continual pain. Bouvia was intelligent and mentally competent. However, her husband had left her and she had suffered a miscarriage. Her search for a permanent place to live, where she could receive the constant care she needed, had been
unsuccessful. In the circumstances, the California Court of Appeals acceded to her request that she have her feeding tube disconnected and that she be allowed, in essence, to starve to death.44

Similarly, when Larry McAfee suffered severe spinal cord injuries in a motorcycle accident, leaving him quadriplegic and dependent upon a ventilator, his application to be allowed to turn off his ventilator was granted by the Georgia Supreme Court.45 In Nevada, Kenneth Bergstedt, a 31-year-old mentally competent quadriplegic was allowed to have the respirator, upon which he was totally dependent, removed. Although Bergstedt had lived with some quality of life for several years in this condition, he had done so with the support and care of his father. When the father was diagnosed as having terminal cancer, the prospect of carrying on, in his condition, after his father died, was intolerable to him.46

Courts have been faced with a number of applications relating to refusals of life-sustaining treatment based on religious grounds. These have been primarily, but not exclusively, for members of the Jehovah's Witness church. A number of earlier cases found courts ordering that blood be given notwithstanding the refusal of the individual. For example, in the 1964 case of Application of the President and Directors of Georgetown College,47 Jessie Jones, the 25-year-old mother of a 7 month-old child - and a Jehovah's Witness - was rushed to Georgetown University Hospital having lost two-thirds of her body's blood from a ruptured ulcer. The D.C. Circuit Court ordered that she be given blood notwithstanding her explicit refusal, and that of her husband. The medical evidence was unanimous that the patient would die without blood and that there was a better than 50% chance of saving her life with the transfusion.

The judge found Mrs. Jones not competent and pointed out that she was the mother of a young child. The state, he argued, as parens patriae, should not allow her, as a parent, to

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47 331 F.2d 1000 (D.C. Cir. 1964).
abandon her child. Finally, the judge argued that Mrs. Jones did not want to die. Death was not her goal, but an unwanted side effect of her religious beliefs and medical condition. Further, the judge took into consideration the position of the doctors and the hospitals whose responsibility it was to treat Mrs. Jones. Their choice was to administer the proper treatment or let her die in the hospital bed, exposing themselves to the risk of civil and criminal liability in either case. The court doubted that Mrs. Jones had the authority to put the hospital and its doctors in this untenable position. Perhaps most important to the decision, the court found that although Mrs. Jones' religion prevented her from consenting to a transfusion, it was plain that she would not resist a court order to that effect. In that event the responsibility would not be hers, but that of the court. It appeared to the court that in complying with an order not of her making, Mrs. Jones would not be sacrificing her religious beliefs. Finally, the fact that a life hung in the balance and that there was little time for research and reflection, militated in favour of a speedy decision to save life. The court was unwilling to accept the risk of refusing to order the transfusion, only to find later that the law required such action.

In 1965, Willie Mae Powell suffered extensive bleeding following a caesarian section operation. However, being a Jehovah's Witness, she refused to give her consent to the administration of a blood transfusion, notwithstanding the urgings of the hospital, its staff, her husband and other members of her family. Mrs. Powell was the mother of six children. In ordering the involuntary transfusion, the court reasoned that although Mrs. Powell did not object to receiving blood, she would not direct its use. Again, although her religious beliefs forbade her consenting to receive blood, she would not object to a court order that blood be administered, since that would not be her responsibility. She wanted to live and the court "could not let her die." Similarly, in John F. Kennedy Memorial Hospital v. Heston, the court ordered a medically required blood transfusion to a 22 year-old woman suffering from a ruptured spleen as a result of an automobile accident. The court based its decision on the interest of the hospital and its staff in carrying out its medical role, and on the state's interest

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48 In re Powell, 267 N.Y.S.2d 450 (1965).
in the preservation of life.

In *United States v. George,*\(^5^0\) a similar situation arose and the judge advised Mr. George that as he was coherent and rational, the court had no power to force transfusion upon him. He was free to resist the transfusion, even simply by placing his hand over the area to be injected by the needle. Mr. George replied that he would not resist the doctor's actions once the court order was signed. The court ordered the blood transfusion.

It is fair to say however that cases which have ordered blood transfusion without consent are earlier, and may be considered overruled by subsequent decisions. In addition, in these earlier cases, the judge typically seemed to assume that ordering a transfusion would not *really* be contrary to the patient's wishes, since the patient is not *really* disobeying the religious prohibition. The patient is shielded by his or her refusal, and is "forced" to accept blood by the court order.

However, in 1965, the Illinois Supreme Court refused to interfere with the refusal of a blood transfusion in *In re Brooks Estate.*\(^5^1\) The patient was a competent adult, with strong religious beliefs forbidding transfusion and the court refused to order a transfusion, even given the medical indication that death would likely result from such refusal. In the case of *In re Osborne,*\(^5^2\) a man who suffered severe traumatic injuries as a result of a tree falling on him did not wish to live if to do so required a blood transfusion. He would be deprived of life everlasting even if he involuntarily received the transfusion. Material provision had been made for his family and wife and the decision was found to be competent. The court found no compelling state interest which would justify overriding his decision.\(^5^3\) In *Mercy Hospital v. Jackson,*\(^5^4\) the court refused to order the pregnant mother of a viable fetus, requiring an

\(^{50}\) 239 F.Supp. 752 (Conn. Dist. Ct. 1965).

\(^{51}\) 205 N.E.2d 435 (Ill. 1965).


\(^{53}\) See also *In re Erickson,* 252 N.Y.S.2d 705 (1962).

urgent caesarian section delivery, to accept a needed blood transfusion. The fetus was not placed at risk by the failure to give blood.55

Courts have also consistently allowed the decision to refuse life-sustaining treatments to be made on behalf of incompetent patients. For example, the U.S. Supreme Court in *Cruzan v. Director, Missouri Dept. of Health* held that an incompetent person, in a permanent vegetative state, could have her feeding tube removed.56 Nancy Cruzan was involved in a serious motor vehicle accident and her parents sought to terminate artificial nutrition and hydration. The Supreme Court held that Cruzan has a right to refuse treatment and that under certain circumstances a surrogate may act for the patient in electing to withdraw life-sustaining treatment, thus causing death. However, it was not unconstitutional for the state of Missouri to require clear and convincing evidence of the patient's wishes in this regard.57

The basis for the right to refuse even life-sustaining treatments in the U.S. has a number of sources. First, as in Canada, there is a right to refuse treatment based upon the common law principle requiring informed choice in medical treatment and the corresponding right to refuse to consent which is clearly implied by that principle.58 It is now also "assumed" that the right to refuse treatment is encompassed in U.S. constitutional protections of the right to privacy and liberty.59 The constitutional right of privacy was first clearly articulated by the U.S. Supreme Court in the 1965 case of *Griswold v. Connecticut*,60 which held that married couples have a constitutional right to use artificial contraception. The right was also found in *Roe v. Wade* extending its reach to a woman's decision to abort a

55 See also *In re Melideo*, 390 N.Y.S.2d 253 (1976).


58 *Union Pacific Railway v. Botsford*, 141 U.S. 250 (1891) and *Schloendorff*, *supra* note 13.

59 *Cruzan*, *supra* note 56.

60 381 U.S. 479 (1965).
pregnancy. Finally, in *In re Quinlan*, the New Jersey Supreme Court found that the right of privacy was broad enough to include the decision to decline medical treatment under certain circumstances, even if such decision would or might lead to the patient’s death. In addition, various state courts have found the right to refuse treatment to be protected under their state constitutions.

However, whether the source of the right is at common law, or under federal or state constitution, courts are unanimous that such right is not absolute. The right must be balanced against countervailing state interests in sustaining a person’s life. Four such interests have been identified, and they are the same as those suggested by the Ontario Court of Appeal in *Malette*. That is, the state has legitimate interests in preserving life, in preventing suicide, in protecting innocent parties and in safeguarding the integrity of the medical professions.

In Canadian and U.S. Constitutional law, countervailing state interests operate as a balance to individual rights. No rights are absolute. Just as a right to free speech does not necessarily preclude an action for slander and freedom of religion does not protect every spiritual activity or religious practice, the right to be free of unwanted medical treatment is likewise subject to limitations. These limitations are represented by state interests which are intended to represent the common interest or the broader social good, exercised and enforced by courts on behalf of society as a whole.

**The State Interest in Preserving Life**

Since Canadian cases on the right to refuse life-sustaining treatment have been decided on the basis of common law, as opposed to constitutional rights or protections, little is written about a balance between individual and state or common interests. The court in *Nancy B.* did

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63 The Supreme Court of Nevada in the case of *McKay v. Bergstedt*, supra note 46, suggests a fifth state interest, being "the interest of the state in encouraging the charitable and humane care of those whose lives may be artificially extended under conditions which have the prospect of providing at least a modicum of quality living."

not mention them. Justice Robins, for the Ontario Court of Appeal in *Malette*, acknowledged the state interest in preserving life, but found it to be insufficient to outweigh the right of a competent person to refuse any medical treatment.

This question was raised, although not directly, in the Supreme Court case of *Rodriguez v. B.C. (A.G.)*. In that case, the right to control one's own death was examined in the context of a challenge to Canada's criminal prohibition of assisted suicide. One issue was whether this prohibition violated the *Charter* s. 7 right to "...life, liberty and security of the person." Justice Sopinka, writing for the majority, finds constitutional acknowledgement of the sanctity of life in s. 7 itself, since it protects life as well as liberty and security of the person. Therefore, life must be taken into account when considering the constitutionality of the individual's right to control his or her own death.

I find more merit in the argument that security of the person, by its nature, cannot encompass a right to take action that will end one's life as security of the person is intrinsically concerned with the well-being of the living person.

The state's interest in the preservation of life is acknowledged to be the most significant of the asserted state interests. According to *Bergstedt*, the interest is fundamental and compelling, and constitutes a basic purpose for which governments are formed. The state interest in preserving life has been found to have two elements. The state has an interest both in the life of the particular patient and an interest in the sanctity of life in general. While a distinction along these lines seems theoretically sensible, in practice it is not made clear. It may be that only respect for the life of the particular patient is at stake in cases of refusal of life-sustaining treatment. Or, it may be that respect for the sanctity of life in general is

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63 *Supra* note 38.
67 *Rodriguez*, *supra* note 38 at 585.
68 *Saikewicz*, *supra* note 57 at 741 and *Bartling*, *supra* note 41 at 194.
69 *Supra* note 46 at 622.
70 *Conroy*, *supra* note 57 at 349 and *Munoz*, *infra* note 72.
fostered by attending to the importance of individual lives. In the case of Claire Conroy,\textsuperscript{71} the court apparently saw the case as focusing on the life of the particular patient. In this first sense, the state's interest is concerned with protecting a life that cannot protect itself. Therefore, where a person is competent to make their own choices, the state interest gives way to the stronger interest of the individual in directing the course of his or her own life. It does not appear that a more general concern about the sanctity of life was thought to be applicable in such cases. The court in \textit{Norwood Hospital v. Munoz}\textsuperscript{72} adopted a similar line. The interest is not applicable when the life sought to be preserved is that of a person who has competently decided to forego treatment. With respect to the sanctity of all life, the court follows \textit{Saikewicz} that respect for life entails respect for the right of choice of a competent human being.\textsuperscript{73} Pointing out that life must eventually succumb, the \textit{Bergstedt} court argues that preserving life "at all costs" is demeaning to death as a natural part of life. Death too has important value. It is not inconsistent with the state's interest to view death, at times, as a welcome relief to suffering or an end to the indignities of a life bereft of self-determination and cognitive activity.\textsuperscript{74}

In balancing the right to refuse treatment against the state interest, a number of factors have been identified as relevant. The prognosis of the patient appears to be of great importance, both with respect to the prospects for survival and the amount of suffering which he or she may be expected to experience. The court in \textit{Saikewicz} found,\textsuperscript{75}

...a substantial distinction in the state's insistence that human life be saved when the affliction is curable...[and] the state interest where...the issue is not whether, but when, for how long, and at what cost to the individual that life may be briefly extended.\textsuperscript{75}

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\textsuperscript{71} \textit{Supra} note 57.

\textsuperscript{72} 564 N.E.2d 1017 (Mass. 1991).

\textsuperscript{73} \textit{Saikewicz}, \textit{supra} note 57 at 426.

\textsuperscript{74} \textit{Bergstedt}, \textit{supra} note 46 at 624.

\textsuperscript{75} \textit{Supra} note 57 at 425-426.
The Bergstedt court apparently saw this issue in terms of quality of life, arguing that as the patient's quality of life diminishes, so does the state interest. Kenneth Bergstedt was the 31-year-old quadriplegic who for 21 years had relied on his father for companionship and support. When his father was diagnosed as having terminal cancer, Bergstedt wished to be allowed to die. The court held that had he enjoyed good health, but was unbearably miserable due to his mental state, he would have no liberty right to terminate his own life.

In the 1979 case of Commission of Corrections v. Myers, a prisoner in a federal penitentiary refused dialysis and a kidney transplant apparently as a protest against his treatment. The court found that inasmuch as his prognosis was good with the treatment, and since Myers would otherwise live a normal and healthy life, including the possibility of a complete cure, the state interest was strong. Inasmuch as no "heavy physical and emotional burdens are imposed to effect a brief and uncertain delay in the natural process of death," Myers did not have the right to refuse treatment necessary to preserve his life. That the patient's illness was terminal was also important to the decision in the Tune case:

The State's interest in maintaining life must defer to the right to refuse treatment of a competent, emotionally stable, but terminally ill adult whose death is imminent, and who is the best, indeed the only, true judge of how such life as remains to him may best be spent. (italics added)

Another important factor weighing in the balance is the extent of the bodily invasion entailed by overriding the patient's wishes. For example, in the Quackenbush case, although the patient was not terminal, the extensive bodily invasion entailed by the required amputation of both legs above the knee was found to outweigh the state interest in preserving life even though, in this case, there was the absence of a dismal prognosis. The court in Quinlan, in permitting the respirator to be removed from a patient in a permanent vegetative state, argued that the state's interest weakens, and the individual's right to privacy grows, as the prognosis dims and the degree of bodily invasion increases. At some degree of invasiveness then, the

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76 399 N.E.2d 452 (Mass. 1979).
77 Ibid. at 262.
78 Supra note 40 at 1455-1456.
individual right overcomes the state interest. Inasmuch as Quinlan’s prognosis was poor - she would never resume cognitive functioning - and the bodily invasiveness was great, the state interest in life was found to be overridden.79

The U.S. jurisprudence around the state interest in preserving life touches a number of themes. For example, the court in Munoz argues that respect for life entails respect for the right of choice of a competent human being.80 With respect, this formulation must be oversimplistic. To say that the state interest in preserving life has no effect with respect to a life-ending choice by a competent person is to say that the state interest in question has no force at all. This is because, at common law, competence is already a pre-condition for the right of independent medical decision-making. In order that the state interest have some content, additional considerations must be relevant.

The court in Saikewicz writes that whether the condition is curable constitutes a relevant consideration in determining if the state interest is sufficiently strong, in a particular case, to outweigh the individual right to refuse treatment. In Bergstedt, the court specifically held that if Kenneth Bergstedt enjoyed good health, he would have no right to terminate his own life.81 In the Tune case, whether the illness was terminal was a relevant consideration.

On the other side, the individual right is held to be stronger when the invasiveness of the treatment is greater. Therefore, prognosis, quality of life and the nature of the treatment proposed are all relevant to the applicability of a meaningful state interest in the preservation of life, when balanced against the individual right to refuse treatment.

The State Interest in Preventing Suicide

The state interest in preventing suicide may be seen as a species of the state interest in preserving life. Nevertheless, courts have consistently considered the two interests to be separate. Suicide, as an intentional act of self-destruction, has been unlawful in most

79 Supra note 62 at 664.
80 Supra note 72.
81 Bergstedt, supra note 46 at 625.
jurisdictions until relatively recently. Legal antipathy toward suicide has persisted notwithstanding its decriminalization and continues to be expressed in existing laws which forbid encouraging, assisting or abetting suicide. As in Canada, the U.S. cases have been more or less unanimous that a refusal of life-sustaining treatment is not suicide and therefore the state's acknowledged interest in preventing suicide is not engaged in such cases. Three distinctions are drawn between suicide and refusals of treatment:

First, at least in general, the person refusing treatment has no specific intention to die. This is most clearly the case where refusal is motivated by religious belief. People refusing treatment by reason of the prohibitions of Jehovah's Witness, Christian Scientist or other religious beliefs may indeed have a fervent wish to live, but refuse life-sustaining treatments either as an expression of a very powerful commitment to their spiritual beliefs, or from a fear of punishment in the afterlife.

The lack of a desire or intent to die has also been found in cases where the treatment itself is burdensome. The intention in refusing treatment is not to bring about death, but rather to be free of the suffering brought about by the ventilator, chemotherapy, amputation or other burdensome treatment. The court in Satz v. Perlmutter, for example, found that Abe Perlmutter wished not to die, but rather to be free of the burden of unwanted treatments. Finally, it is sometimes said that a person refusing life-sustaining treatment wishes not to die, but rather to be free of a life which, because of the emotional or physical suffering caused by his or her illness, is no longer bearable.

The second reason why refusing life-sustaining treatment is not the same as suicide, according to the cases, is that the cause of death was not the act of the patient. Rather, the cause of death is the patient's underlying illness or medical condition. In this regard the Saikewicz opinion has been highly persuasive. It held that even if the patient had the intent

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82 Criminal Code, s. 241.
83 Malette v. Shulman, supra note 9 and Nancy B., supra note 3.
84 In re Osborne, supra note 52.
85 Supra note 37.
to die, "...to the extent that the cause of death was from natural causes, the patient did not set the death-producing agent in motion with the intent of causing his own death." 86 A refusal of treatment is not suicide, according to Satz, because the patient did not self-induce "his horrible affliction." 87

The third reason that the state interest in preventing suicide is thought not to apply to refusals of life-sustaining treatment is that, again according to the Saikewicz court, "...the underlying state interest in this area lies in the prevention of irrational self-destruction." 88 The interest is not applicable where a competent, rational decision to refuse treatment is made, where death is inevitable and the treatment offers no hope of a cure or preservation of life. The notion of a rational decision to refuse treatment, or an irrational act of self-destruction, are concepts which are not closely analyzed. However, both Bartling and Saikewicz offer the view that suicide is in any event not irrational when competent and reasoned, and where death is inevitable and medical science offers no hope of cure or means of preserving life.

In Chapter 3, it is argued that it is misleading and unhelpful to draw a general distinction, for purposes of policy, between acts of suicide and refusals of life-sustaining treatment. Admittedly, this view is at odds with the preponderance of judicial opinion, both in Canada and the United States. In Chapter 3 however, some reasons why courts may be tempted to draw this distinction are suggested. Nevertheless, the distinction is not clearly relevant from a moral or policy standpoint.

The argument seems to be that intervention to stop an overt attempt at suicide is usually or always legitimate, while failing to respect a refusal of life-sustaining treatment is typically not acceptable. Accordingly, the moral justification for these two types of intervention must be evaluated in different ways. For the time being, it is sufficient to note that the problem of suicide in modern society is great and very troubling. That courts should take seriously society’s broadly-based concern and interest in preventing suicide is proper and a matter of

86 Supra note 57 at 427.

87 Supra note 37.

88 Supra note 57 at 427 (italics added).
pressing importance. It signals a resolve that suicide is not merely a lifestyle choice removed from the concern and competence of others. Suicide is a social tragedy to which an appropriate response is not disregard, but protection, care and some effort to mobilize resources on the victim’s behalf.

The State Interest in Protecting Innocent Third Parties

In Canada, there has been little judicial discussion of this interest in the specific context of refusals of life-sustaining treatment, although it was acknowledged in the Malette decision. U.S. Courts have consistently held that the right to refuse life-sustaining treatment must be balanced against the harm which may thereby be caused to innocent others. Analysis of this interest is sparse. However, according to Farrell, in practice:

When courts refuse to allow a competent patient to decline life-sustaining treatment, it is almost always because of the state’s interest in protecting innocent third parties would be harmed by the patient’s decision.89

Clearly, a parent may be involuntarily treated, at least sometimes, where treatment is required to preserve her life and she or he has children or other dependents.90 However, in Public Health Trust of Dade County v. Wons,91 the refusal of blood transfusion by a Jehovah’s Witness parent was not overridden where there was a supportive husband remaining to raise the children. The court has displayed sensitivity to the fact that, aside from those to whom fiduciary or special obligations are owed, it cannot be expected that persons will make what must seem to them an extraordinary sacrifice, by reason only of the good they might do for others. Nevertheless, when legal obligations are owed, the court is empowered to step in and order treatment, against the patient’s own wishes, on this ground.

For these purposes however, in order to address squarely the question of suicide intervention undertaken solely or primarily for the person’s own good, it is assumed that no

89 Supra note 39 at 412.

90 Georgetown College, supra note 47.

91 541 So.2d 96 (Fla. 1989).
other person's interests are implicated in the particular decision to die, or in any event, that such interests are clearly outweighed by those of the suicide. Accordingly, the state interest in protecting innocent third parties will be left aside in this discussion.

The State Interest in Preserving the Ethical Integrity of the Medical Profession

In *United States v. George*, the court considered the right of a Jehovah’s Witness patient to refuse the transfusion of blood. It had this to say about the obligations of the medical profession:

In the difficult realm of religious liberty it is often assumed only the religious conscience is imperiled. Here, however, the doctor's conscience and professional oath must also be respected...to require these doctors to ignore the mandates of their own conscience, even in the name of free religious exercise, cannot be justified under these circumstances. The patient may knowingly decline treatment, but he may not demand mistreatment.\(^\text{92}\)

In another Jehovah's Witness blood transfusion case, the court in *John F. Kennedy Memorial Hospital v. Heston* wrote:

Hospitals exist to aid the sick and the injured. The medical and nursing professions are consecrated to preserving life. That is their professional creed. To them, a failure to use a simple, established procedure in the circumstances of this case would be malpractice, however the law may characterize that failure because of the patient's private convictions. A surgeon should not be asked to operate under the strain of knowing that a transfusion may not be administered even though medically required to save his patient. The hospital and its staff should not be required to decide whether the patient is or continues to be competent to make a judgment upon the subject, or whether the release tendered by the patient or a member of his family will protect them from civil responsibility.\(^\text{93}\)

Courts agree that the ethics of medical practice do not require, in every case, that life be preserved. Therefore, in some circumstances, cooperating with a decision to die may be consistent with the traditions of the medical professions. The question whether a particular act of cooperation with such a decision is permitted by the ethics of the medical profession is

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\(^\text{92}\) *Supra* note 50 at 754.

\(^\text{93}\) *Supra* note 49 at 673.
characterized in different ways. In *Quinlan*, the court sees the balance struck in this way: "...physicians distinguish between curing the ill and comforting and easing the dying; that they refuse to treat the hopeless and dying as if they were curable."94 This passage seems to track the distinction between saving life and prolonging death. It is said that once the process of dying has begun, that is, once death is inevitable and coming soon, the appropriate medical response is no longer to preserve life at all costs, but rather to comfort and ease the suffering of the dying patient even if it would be possible to extend life a little longer by the use of available medical means. Therefore, it is not contrary to principles of medical ethics:

...to refuse to inflict an undesired prolongation of the process of dying on a patient in an irreversible condition when it is clear that such "therapy" offers neither human nor humane benefit.95

However, another conception of the ethical requirements of the medical profession also appears in a number of cases. The idea is that the ethical obligation of a physician is to respect competent refusals of treatment.96 When faced with a competent refusal of treatment, medical practitioners have no special duty to preserve life or promote health which is inconsistent with these instructions. The court in *Conroy* writes:

Indeed, if the patient's right to informed consent is to have any meaning at all, it must be accorded respect even when it conflicts with the advice of the doctor or the values of the medical profession as a whole.97

A similar line is taken by the court in *Brophy v. New England Sinai Hospital* which argues that the integrity of the medical profession is not threatened by allowing competent patients to decide for themselves whether a particular treatment is in their best interests. The obligation to provide treatment, grounded in the ethical integrity of the medical profession, is seen to be based upon a determination that treatment offers a reasonable hope of benefit to

94 Supra note 62 at 667.

95 Ibid. at 667.

96 Bergstedt, supra note 46.

97 Supra note 57 at 352-353. This is similar to the argument made by the court in the *Malette* case, supra note 9.
the patient. Therefore, a withdrawal of treatment would be ethically permissible where it no longer offers any hope of benefit to the patient.\footnote{497 N.E.2d 626 (Mass. 1986) at 639.}

In summary, two important themes are found in the cases respecting the state interest in the preservation of the ethical integrity of the medical professions. The first is a recognition that physicians are themselves moral agents, whose personal values matter and who have particular socially valued duties and responsibilities qua medical practitioner. Physicians are accorded significant power within health care institutions, high social status and above-average incomes by reason of their privileged access to medical information, experience, skills and facilities. At the same time, physicians and other medical practitioners accept special responsibilities to care, relieve suffering and preserve life. While these duties are not absolute, they are nevertheless very powerful. In particular, the medical duty to treat and attempt to save a life, where life might be saved is, one hopes, deeply ingrained in the traditions of medical practice. Physicians should be relieved of such duty, or forbidden from acting on it, only in extraordinary circumstances. To the extent that exceptions are made, there is a danger that the social and professional commitment to preserving life will diminish.

The second theme involves a judicial recognition of the empirical claim that at some point a person is alive but in the irretrievable process of dying. For most people, if their life is saved, they are restored to a level of functioning which will allow them to carry on living in some meaningful sense. When steps are taken to rescue from death a person who is already in the process of dying, it is the process of dying which is extended and not life that is preserved. The ethics and integrity of the medical professions impose a strong commitment to preserve life, but not to prolong death. Accordingly, medical practitioners have no ethically based obligation to provide life-sustaining treatment in these latter cases.

The ethical integrity of the medical profession, supported by a judicial recognition that individual rights must sometimes be limited, imposes on physicians a special duty which provides a foundation for overriding individual rights to refuse treatment, at least in some circumstances. The scope of this duty (and therefore the extent of this legal sanction) has not
been clearly delineated by courts. It can be said that it does not apply when the patient is in the process of dying and treatment would merely prolong death. Beyond that, little can be said in any definitive way.

Conclusion

It is fair to say that U.S. courts have been, except in extraordinary circumstances, strongly supportive of the individual right to refuse life-sustaining treatment. Whether characterized as a common law, or state or federal constitutional right, countervailing state interests, against which such right must be balanced, have in recent years been largely found to be insufficient. It is worth noting however, that courts have been faced overwhelmingly with cases where the sympathetic or compassionate ground for permitting a refusal of treatment is strong. The patients involved are typically terminal within a short period of time, in a permanent vegetative state, are permanently ventilator dependent, or in great suffering. Examples of courts upholding competent but irrational decisions to die, decisions which are not in some sense reasonably understandable, are difficult to find.

One major exception is where the patient is motivated by religious principle. This is perhaps not surprising, considering the very great importance at least some people place on their spiritual and religious convictions. Treatments which violate deeply held spiritual beliefs may be seen as a most fundamental invasion of the individual’s intimate and personal self. In addition, it will often be the case that the person who believes, on religious grounds, that a certain type of treatment is forbidden, will also believe that accepting such treatment may result in some very serious consequence after death. Conversely, abiding by the religious tenet, although probably speeding their departure from this world, will be rewarded in the next. Whether such beliefs are either justified or true is less important than the strength and enduring character of the belief. The distress and anguish which may be caused by imposing treatment in these circumstances may well outweigh the benefit of the life-sustaining treatment.

Another substantial exception is found in cases where the patient is resisting the needed amputation of limbs, usually a leg. In such cases, the patient may have quite a good prognosis for continuing life and health if the amputation is performed. However, courts have typically
not forced such persons to undergo amputation. These may also be seen as highly sympathetic cases and that lives following an amputation are such that they may reasonably be rejected. Therefore, a decision to die under such circumstances may be seen as rational or be viewed at least not unsympathetically. In addition, the horror one may imagine at the thought of having a limb removed involuntarily naturally makes one recoil from contemplating the prospect. The highly invasive nature of the treatment, and the feelings of outrage and personal assault which may be expected to accompany forced amputation, might just be too great to justify proceeding. The same may perhaps be said about victims of serious burns. The person's own sense of the suffering which will result from either of these conditions may be sufficient that others ought to stand aside and permit the person to give effect to a refusal of treatment, even when it will predictably result in death.

Another class of cases in which courts have been prepared to permit refusals of life-sustaining treatment, where the illness is not terminal, involves victims of quadriplegia. This was the situation in the Bergstedt case. It can be imagined that the limitations imposed upon one so afflicted may render a reasonably happy or fulfilled life impossible. While acknowledging that many people live full lives with very severe disabilities, it might not be irrational to conclude that, for oneself, life could not be acceptable. For this reason, the choice to die in such circumstances is one which should be honoured. Of course, victims of quadriplegia may not require any life-sustaining treatments at all, aside from food and fluids.

It is worth pointing out however that disabled persons, and groups speaking on their behalf, have forcefully argued that life with a disability may be happy and fulfilled. Further, it is argued that the attitude that disabilities render life not worth living causes a tremendous amount of misunderstanding and grief to those living with disabilities.99 It is understandable that one who is the recent victim of a disabling accident or illness may see little hope for life. Nevertheless, in time such feelings may pass, and therefore it may be sensible to require some waiting period before permitting a judgment about the unacceptableness of that life to be

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irrevocably acted upon.¹⁰⁰

3. SUICIDE AND REFUSAL OF LIFE-SUSTAINING TREATMENT

Overview

In the first chapter, the life-ending decisions of Allan, Betty and Kenneth were chronicled. The contention is that these three stories describe cases where intervention to save life would be justified, although the persons in question were apparently competent and specifically refused the life-sustaining treatment offered. It is the project of this thesis to argue both that intervention in such cases is morally justified, and that the law can and should provide a defence to any legal action taken by a person, or their family, against a medical practitioner for giving life-sustaining treatment on such occasions. It is sometimes argued (or assumed) however that there are two types of cases which are, morally speaking, distinct. That is, an act of suicide is different than a refusal of life-sustaining treatment for purposes of determining whether intervention is acceptable.

Specifically, as discussed in Chapter 2, competent adults have a broad right, at common law, to refuse medical treatment, even if such treatment is necessary to sustain or prolong life. In doing so, courts have fairly consistently held that a refusal of life-sustaining treatment does not constitute suicide. Whether the refusal of life-sustaining treatments may properly be termed "suicide" is likely of marginal importance. However it does matter, for legal and policy reasons, whether such refusals share enough relevantly in common with overt acts of suicide, that paternalistic intervention may be appropriate on the same basis, in respect of both such life-ending choices.

Suicide vs. Refusal of Life-Sustaining Treatment: Practical Differences

With respect to an overt attempt at suicide, the justification for intervention is taken to be relatively uncontroversial. Indeed, intervention is typically viewed as the professional obligation of health care practitioners who become involved, and a praiseworthy act of citizenship on the part of others who come upon the scene. However, a strong legal and
academic consensus appears to have emerged that a refusal of life-sustaining treatment is both morally and legally an acceptable expression of one's own self-determination, when competently made in the context of an established medical relationship, and where death would result from the underlying disease or condition.

For reasons taken up more fully in Chapter 10, it is by no means clear that it is always or usually lawful to treat someone who has attempted suicide, in the absence of that person's consent. At least in existing case law, there is no clear basis upon which medical practitioners may presume the incompetence of a suicide attempter, the irrationality of an attempt, or the true intentions of the suicide. A suicide may not be treated as an emergency where treatment is explicitly or impliedly refused, either concurrently or in advance. Nevertheless, such intervention is usually appropriate and it is precisely for this reason that some legal defence is required to shield medical practitioners, acting in an urgent situation, from liability for acting reasonably and compassionately to save life.

The same reasons which compel emergency room staff to rescue those attempting suicide are sometimes present in those seeking the withdrawal of life-sustaining treatment in the context of a subsisting medical relationship. However, courts have overwhelmingly held that a refusal of life-sustaining treatment is not suicide. Many commentators have endorsed this view. Notwithstanding the weight of such learned opinion, it is proposed that this distinction, at least for legal and policy purposes, is unpersuasive and in any event not particularly helpful to a determination of whether paternalistic intervention in a decision to die should render the intervenor civilly liable. There are a number of practical reasons why courts may have found refusals of life-sustaining treatment not to be suicides and therefore that differing legal treatment is appropriate:


\[3\] For example, N.L. Cantor, "A Patient's Decision to Decline Life-Saving Medical Treatment" (1973) 26(2) Rutgers Law Review 228-264 at 254-58.
Withdrawal of Treatment as Assisted Suicide: Canada, Great Britain and most of
the United States have criminal laws prohibiting assisted suicide. If a refusal of life-
sustaining treatment is suicide, then the physician who cooperates with such refusal would
arguably be assisting that suicide, and so would apparently be guilty of a crime. However
courts, as most people, accept that at least some refusals of life-sustaining treatment are
unobjectionable. Where continuing treatment is burdensome, futile, or the subject of strong
religious prohibition, or where the patient experiences untreatable suffering, the decision to
refuse treatment, and the resulting death, may be quite understandable and sensible.
Therefore, such refusal should not be characterized as suicide.

However, this complication to do with the criminal law of assisted suicide is not really
relevant to the question whether paternalistic intervention in a request to discontinue life-
sustaining treatment should be treated, for purposes of civil liability, the same as intervention
to rescue a suicide. Even assuming that a distinction along these lines makes sense in one
context, it hardly follows that cases must be treated dissimilarly in another. Accordingly,
statutes proscribing assisted suicide make a poor basis for defining a helpful and ethically
relevant distinction between suicide and refusing life-sustaining treatment.

Suicide Intervention is Not Battery: Next, interfering with a right to refuse treatment
is said to be inconsistent with our present laws against battery. The right to refuse treatment
is grounded in the right to be touched only with one’s own consent. A doctor’s refusal of a
demand that treatment be withdrawn or withheld, would require his or her committing a
battery against the patient who has refused. On the other hand, courts in common and civil

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4 In Canada, Criminal Code, R.S.C. 1985, c. C-34, s. 241(b).

5 Malette v. Shulman (1990), 72 O.R. (3d) 417 (C.A.)


law jurisdictions consistently proclaim that the state has a fundamental and abiding interest in, among other things, the prevention of suicide. If refusals of life-sustaining treatment were suicidal, then courts would have a difficult time explaining how such refusals could be lawful in light of the acknowledged social good of preventing suicide.

The argument here, however, is that either suicide intervention or refusing to honour a request to withdraw treatment may constitute a civil battery. Let it be generally true that the medical practitioner who refuses to withhold or withdraw treatment following a competent demand thereby commits a battery. The medical practitioner who treats someone who has attempted suicide also may be committing a battery if the attempter refuses needed treatment, either in advance or at the time it is offered. Ignoring such refusal may give rise to a right of action, however the life threatening condition came about. The issue is not whether such treatment is prima facie a civil wrong. The question is whether, and in what circumstances, the medical practitioner should have a defence against any potential civil suit arising therefrom. Attempting to draw distinction on the basis of whether the suicide was an overt act confuses the issue by ignoring the ethical and policy considerations which are truly relevant. In Chapter 10, a canvass of such relevant considerations is attempted.

Contextual Differences: The present attitude towards suicide is that, among other things, it invites intervention. The natural response to a suicide attempt is to try to stop it. However, it is now thought that intervention is usually not appropriate for refusals of life-sustaining treatment. This may be because in thinking about refusals of treatment, we tend to imagine a person with a short time to live, and who is the victim of considerable physical or psychological suffering. The vision which suicide conjures is typically that of a younger person, not terminally ill, but very likely depressed or suffering from some treatable mental illness, who is not thinking clearly about the consequences of his or her action. The latter case seems right for intervention, whereas the former case does not.

These arguments are in fact quite helpful inasmuch as they underscore the importance of paying attention to the context in which a particular decision to die is made. Certainly the

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extent and treatability of a person's suffering and the realistic potential that he or she may come to have a satisfying life are relevant considerations in assessing whether paternalistic intervention is justified in a particular case. It is not the case, however, that untreatable suffering and irreparably poor quality of life are associated only with refusals of treatment and not with overt acts of suicide. Conversely, just as the suffering of a person overtly attempting suicide may be treatable, so might that of a person demanding the refusal of life-sustaining treatment. Again, focussing on the suicide/refusal of treatment distinction diverts attention to the considerations that are relevant to the reasonableness of intervention.

Slippery Slope: Szasz has suggested that viewing refusals of life-sustaining treatment as suicide, and allowing some interference with such refusals, would entail a requirement that physicians interfere much more drastically in the personal lives of their patients than would likely be found generally acceptable. The slippery slope is that there is no logical stopping point between interfering with a refusal of a ventilator, in the end-stages of terminal and painful disease, and intervening in a patient's failure to undergo treatments or take medications of other kinds which, though ultimately necessary to sustain life, are much farther removed from the moment of death. While in general we encourage interference with suicide attempts, interferences with treatment refusal would lead, at least by logical extension, to individual practitioners forcing other treatments, like heart or diabetes medication, on their patients.¹⁰

Two things however may be said. First, the law is called upon to draw lines and set limits in a variety of contexts, when there exist cases which inspire clearly opposing responses at the margins. This surely makes the task of policy formation more difficult, but by no means impossible. Certainly, it does not render such line-drawing unimportant. Second, so long as the issue is that of unconsented treatment, interference with even an overt suicide attempt may involve administering treatment without consent, so interference in that situation threatens to start a descent down the same slippery slope. If it is legally perilous to fail to honour a request that life-sustaining treatment be withheld or withdrawn, it must also be

dangerous to treat a person whose life-threatening condition is self-inflicted, who refuses such treatment.

Suicide vs. Refusal of Life-Sustaining Treatment: Conceptual Differences

**Active/Passive Distinction:** The distinction between suicide and refusing life-sustaining treatment is defended on a number of theoretical bases as well. One reason to draw a distinction between suicide and refusals of life-sustaining treatment is found in the so-called acts/omissions distinction. That is, suicide requires that the individual take some active means to bring about his or her own death. In refusing a life-sustaining therapy, the person only passively allows death to come. Because no active means are taken in the latter case, a suicide has not taken place, and more importantly, such refusal is ethically and legally distinct from suicide.\(^{11}\) Norman Cantor suggests that suicide requires both the intention to die and a self-initiated act.\(^{12}\) He points to an instinctive response that there is a difference between, for example, administering a poisonous drug and withdrawing a ventilator. For one thing, the active administration of death-inducing means leaves no chance for unexpected remission, which might occur when a ventilator is withdrawn. Karen Ann Quinlan confounded medical opinion by surviving ten years after the withdrawal of "life-sustaining" treatment when the best medical evidence indicated that she would quickly and certainly die.

The point of intervention in suicide, it is argued, is to assist the patient. Accordingly, even where life is salvageable, requests for withdrawal of treatment should, except in extraordinary circumstances, be respected. Both Beauchamp and Heyd and Bloch\(^{13}\) have pointed to the fairly common intuition that we are more likely to see intervention as appropriate where active self-destructive means are chosen, than when passive means are employed. It feels more like suicide when death is caused by the person than when it is caused

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to the person. For Beauchamp, an act is not suicide if the person who dies suffers from a terminal illness or mortal injury where, by refusing treatment, death is passively allowed to come, even if death is intended.14

However, this distinction between suicide and refusals of treatment cannot helpfully be maintained. The difficulties distinguishing between acts and omissions have been extensively canvassed in the bioethics literature15 and case law.16 After all, removing a ventilator or other treatment intervention is also describable as an active, not passive, means of bringing about death.17 If the person oneself were to unplug the machine, would that constitute an act (a suicide) or the withdrawal of a life-sustaining treatment (not a suicide)? There is no sensible and ethically relevant distinction to be drawn between insisting that treatment be withdrawn and disconnecting oneself from the treatment once started.

The assumption is that where active means are employed to end life, the cause is different than when passive means are employed. When treatment is refused, the cause of death is said to be the lethal effect of the underlying disease. But, when active means are chosen, the death is properly viewed as resulting from the act in question. However, Martin Benjamin points out that identifying the "cause" of any death is inherently ambiguous and may be described in a number of ways. Death may have a pathological or scientific cause, but may have also a "social cause," which explains why the person ended up in the particular circumstances at that particular time. It is a confusion to reply to a question about social cause

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16 For example, Rodriguez v. B.C. (A.G.), [1993] 3 S.C.R. 519 (per Sopinka J.)

with a pathological explanation.\(^\text{18}\)

Howard Brody points out that we only describe decisions to die in terms of the pathological explanation (the underlying disease caused the death) when the death is praiseworthy, or at least not blameworthy. If a physician negligently bungles a diagnosis and a patient dies as a result of not receiving the appropriate treatment, the physician could not defend himself by arguing that he did not kill the patient, the underlying disease killed the patient. Brody asks us to consider the case of a physician who unplugs a ventilator, at the request of the patient, following which the patient dies as expected. How would we describe the death of that same patient if, prior to unplugging the ventilator, the physician is called away and one of the patient’s enemies enters the room and unplugs the ventilator, with the malicious intent to kill the patient, and again the patient dies. Surely we would say that the enemy in the latter case caused the death. Since the physician’s action was precisely the same in the first case, it must be that the physician causes the death of the patient. Both intended to effect the death. The enemy would have no defence to a murder charge that he did not really cause the death of the patient, it was the underlying disease that killed him.\(^\text{19}\)

A person still commits suicide who allows the tide to wash over and drown him, just as does a person who rushes forward into the water to be drowned.\(^\text{20}\) Robert Martin agrees, suggesting that a man who bleeds to death because he will not close an open artery is not less a suicide than one who opens an artery with the intention of taking his own life. Certainly one may cause one’s death voluntarily either by a positive act of self-destruction or by refusing or neglecting to do something known to be necessary for the preservation of one’s life.\(^\text{21}\) In each case, the concern is to bring an end to one’s life. It may be that the distinction between suicide and refusing treatment should be maintained on pragmatic grounds, for example out


\(^{19}\) Brody, "Causing, Intending, and Assisting Death" supra note 17 at 112, 113.


of concern for the risk of abuse or other negative consequences for society. However, the distinction cannot be maintained on grounds of principle.

In any event, for our purposes, whether a request for the withdrawal or withholding of life-sustaining treatment which is honoured is termed a “suicide” or not is unimportant. What matters is whether a paternalistic refusal to honour the demand for withdrawal of life-sustaining treatment should ever be allowed in the way that a paternalistic intervention to stop a suicide regularly is. Consider two cases: The first is of an elderly woman suffering from a painful, terminal bone cancer. Her husband, along with most of her friends, has died, and she is childless. The second case is that of Betty, from Chapter 1, a college-age woman who was the driver in a serious car accident which killed three people, including her fiancé. She had been drinking and suffered serious, although not life-threatening, traumatic injuries and required short-term ventilatory support.

Suppose the elderly victim of bone cancer, in the first case, decided that life was no longer worth living, and wished to end it. Why would it matter whether she chose to die by refusing needed antibiotic treatment or refusing food and fluids, or whether she chose to end her life by taking an overdose of pills? If her designs became known to the medical team, as an ethical matter, would the answer to the question whether she should be stopped from ending her life depend on which method she chose? If the younger woman in the second case, feeling guilty and depressed, chose to end her life by shooting herself with a gun smuggled up to her room, would we feel differently about her decision if she chose instead to demand that her ventilator be removed?

If there is a strong moral distinction between killing oneself and allowing oneself to die, then the elderly woman’s refusal of treatment should have more in common, ethically speaking, with the young woman’s refusal of treatment than with her own overdose. But in fact the cases are not at all similar. What makes these two cases so different is the context and details of the circumstances in which each find themselves. What is relevant to whether a decision to die should be the subject of intervention is not whether an act of suicide or a refusal of treatment is chosen. What matters for the elderly woman is, among other things, the durability and treatability of her suffering, and the possibility that she will be able to
recapture a minimally satisfying life. What matters for the young woman is not whether she dies by self-inflicted gunshot wound or by other-inflicted extubation, but rather facts about her state of mind at the time, the likelihood that her desperate feelings will pass, and her future ability to build a reasonably contented life, notwithstanding this tragedy. It does not matter how the proposed death is described. What is relevant is the context and circumstances surrounding the decision to die.

**Natural and Unnatural Death:** It is also suggested that a helpful distinction can be drawn by seeing refusals of treatment as allowing a natural death to take place, and suicide as bringing about an unnatural death. This was the reasoning of the Quebec Superior Court in the *Nancy B.* case, in which the judge found that the request by Nancy B. to have respiratory support withdrawn was not suicidal, but rather simply allowed nature to take its course. The intention was not to kill herself, but that she be allowed to succumb to the natural course of the underlying disease. The idea that refusals of treatment permit a natural death, as distinct from the unnatural death brought on by suicide, has strong appeal. A natural death seems more dignified, more fitting. The sense is that one is dying at the "right" time, or when one's time is up. On this view suicide, in which one takes one's own life, and is the cause of one's own death, is different from a refusal of treatment in that it is the natural course of the underlying disease which causes death, not the person him or herself.

The idea that death following a withdrawal of treatment is "natural" has been expressed in a number of ways. A distinction is drawn, for example, between preserving life and prolonging dying. Most medical treatments have the effect of sustaining one's life. That is, they aim at least to restore the patient to a state of health, or at least of reasonably normal functioning. On the other hand, "extraordinary" treatment is motivated by the attitude that

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death should be battled to the very end by all of the tools and instruments of medical science. 25 Once the process of dying has begun however, keeping a person alive by such heroic means can be seen rather as prolonging death in an undignified and unpeaceful way, a way which Callahan sees as "deforming." The process of dying is deforming when it is subject to the violence of technological intervention and brinkmanship; when it allows the fear of death to become obsessive; and if a desperate battle against an inevitable death diverts resources from more hopeful uses.

The clear implication is that there is no virtue in means which prolong death (as opposed to those which sustain life) and that a natural death is thereby denied the patient. Pellegrino suggests that a withdrawal of treatment is acceptable and distinct from suicide when the patient is "overmastered" by the disease. In such cases, death has already taken hold of the patient and interventions no longer serve a beneficial purpose. For this reason, continuing treatment is unethical, and morally distinct from killing, where it is futile, burdensome or expensive and forced on the patient in violation of the canons of good medicine and the patient's best interests. 26

While a distinction between a natural and an unnatural death is appealing, Battin points out that there is really very little that is "natural" about almost any modern death. 27 Any successful medical treatment will impede the natural course of illness. 28 The question then arises: what medical interventions which delay death are "unnatural"? The answer seems to be those treatments which prolong death, as opposed to those which preserve life. It is suicidal to refuse the latter treatments, but an acceptable non-suicidal exercise of autonomy to refuse the former. Even assuming that the distinction between preserving life and prolonging death may sensibly be drawn, there remain difficulties in reliably identifying the

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point at which death has "overmastered" the patient, and treatments would only prolong death. Nevertheless, even supposing that the irrevocable onset of death can be identified, and that this fact is relevant to whether treatment may be withdrawn on request, the important fact would be that death had begun, and not the means by which the decision to die is effected. If it is true that upon the onset of death a decision to die is acceptable, then it should not matter whether that death is effected actively or passively. And the reverse is also true. If there are circumstances under which an act of suicide should be stopped, then, under those same circumstances, a refusal of life-sustaining treatment should also be resisted. The context and circumstances are relevant, not the means.

Intent to Die: Finally, it has been suggested that suicide properly expresses a desire to die, whereas withdrawing treatment may be seen rather as a way to avoid a greater evil, particularly the suffering brought about by the medical condition or by the treatment itself, if the suffering is caused more by the life-sustaining treatment than by the underlying disease. On this view, when one refuses treatment, one does not wish to die per se, one wishes to be free. Joseph Margolis characterizes suicide only as those acts which have no instrumental purpose or intention aside from the taking of one's own life. That is, there is no independent objective that, in principle, one might pursue in another way. So long as the subsequent purpose to which the death is instrumental is itself rational, then there is no suicide. On this basis, suicide would be distinguished from a refusal of life-sustaining treatment, so long as it is rational.

The difficulty about this view is that it seems that one always, or almost always, dies for some other purpose. Kadish argues that all suicides are motivated by a desire to put an end to some unbearable experience in one's life. Indeed, it seems odd that there would be


32 Kadish, "Letting Patients Die," supra note 17.
a suicide purely arising out of the wish to die, with no reference to its consequences or to the harms or suffering which one may be spared. Although the desire to die may be psychologically complex, it cannot be that an intentional killing of oneself is not suicide if done, for example, in order to avoid prosecution, to end unbearable pain, or to teach someone else a lesson. Cantor notes that where life is salvageable, it is difficult to argue that there is no specific intent to die in a refusal of life-sustaining treatment.

In any event, what is raised here is a semantic quibble. The idea is that if one intends purely to die, then this is suicide and intervention is acceptable. However, if one is choosing a life-ending means in order to achieve some other purpose, then it is not suicide. In such circumstances, if refusing life-sustaining treatment is the means chosen, then that decision must be respected. But one may choose to effect death with the “pure” intention to die by either active or passive means. Conversely, one may seek the attainment of other purposes through death by either an overt act of suicide or by demanding a withdrawal of treatment. Intent is not inferable from the means chosen to effect one’s own death. So, if intent is an important consideration, then it makes more sense to focus directly on the intent than on the means employed as a proxy for intent. Parenthetically, it seems odd that this view would sanction allowing a person to die only when they do not really want to and would stop a person only when they really do.

Suicide vs. Refusal of Life-Sustaining Treatment: a Relevant Difference?

There is a sense in which the above attempts to draw a distinction between suicide and refusals of life-sustaining treatment, however persuasive they may be, have little relevance for the present debate unless it can be shown that the distinction bears on the appropriateness of allowing paternalistic intervention. Beauchamp notes the strong emotional response which society still bears toward suicide. Therefore, our characterization of an act as either suicide

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33 Wood, in “Suicide as Instrument and Expression,” supra note 23, describes the “expressive suicide,” committed to express some strongly held emotion or to make some statement.

34 Cantor, Legal Frontiers of Death and Dying, supra note 12, ch. 2.
or not may be more a matter of our own attitude towards the act in the particular circumstances, and less a reflection of comprehensive definitional conditions. We tend to think of suicide as an act which is irrational, blameworthy or troubling in some fundamental way. If a refusal of treatment is understandable, or seems to be a decision that we would make in the same circumstances, then there is some hesitation to categorize such refusal as suicide. Margolis suggests that the notion of suicide is bound to particular cultures or religious doctrine. Its scope may be different in different times or within the context of different cultures.

Battin proposes that suicide be defined expansively. That is, suicide occurs when anyone chooses, acquiesces, determines or brings about one's own death. Most agree that an intention to die is necessary, however the question of when such intention is present is itself problematic. Self-destructive acts may be described in a number of ways. For example, does a person who kills himself in order to avoid public embarrassment and possible prosecution intend to die if he doesn't really want to die and would take another means to avoid embarrassment and prosecution if such were available? If it is only through death that a desired result can be achieved, does one intend to die? What if one harbours a perhaps subconscious death wish and engages in very risky activity such as skydiving or mountain-climbing? If death results, would the unconscious intention be enough to render the act suicidal? These questions and many others have puzzled philosophers and others, and it is not proposed that any enlightenment may here be found. Rather, it will be enough to attempt

35 Beauchamp, "What is Suicide?" supra note 14.

36 Margolis, "Suicide," supra note 30 at 94.


38 Beauchamp, "What is Suicide?," supra note 14.

to delineate those self-destructive or life-ending acts for which paternalistic intervention is appropriate. This question is taken up in Chapter 10.

However, it is clear that many factors present in the circumstances of a suicide, and which invite intervention, may be found also in the circumstances of a person refusing life-sustaining treatment or nutrition and hydration. On its face, it would be arbitrary to argue that paternalistic intervention in suicide is sometimes justified, but that intervention in a withdrawal of treatment can never be. A convincing rationale must be found in the former case no less than in the latter.

Accordingly, for the purposes of this thesis, no such distinction will be drawn. Failing to honour a refusal of life-sustaining treatment, no less than intervention in a suicide attempt, may be acceptable depending upon the context and circumstances of the particular case. The considerations relevant to a determination of whether intervention is morally acceptable may be relevant to either type of life-ending decision.

The next chapter is devoted to addressing the suggestion that the problem of whether and when to intervene in decisions to die may be dealt with solely by assessing the person's competence. If intervention is only appropriate for those persons who lack decisional competence, then the 'problem' of paternalistic intervention may be answered in the context of relatively familiar medical-legal concepts. It will be argued however that the notion of incompetence does not supply a helpful test of the acceptability of intervention.
4. WHY NOT INCOMPETENCE?

Overview

At this point, a fundamental objection to this project may be proposed. The aim of this work is to suggest the need for some legal structure which will, under appropriate circumstances, protect those who intervene in another's suicidal or life-ending decision, from civil or criminal liability for battery or assault. It is commonly argued that a competent patient may refuse any life-sustaining treatment, so long as the decision to do so is made freely. Therefore, it is incompetence alone that triggers another's entitlement to intervene.\(^1\) If this is so, then no novel legal machinery need be developed since the well-established legal category of incompetence, or incapacity, serves precisely this purpose.

In this chapter, it will be argued however that the legal notion of incompetence is not adequate to delineate those persons in those circumstances in which intervention is appropriate. This is because the existing legal-ethical notion is both conceptually uncertain and practically difficult to apply. When the decision is to end life, it fails helpfully and clearly to identify the considerations relevant to this irrevocable and potentially disastrous decision. Accordingly, a reconceived defence of necessity, as characterized in Chapter 5, provides an additional test of the justification for intervention to save the person's life.

The concern is that medical practitioners will be sued for giving life-saving medical treatment, without consent, notwithstanding that in some such cases, the practitioner's intervention will have been ethically appropriate. A patient's incompetence constitutes an exception to the requirement of obtaining informed consent to treatment, at least from that patient. That is, treatment may be given to an incompetent patient without his or her informed consent, so long as consent is secured from the appropriate surrogate decider. If none is

\(^1\) G.J. Annas and L.H. Glantz, "The Right of Elderly Patients to Refuse Life-Sustaining Treatment" (1986) 64 (2nd Supp.) Milbank Quarterly 95-162.
available, then treatment may be given on the basis of the emergent nature of the medical need. If those persons for whom paternalistic intervention appears warranted are incompetent, then, under the existing law, they may be given life-sustaining treatment notwithstanding their refusal. The difficulty then lies in demonstrating that those persons in need of paternalistic intervention are just those who may rightly be judged incompetent. At first glance, it may seem plausible to suppose that this is so.

Of course, a finding of incompetence is not sufficient, in itself, to authorize the giving of indicated medical treatment. If one is available, consent is still required from a validly authorized surrogate. If the surrogate also refuses consent to life-sustaining treatment, perhaps on the basis of substituted judgment, or on some other ground, the practitioner may still be liable for battery for treating without valid consent. Therefore, even if the medical practitioner strongly believes that a mistake is being made or that a great harm may be averted, in the absence of a specific defence he or she remains in jeopardy of an action for battery in proceeding with treatment without the consent of the surrogate. Such consent might not be given.

The Notion of Competence

The paradigm cases of those who are incompetent include young children, the unconscious or comatose, those suffering from neurological impairment or other developmental delay, and those suffering from psychiatric illness. Those who are unconscious, very young children, the severely learning disabled and those suffering from severe mental illness are incompetent in a general or global sense, that is, such persons could not give valid consent to any medical treatment. However, children as they grow older, and those with less severe learning disabilities or mental illness may be of questionable or marginal competence.² That is, they may be capable of making some types of decisions for themselves.

but not others. Specifically concerning medical treatment, they may be authorized to give consent, on their own, to some medical treatments, but not to others. Again, if one is not competent to make a particular decision, then authority to consent, or to refuse to consent to that decision, must be exercised by another, usually a parent, guardian, spouse or other family member.

The terms "competence" and "capacity" are both used to describe the concept. It has been thought that the word "incompetent" should not be applied to a person because it carries the negative stigma of a global judgment about that person's mental status. The word "capacity" is said to be preferable because it focuses not on the person as a whole, but on the person's abilities with respect to the particular decision or task at hand. However, the terms "competent" and "incompetent" are still more widely used, particularly in reference to the legal categories, and so they will be used here.

Of course, an unconscious or comatose person cannot decide to end his or her own life. However, if a young, learning disabled or severely mentally ill person were to do so, paternalistic intervention, including medical treatment if necessary, would no doubt usually be acceptable, even morally obligatory. In the same way, if a person who, though not globally incompetent, is nevertheless incompetent to make the particular decision to refuse life-sustaining treatment, he or she may not effectually do so. This may be just the sort of person who seems, at least intuitively, to require protection from his or her own suicidal decision.

The Purpose of Determining Incompetence

To see why we cannot safely rely on judgments of incompetence to mark those life-ending decisions which may be interfered with, it is necessary to review, at least briefly, the philosophical and legal background of the notion of competence. "Competence" describes the

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4 Ontario, Enquiry on Mental Competency - Final Report, D.N. Weisstub, chair (Toronto: Queen's Printer, September 18, 1990) at 26-33.
ability to perform a task in a way which is appropriate to that task. Therefore, competence and incompetence must be judged in the context of the particular task. One may be competent to perform a task, but not to perform another. And, one may be competent at a particular time to perform a particular task, but not competent at another time. In the medical context then, one may be competent to make a decision about some treatments, but incompetent with respect to others. Further, one may be competent to consent to a particular treatment at one time, but not competent with respect to the same treatment at another time.

However, this does not tell us what competence is for. The purpose of judgments about competence, the "concept" of competence, as Freedman puts it, is to balance the protection of autonomy or self-determination, as expressed by the doctrine of informed consent, against protection of the patient's well-being when he or she is unable to protect him or herself. It attends both to the patient's interest in self-determination and to his or her interest in being protected from the seriously harmful affects of unwise choices. The challenge of characterizing the concept of competence is to discover an appropriate mix of these two important values. Alan Meisel writes:

...the criteria selected for the determination of competency ought to promote the values sought to be achieved by the doctrine of informed consent - primarily individualism, and secondarily rational decision-making - while simultaneously showing due regard for the preservation or promotion of the

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7 Enquiry On Mental Competency, supra note 4 at 45-47.


patient's health.\textsuperscript{11}

It is clear that the notion of competence necessarily involves an appeal to the welfare, and not just the self-determination, of the patient, by the fact that we have a notion of incompetence at all. If its purpose is only to protect self-determination, this would best be accomplished by making no such exception to the requirement for consent. We have no reason, aside from the welfare of the patients and the possibility of their making dangerous medical decisions, to make a declaration of incompetence. The Ontario District Court reflects this view: "It is generally accepted as a fundamental principle of our society that the state has an obligation to care for disabled persons who are unable to care for themselves."\textsuperscript{12} In \textit{U.S. v. Charters}, the 4th Circuit Court writes: "...competency represents a delicate balance of individual freedom and the need to protect and care for those who cannot care for themselves."\textsuperscript{13}

Buchanan and Brock suggest that in assessing competence there are two types of mistakes that might be made by the assessor. The first is to declare a patient to be competent who is not, and the second is to declare someone incompetent who \textit{is} competent. If the welfare of the patient was not a factor, then declaring an incompetent patient to be competent would not be a problem. And, the best way to guard against the error of declaring a competent person incompetent is simply never to declare anyone incompetent.

Accordingly, the well-being of the patient is important and the point of making a determination of competence is to balance patients' well-being against the undoubted individual interest in self-determination. Of course, this does not determine how that purpose should be given effect or how the balance between self-determination and welfare ought to be struck.

\textsuperscript{11} A. Meisel, "The 'Exceptions' to the Informed Consent Doctrine: Seeking a Balance Between Competing Values in Medical Decisionmaking" (1979) \textit{Wisconsin Law Review} 413-488 at 441.

\textsuperscript{12} \textit{Howlett v. Karunaratne} (1988), 64 O.R. (2d) 418 at 430 (per McDermid, D.C.J.)

\textsuperscript{13} 829 F.2d 479 (4th Cir. 1987) at 496, note 26.
The Standard of Incompetence

An initial distinct question then is that of the appropriate standard or standards which must be met for a person to be found competent, or rather, which must fail to be met in order for a person to be found incompetent. That is, what quality or qualities of the individual, or of the decision, must be present (or absent) in order for a person to be found competent (or incompetent) to make the particular decision. There seems little controversy that a functional approach to competence is preferable to one which focuses either on the acceptability of the outcome of decision-making, or on the psychiatric or medical status of the patient. The important consideration is not the outcome of the decision-making process, or the diagnosis of the patient, but rather the patient’s ability to function appropriately in the task of making the particular health care decision. Freedman argues that it is the decision-making process that matters and that the quality of that process cannot be judged by reference to its results. The functional approach also reflects the characterization of competence as task- or decision-relative.

While there is no consensus around the precise standards to be applied in judgments of competence, even as a functional matter, proposals have focused on a number of factors:

Ability to Communicate Decision: As a preliminary matter, in order to be competent to make a particular medical decision, or at least in order to have that decision honoured, it is necessary that one be able to communicate one’s decision. In the absence of the ability to express a choice, it is necessary that another be authorized to choose instead. What is required is the ability to maintain and communicate reasonably stable choices long enough for them to

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14 Freedman, “Competence, Marginal and Otherwise,” supra note 2.


16 Annas and Densberger, “Competence to Refuse Medical Treatment,” supra note 3.

17 “Competence, Marginal and Otherwise,” supra note 2.

be implemented.  

**Understanding:** Next, while the legal obligation to inform patients of proposed treatments is found in the legal doctrine of informed consent, competence requires that the information given be understood by the patient, or at least, that the patient has the ability to understand relevant information about his or her own medical condition and the reasonably foreseeable consequences of the proposed treatment, alternative treatments and no treatment at all. 

The Ontario Court of Appeal, in *Khan v. St. Thomas Psychiatric Hospital*, describes the concept as follows: “Competence is sometimes characterized as the ability to understand the nature, purpose and effects of proposed treatment.” The court in *In re Schiller* adds the requirement that the patient must understand the attendant risks associated with not pursuing the treatment and pursuing the treatment.

The capacities at stake include a memory for words, phrases, ideas and the sequence of information. The patient must be able to comprehend the fundamental meaning of information about treatment and that he or she has a critical part to play in the decision-making process. Understanding may be tested by having the patient relate back to the evaluator, in his or her own words, the relevant medical information and explain the rationale used in decision-making.

**Appreciation:** It is generally supposed also that one must be able not only to

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20 For example, Ontario *Substitute Decisions Act*, S.O. 1992, c. 30, s. 45.


22 372 A.2d 360 (N.J. 1977). This test was approved in *In re Conroy*, 486 A.2d 1209 (N.J. 1985) and *In re Clark*, 510 A.2d 136 (N.J. 1986).


24 S.A. Kline, *Mental Competency to Make Medical Decisions* *Health Law in Canada* 70-78.
understand the information furnished, but also be able to appreciate the relevant information.\textsuperscript{25} "Appreciation" is characterized in a number of ways to include the ability to imagine life in certain states or conditions and to have an appropriate grasp on the current situation and the consequences of various options. Wicclair argues that competence requires an ability to imagine what life would be like under described states and conditions.\textsuperscript{26} Appelbaum and Grisso note that:

...patients may comprehend information yet fail to grasp what it means for them. One can understand what one is told without understanding the specific implications that it carries for one's future.\textsuperscript{27}

**Capacity to Reason and Deliberate:** The capacity to reason and deliberate is also seen to be necessary to competence. This would include the ability to manipulate information rationally, to draw appropriate conclusions from premises and to apply the information about treatments to the attainment of one's own goals and values in a sensible and effective way.\textsuperscript{28} This condition is characterized by the ability to use logical processes to compare the benefits and risks of the various treatment options, and to reach conclusions that are logically consistent with the original premises.\textsuperscript{29} The court in the *Charters* case found that a determination of competence should evaluate whether the patient, "...has followed a rational process and can give rational reasons for his choice." That is, whether the person "...is unable to engage in a rational decision-making process regarding...treatment."\textsuperscript{30} Kline warns however that perfect rationality is not required. It is enough that the decision be based on recognizable reasons and

\textsuperscript{25} Annas and Densberger adopt the "understand and appreciate" standard of competence in "Competence to Refuse Medical Treatment," *supra* note 3.

\textsuperscript{26} M.R. Wicclair, "Patient Decision-Making Capacity and Risk" (1991) 5(2) *Bioethics* 91-104.

\textsuperscript{27} "Assessing Patient's Capacities," *supra* note 8 at 1636.

\textsuperscript{28} *Riese v. St. Mary's Hospital*, 271 Cal. Rptr. 199 (Ct. App. 1989).

\textsuperscript{29} Appelbaum and Grisso, "Assessing Patient's Capacities," *supra* note 8.

\textsuperscript{30} *Supra* note 13 at 499.
be minimally acceptable from that standpoint.\textsuperscript{31}

However, Elliott rejects the requirement of reason, since it is not contradictory to say that even the irrational choices of competent people should be honoured. What is important is whether a person is able to make decisions for which he or she can reasonably be judged accountable. That is, does any praise or blame that the decision carries reasonably belong to the person, since the decision was truly his.\textsuperscript{32}

Coherent Set of Values: Buchanan and Brock argue that in order that information may be rationally assessed in terms of one's own goals and values, it is necessary that one possess a more or less stable set of values in the context of which one's options may be assessed. In addition, these values must be more or less accessible or apparent to the individual. Such goals need not be comprehensive or fully consistent. However, some consistency is required, together with a certain stability over time.\textsuperscript{33}

Determining Incompetence - Practical Issues

The question of the standard or standards to be employed in assessing competence is itself distinct from a number of practical issues about the determination of incompetence:

Instruments for Testing Competence: There is the separate question for example of the appropriate means or instrument(s) to be employed in testing competence - to be used to determine whether the appropriate standards of competence (which themselves give expression to the socially-determined concept or purpose of competence determination) are absent to a sufficient degree that a finding of incompetence is warranted. A number of standardized tests of mental status have been developed which aim to assess competence. It may be however that such tests are either of little help in itself in determining competence, or may give misleading

\textsuperscript{31} Kline, "Mental Competency," \textit{supra} note 24.

\textsuperscript{32} C. Elliott, "Competence as Accountability" (1991) 2(3) \textit{Journal of Clinical Ethics} 167-171.

\textsuperscript{33} \textit{Deciding for Others, supra} note 6, ch. 1.
results in certain types of marginal cases. A less structured discussion with the patient may more effectively reveal the extent of his or her understanding and ability to reason and evaluate the various treatment options.

Who Should Assess Incompetence?: In addition, there is the practical question, who should perform a competence assessment? If challenged in court, judges typically rely on psychiatrists as best qualified to give an expert opinion about competence, based on their background in psychiatric and medical illness and experience in performing mental status exams. However, everyday assessments about competence are typically made by the doctor at the bedside, usually without the consultation of a psychiatrist. Some have suggested that competence is a common-sense notion, the assessment of which requires no specialized training. Annas and Densberger take the view that a reasonable person can reliably assess competence applying the "understand and appreciate" standard. Margolis argues further that the physician's natural interest in the well-being of the patient creates a conflict with the patient's interest in self-determination. Accordingly, physicians should not be permitted to perform assessments of competence at all.

Institutional Arrangements: Finally, related to competence, is the practical issue of the appropriate institutional arrangements to be established in the health care setting for determinations of competence. In particular, it will be important to have procedures in place to decide the circumstances under which patients are to be assessed for competence; to ensure that the patient has been advised of the information required to make a decision in a competent way; to ensure that the assessor of competence has sufficient information about the patient's


35 Kline, "Mental Competency," supra note 24.

36 Annas and Densberger, "Competence to Refuse Medical Treatment," supra note 61.


38 "The Doctor Knows Best?", supra note 10.
background and the background of any decision to be made; and to ensure that appropriate lines of appeal are available to a patient found to be incompetent.

**Why Not Incompetence?**

In the context of this rough overview of competence, there are both conceptual and practical reasons why a judgment of incompetence is not a satisfactory standard for determining that intervention is appropriate to authorize appropriate intervention in decisions to die.

**Conceptual Difficulties**

The complexity of a competence determination has both theoretical and practical dimensions which bring into question the reliability of an assessment, particularly in doubtful cases. Theoretically, the notion of decision-making competence raises a number of difficulties. It is tempting to see the various capacities and abilities required for decision-making authority as objective and testable. The reality is that the notion of competence is normative on a number of levels and that there is no strong consensus about any of these matters.

**A Balance Between Autonomy and Protection:** First, the concept of competence, which requires a balance between the values of self-determination and protection of the welfare of the individual, offers no obvious way of determining how such balance is to be struck. Margolis argues that any determination of decision-making competence is itself the product of a pre-established balance of the moral principles of autonomy and beneficence.  

The conceptual issue requires a theory about why some people (the competent) are allowed to make their own decisions, even silly ones, while others (the incompetent) may not. The relative importance of welfare and autonomy is a matter about which social consensus must be sought, and which may in fact be a developing or shifting target. Buchanan

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40 Freedman, "Competence, Marginal and Otherwise," *supra* note 2.
and Brock suggest that the balance of self-protection and protection:

...should be grounded in (1) a reflective appreciation of the values in question; (2) a clear understanding of the goals that the determination of competence is to serve, and (3) an accurate prediction of the practical consequences of setting the threshold at this level rather than elsewhere. 41

At least at present, our theories about the notion of competence are a long way from settling these questions.

In practice, a consensus about the balance of self-determination and welfare is, at best, expressed on an intuitive basis by practitioners and courts in making determinations of competence. The degree to which the well-being of the patient can override his or her self-determination is an important conceptual issue for competence because it is on that basis that the standard of competence is justified. It suggests which qualities of the person should count as either indicating competence or a lack thereof. In addition, such consensus would give an indication of the extent to which the particular qualities relevant to a determination of competence must be present in order to justify that determination. However, no such consensus exists.

**Determining a Standard:** But even if it became clear how these important values should be traded off, the normative question remains as to how the concept of competence should be given effect. Bursztajn *et al.* point out that precise standards have never been articulated for competence in relation to particular acts, tasks and choices. They are "...undefended, ambiguous or inconsistent among authorities and practitioners." 42 A number of standards have been proposed, including: the ability to express a choice; the ability to understand the relevant medical information; actual understanding of the specific medical information relevant to the particular case; a decision which is reasonable or rational in all the circumstances; the ability to reason and deliberate about the decision; whether the decision was actually reached by a rational or otherwise acceptable decision-making process; and others.

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41 *Deciding for Others*, supra note 6 at 48.

Any of these, or some combination of these may be seen as the appropriate framework for assessing competence. In different circumstances, all of these appear to be to some extent relevant. Again, the relative importance of these various questions is not an objectively determinable matter and they remain "essentially contestable."43

In addition, even if a consensus could be reached about these matters, it is still a normative question to what extent each of the abilities and capacities in question must be present in order for decision-making competence to be acknowledged. These various capacities and abilities may be present to varying degrees. Therefore, it makes sense to say that one may be more or less competent to perform a particular task. However, practically speaking, in order to allocate decisional authority, either to the individual or to a substitute decider, a threshold point must be found. That is, there needs to be a point on the spectrum of competence, above which the individual makes his or her own decisions, and below which a surrogate decider has authority."44 Certainly, for different types of decisions a different threshold may be appropriate. Nevertheless, some threshold must be found and there is no objective determination of where that threshold, for any particular decision, should lie.

**Rational Decision-Making:** The notion of competence is tied to decision-making by a rational process, or which yields a rational result, or which may be defended by the patient giving rational reasons.45 Assuming that these types of considerations are relevant, we are left with the uncertainties inherent in an appropriate conception of and standard for rational decision-making, the limits of rationality vis-a-vis other decision-making dynamics, and with the difficult question, what counts as a reason. Again, this question does not admit of objective or scientific determination, and is left fundamentally as a social question.

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44 Buchanan and Brock, *Deciding for Others*, supra note 6, ch. 1.

Appreciation and Affective Disorder: However, theoretical difficulties around the notion of competence run deeper. The modern view of decision-making competence is that it entails centrally (although perhaps not exclusively) the ability to understand and appreciate the relevant medical information pertaining to the proposed treatment, and alternatives. Statutes which define competence, for legal purposes, tend to include this kind of wording. However, just what is meant by "appreciation" is by no means clear and the difficulty runs deeper than the uncertainties and ambiguities which necessarily arise in this discussion.

The difficulty arises from the fact that testing for competence tends to focus on cognitive factors, notably understanding and the ability to reason properly. For example, Abernethy argues that the test should be restricted to cognitive capacities, focusing on the ability to receive, understand and process information. However, Bursztajn is troubled that the primary focus has been on cognitive functioning, while the importance of the patient’s affective state, and the presence of affective capacity or disorder has largely and wrongly been neglected. Morreim agrees and argues further that the cognitive approach mistakenly relies exclusively on the patient’s rational capacity to test for competence. However, other factors such as mistrust, misunderstanding, poor communication, emotional factors, emotional exhaustion and spiritually or ethnically based beliefs not in line with accepted medical judgment can also impair a decision in accordance with one’s goals and values.

There are then a variety of affective or behavioural disorders which appear to be relevant to the question of whether intervention is justified, but which do not straightforwardly

46 Enquiry on Mental Competency, supra note 4 at 16, 81ff, 248ff.

47 For example, the Ontario Health Care Consent Act, S.O. 1996, c. 2, s. 3(1).


49 "Beyond Cognition," supra note 42.

impair cognitive abilities.\textsuperscript{51} Perhaps most notably, depression may distort decision-making in a number of ways, without impairing the ability to understand medical information supplied and, at least in general, reason and deliberate in a more or less appropriate way. According to Buchanan and Brock, depression may distort the ability to choose in light of one's goals and values. Such distortion may arise from an unreasoning exaggeration of the potential risks of particular medical treatments or to adopt an unrealistically pessimistic view of the possibilities for one's own future life.\textsuperscript{52} Conversely, potential benefits or salutary consequences of medical treatment may be minimized or ignored. Such distortion may take place even if the depressive person understands the information supplied by medical or other caregivers. Bursztajn notes the phenomenon of fixity, that is where, based on feelings of hopelessness, the person is convinced that one's present mood will not or cannot change for the better; and that of a self-convincing preoccupation with the risks of treatment coupled with a denial of the benefits.\textsuperscript{53} Depression can prevent an appreciation of the situation because appreciation implies the capacity to grasp that a decision is in accordance with one's strongest desires, all things considered.\textsuperscript{54} Wear suggests that depression has the effect of skewing one's conception of causation, or disturbing the ability to draw appropriate causal inferences.\textsuperscript{55}

More generally, affective states may influence competence by distorting the meaning and weight given to treatment risks and benefits.\textsuperscript{56} Decision-making may also be distorted by denial rendering one unable to accept particular facts or circumstances notwithstanding that they may understand perfectly well that others with relevant expertise strongly believe them

\begin{itemize}
\item \textsuperscript{51} Elliott, "Competence as Accountability," \textit{supra} note 32.
\item \textsuperscript{52} Buchanan and Brock, \textit{Deciding for Others, supra} note 6 at 56.
\item \textsuperscript{53} Bursztajn \textit{et al., Beyond Cognition,} \textit{supra} note 42.
\item \textsuperscript{54} Checkland and Silberfeld, "Mental Competence and the Question of Beneficent Intervention," \textit{supra} note 43.
\item \textsuperscript{55} S. Wear, "Patient Autonomy, Paternalism, and the Conscientious Physician" (1983) 4 \textit{Theoretical Medicine} 253-274.
\item \textsuperscript{56} Bursztajn et al, "Beyond Cognition," \textit{supra} note 42.
\end{itemize}
to be true.\textsuperscript{57} In addition, patients may suffer from delusions of various kinds, including a delusional perception of their own condition.\textsuperscript{58} Persons facing serious medical decisions may suffer ambivalence or be subject to a variety of phobias, mania or difficulties controlling their emotions, drives and impulses. These may include anxiety, euphoria, rage, hopelessness and despair.\textsuperscript{59}

The problem is to account for these types of affective impairments in a coherent framework of competence. This difficulty has at least two dimensions: First, must the notion of competence, usually seen as fundamentally a cognitive matter, be expanded to include the absence of affective impairments of these kinds? Some have suggested that such amendment would not be necessary, and that such disorders really affect the ability to appreciate (as opposed to understand) the information supplied.\textsuperscript{60} If this is the case, then something like the traditional characterization of competence would suffice, with the understanding that impairments of this kind may rob one of competence, since they rob the ability to appreciate.

However, the presence of these particular affective disorders reveals a tension found in the medical, philosophical and bioethics literature around competence. The issue is whether competence must be determined prior to having the patient's decision with respect to a proposed treatment. The traditional, and perhaps common sense view, is that the competence assessment should be neutral of the particular decision made. That is, it is no part of such assessment to pre-judge the "proper" decision. Rather, the point of assessment is to determine whether the patient possesses the capacities and abilities to make the decision, and if he or she does, the content of the decision is beside the point. Basing an assessment on the content of

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\item \textsuperscript{57} L.H. Roth et al., "The Dilemma of Denial in the Assessment of Competency to Refuse Treatment" (1982) 139(7) American Journal of Psychiatry 910-913.
\item \textsuperscript{58} Blakely v. Kingston Psychiatric Hospital, [1995] O.J. No. 2847 (QL) (Ont. Ct. - Gen. Div.)
\item \textsuperscript{59} A.C. Snyder, "Competency to Refuse Lifesaving Treatment: Valuing the Nonlogical Aspects of a Person's Decisions" (1994) 10(3) Issues in Law & Medicine 299-320.
\item \textsuperscript{60} Freedman, "Competence, Marginal and Otherwise," supra note 2, Culver and Gert, Philosophy in Medicine, supra note 5; Bursztajn et al., "Beyond Cognition," supra note 42; Checkland and Silberfeld, "Mental Competence and the Question of Beneficent Intervention," supra note 43 and Appelbaum and Grisso, "Assessing Patients' Capacities to Consent to Treatment," supra note 8.
\end{itemize}
the decision constitutes a violation of the patient's autonomy. The competence assessment is meant to protect only those patients requiring protection, that is, those whose decision-making capacity is compromised. Therefore, if such capacity is present, then the outcome of the patient's own individual decision-making process is not relevant, and should not be interfered with.61

Clinical experience has shown however that otherwise reasonably competent persons may exhibit distorted thinking only around a quite narrow issue. Abernethy and Lundin point to instances of "selective incompetency" which may be limited to the facts and prognosis of a particular medical illness only.62 When distorted belief or reasoning affects the particular decision at issue, intervention may seem appropriate even though the individual generally is or seems competent. For this reason, until the particular decision itself is explored with a patient, such non-logical or affective factors may not appear. Therefore, the traditional determination of competence, focusing on the person's decision-making capacity without reference to the decision itself, may fail to protect persons affected by depression, denial, ambivalence or any of the other factors noted earlier. Checkland and Silberfeld agree that the rationality of a particular choice made may be relevant to a determination of competence. Investigating the reasons for a particular decision is often the most reliable way to get at the pattern of attitudes that bear on what and whether a person understands.63

But even assuming that affective impairments can in some meaningful way be made part of the conditions for decision-making competence, either by seeing them as part of the notion of "appreciation" or by expanding the characterization of competence, there is a further difficulty. Affective impediments do not always arise from any recognizable psychiatric illness. At an extreme, they may no doubt be crippling. However, within limits, these non-logical factors constitute quite natural and even healthy human responses to life's unfolding

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62 "Competency and the Right to Refuse Medical Treatment," supra note 48 at 92.

63 Checkland and Silberfeld, "Mental Competence," supra note 43 at 124.
events. There is something that seems less human about a purely rationally calculating or absolutely cognitively driven individual. Emotional responses may interfere with perfect reasoning and absolute rationality. However, emotional trade-offs with reason are a natural and healthy part of the human experience.

For example, during a period of grieving following the death of a loved one, a certain amount of denial about the reality of the situation may be a protective response which helps the bereaved person work through the process of accepting a loss. A certain amount of "distorted reasoning" is natural and, within limits, not unhealthy when contemplating loved ones, or feelings which support and protect units of family or community. Abernethy argues that hoping for a recovery when ill is itself evidence of neither psychotic denial or incompetence. It may be seen rather as a defence mechanism which has been associated with better outcomes during the course of hospitalization, at least in some studies.

Accordingly, affective responses may be very positive. Indeed, Bursztajn et al. argue that attention to affective states is unavoidable. "[D]ecision-makers under conditions of uncertainty are inevitably bound to engage in an affect-laden decision-making process." Access to one's affective states is necessary to a process that involves the evaluation of the risks and benefits of treatment outcomes. Therefore, the presence of affective factors does not necessarily vitiate competence.

And, if certain affective distortions may be shown to be necessary or healthy, they may be seen as elements of the individual personality integral to authentic decision-making. The purpose of a determination of decision-making competence is by no means to ensure that only fully rational decisions are respected. Therefore, it cannot be that competence requires the absence of affective behavioural impediment. On a theoretical level, it would be important to distinguish those types of affect, the presence of which justifies another's intervention, from

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64 Abernethy and Lundin, "Competency and the Right to Refuse Medical Treatment," supra note 48 at 92.


66 "Beyond Cognition," supra note 42 at 384.
those that do not. Guidelines for accomplishing this are entirely absent, at least in the published literature.

**How Much is Enough?:** Further, and with respect to all impediments to reliable assessment, it is at best a matter of judgment just how thorough understanding and appreciation must be, how clear must be the communication of a choice and how perfect must be the process of reasoning in order that a resulting decision is competently made.\(^6^7\) Competence is a continuum concept, but a line must nevertheless be drawn.\(^6^8\) It is difficult indeed to draw any sort of satisfactory line with respect to any of these matters and it is reasonable to suppose that there is substantial diversity among assessors.

**Practical Difficulties**

In addition to these conceptual difficulties about the determination of competence, there are a number of practical difficulties which cast a shadow over the reliability of a particular assessment.\(^6^9\)

**Effects of Illness:** The stresses of illness and the side effects of certain medications may complicate the assessment of decision-making competence. The patient finds him or herself in the dependent and vulnerable situation of sickness, possibly accompanied by fear, distress, confusion, uncertainty and perhaps under the influence of powerful drugs. All of these factors may confound a reliable determination of competence.\(^7^0\) In addition, the hospital setting in which most such determinations are made will be to most patients unfamiliar, disorienting and perhaps quite frightening. The effect of the interrelationships with members of the medical team is a dynamic which may affect the determination of competence. The patient may feel ill, distressed, fearful or hostile toward the assessor or other caregivers.

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\(^6^7\) Tepper and Elwork, "Competence to Consent," *supra* note 61.


\(^6^9\) But see M. Silberfeld *et al*, "Legal Standards and the Threshold of Competence" (1993) 14 *Advocates' Quarterly* 482-487.

\(^7^0\) Amas and Glantz, "The Right of Elderly Persons," *supra* note 1.
lack of trust by the patient for the evaluator may compromise a determination of competence. The ability to communicate a choice will be affected by impairments of consciousness, thought disorder, disruption of short-term memory or ambivalence. In addition, Watson points to the not uncommon attempt by hospitalized patients to regain control of their lives and circumstances, by engaging in power struggles with doctors or hospital team members. Such struggle may complicate and compromise a reliable determination. Competence also may fluctuate over time as a function of the natural course of illness, as a response to treatment, psycho-dynamic factors, metabolic states or the effect of medications.

Informational Deficiencies: Certainly the sufficiency of the information possessed by the patient will often be a factor in assessing competent decision-making. Adequate disclosure of the relevant information must precede any meaningful evaluation of competence. However, Faden and Faden note that information cannot and need not be perfect. Even someone with a seriously false belief about their own medical condition or treatment may be competent. Barriers such as stroke and short-term memory difficulties may leave the patient unable to marshal sufficient and appropriate information for decision-making, even if such information was understood and grasped at an earlier time. And, if there is no such mental confusion, in large hospitals with diverse and busy health care team members, it may not be anyone’s clear responsibility to ensure that the patient has been provided adequate disclosure. The patient may not be aware that each of the team members has assumed that

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71 E.G. Howe, "Approaches (and Possible Contraindications) to Enhancing Patients' Autonomy" (1994) 5(3) Journal of Clinical Ethics 179-188.


73 Abernethy describes such a case in “Compassion, Control, and Decisions About Competency,” supra note 65, with facts taken from the case of State Dept. of Human Services v. Northern, 563 S.W.2d 197 (Tenn. Ct. App. 1978).


75 Tepper and Elwork, Competence to Consent," supra note 61.

some other person has ensured that the patient is in possession of adequate information. Conversely, it may be that the assessor of mental competence lacks sufficient knowledge about the background or particular circumstances of the patient. In the absence of such adequate background, an assessment of competence may be unreliable.\textsuperscript{77}

Effects of Cognitive Disorders: The presence of cognitive disorders will clearly affect decision-making competence. Organic brain diseases of various types and psychotic thought disorders impair reasoning and understanding. Phobias, delirium, dementia and hallucination are all conditions which compromise the capacities and abilities required to form a competent decision. Mental illness may render a person incompetent, but it need not.\textsuperscript{78} Certainly, deficits in attention span, intelligence and memory may detract from the ability to understand relevant information.\textsuperscript{79} However, identifying the presence or absence of these conditions is, as a practical matter, prone to error. In addition, a relatively mild affliction of any of these disorders may not render one incompetent, but may compromise decision-making ability. The patient in the case of \textit{In re Yetter}, was confused and made what was acknowledged to be an irrational and foolish decision to refuse a needed amputation of her leg. She was nevertheless found to be competent.\textsuperscript{80} In the case of \textit{In re K.K.B.}, a mentally ill, civilly committed person was also found to be competent.\textsuperscript{81} The circumstances of the decision and the severity of the impairment will be relevant. At what point is a particular impairment sufficient to rob one of decision-making competence?

Effects of Affective Disorders: Of course, the same may be said for the variety of affective disorders discussed earlier. Depression, denial, ambivalence, delusional perceptions, skewed notions of causation and the presence of strong emotional drives and impulses are not

\textsuperscript{77} Morreim, "Impairments and Impediments in Patients' Decision Making," \textit{supra} note 50.


\textsuperscript{79} Appelbaum and Grisso, "Assessing Patient's Competence," \textit{supra} note 8.


\textsuperscript{81} 609 P.2d 747 (Okla. 1980). See also \textit{Winters v. Miller}, 446 F.2d 65 (2nd Cir. 1971).
only difficult to situate in terms of accepted notions of competence, but must in any event be of a sufficient degree to justify a finding of incompetence. Again, practical difficulties arise both in identifying the presence or absence of such conditions and in determining whether, even if present, such affect renders a particular individual, in a particular circumstance, incompetent to make a particular decision. Gutheil and Bursztajn argue that the incompetence of patients with paranoid states, depression, mania and anorexia nervosa may be so subtle that both assessors and the court are deceived.\(^{82}\)

Depression may be temporarily distorting, even though understanding is present. The patient might just not care enough to carry on.\(^{83}\) The ability to appreciate information may be impaired as a result of pathologic distortion, denial or delusional perception of the nature of the condition, the probable outcome of treatment or the motivations of those giving care.\(^{84}\) However, the presence of these states does not prove incompetence. Depression and other affective disorders do not necessarily render one incompetent.\(^{85}\) Delusion may not render one incompetent if the delusion is not related to the specific medical decision in issue.\(^{86}\)

**Testing Competence:** The various instruments that have been developed for assessing competence have proven, to date, to be fairly crude and of limited reliability. As a device for initial screening, they may be of some value, but as a definitive assessment tool, they are inadequate.\(^{87}\) Deficiencies in the instrument or testing methods used to assess competence

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83 Buchanan and Brock, *Deciding for Others*, supra note 6.


86 *In re Yeterer*, supra note 80.

obviously threaten the integrity of an evaluation. Buchanan and Brock note the difficulties inherent in developing such an instrument:

...the lack of such a scale merely reflects the reality that competence involves too complex a meshing of various capacities and skills of each patient with the demands of a specific decision situation to yield a single, unified, formal summary.\(^{68}\)

If a standardized test is to be given, which test is appropriate and what sorts of questions will best serve to determine whether or not the appropriate capacities and abilities are present? If, either instead of or in addition to such standardized tests, an interview is to be done, what sorts of questions should be asked and what issues should be addressed to reach a reliable assessment about competence? How should responses be analyzed to make a confident determination? Naturally, the individual style of the assessor will vary and no clear guidelines have been offered to ensure that such interview will yield a reliable determination.

**Institutional Arrangements:** In practice, the structure of the institution in which determination of competence is performed may complicate or threaten a reliable determination. Particularly in a large institution, care must be taken that the patient being assessed is adequately informed about his or her medical condition and prognosis such that a fair test of competence may be given. The assessor also needs to be adequately informed about the patient’s situation, including the patient’s background and present circumstances. The patient’s responses in a competence interview may be misinterpreted, or appear more or less rational than they really are in the absence of some understanding of the patient’s situation. The talking and probing which may be required to gain an understanding of such a situation may be the type of thing which “falls through the cracks” in the particular institutional setting. This may result not from the ill will or laziness of any particular member of the treatment team, but from the lack of effective institutional policies or arrangements designed to ensure that it is someone’s particular responsibility to ensure that this is done. In addition, the lack of an effective mechanism to have a determination of competence reviewed would be a deficiency within the institution. If there is no mechanism in place to revisit a determination

\(^{68}\) *Deciding for Others,* supra note 6 at 74.
either of competence or incompetence, then mistakes or doubtful conclusions may not be questioned. While it is not impossible that a particular institution has appropriate arrangements in place to address all of these concerns, there are a variety of ways in which the structure of the institution, even given the goodwill and expertise of the practitioners within it, threaten the validity of a competence determination.89

A Risk-Related Standard of Competence?

Characterizing the Risk-Related Standard: As noted earlier, the traditional view of competence has been that it should be assessed prior to asking the patient to give or refuse consent to a particular treatment or procedure.90 This represents a rejection of the outcome approach to competence determination.91 The reasoning is that allowing the content of a particular decision to affect the determination of competence is unjustifiably paternalistic, and would permit the assessor to inject his or her own values into the decision-making of the patient.92 It is often pointed out, typically with disapproval, that a patient’s competence is rarely challenged except when he or she attempts to refuse treatment, thereby disagreeing with the recommendation of the physician.93

These considerations suggest that it is the process of decision-making rather than its outcome that matters. However, in practice some apparently competent decisions, particularly those carrying very serious consequences, seem to cry out for intervention. What happens when an apparently competent person makes a treatment decision which will result, or will

89 Appelbaum and Roth, “Clinical Issues in the Assessment of Competence,” supra note 74 and Buchanan and Brock, Deciding for Others, supra note 6 at 80-83.

90 Annas and Denisberger, “Competence to Refuse Medical Treatment,” supra note 3.

91 However, Checkland and Silberfeld, “Mental Competence,” supra note 43, argue that the irrationality of a particular medical decision can itself provide evidence of competence or incompetence that “tips the scales” in light of other evidence (at 124).

92 Buchanan and Brock, Deciding for Others, supra note 6.

likely result, in death or serious bodily harm?

In response to cases of this kind, some writers have proposed that the standard required for competence should be variable, depending upon the relative risks and benefits of accepting or refusing a particular treatment. Therefore, a relatively low standard of competence would be sufficient for one to accept a clearly beneficial treatment or to refuse a clearly risky one. However, the level of competence must be high for one to refuse a relatively beneficial, low-risk treatment or to consent to one which is dangerous and of questionable benefit. This "sliding scale" approach has significant appeal. Buchanan and Brock point out that it best gives effect to the philosophical basis for assessing competence, that is, to balance protection of the patient's health and well-being against his or her legitimate interest in self-determination. This is because, as the need for protection rises (the consequences of a decision become more dangerous) the patient's autonomous abilities likewise need to be greater.94 Autonomy is best served by a low standard of competence, which will honour more patient choices. Protection of the patient is best served by a high standard of competence which will honour fewer of the patient's choices, but will tend to save the patient from the consequences of more harmful decisions.

Another proponent of this view, James Drane, argues that a "sliding scale" of competence assumes three things: First, the objective content of the decision must be taken into account in making a determination of competence; second, the value of reasonableness operates at every level, and the surrounding circumstances are relevant to what is reasonable; and third, a reasonableness assumption justifies some paternalistic behaviour. Drane agrees that a patient's decision is sometimes set aside on the basis of his or her well-being. Beneficence is balanced against the value of self-determination.95

In addition, Buchanan and Brock urge that the variable standard best reflects the role assigned by law to determinations of competence. It is the law that has established competence as the threshold for decisional authority. That being the case, the notion of

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94 Buchanan and Brock, *Deciding for Others*, supra note 6, ch. 1.

competence, as a legal notion, must in itself be rich enough to mark out when the individual may give a binding consent or refusal, and when that task must be assigned to another.

It is important to be clear what a variable or risk-related standard does and does not entail. It does not entail that when the consequences or risk to the patient is greater, the assessment of competence should be carried out more carefully or thoroughly. A more careful assessment is consistent with maintaining the same standard for competence. In addition, it is not inconsistent with the traditional account of competence that a more complex or difficult decision may attract a higher standard of competence. That is, since competence is decision-relative, a higher degree of decision-making ability may be required for one to be competent to make a more complex decision. A riskier decision is not necessarily more complex, although it might be. The President’s Commission found that although a decision to forego life-sustaining treatment is “awesome,” this does not alter the elements of decision-making and need not require greater abilities on the part of the patient.

**Objections to the Risk-Related Standard:** An initial difficulty is that the evaluation of risks and benefits is not an objective process. Individuals place different values on risks and benefits. Therefore the assessor of competence, under a risk-related standard, may be importing his or her own values with respect to particular possible eventualities in a way that is not shared under the value system of the person being assessed. Wicclair notes that the calculus of risk is by no means objectively determinable, since the individual’s goals and values will result in risks and benefits carrying individual weightings. To take a simple example, a Jehovah’s Witness patient requiring transfusion may reasonably weigh the risk of foregoing blood differently than someone who attaches no special spiritual significance to the

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97 Culver and Gert, "The Inadequacy of Incompetence," *supra* note 45.

98 Elliott, “Competence as Accountability,” *supra* note 32.

99 *Supra* note 15 at 45.

transfusion of blood.

Again, a difficulty is that the patient’s own individual goals and values are pre-empted by those of the assessor, usually a physician. Drane allows that in balancing the welfare of the patient against his or her autonomy, some paternalism is introduced. However, the value of protecting patients justifies, in some circumstances, such interference.101

But, the primary objection to a risk-related standard has been that it conflates two questions which, it is argued, are best kept separate. The question of the patient’s decisional capacity is mixed up with the question of whether a particular decision should be honoured.102 The factors relevant to the determination of these two questions, it is proposed, are very different and accordingly, each should be answered individually.103

The variable standard results in what many consider to be anomalous results. The view entails for example that two patients, of equal decision-making capabilities, facing a similar clinical decision, may nevertheless be assessed differently for competence. That is, one may be determined to be competent and the other incompetent by virtue only of differences in personal circumstances rendering the particular decision more risky for the latter.104 Indeed, a person may at the same time be found either competent or incompetent depending upon the choice they make with respect to the same medical decision. That is, they may be incompetent to refuse a particular decision, but competent to consent. The variable or risk-related standard draws the question away from a determination of the presence or absence of the patient’s decision-making abilities and capacities, and toward the consequences of the patient’s decision. This is not only counter-intuitive to our common understanding of “competence” but also raises the question just what is really going on in an assessment of competence, at least in close cases.


102 Checkland and Silberfeld, “Mental Competence,” supra note 43.

103 Elliott, “Competence as Accountability,” supra note 32.

Brock responds that these results are not really problematic, since differences of context - of the dangerousness of the decision - make for a relevant difference with respect to decision-making. The degree of harm risked is relevant because protection of the patient’s well-being is a necessary part of the notion of competence. The two purposes of competence, protecting self-determination and protecting welfare, are not conflated, but rather are balanced in the context of the particular circumstances to achieve a result which takes account of both values.105

What’s Really Going On?: When a person refuses medically indicated treatment, and a finding of incompetence is considered, what is really going on? Are we really wondering about that person’s decision-making abilities, or are we really wondering whether we should intervene? Wicclair points out that if the latter is the predominant question, then the search for competence in such cases is artificial. If so, competence is not purely a judgment about the patient’s decision-making process and threatens to become a test of whether the patient’s decision, the outcome, is itself reasonable, or in any event, acceptable to the assessor.106

Buchanan and Brock may respond that the purpose of assessing competence is both to make a judgment about decision-making capacities and to decide whether intervention is appropriate, and argue that this is as it should be. But the result of this attempt to shoe-horn paternalistic motivation into the notion of competence is that the determination of incompetence becomes solely or primarily a judgment that the patient is in need of protection.

Practically speaking, when a person who would otherwise be found competent makes a dangerous or extremely risky treatment decision, do we assess the unacceptability of the decision and then look for some incompetence-making feature? Even after exploring the patient’s own reasons and values for an explanation, would it make a difference if we could not find some relevant pathology sufficient to justify a finding of incompetence? In practice, would we in fact conclude that there must be some disorder, so that the person must be incompetent. The medical and bioethics literature presents many cases of apparently


competent persons making decisions with dangerous consequences which cry out for intervention.107 If unacceptable decisions are always the product of some physical condition or psychiatric disorder, and so a judgment of incompetence is always appropriate in such cases, then it seems we can abandon a process-centred notion of competence. The reasonable outcome standard would yield the same results much more simply. If however eccentric or dangerous treatment decisions may be made in the absence of substantial physical, emotional or psychiatric disorder, then, in such cases, we are called upon either to permit the seemingly tragic decision to be effectuated, or raise the standard of competence so high that no person would be found competent to make such a harmful decision.

The introduction of a sliding scale of competence determination has the effect of confusing a rational determination of the patient’s decision-making capacities per se and allows the injection of paternalistic considerations in a way which is both conflated with other considerations and which allows paternalistic considerations to be exercised by the assessor without forthrightly acknowledging that he or she is doing so. Freedman refers to this as “playing it safe” and sees it as an ultimately unsuccessful way of escaping from a difficult moral dilemma.108 According to Margolis, such an attitude permits physicians and courts to overrule the decisional rights of patients on grounds which are inappropriate, since not reasonably related to the patient’s decision-making abilities.109

But, the fact that paternalistic considerations are introduced is not, in itself, problematic. The justification for paternalistic intervention will be addressed more fully in Chapters 8 and 9. What is misguided is the effort to introduce such considerations in the guise of something else. Paternalistic factors should be considered, and in some circumstances, should be determinative. But this should only be done with a consciousness that some

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108 Freedman, “Competence, Marginal and Otherwise,” supra note 2 at 68.

paternalistic considerations are relevant and legitimate and others are not. By acting forthrightly, the decision whether paternalistic interference is acceptable may be taken with relevant factors clearly in view. Leaving aside the notion of competence, most decisions ought be left to the individual. However, some decisions are such that, while others may not agree, or may find the reasons offered to be unpersuasive, the decision should nevertheless be permitted since the threatened harm is, on balance, within some acceptable limit. The focus of this work is on a third type of situation, involving the life or death of the individual where, on a human level, intervention seems to be required. In such cases, acquiescence seems more like abandonment than respect.

Suicidal decisions, and decisions to refuse life-sustaining treatments will sometimes be of this third type. It is clear that decision-making autonomy is not the only value at work either in decisions to intervene, or in decisions about competence. The well-being and protection of the individual is also at play. To decide when paternalistic intervention is justified is a difficult question, and one that should be faced squarely. The attempt to mix it together with indicia of decision-making ability promotes neither clear understanding or compassionate treatment.

Buchanan and Brock acknowledge that the variable standard may not be an ideal framework, owing to its conflation of the questions of decision-making ability and the justification for intervention. Nevertheless, it remains the accepted legal and medical mechanism for allocating decisional authority. The law requires rules upon which to base the decision who is to give the informed consent to treatment for a particular patient. Buchanan and Brock argue that the notion of competence is well established in law as the accepted ground upon which medical decision-making is allocated.110 If some workable way were found to extricate the question of the circumstances in which intervention is justified, from that of competence, the determination would be, in any event, more straightforward. Culver and Gert are explicitly prepared to take this step, although not on the same basis as is here

110 Buchanan and Brock, Deciding for Others, supra note 6 at 61-63.
Where a decision entailing death is made, and health care providers must decide whether to refuse, acquiesce or assist, we should examine the relevant considerations straightforwardly, not within a framework ill suited to the task. Certainly the decisional capacities of the person making a suicidal decision will be relevant. However other considerations, unrelated to competence will also be of crucial importance. Therefore, some independent means of determining the appropriateness of intervention is indicated.

The Insufficiency of Incompetence

All of this is not to say that determining decision-making authority in the usual way is generally a bad idea, or that some other process should be used. No doubt the vast majority of practitioners assessing competence do so sincerely and with some skill with a view both to respecting the patient’s autonomy and their well-being. It is to say that, at least at this point, our notion of competence and our means of testing for it remain relatively crude and to some extent ungrounded in a firm social consensus.

The assessor of competence is called upon to perform a very difficult task. As part of the process of determining whether a patient has sufficient understanding, appreciation and reason to make decisions for him or herself, Appelbaum and Roth argued that the assessor must consider also: psychodynamic elements of the patient’s personality; the accuracy of the historical information conveyed by the patient; the accuracy and completeness of the information disclosed to the patient; the stability of the patient’s mental status over time; and the effect of the setting in which consent is obtained. Even leaving aside the very substantial conceptual uncertainties surrounding competence, there is abundant opportunity, at least in close cases, for such determinations to go astray.

In most circumstances, a decision to die is the most important one can make. The stakes are higher with this decision than most and the consequences of a poor or mistaken

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111 Culver and Gert, "The Inadequacy of Incompetence," supra note 45 at 639-640, 642.

112 Appelbaum and Roth, "Clinical Issues in the Assessment of Competency," supra note 74.
assessment are correspondingly great. Inasmuch as the competence assessment involves too the need for protection of the patient's well-being, it is sensible to use a further test which focusses straightforwardly on this vital consideration. For serious cases at least, it seems difficult to justify reliance only on the vague and problematic concept of competence, particularly given its difficulties of application.

Sliding scale or risk relative standards of competence attempt to take account of the interest in patient welfare which is acknowledged to be inherent in the purpose of competence determination. It does so however by raising or lowering the requirements for decision-making function on the basis that the decision is more or less risky, or likely to be more or less harmful, all things considered. Of course, riskiness and harm or benefit must be weighed in the context of the available alternatives. This added complexity is introduced not because riskier decisions are necessarily more complex or more difficult, but rather because there are certain decisions which we are very uncomfortable permitting people to make on their own. Some decisions, and here we focus on decisions involving the death of the patient, carry risks or harms that simply do not seem to be justified by any benefit predictably to be derived.

If this is the case, then why not deal with that beneficent motivation directly? In order to accomplish the goal of testing whether the decision is simply too risky or dangerous to be permitted, then the sliding scale approach seems, at best, over complex. It is preferable to address specifically the paternalistic beneficent considerations which are, it is acknowledged, operating in the background.

A sensible way of making such beneficent considerations explicit lies in applying an additional test, after a determination of decision-making capacity is made. For legal purposes at least, it is proposed in Chapter 5 that the defence of necessity provides a suitable legal context in which the good of the patient may be balanced against his or her undoubted interest in self-determination. Such balance would be a separate issue from the question of his or her competence and would raise somewhat different issues. It would be possible then that the defence of necessity could succeed even where the patient is found competent. That is, it might be the case that the defence succeeds even where a competent refusal of treatment was given, at least where the treatment was reasonably necessary to preserve life.
5. THE DEFENCE OF NECESSITY

Overview

In Chapter 1, it was suggested that, under certain circumstances, rescuing a person from a suicide attempt, thereby saving their life, will sometimes be an appropriate response, even when the attempter is apparently competent and has expressly or impliedly refused treatment. In Chapter 2 however, a canvas of the recent Canadian, U.S. and English case law indicated that treating a person without consent, even treatment which will likely have the effect of preserving their life, typically constitutes a battery, potentially rendering the would-be saviour liable in damages.\(^1\) It may also constitute the crime of assault. It is fair to say however that in most circumstances, intervention is a caring, appropriate, and professional response by one, particularly a health care provider, confronted with a person who might die.

Studies have shown that suicidal feelings are usually transient, very often associated with severe psychiatric illness,\(^2\) and usually responsive to prompt treatment.\(^3\) Depression is common in suicidal persons and the natural course of clinical depression may be six months to as long as two years.\(^4\) Even if some suicidal decisions are rational, it is clear that most are not. The decision to die is, if carried out, irretrievable, and more likely to reflect a failure by others to meet the needs of the suicidal person than his or her autonomous choice. Accordingly, to the extent that the present law renders interference with decisions to die

\(^{1}\) For example, George Annas concludes that competent patients may refuse any medical life-sustaining treatment, even food and fluids, in “When Suicide Prevention Becomes Brutality: The Case of Elizabeth Bouvia” (1984) 14(5) Hastings Center Report 20-21.


\(^{3}\) D.C. Clark, “‘Rational’ Suicide and People with Terminal Conditions of Disabilities” (1992) 8(2) Issues in Law & Medicine 147-166.

unlawful, such law is in need of modification.

At this point, it would be well to address a cluster of objections concerning the project of identifying those cases of suicide intervention, where valid consent is lacking, which should be permitted by law. It may be argued first that it is not necessary to develop novel legal machinery to address these types of cases, since it is very unlikely anyway that a lawsuit may be brought against the person offering treatment in such circumstances. Further, even if such lawsuits are brought, courts have shown themselves to be extraordinarily unwilling to award damages in respect of wrongful living. That is, even if liability could be demonstrated, it is unlikely that the damages awarded would be more than nominal.\(^5\)

Anyway, it may be argued, decisions to end life of the sort referred to are virtually always irrational and so must be evidence of an incompetent agent. Therefore, since no valid consent can be given by a person who lacks decisional competence, intervention is not unlawful because of the common-law exception made for emergencies. In any event, since studies show that most suicide attempters are severely depressed or suffer from other psychiatric illness,\(^6\) a lack of competence may be presumed and again, treatment may be justified on the basis of emergency.

A number of things may be said in response to these objections and in support of the need to develop a legal defence with application to appropriate cases of life-ending decisions. First, while litigation of this type has been scarce, there can be no assurance that it will remain so. Despite Supreme Court rulings in both Canada\(^7\) and the United States denying a constitutional right to assisted suicide, large numbers of both Canadians and Americans are

\(^5\) In the English Court of Appeal case of *Re T.*, [1992] 3 W.L.R. 782; [1992] 4 All E.R. 649, Lord Justice Staunton referring to the damage award of $20,000 in *Malette v. Shulman*, remarks, “I doubt if an English Court would have awarded such a sum; but the liability would exist.” at 669. See also *Anderson v. St. Francis-St. George Hospital*, 671 N.E.2d 225 (Ohio 1996) where the judge refused to award damages either for “wrongful living” after the hospital ignored a DNR order, or in respect of injuries suffered after the life-prolonging resuscitation.


anxious to take greater control over the timing and means of their own death. It is reasonable to suppose that, for some, a strong feeling of right to end their own their life would provide the basis for a lawsuit if such decision were frustrated.

Further, in Chapter 3, it is urged that, for these purposes, the scope of "suicide" should include refusals of life-sustaining treatment, at least where the patient brings about or accepts his or her own death. Accordingly, it is proposed that, in some instances of such refusal, practitioners should not be liable for the tort of battery for continuing to treat without consent. Unconsented treatment to preserve the life of a patient in these latter circumstances, while sometimes ethically mandated, may well provide more fertile ground for litigation. *Malette v. Shulman*\(^9\) was the case of an unconscious Jehovah’s Witness involved in an automobile accident and who required transfusions of blood. However, she carried in her handbag a card giving notice of her refusal, on religious grounds, of blood transfusion. When blood was given, she successfully sued the doctor for battery. This case may be seen as an example of a request to withhold life-sustaining treatment which was ethically problematic for her caregivers.

Indeed, other such cases are beginning to come before the courts, at least in the U.S. In one case in Martinez, California, Linda Schneider had a serious neurological disorder when admitted to the Walnut Creek Hospital with seizures. Allegedly in spite of the instructions of her husband, who was also the agent designated by her Durable Power of Attorney for Health Care, and a DNR order previously written, hospital staff treated her with antibiotics for pneumonia and tube feeding for nutrition and hydration, thereby apparently extending her life. An action was launched seeking damages for the cost of her past and future care.\(^10\) In Flint, Michigan, a jury awarded a mother and her daughter over $16 million for treating the daughter, after being instructed by the mother (who also held the daughter’s DPAHC) to treat “only if it will restore my daughter to her pre-existing condition.” The daughter had a seizure.

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\(^9\) (1990) 72 O.R. (2d) 417 (C.A.)

\(^10\) *Schneider v. John Muir Medical Center*, Contra Costa Superior Court, *The [San Francisco] Examiner*, Apr. 9, 1997, A5. The plaintiffs lost at trial, perhaps in large part because of the testimony of Mrs. Schneider herself who gave evidence that she was “happy to be alive.” (*Examiner*, May 3, 1997, A4).
disorder post-treatment, resulting in a worsened condition. The award was reduced on appeal to $324,900 for the daughter for medical care and over $1 million to the mother for emotional suffering.11

These cases suggest that lawsuits are possible and damages are at least potentially substantial. While it is true that courts have traditionally been hesitant to award damages in respect of an unwanted continuation of life, so long as it is accepted that interference is tortious, why should courts not award compensation to its “victims”? Even if courts remain unwilling to award damages in respect of wrongful life,12 plaintiffs in future cases may be able to prove other types of damages suffered as a result of being rescued against their wishes. In the Michigan case described above, the daughter was entitled to nothing for pain and suffering as this would amount to recovery for “wrongful living.” However, the other damages came to over $1.3 million, primarily for the emotional distress of the mother. In any event, so long as there is any uncertainty about the availability of damages, health care practitioners and others intervening in life-ending decisions remain exposed to lawsuits which may be emotionally and financially costly, even if the ultimate result is that nominal damages only are awarded.

Further, even granting that most suicide attempts are incompetently made, in many cases there will be no opportunity to test the competence of the decision. That is, for example, if a person, such as Allan whose story is briefly told in Chapter 1, is brought to an emergency room having attempted suicide and leaving a note which states or implies the genuineness of the decision to die, the competence of the person at the time of the suicide attempt, or the time of writing the suicide note, will be difficult or impossible to gauge. Even if, statistically speaking, it may be concluded that a particular person was probably incompetent at those times, the law supplies no basis for presuming a patient’s incompetence.13

11 Osgoode v. Genesys Regional Medical Center (Genesee Cty. Cir. Ct. 1997).
12 Anderson v. St. Francis-St. George Hospital, supra note 5.
13 G.J. Annas and L.H. Glantz, "The Right of Elderly Patients to Refuse Life-Sustaining Treatment" (1986) 64 (2nd Suppl.) Milbank Quarterly 95-162, as well as V. Abernethy and K. Lundin, "Competency and the Right to Refuse Medical Treatment" in V. Abernethy, ed., Frontiers in Medical Ethics: Applications in a Medical Setting
That is, for each patient, the presumption is of competence, and in every case incompetence must be proved. The Washington Supreme Court, in *Grannum v. Berard* held that incompetence must be proved on the "clear and convincing" evidence standard. Accordingly, if someone saved against their wishes did sue, the defense that the person was likely incompetent anyway should fail, since the medical practitioners rendering treatment would probably have had no way of displacing the presumption of decisional competence.

To the related objection that studies show high rates of depressive or other psychiatric illness among suicide attempters, the response is the same. Even assuming that a majority of suicide attempters are depressed, this does not by itself provide anything like conclusive evidence that a particular suicide attempter suffers from depression, nor does it give legal warrant to conclude that the person lacked decision-making competence. People may be competent notwithstanding that they suffer from depression or other psychiatric disorder.

As noted earlier, a defense of necessity would also provide a basis upon which a court may determine an application for an injunction either to restrain or authorize treatment in the face of an apparently competent refusal. Even if lawsuits after the fact remain relatively rare, these questions are more likely to come to court, at least initially, prior to giving treatment. While the *Malette* case came to the courts on an action for battery, the *Nancy B.* Case came by application of Nancy B. herself, in anticipation of any dispute about her legal position. And, most of the U.S. litigation relating to this question has arisen in this way.

In Chapter 10, certain conditions will be proposed to guide courts in determining whether a practitioner sued for giving life-sustaining treatment without consent should be

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14 422 P.2d 812 (Wash. 1967). Indeed, in *U.S. v. Charters*, 829 F.2d 479 (4th Cir. 1987), the court held that a person found incompetent to stand trial on a criminal charge could not, on that basis alone, be presumed incompetent to consent to treatment.


entitled to avoid liability. These are considerations relevant to whether such treatment is justified notwithstanding its refusal. They would apply equally to provide a basis for a prospective court determination that a particular refusal of life-sustaining treatment either must be honoured, or may not be.

More fundamentally, it may be argued that no civil liability could arise for failing to honour a refusal of life-sustaining treatment, and so no such defence is required. Criminal Code s. 14 provides:

14. 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.

If failing to give life-sustaining treatment amounts to inflicting death upon the person, then it cannot be unlawful to give such treatment, no matter the wishes of the patient, since one cannot be required to act in violation of the requirements of the criminal law. Of course, if this argument is correct, then it applies equally to a refusal of treatment following an overt suicide attempt as to one in the context of a threat from an underlying condition. However, courts in Canada, England and the U.S. have held that withholding or withdrawing treatment, in appropriate circumstances, does not constitute inflicting death upon the person. Accordingly, honouring a refusal of treatment would not, by itself, give rise to criminal liability.

However, perhaps the most important reason why a defence of some kind is necessary to address treatment refusals, in the context of a decision that will predictably result in death, has little directly to do with the possibility of legal action. When faced with a decision to die, or at least to accept death, medical practitioners and others may feel a profound professional conflict about their duty and appropriate role in the circumstances. If such decision seems irrational, or if some potentially decent quality of life appears to be salvageable, strong

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19 Barber v. Superior Court of Los Angeles 195 Cal. Rptr. 484 (C.A. 1983)
instincts, arising out of an understanding of the mission and traditions of medical practice, together with a natural human instinct to preserve life, may impel practitioners to give the treatment which they are uniquely trained to offer. Whether or not they are at risk of being sued, it is important that the law reflect and validate these feelings by acknowledging that life matters, and that preserving life is an important and difficult social responsibility, borne by those practicing the medical professions. This is not to say that a practitioner may always give life-sustaining treatment in the face of a refusal. It is to say that there is another side to the equation, one which cannot be routinely ignored once the patient is judged competent.

Accordingly, if there are circumstances in which it is appropriate to render treatment or other intervention to stop a decision to die, notwithstanding a lack or refusal of consent, then the law should reflect this and recognize a defence applicable in such circumstances. Clarity about such defence would have a number of benefits: First, practitioners and others could act with greater confidence and with reduced fear of being sued, at least when acting within the scope of such defence. Second, a clear statement would allow practitioners to know also when they could be liable - when the defence does not apply and intervention would be unlawful. Finally, the law itself would gain credibility by endorsing professional and caring conduct by practitioners seeking to give life-preserving assistance to those in danger of dying. The fact is that hospitals virtually always treat people brought in following a suicide attempt, even if there is a note or some other evidence of the sincerity of the decision to die. Generally, it is right that they do so. The law should reflect and support this reality, in appropriate cases. And, in those circumstances in which treatment is not appropriate, medical practitioners should be clear that treatment exposes them to legal action.

The project of this thesis then is two-fold: First, it argues that such a defence is needed and applicable to a significant number of cases. Second, it proposes the nature and scope of such defence, together with a sketch of the conditions and restrictions limiting its reach. Such defence may be framed in terms of legal principles well established in the common-law

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tradition.

Emergency Exception to the Requirement of Consent

The most common exception to the requirement that valid consent be obtained to medical treatment is found in the exception made for emergency medical situations. The general rule is that a physician may and indeed often will have a duty to render medical treatment to a patient who requires such care, in circumstances of urgent or immediate threat to life or health. In such situations, a physician may treat without obtaining the patient’s consent.

Certain of the conditions required to justify emergency treatment would tend to be present in the case of suicide intervention. First, the person must be suffering an immediate threat to life or health. Therefore, urgent action must be required. For example, in Marshall v. Curry, the defendant surgeon was held justified in removing the plaintiff’s testicle during the course of an operation, without consent, where the need for its removal could not have been ascertained in advance. The court accepted that such removal was required to preserve the life or health of the plaintiff. In Luka v. Lowrie, the 15-year-old plaintiff had his foot crushed by a moving train. The court held that the physician defendants were justified in amputating his foot, even in the absence of parental consent, owing to the urgency of a prompt response. The risk of death without the operation was held to outweigh the harm suffered to the boy by the mutilating operation.

However, in Pratt v. Davis, the defence of emergency was not available in respect of the unconsentenced removal of the plaintiff’s uterus and ovaries during the course of a caesarian operation, where the court found no necessity for urgent treatment. Where an unexpected situation arises during the course of an operation, which the surgeon believes

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21 See generally, Dunham v. Wright, 423 F.2d 940 (3rd Cir. 1970).


24 79 N.E. 562 (Ill. 1906).
warrants some procedure beyond that consented to, it must be necessary that the procedure be performed urgently at that time. It is not enough that it would be convenient for the surgeon or the patient to have the procedure, for which consent is lacking, attended to during the operation.\textsuperscript{25} In \textit{Murray v. McMurchy},\textsuperscript{26} the defendant surgeon tied the patient's fallopian tubes, also during a caesarian procedure, when it appeared during the course of the surgery that a subsequent pregnancy would be hazardous to the patient. Notwithstanding that the patient would likely have agreed to have the sterilizing operation performed anyway, and that a further operation would entail substantial inconvenience and some additional risk to the patient, the surgeon committed a battery by proceeding as he did.\textsuperscript{27}

An intervention to rescue a person seeking to die seems typically to satisfy these conditions. Clearly the patient is facing an immediate threat to life and urgent treatment is required, if such threat is to be averted. However, the exception carved out for medical emergencies has been found to be subject to other conditions which render it inapplicable to a situation of suicide intervention. Specifically, the law requires that the patient be unconscious or otherwise incompetent. That is, there must be no possibility of obtaining consent to the treatment. So, in the case of \textit{Mulloy v. Hop Sang},\textsuperscript{28} no justification was found for the amputation of the plaintiff's hand, even though the court accepted the medical necessity for such amputation, where the plaintiff had specifically instructed that his hand not be amputated.

Even though the emergency defence is likely to be of little assistance to a practitioner facing legal action for intervening in a life-ending act, the public policy bases which underlie the defence are of interest. The emergency exception has been justified on the basis of implied agency, at least in the situation where the patient has chosen his physician and willingly put

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\item \textsuperscript{25} See also, \textit{Tabor v. Scobee}, 254 S.W.2d 474 (Ken. Ct. App. 1951) and \textit{Franklyn v. Peabody}, 228 N.W. 681 (Mich. 1930).
\item \textsuperscript{26} [1949] 2 D.L.R. 442 (B.C.S.C.)
\item \textsuperscript{27} Also, \textit{Beringer v. Lackner}, 73 N.E.2d 620 (Ill. App. Ct. 1947).
\item \textsuperscript{28} [1935] 1 W.W.R. 714 (Alta. App. Div.)
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him or herself under that physician's care. In these circumstances, it has been argued the patient may be taken impliedly to have appointed the physician his agent to make treatment decisions on his or her behalf while incapable and in need of treatment. Related is the view of a number of courts which found the justification for the emergency defence in the implied consent of the patient, arguing that it is reasonable to suppose that in such circumstances consent would be given.

The modern tendency has been to reject such deemed consent or agency as artificial, relying instead on a public policy which favours permitting, and indeed typically requiring, a medical practitioner to intervene in certain circumstances of medical emergency. Justice Robins, in *Malette*, sees the emergency exception as justified on the following basis:

The delivery of medical services is rendered lawful in such circumstances either on the rationale that the doctor has implicit consent from the patient to give emergency aid or, more accurately in my view, on the rationale that the doctor is privileged *by reason of necessity* in giving the aid and is not to be held liable for doing so. (italics added)

The court in *Sullivan v. Montgomery* writes:

Many persons are injured daily in our city and emergency cases constantly arise. To hold that a physician or surgeon must wait until perhaps he may be able to secure ... consent ... before administering an anaesthetic or giving to the person injured the benefit of his skill and learning, to the end that pain and suffering may be alleviated, may result in the loss of many lives and pain and suffering which might otherwise have been prevented.

On a similar basis, it has been held that the "...impracticality of conferring with the patient dispenses with the need for it." Neill, L.J., in *Re F.* describes the basis of the emergency doctrine in this way:

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31 *Supra* note 9 at 424-425.

32 *Supra* note 23 at 577.

For my part, I would prefer to explain the emergency cases on the basis that it is in the public interest that an unconscious patient who requires treatment should be able to receive it and that those who give this treatment in an emergency should be free from any threat of an action for trespass to the person.\textsuperscript{34}

The Defence of Necessity

Consistent with the view that the emergency exception is based fundamentally on the public policy that physicians may treat because of the pressing and dangerous circumstances brought about by the medical urgency of the situation, it has been suggested that the emergency exception to the medical requirement of consent is simply an instance of the broader legal defence of necessity.\textsuperscript{35} In \textit{Re F.}, a case concerning the sterilization of an incompetent adult, Lord Goff of Chieveley discusses the legal basis for the emergency exception:

Upon what principle can medical treatment be justified when given without consent? We are searching for a principle upon which, in limited circumstances, recognition may be given to a need, in the interests of the patient, that treatment should be given to him in circumstances where he is (temporarily or permanently) disabled from consenting to it. It is this criterion of a need which points to the principle of necessity as providing justification....That there exists in the common law a principle of necessity which may justify action which would otherwise be unlawful is not in doubt.

... There is, however, a third group of cases, which is also properly described as founded upon the principle of necessity.... These cases are concerned with action taken as a matter of necessity to assist another person without his consent. To give a simple example, a man who seizes another and forcibly drags him from the path of an oncoming vehicle, thereby saving him from injury or even death, commits no wrong.\textsuperscript{36}

It is on this basis that Lord Goff finds the legal sanction for unconsented treatment where emergency circumstances arise. That the doctrine of emergency may be seen as an instance...

\textsuperscript{34} \textit{Re F.}, [1990] 2 A.C. 1 (H.L.) at 30.

\textsuperscript{35} For example, \textit{Re T.}, supra note 5, where the doctrine of emergency is referred to instead as one of "necessity."

\textsuperscript{36} \textit{Supra} note 34 at 73-74.
of the broader legal doctrine of necessity shows that one may helpfully look to this more fundamental principle in questions of health care consent.

Broadly speaking, the traditional defence of necessity gives effect to the intuition that, under certain circumstances, otherwise unlawful behaviour may be justified or excused where necessary to avert a greater harm; when the act is not seen as blameworthy; where the purported wrongdoer was forced to choose between conflicting legal obligations; or where, primarily in criminal cases, the deterrent ends of the law cannot reasonably be achieved by a finding of liability.

In addressing the legal liability of a practitioner intervening in a decision to die, the primary concern is with the civil liability which may attach. The issue of the potential criminal liability in such case is relatively inconsequential. While a criminal charge of assault in these circumstances would be possible, it would be unlikely to be brought, and anyway the court would likely have difficulty finding the required mens rea to support a conviction. Nevertheless, like other defences applicable to both civil and criminal acts, such as self-defence and duress, there has been no firm distinction drawn between the application of the defence of necessity to civil and criminal cases. Accordingly, while the defence may not apply identically, judicial and academic sources concerning the defence of necessity in criminal cases are relevant and helpful to a discussion of its application to civil cases.

Cases which have accepted a civil defence of necessity have tended to be of two different kinds, so-called "private" and "public" necessity. In cases of private necessity, the defendant acts to protect a private or individual interest, either his own or that of another. For example, in Dwyer v. Staunton, a passerby was found not to be civilly liable for trespass, when he entered upon the plaintiff’s property in order to complete his journey, because the roadway was rendered impassable by a large snowdrift. In the 1962 U.S. case of Cross v.


State, a farmer was found not guilty of shooting a moose out of season and without a license because the moose were feeding on his crops.

The reasoning in such cases is similar to that of self-defence and defence of property. Circumstances sometimes arise in which unlawful action is made necessary, at least in order to permit an individual to carry out socially valuable activities. So, it was held to be generally for the public good that people have free passage along thoroughfares and that farmers be entitled to defend their agricultural labour. In such cases, the defence has been confined to those cases in which there has been no substantial infliction of harm by the wrongdoer and the otherwise unlawful conduct is carried out reasonably and with the minimal possible harm and inconvenience to affected others.

A larger privilege is extended to acts which would otherwise be tortious, but which are committed in good faith for the protection of some public good or to serve some larger public interest. Such cases of "public" necessity present a stronger case for justifying otherwise tortious conduct. The following cases are typical: In Saltpetre's Case, agents of the king were found entitled to go on private land to mine and take saltpeter needed to make gunpowder. Because the king was responsible for defending the country's interests against foreign forces, and saltpeter was necessary to achieve these interests, the defence of necessity applied to permit what would otherwise be trespass and unlawful taking of property. In Mouse's Case, a barge caught in a storm was in danger of being swamped, and the lives of all those on board were imperiled. In these circumstances, the ferryman was entitled to hurl a trunk, owned by one of the passengers, overboard since he did so to protect the lives of the passengers on the barge. The applicable defence was that of necessity, since if the casket and other possessions were not discarded, it was reasonable to suppose that the passengers may have been drowned.

40 (1606) 77 E.R. 1294.
41 (1608) 77 E.R. 1341.
In *Rigby v. Chief Constable of Northampton*,42 in an attempt to arrest an intruder, police fired a tear-gas canister into some business premises. The tear-gas canister caused a fire doing considerable damage to the premises. The owner of the premises sued the police authority for negligence in respect of this damage. The action was successful but only because it was held that the police officers should have anticipated the possibility of fire and made arrangements for appropriate firefighting equipment to be available. It is clear that had the officers made reasonable attempts to minimize the damage which they could have anticipated would be caused, the defence of necessity would have been successful.

In a similar case, *Watt v. Hertfordshire District Council*,43 the plaintiff was a fireman riding in the back of a fire truck responding to a call, when the driver was forced to make an unexpected stop. The fireman was struck by a large jack being carried on the fire truck, which had not been properly secured, since the truck was not outfitted to carry the jack safely. The truck which was intended to carry the fire jack was out on another call. It was agreed that if the firemen had not been on an urgent public duty, that is, if it had been an ordinary case of employer and employee, then the employer would have been negligent and liable. However, since the purpose served by rushing to the fire was to save life, the defendant District Council was not liable for negligently permitting an unsafe work environment. The necessity of meeting the public emergency was sufficient to outweigh the normal duties owing by an employer to an employee and liability was denied. In *Surocco v. Geary*,44 a San Francisco fire crew tore down a building adjacent to premises which had caught fire. When sued by the owners for damages for destruction of the building, the fire authority argued successfully that, inasmuch as they had done so to prevent the conflagration from spreading, their actions were necessary, and therefore not unlawful.

The defence of necessity has been justified in three broad ways: First, it is sometimes held that an unlawful act is necessary because the harm resulting from acting in apparent

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42 [1985] 1 W.L.R. 1242 (Q.B.D.)
43 [1954] 1 All E.R. 141 (Q.B.D.)
44 3 Cal. 69 (1953).
violation of the law will predictably be less than that produced by adherence. Second, necessity operates when the legal breach is substantially involuntary. Third, it applies in cases where the defendant faces a conflict of legally recognized duties, and the duty to act in violation of the law outweighs that to obey.

Necessity - Avoidance of Greater Harm or "Choice of Evils"

The first basis for the defence of necessity is found primarily in earlier academic writings in England and in the U.S. case law. Such sources describe the defence as having application when the harm averted by violating the law is greater than the harm which would result from obeying the law. For example, William Blackstone, in his Commentaries on the Laws of England, sees one type of necessity as follows:

There is a ... species of necessity, which may be distinguished from the actual compulsion of external force or fear; being the result of reason and reflection, which act upon and constrain a man's will, and oblige him to do an act, which, without such obligation, would be criminal. And that is, when a man has his choice of two evils set before him, and, being under a necessity of choosing one, he chooses the less pernicious of the two.\footnote{Vol. 2, 2nd ed. (Chicago: Callahan & Co. 1879) Bk. IV, Ch. 3 at 30.}

Clerk & Lindsell on Torts offers the following:

The test of necessity is the same with regard to persons and property, namely that the act was reasonably necessary to prevent harm to a third party, or to the plaintiff, or to the defendant himself.\footnote{R.W.M. Dias, Gen Ed., 16th ed. (London: Sweet & Maxwell, 1989) at 1-182.}

One U.S. source characterizes the defence in this way:

Under the force of extreme circumstances, conduct which would otherwise constitute a crime is justifiable and not criminal; the actor engages in the conduct out of necessity to prevent a greater harm from occurring.\footnote{Wharton's Criminal Law, C.E. Torcia, ed., 15th ed., vol. 1 (New York: Clark, Boardman, Callaghan, 1993) § 90 at 614.}

In \textit{U.S. v. Bailey},\footnote{444 U.S. 394 (1980).} the United States Supreme Court considered the defence of
necessity in a case where prisoners were charged with unlawfully escaping a maximum security prison at the District of Columbia jail. They were captured between one-and-a-half and three months later. The defendants argued that in fleeing the jail they acted out of necessity, bringing evidence of frequent fires in their cell block, which were alleged to have been set by the guards, and that guards at the jail had subjected them to beatings and to death threats. In addition, there was evidence that one of the accused had suffered an epileptic seizure, but had received inadequate medical attention for his condition. Justice Rehnquist describes the defence of necessity as involving a "...choice of evils where physical forces beyond the actor's control rendered illegal conduct the lesser of two evils." He holds further that, in any event, if there is a reasonable legal alternative to violating the law, that is, the opportunity to avoid the threatened harm while acting in conformity with the law, the defence must fail. In this case, the defence of necessity was held not to apply because the crime of escaping from jail is a continuing offence. Even if the defendants had escaped in order to avoid mistreatment at the hands of the prison guards, they should have immediately turned themselves in. Inasmuch as they did not, the defence failed.

In *U.S. v. Richardson*, the defendants were charged with conspiracy to smuggle the cancer drug laetrile into the country. The defence of necessity, or justification, was argued. Pointing to the desperate need of cancer patients, they attempted to invoke the defence as a "choice of evils," that the harm done by violation of the law against smuggling was outweighed by the harm which would result from the lack of availability of the drug to cancer patients. Judge Merrill, of the 9th Circuit Court, characterizes the defence of necessity as follows:

This defence is said to be available when the actor is faced with a choice of two evils and finds himself in a position where he may "either do something which violates the literal terms of the criminal law and thus produce some harm or not do it and so produce a greater harm". Thus it is asserted that society will benefit from the greater good that is accomplished by the violation of the literal

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50 588 F.2d 1235 (9th Cir. 1978).
language of the law.\textsuperscript{51}
The court found however that other courses of action, consistent with the law, were available. The defendants could have taken steps seeking to compel the FDA to have laetrile approved as a new drug. Therefore, the defence was inapplicable.

The 9th Circuit Court in \textit{U.S. v. Simpson} characterizes the defence as follows:

The theoretical basis of the justification defences is the proposition that, in many instances, society benefits when one acts to prevent another from intentionally or negligently causing injury to people or property.\textsuperscript{52} Simpson had broken into the Selective Service Office in San Jose, California, and set fire to draft records to protest the war in Southeast Asia, and to help bring a speedier end to the fighting. The court upheld the conviction on the basis that the defence of necessity cannot succeed when the person seeking to avert the anticipated harm does not act reasonably in doing so. Although no one was hurt, setting a fire in an office building was found to be so reckless and dangerous that it could not be reasonable. In addition, it is essential that a “direct causal relationship be reasonably anticipated to exist between the defender’s action and the avoidance of harm.”\textsuperscript{53} It was not reasonable to anticipate that burning draft records would be at all successful in ending the conflict.

\textit{U.S.} courts have consistently rejected the view that a defendant’s strong moral belief in the wrongness of a law excuses its violation. \textit{U.S. v. Moylan}\textsuperscript{54} is a case similar to that of \textit{Simpson}, in which the defendants, which included Father Daniel Berrigan, entered and burned draft records in the Selective Service Office in Catonsville, Maryland. It was not doubted that the defendants’ objection to the war in Vietnam was strong and sincerely felt. The court addressed the defendants’ appeal to morality or personal conscience by way of justification of their conduct. The issue was the way in which civil society responds to those who choose to

\begin{footnotesize}
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\item \textsuperscript{51} \textit{Ibid.} at 1238, quoting from LaFave and Scott, \textit{Handbook on Criminal Law} (St. Paul, Minn.: West Publishing Co., 1972) s. 50 at 387.
\item \textsuperscript{52} 460 F.2d 515 (9th Cir. 1972) at 517-518.
\item \textsuperscript{53} \textit{Ibid.} at 518.
\item \textsuperscript{54} 417 F.2d 1002 (4th Cir. 1969).
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commit acts of disobedience in the name of justice. While acknowledging that history has shown many instances of morally heroic and ethically justified acts of civil disobedience, the court held that such acts do not carry legal justification or immunity from punishment. In order to uphold the rule of law, the actor must accept the penalty for his or her actions.

To encourage individuals to make their own determinations as to which laws they will obey and which they will permit themselves as a matter of conscience to disobey is to invite chaos. No legal system could long survive if it gave every individual the option of disregarding with impunity any law which by his personal standard was judged morally untenable. Toleration of such conduct would not be democratic, as appellants claim, but inevitably anarchic.  

The Canadian courts reached a similar determination in the case of *MacMillan Bloedel Ltd. v. Krawczyk*. In this case, 44 persons appealed their conviction on charges of criminal contempt for disruptive actions taken in protest against the logging practices of MacMillan Bloedel carried on in the Clayoquot Sound region of Vancouver Island. The B.C. Court of Appeal dismissed the appeal on the ground, among others, that the defence of necessity did not apply. Quoting Justice Dickson in the *Perka* case, the court held that the defence was not available because the protestors had a legal alternative to disobeying the law, namely legal action to challenge the original court order of injunction which prohibited such protests.

More recently, Canadian and English courts have rejected this approach and, as is plain from the above discussion, U.S. courts have looked upon it with some scepticism. The difficulty is that while it is easy enough to imagine cases where the utility of violating a law may be greater than that of adherence, developing a general rule has proved problematic. It would seem to be unacceptable to leave the question of adherence to law to the subjective judgment of the individual defendant.

This concern was expressed powerfully in the case of *Southwark London Borough

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55 Ibid. at 1009. See also *U.S. v. Cullen*, 454 F.2d 386 (7th Cir. 1971).

56 (1994), 43 B.C.A.C. 136 (C.A.)


58 *Krawczyk*, supra at 137-138.
In that case a group of homeless persons had moved into and squatted in abandoned housing owned by the Borough of Southwark. The Borough brought an application to have them ejected, as their occupation seemed straightforwardly to be an unlawful trespass. One defence raised by the squatters was that of necessity. Having no other home, it was necessary that they take refuge in the abandoned premises. Their pressing need for shelter threatened harm to them which was sufficient to outweigh the harm resulting from the otherwise unlawful trespass. The English Court of Appeal rejected their plea of necessity. Lord Denning argued that the defence of necessity may apply in case of great or imminent danger, and in order to preserve life, permits encroachment on private property. However, the doctrine must be carefully circumscribed, "[e]lse necessity would open the door to many an excuse." It could not be a warrant for stealing, even by one in need, since allowing such cases would threaten to give rise to disorder and lawlessness. As the defence would constitute an excuse for all kinds of wrongdoing, the courts feel obliged to take a firm stand, that necessity "...not become a mask for anarchy."

Necessity - "Normative Involuntariness"

Accordingly, some objective determination or acceptable operationalization of the defence is required. Courts have been wary of the view that either judges or juries should be left with the task of deciding whether a person should be excused from liability, for an otherwise unlawful act, by reason only of its positive consequences. In the criminal law context, the concern that the defence of necessity involves an improper legislative role being undertaken by the judiciary was addressed by the Supreme Court of Canada in R. v. Perka, suggesting that the defence of necessity must for this reason be sharply limited.

In this case, the defendants had been travelling from Colombia up the coast of British

\[\text{\textsuperscript{59}}\] 1971] 2 All E.R. 175 (C.A.)

\[\text{\textsuperscript{60}}\] \textit{Ibid.} at 179 (per Denning, M.R.)

\[\text{\textsuperscript{61}}\] \textit{Ibid.} at 181 (per Edmund Davies, L.J.)

\[\text{\textsuperscript{62}}\] \textit{Supra} note 57.
Columbia toward Alaska, transporting illicit drugs. Encountering a series of mechanical problems, aggravated by deteriorating weather, they decided, for the sake of the safety of the ship and of the crew, that they should seek refuge on the Canadian shoreline to repair the vessel before proceeding on to their intended destination. They were discovered and charged with importing cannabis into Canada and possession of the drug for the purposes of trafficking. At trial, they raised the defence of necessity, arguing that they had no intention of bringing their cargo to Canada, but were forced to do so only by the necessity created by the weather and other unforeseen circumstances. At trial, the defence of necessity was left with the jury, and the defendants were acquitted. On appeal, the Supreme Court held that the defence of necessity was not available in this case and ordered a new trial.

Writing for the majority, Dickson, C.J.C. affirmed the traditional, but much criticized, distinction between defences based on justification and those based on excuse. The distinction is drawn as follows: An otherwise unlawful act is justified if it is condoned or found not, in the circumstances, to be a wrongful action. By contrast, when an otherwise unlawful action is excused, its wrongfulness is maintained, even in the circumstances, but the wrongful conduct is not punished because of factors surrounding the act, not because the act itself is justified. The majority saw necessity operating as an excuse, not a justification.

As an excuse, according to Justice Dickson, the criminal defence of necessity acts something like that of duress or self-defence. That is, the defendant is excused because his action is "normatively involuntary." Otherwise criminal behaviour is excused on the basis that, by virtue of the circumstances in which the accused was placed, society cannot reasonably expect that the pressures exerted by such circumstances could be resisted by the accused. At bottom, the issue is the voluntariness of the act. Although of course the act cannot be said to be involuntary in the strict sense, the force of the circumstances must be such that it may not reasonably be expected that a person could do otherwise than violate the law.

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64 This distinction is endorsed and described by G.F. Fletcher, in Rethinking Criminal Law (Boston: Little, Brown, 1978).
It [the defence of necessity] rests on a realistic assessment of human weakness, recognizing that a liberal and humane criminal law cannot hold people to the strict obedience of laws in emergency situations where normal human instincts, whether of self-preservation or of altruism, overwhelmingly impel disobedience. The objectivity of the criminal law is preserved; such acts are still wrongful, but in the circumstances they are excusable.65

In addition, punishing such involuntary behaviour is purposeless as well as unjust. He quotes George C. Fletcher, who writes: "...involuntary conduct cannot be deterred and therefore it is pointless to punish involuntary actors."66

Justice Dickson rejects the view that necessity could act as a justification. The difficulty, as noted earlier, is that allowing violations of the law, on the basis of individual judgments of what is best in the particular circumstances, would lead to unfortunate or disastrous consequences. The defence of necessity had been raised in the context of the criminal law prohibiting abortion in one of the Supreme Court's Morgentaler cases, where Justice Dickson himself had observed:

...[n]o system of positive law can recognize any principle which would entitle a person to violate the law because on his view the law conflicted with some higher social value.67

The acceptance of such principle would require the court to adopt an attitude inappropriate to its proper role:

To go beyond that and hold that ostensibly illegal acts can be validated on the basis of their expediency, would import an undue subjectivity into the criminal law. It would invite the courts to second-guess the legislature and to assess the relative merits of social policies underlying criminal prohibitions. Neither is a role which fits well with the judicial function. Such a doctrine could well become the last resort of scoundrels and in the words of Edmund Davies L.J. in Southark London Borough Council v. Williams ... it could "very easily become simply a mask for anarchy."68

65 Perka, supra note 110 at 248.

66 Fletcher, supra note 64 at 813.


68 Perka, supra note 110 at 248
However, if the defendant has responded involuntarily, with voluntariness measured "...on the basis of society's expectation of appropriate and normal resistance to pressure"\(^9\) then otherwise unlawful conduct may be excused.\(^7\)

**Necessity - Conflict of Duties**

In a concurring judgment in the *Perka* case, Justice Wilson disagrees, in part, with Dickson's analysis. While granting that necessity may act as a defence, she rejects that it may do so on the basis of normative involuntariness. She argues rather that an act, to be excused, must be characterized not by its lack of voluntariness, but by its unpunishable nature, where compliance with the law is no less distasteful than the punishment which the law would exact for violation. In such cases, the role of deterrence in criminal punishment loses its force. Accordingly, if an important end of punishment is substantially frustrated, then the point of imposing criminal sanction recedes. However, if the defence is based upon the unpunishable nature of the offense, then the appropriate judicial response, much like that when the circumstances give rise to compassion for the accused, is to fashion a sentence which reflects such reduced culpability, but should not constitute a complete defence.

She also agrees that necessity cannot be founded merely on an individual or court determination that, on balance, it is in some sense preferable that the law be violated in a particular case. This would be an invitation to "anarchy" or to the courts taking upon themselves the role of legislators. She further rejects the view that unlawful conduct may be justified by an *ethical* duty internal to the conscience of the defendant, however firmly such belief may be held. The defence of necessity *does* arise however where the accused is faced with a conflict of duties *recognized by law*, that is, where the duty to obey the law conflicts with another duty which, in the circumstances, requires its violation. Then, and subject to the limitations which follow, the legal violation may not simply be excused, but is in fact justified.

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\(^7\) The Supreme Court of Canada re-affirmed this characterization of the defence of necessity in the 1995 case of *R. v. Hibbert*, [1995] 2 S.C.R. 973 (per Lamer, C.J.C.) in comparing it with the defence of duress.
The law must condone the act of the defendant, not merely be prepared to understand, accept or forgive it.\(^{71}\)

Necessity conceived as an excuse is less well suited to tort than to criminal law, where deterrence and retribution are important punitive aims. If the accused in a criminal matter acts under the pressure of powerfully affecting circumstances, such that his act is normatively involuntary, it seems reasonable that much of the rationale for imposing criminal liability is absent. In this context, where compensation of a wronged party is not the predominant consideration, the defence of necessity, seen as an excuse, makes some sense since it permits the law to avoid punishing one for whom the ends of punishment will not be met.

Tort law however, with its focus less on deterrence and more on compensation, should be hesitant to excuse behaviour acknowledged to be wrongful, since there still remain the interests of the wronged party who seeks to be compensated for losses suffered by reason of the admittedly unlawful act. If, however, a civil defence of necessity is effective to render the otherwise wrongful act justified, then the question of compensation should not arise, since the act is not wrongful.

For a civil defence of necessity then, Justice Wilson adopts a preferable view, acknowledging that in acting unlawfully, the defendant really does face a choice whether to obey the law. But, the option of obedience, because of the special circumstances of the situation, is not tenable. The choice to act unlawfully may not be made on the basis of the defendant’s own evaluation of the better course of action, all things considered. Nor is the defence of necessity applicable to a case of civil disobedience, where the moral conscience of the defendant forbids compliance with a law judged by the defendant to be unjust. The choice must be between courses of action each of which are dictated by legal obligation. To avoid the concern that persons not be encouraged to take the law into their own hands, the best justification for violating a legal obligation is that one has, at the same time, a conflicting legal obligation of greater importance which, in the circumstances, cannot be postponed. Where such conflicting obligation overrides the duty to obey the law in question, the violation is not

\(^{71}\) Perka, supra note 57 at 276 (per Wilson, J.).
wrongful and so the basis of the obligation to pay damages as compensation is similarly absent.

This interpretation of the defence of necessity also accords more sensibly with Canadian, U.S. and English case law, before and since the Perka case. For example, in the Supreme Court of Canada case of Priestman v. Colangelo,\(^2^2\) two uniformed police officers in a patrol car, were speeding in pursuit of a suspected criminal. During the chase, one of the officers fired a shot at the rear tire of the stolen car. At that moment the police car struck a bump in the pavement and the bullet struck instead the rear window of the stolen car, ricocheted and struck the innocent driver of another car, rendering him unconscious. As a result, this third car, now out of control, drove up on the curb and fatally struck two student nurses who were standing on the sidewalk. In an action for negligence by the administrators of the estates of the nurses, against both the police officer who fired the shot and the driver of the stolen car, the Supreme Court held that the officer was not liable. Clearly, in other circumstances, one who shoots at another car while riding in a moving car, would be guilty of such recklessness that he would certainly be found liable for negligence in causing such injuries as may result. Nevertheless, the fact that the officer was engaged in the performance of a duty imposed on him by law rendered his action necessary under the circumstances, and no liability arose. While the defence of necessity was not specifically discussed in the Supreme Court judgment, the traditional principle of the defence was clearly applied. Unlike Perka, but like an action for battery, this was a civil, not a criminal action. Certainly, the exercise of the officer’s duty must be reasonable in the circumstances. The court held that the actions of the officer were necessary to meet the urgent and immediate circumstances facing him, and were taken reasonably to protect those persons whose safety might have been endangered by the escaping car.

While cases specifically pleading the defence of necessity have met with limited success, it was found to be applicable in R. v. Morris.\(^2^3\) In that case, a husband and wife were


\(^{23}\) (1981) 61 C.C.C. (2d) 163 (A.Q.B.)
driving home at night along a lonely stretch of highway. The wife, who was quite drunk and very upset, demanded that her husband, the defendant, either drive her back into town so she could confront the police about an incident which occurred earlier that evening, or to let her out on the highway so that she could return on her own. The husband continued driving and when the wife attempted to grab the steering wheel to make the car pull over, he grabbed her around the neck and held her until they had returned home. He was charged with assault in restraining her as he did. The defence of necessity was successfully argued on the basis that the husband had been placed in a position where he was obliged to choose the lesser of two evils. The evil of restraining and thereby assaulting his wife was balanced against the evil of allowing his wife to get out of the truck to walk on a dark road in a drunken state. The court clearly saw an element of marital duty in his actions, arguing that to have allowed her to get out, in the circumstances, would have shown wanton or reckless disregard for her life or safety and could have constituted criminal negligence on his part. As to the limiting conditions, the court held that the husband had acted in good faith and on reasonable grounds, believing that intervention was necessary and proportionate, and that no other alternative lawful means existed.

The ferryman in *Mouse's Case* may also be seen as acting in furtherance of an established nautical duty to his passengers, which conflicted with, and outweighed, his ordinary duty to take care with the property of his passengers - in this case, the plaintiff's trunk. In *Rigby v. Chief Constable*, similar to the *Priestman v. Colangelo* case, the policemen may be seen to have been acting in furtherance of their public duty by firing the tear-gas canister into the premises in an attempt to arrest the suspect within. This too may be viewed as a case of necessity, arising out of the officers' public duty as policemen. In both

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74 *Criminal Code*, s. 215(1)(b).

75 *Supra* note 41.

76 *Supra* note 42.
Watt v Hertfordshire District Council and Surocco v. Geary, the actions of the firemen would, absent their public duty, be reckless and negligent. In the circumstances however, they acted in furtherance of the important public obligations which they had undertaken. The duty to fight the fire was compelling, and outweighed the obligations of care and prudence to which they would otherwise be bound.

The U.S. cases which view necessity as a choice of evils may be seen as adopting roughly this analysis. if the evil or harm occasioned by obedience to the law is one which the agent has a duty not to cause. While this condition is not explicitly stated, it may fairly be inferred. In any event, medical practitioners have a general duty to do no harm in their dealings with patients, and this duty is arguably one which has been recognized by law. Accordingly, at least in the context of medical treatment without consent of a person seeking to die, the choice of evils facing the practitioner will typically amount to a conflict of duties.

Necessity - Limiting Conditions

In considering the defence of necessity, the courts have laid down a number of restrictions on the availability of the defence. First, the necessity to act in apparent violation of law must be urgent, immediate and inevitable. This condition roughly parallels a similar restriction on the emergency exception to the requirement of consent to treatment. Necessity is no defence where the otherwise unlawful act was not required to be done urgently. Second is the requirement of proportionality. That is, the harm which is thought to be avoided by violating the law must be greater than the harm caused by such violation. Third, there must be no available lawful alternative to the legal violation, which would be effective to avert the harm sought to be avoided, or to satisfy the conflicting duty. Fourth, the action must be reasonably designed effectively to prevent the threatened greater harm.  

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77 Supra note 43.
78 Supra note 44.
79 Perka, supra note 57 at 250-253 (per Dickson, C.J.C.)
Necessity - Application of These Tests

The health practitioner who commits a battery by treating against the wishes of the suicide attempter may, in appropriate circumstances, be relieved of liability on the basis of any of these three broad statements of the defence of necessity. If the justification is that of averting a greater harm, or choosing the lesser of evils, it can readily be imagined that a practitioner (or indeed anyone else) may encounter a situation where the greater evil, or greater harm, lies in allowing another to carry out a decision to die. Realistically, any of the cases discussed in this chapter which have allowed a defence of necessity, or similar justification, may be seen as cases where the evil averted by violating the law is greater than that arising from a failure to act in the otherwise unlawful manner. If this correctly states the defence of necessity, then it will be applicable, and may be relied upon in many cases of intervention in a decision to die.

The second justification, necessity as normative involuntariness, is more difficult, but the argument can be made. The *Perka* case is presently the authoritative Supreme Court of Canada case on the criminal defence of necessity and Justice Dickson wrote the opinion of the majority of the Court. For reasons canvassed earlier, it was suggested that Justice Wilson's notion of necessity based on a conflict of duties approach is preferable, particularly in connection with a civil lawsuit. As *Perka* is a criminal law case, it may be that its approach is not straightforwardly applicable to civil law matters. Nevertheless, the project of bringing suicide intervention within the ambit of the *Perka* decision is far from hopeless. Recall the passage from Justice Dickson's judgment quoted earlier: The defence applies "... in emergency situations where normal human instincts, *whether of self-preservation or of altruism*, overwhelmingly impel disobedience." It is clearly acknowledged that altruism may act as a "normal human instinct," which may impel disobedience. For most people, particularly perhaps those who have chosen a medical profession as their life's calling, the impulse to preserve life may be very strong, and arguably, something like overwhelming in some cases. Normative involuntariness may quite straightforwardly account for cases of

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80 *Supra* note 57 at 248.
urgent measures taken to prevent a suicide. Rushing to stop someone from throwing himself off a bridge, or administering urgent treatment in a hospital emergency ward, would be cases of this kind.

More difficult are cases where a patient seeks the withdrawal of life-sustaining treatment. It is an important aspect of this thesis that in some circumstances, practitioners must be relieved of the duty to honour that request, even if given by a competent patient. In such cases, the practitioner typically has time to consider the request and action may be undertaken in a deliberate and thoughtful way.

Even in such cases however, it is not unreasonable to suppose that, notwithstanding the opportunity to consider his or her decision, the practitioner may nevertheless be overwhelmed by a quite natural instinct to protect this particular life and that such instinct impels him or her to disregard the patient’s right to refuse treatment. Such feeling may sometimes be of a kind which it is not reasonably to be expected that one may resist. It will be argued in Chapter 10 that the circumstances in which such intervention are appropriate would be ones where the intuition that life should be saved is particularly compelling. Therefore, the intervention by a medical practitioner in such circumstances may be seen as “involuntary” in the requisite sense.

Third, intervention in the life-ending decision of persons may in some cases be justified because the person seeking to intervene has a positive duty to do so which conflicts with his or her duty to respect the refusal of treatment. Unlike the analysis that interference is wrong but in some sense understandable due to its lack of normative involuntariness, the conflict of duties theory provides a defence on the basis that the apparently wrongful act was justified - that is, not wrongful at all. However, for reasons canvassed earlier, it is not sufficient that the health practitioner subjectively believes that the harm avoided by interference outweighs the harm or affront to the individual who is interfered with. It is not enough that the health practitioner, or the court trying the case, determines that liability should not lie, even subject to the restrictions outlined above, simply because they feel that, in the isolated circumstances of the case, intervention was preferable for those concerned. Such reasoning would be vulnerable to the objection that practitioners or judges thereby take the law arbitrarily into
their own hands, and risk a chaotic development of the law and uncertain application of legal rules in future cases. It would not be appropriate to apply the defence of necessity, in cases of suicide intervention, on the basis of an all-things-considered balance of utilities, whether based upon the determination of the individual defendant or of the court.

However, as Justice Wilson has suggested, concerns about courts undertaking an improper legislative role, or encouraging the arbitrary or individual application of the law, are not engaged where the defence is invoked by one facing a duty, recognized by law, which conflicts with the duty to obey the particular law, in this case, the law which requires consent to treatment. Even granting that the defence of necessity may apply in such cases on something like a conflict of duties or even a "choice of evils" analysis, two important questions remain. First, if the defence of necessity requires that intervention be founded upon some legally recognized duty, what is the source of that duty? What makes the interference by a medical practitioner in another's self-destructive act anything other than arbitrary, justified only by his or her unconditioned and subjective judgment about the best course to be followed in the particular case? Second, granting that a conflict of duties exists in some such cases, what considerations are relevant to determining whether the conflicting duty is sufficiently important as to justify relieving the intervening medical practitioner from liability? The second of these questions will be addressed in Chapter 10, where conditions as to the scope and limitations of the defence will be proposed. About the first question however, something may be said at this point.

**The Medical Practitioner’s Duty to Preserve Life**

In fact, there are a number of sources of legal obligation which have direct application to physicians, nurses, and other medical practitioners, and which would be appropriate to balance against the admitted prohibition against treating without consent. Perhaps the clearest legal duty of this kind is found in the medical practitioners’ undoubted fiduciary obligations owed to their patients. A fiduciary relationship is one of trust, which imposes upon the physician a family of particular obligations to patients, including those of utmost good faith and loyalty, honesty, respect for confidential information and an obligation to act in the
patient's best interests. Courts have imposed fiduciary obligations upon physicians because of the inherent vulnerability of patients and the imbalance between them of information and power in the medical setting. While the precise reach of practitioners' fiduciary obligations cannot be comprehensively characterized, except perhaps in the context of a particular situation, legal duties not to abandon a patient under care are well established. That is, having undertaken, either expressly or impliedly, the care of the person requiring medical care, the obligation to render such treatment is recognized by law. Physicians have well established duties to treat, and not to abandon their patients.

More particularly with respect to "right to die" cases, it was noted in Chapter 2 that a person's right to refuse life-sustaining treatment must be weighed against certain legally-recognized state interests acknowledged in both Canada and the U.S. case law. Of these, three are directly relevant. The state has a well established interest in protecting the sanctity of life, preventing suicide and preserving the integrity of the medical professions. The fourth interest, that of protecting the interests of innocent third parties, will be left aside in considering these cases.

The state's interest in preserving life has given rise to a judicial acknowledgement that,

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85 Malette v. Shulman, supra note 9 and Rodriguez, supra note 7 (per Sopinka, J.)
in some cases, the legal obligation to protect the life of the would-be suicide conflicts with his or her right to refuse life-sustaining treatment. That being so, in appropriate cases, the necessity created by the impending threat to life may impel intervention, founded upon the duty to preserve life, and raise a defence to a civil claim for treatment without consent. It would do so when the harm averted by such intervention is reasonably predicted to be greater than that caused by failing to respect the refusal.

The Australian case of *R. v. Davidson* suggests the application of this duty. Davidson was a physician charged criminally under a statute prohibiting “unlawfully using an instrument to procure an abortion.” The court accepted that the woman on whom the abortion was performed faced a serious danger to her life if the pregnancy were continued. The court considered the inclusion of the word “unlawfully” in the statute and concluded that it must refer to the concept of necessity. The physician was acquitted, since the abortion was “lawful,” inasmuch as it was performed in the reasonable belief that it was necessary to preserve the life of the patient. The court adds the familiar condition that the circumstances of the otherwise unlawful act must not be out of proportion to the harm sought to be averted. Therefore, the question whether the defendant acted to preserve life was relevant to whether he acted “unlawfully.” By applying the defence of necessity, the court affirmed that the physician has a duty to actively preserve his patient’s life and, by the principle of proportionality, that duty outweighed the criminal prohibition of abortion.

The *Davidson* case relied heavily upon the English case of *R. v Bourne*, in which the accused surgeon performed an abortion upon a young girl, of fifteen years of age, who had become pregnant as a result of rape. The abortion was performed by an experienced surgeon in a London hospital, for no fee. The trial judge, in his instructions to the jury, described the word “unlawful,” used in the statute describing the performance of a criminal abortion, as

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89 [1938] All E.R. 615 (Cent. Crim. Ct.)
being satisfied only when the abortion is performed not for the purpose of preserving the life or health of the patient. The implication of these two cases is clear, although the words "defence of necessity" are not used. That is, acting to preserve life is inconsistent with acting "unlawfully". Similarly, with respect to the state's interest in preventing suicide, courts would be entitled to see this interest as giving rise to a conflict of duties when the medical practitioner confronts a suicide attempt. This legal interest, the existence of which is regularly re-affirmed, must have some content. Accordingly, in some cases, the duty to intervene to prevent suicide may create a necessity to do so, which necessity provides a defence.

In Canada too the legal duty to preserve life has a constitutional basis. In the Rodriguez case, the Supreme Court found no Charter right to assisted suicide. Justice Sopinka, for the majority, interpreted the s. 7 rights to life, liberty and security of the person as evidencing an important legal recognition of the sanctity of life:

As members of a society based upon respect for the intrinsic value of human life and on the inherent dignity of every human being, can we incorporate within the Constitution, which embodies our most fundamental values, a right to terminate one's own life in any circumstances? Clearly, his answer is negative:

Sanctity of life, as we will see, has been understood historically as excluding freedom of choice in the self-infliction of death and certainly in the involvement of others in carrying out that choice.

In that case, Justice Sopinka addresses the purpose of the criminal prohibition of assisted suicide. His remarks are clearly relevant also to decisions to accept death by refusing life-sustaining treatment.

Section 241(b) has as its purpose the protection of the vulnerable who might be induced in moments of weakness to commit suicide. This purpose is grounded in the state interest in protecting life and reflects the policy of the state that human life should not be depreciated by allowing life to be taken. This policy finds expression not only in the provisions of our Criminal Code which prohibit murder and other violent acts against others notwithstanding the consent of the

90 Supra note 7 at 585.

91 Ibid.
victim, but also in the policy against capital punishment and, until its repeal, attempted suicide. This is not only a policy of the state, however, but is part of our fundamental conception of the sanctity of human life.92

A legally based duty to preserve life is also given expression in certain Criminal Code provisions respecting the standard of care owed to others.93 Section 215(1) provides, in part:

215. (1) Every one is under a legal duty

(a) 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.

The medical practitioner’s fiduciary duty is one which gives rise to an obligation to provide necessaries of life, at least to their patients requiring life-sustaining treatment. As to (1), the patient may be unable, by reason of illness, to withdraw from the practitioner’s charge, and (2) will typically be unable to provide treatment to him or herself. The failure to treat will, ex hypothesi, endanger the life of the patient.

Criminal Code section 216 provides:

216. 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.

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92 Ibid. at 595.

Note that there is no explicit exception made for treatments which are refused by the patient.

Finally, s. 217 provides:

217. 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.

While these provisions must be interpreted in a way which gives effect to the common law right to refuse treatment, they nevertheless demonstrate a clear, legally-based duty to preserve life, at least by those with subsisting fiduciary obligations. Medical practitioners, treating their own patients, are clearly included. These provisions show the importance which the law places on protecting life and indicate the special role which physicians in particular are expected to play in giving effect to that strong social interest.

It may be that duties to preserve life or prevent suicide do not apply to all persons. The common law is rightly wary of imposing such duties upon those without a substantial relationship of obligation and dependence with the person. However, the medical practitioner's fiduciary obligations, and the state's acknowledged interest in upholding the integrity and standards of the medical professions, provide a clear nexus between the state interests in preserving life and preventing suicide and the intervention of a particular practitioner. Strongly allied to the medical practitioner's fiduciary obligations, broadly speaking, is the obligation to treat and care for their patients.

This legal duty, or at least the privilege to intervene to preserve the life or health of others, is underscored by Lord Goff's framing of the notion of necessity, given in the Re F. case, as:

...the basic requirements, applicable in these cases of necessity, that, to fail within the principle, not only (1) must there be a necessity to act when it is not practicable to communicate with the assisted person, but also (2) the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person. ...[A]s a general rule, if the above criteria are fulfilled, interference with the assisted person's person or

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95 See sources at note 83.
property (as the case may be) will not be unlawful.\textsuperscript{96}

The defence which is here proposed will have difficulties with this precise statement. In particular with (1) which is inconsistent with interference against the wishes of the person. This is, of course, the fundamental difficulty which must be adequately addressed in this thesis, and will be taken up in the chapters which follow. It is enough for the time being that an action for battery may be met with a defence based upon the necessity of acting for the good of the person battered.

Certainly, neither the medical practitioner's fiduciary duties, nor duties arising out of the state's interests in preserving life, preventing suicide, or protecting the integrity of the medical professions create absolute or unqualified duties. Nevertheless, they are well established in the common law traditions. Again, while courts throughout the common law world have been wary of finding legally enforceable duties on the part of people generally to offer assistance or rescue to others, a clear exception exists when the parties stand in certain kinds of relationship to one another. Examples of such relationship include that of parent to child or trustee to beneficiary. The relationship of doctor and patient, which may be extended at least for these purposes to the relationship which patients have toward other medical practitioners, is another. The existence of such relationship is sufficient to give rise to a legal duty to treat and to rescue.

To be clear, however, this is not to say that such duties are unconditional or overriding in all cases. This is not to say that a defence of necessity ought to be successful in every case where a medical practitioner intervenes in a decision to end life. It is to say that such duties exist and are recognized in law. The fact that such duties exist gives a civil defence of necessity some purchase. The challenge indeed is to develop a framework to determine the considerations which are relevant to the applicability of such a defence in a particular case. Proposals for such considerations are found in Chapter 10.

In the cases with which we are concerned, the patient him or herself, by withholding consent to treatment, will have expressly or impliedly waived the "benefit" of the duty in

\textsuperscript{96} Supra note 34 at 75-76.
question. This is of course a highly material consideration, and one which in essence grounds the right to refuse life-sustaining treatment. The fact that the duty in question is to act in a way which is contrary to the wishes of the beneficiary of the duty imposes a high burden of justification on one who seeks to show that this individual preference may be overridden. Clearly, such justification for overriding the expressed wish of the patient to die is required to provide a basis for the argument that a specific, legally recognized duty to rescue or treat should be sufficient to defeat an action in battery for treatment without consent. As Justice Wilson argues in the Perka case, the justification which underlies a successful defence of necessity is not established simply by demonstrating a conflict of legal duties. Since the defence rests on the rightness of the accused's choice of one duty over another, the rule of proportionality is central to the evaluation of the justification.

It is easy to imagine, indeed it will usually be the case, that a suicide intervention satisfies the limiting criteria about which there is substantial judicial agreement, in both criminal and civil cases. First, intervention in a self-destructive act will typically require urgent and immediate action. Second, it can readily be imagined that intervention will commonly be contemplated in circumstances where no alternative exists to treating without consent, aside of course from allowing the person to die. Third, such intervention may well be reasonably designed effectively to prevent the threatened greater harm - the person's death - and fourth, that the harm avoided (the life saved) may well be greater than the harm inflicted (the affront to dignity and burdens of treatment or continued life which may result from interference). Fifth, the intervention may constitute the least harm inflicted, which is at the same time consistent with averting the harm sought to be avoided - that is, consistent with preserving the life of the suicide attempter.

The application of the defence of necessity to the law of consent generally, and to life and death decisions specifically, has so far been largely speculative. It is true that the case law is, at best, thin. With respect to treatment without consent, the cases tend to speak in absolute terms about the obligation to respect a refusal of treatment, notwithstanding that such treatment is necessary to preserve life. This is in part due to the fact that cases which have come before the courts have most often involved patients whose medical condition is very
serious and whose life is in any event nearing its end. Cases in which the patient is neither terminal nor experiencing untreated pain are most usually cases of religious objection to treatment (Jehovah’s Witnesses97 and Christian Scientists98), or hunger strikers99 and victims of quadriplegia.100 It is worth noting also that people tend not to sue medical practitioners for saving their lives, *Malette v. Shulman* being a notable exception.

However, the 1992 English Court of Appeal case of *Re T.*101 offers an interesting, if somewhat cloudy, perspective. T. was the adult daughter of parents who had been separated since she was three years old. Mrs. T., her mother, was a fervent adherent of the Jehovah’s Witness faith, a religious belief which Mr. T. did not share. At a young age, custody of T. had been awarded to her mother, with the express proviso that she not be brought up as a Jehovah’s Witness. The intention was that she should make her own decision when she was old enough to do so. When T. was 17 or 18 years of age, she moved from her mother’s home to live with her paternal grandmother. A year later she met and began to live with the father of the baby with which she was pregnant during the relevant time. During this period, T.'s close relationship with her father was revived. According to her father, they had discussed the beliefs of the Jehovah’s Witness faith and she informed him that she was not a Jehovah’s Witness.

When T. was 34 weeks pregnant she was involved in an automobile accident and admitted to hospital. Although the situation did not appear to be improving, the family and T. were told that there was little need for concern and that she would likely not require a blood

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98 *Winters v. Miller*, 446 F.2d 65 (2nd Cir. 1971) and *In re Boyd*, 403 A.2d 744 (D.C. Ct. App. 1979)


101 *Supra* note 5.
transfusion. On her fourth day in hospital, in the afternoon, Mrs. T. spent considerable time alone with T. What passed between them is not known but soon thereafter T. told her nurse that she would not accept a blood transfusion. She was offered, and signed, a release in respect of her refusal of blood. She said that she had been a Jehovah’s Witness, and still maintained some beliefs. That evening, T. went into labour and because of complications, the physicians determined that the delivery should be undertaken by caesarian section. When advised that it may be necessary that she be transfused, T. again told the midwife that she did not want a blood transfusion. The judge later found that it had not been explained to T. that it may be necessary to give blood to prevent injury to health or life, and that the release form was not read to her or its contents explained to her. The caesarian section was performed in the early hours of the following morning, but the baby was stillborn. The situation was such that, if not for the refusal, the anaesthetist would unquestionably have administered blood.

T. was then put on a ventilator and paralyzing drugs were administered. She remained sedated and in a critical condition throughout the following day. She continued to be in some danger and T.’s father and common-law husband sought a court declaration that it would not be unlawful for the hospital to administer blood to her. A hearing was held on an expedited basis and Ward, J. made the order requested. The case came before the same judge two days later for a fuller hearing. At that hearing, it was found that T. was mentally competent, but that she had reached her decision with respect to blood transfusion under the influence of her mother, although such influence was not found to be undue in the usual legal sense. Ward, J. concluded however that T.’s convictions with respect to the Jehovah’s Witness faith were not so deep seated or fundamental as to constitute hers an immutable decision as to her way of life. Further, at the time she refused blood, T. did not fully appreciate the risks entailed by foregoing blood. She had been advised that she need not be concerned and that it was unlikely that blood would be required.

The matter was brought to the Court of Appeal on the same question, that is, whether it would be lawful for the hospital to administer blood to T. On that narrow issue, the court upheld the decision of the trial judge. However, the court sought to give further guidance to physicians and hospitals in respect of the type of situations presented in the Re T. case. Lord
Donaldson of Lymington, M.R., framed the dilemma in the following way:

Where the problem arises is in the comparatively rare situation in which an adult patient declines to consent to treatment which in the clinical judgment of those attending him is necessary if irreparable damage is not to be done to his health or, in some cases, if his life is to be saved. It is only in that context that this appeal may afford guidance to the hospitals and doctors. 102

He framed the "conflict of principle" as follows:

This situation gives rise to a conflict between two interests, that of the patient and that of the society in which he lives. The patient's interest consists of his right to self-determination - his right to live his own life how he wished, even if it will damage his health or lead to his premature death. Society's interest is in upholding the concept that all human life is sacred and that it should be preserved if at all possible. It is well established that the ultimate right of the individual is paramount. But this merely shifts the problem where the conflict occurs and calls for a very careful examination of whether, and if so the way in which, the individual is exercising that right. In case of doubt, that doubt falls to be resolved in favour of the preservation of life for if the individual is to override the public interest, he must do so in clear terms. 103

In terms relevant to this thesis, that conflict is between the individual right to refuse life-sustaining treatment and society's interest in preserving life. Even when the patient is competent to make decisions about medical care, there often arises a special problem if the patient has been subjected to some influence depriving him or her of the ability to make a meaningful decision. In such case, the physicians are obliged to determine whether the choice is really that of the patient. He points out that the strength of the will of the patient may be very much diminished in one who is tired, in pain, or depressed. Such a person will be less able to resist having their will overborne than one who is rested, free from pain, and cheerful. Further, the relationship of the "persuader" to the patient may be of crucial importance. In this case, the mother's influence came at a time when T. was under the debilitating psychological and physical effects of her medical condition, and was exercised by a parent.

As noted, it may also be unclear just what follows from the decision. If there is some uncertainty, physicians will be called upon to attempt to determine whether the decision

102 Supra note 5 at 661.

103 Ibid.
reached was intended to apply to the particular situation. In addition, if a patient is inadequately informed or is misinformed with respect to relevant aspects of treatment, or if there exists some misunderstanding about the risks involved, such failing may result in an invalid consent or refusal. In Re T., since there was found to be no “true” refusal of blood transfusion, and of course no consent, the matter was treated as an emergency. Blood was therefore administered since medically indicated. At the close of the opinion, Lord Justice Staughton sums up his decision as follows:

In the present case I agree with [the other Lord Justices sitting on the Appeal Court case] ... that there was no valid refusal of consent, and that the doctors were justified in their treatment of Ms. T. by the principle of necessity.104 (italics added)

On its face, this case is simply about what happens in England when choice with respect to a particular medical decision is absent. Seen in this light, it describes in a relatively non-controversial way the emergency exception to the requirement of consent, which is brought within the ambit of the principle of necessity. On a closer reading, however, it is proposed that there is more that may be taken from this case than that relatively straightforward principle of law. Two very important practical observations are made by the court, both of which were relevant to the outcome of the case. First, whether a medical decision is a true one depends importantly on the patient’s state of mind. The court considers T.’s pain, uncertainty and vulnerability at the time of her refusal of blood. Second, it matters that she could have died. It is not too strong to conclude that where life is at stake, the public interest in preserving life creates a presumption of treatment. Unless the patient exercises the right to refuse life-sustaining treatment, as a “true” choice, in clear terms, then the doubt falls to be resolved in favour of life.

The English Court of Appeal, in Re W.105 approved the involuntary treatment of a competent 16 year old girl for symptoms of anorexia nervosa. Admittedly, the English law in this area is somewhat different than Canadian or U.S. law, giving the mature minor the

104 Ibid. at 670.

right to consent to treatment, but not to refuse, where the court determines that treatment is in the minor's best interests. Nevertheless, the English courts in Re T. and Re W. are clearly struggling with a conflict between the self-determination of competent patients and the choices they have made which are, in the courts' view, disastrously contrary to their interests. In the Re W. case, it was fortunate that the woman in question was under the age of 18, such that a particular aspect of English law could be used to allow the "right" decision to be made. In Re T., the court strained to find that T.'s decision, although competent, apparently reasonably well informed and not the object of undue influence, was nevertheless not a "real" decision and therefore the medically much safer course could be endorsed. In both cases, the conflict is real and important, and it is suggested that the decisions were correct.

However, the decisions were correct for the wrong reason. The law should permit physicians to administer blood to a woman in T.'s circumstances, or to employ strongly coercive measures to oblige W. to accept treatment precisely on the basis of a balance struck between the conflicting duties which have arisen in the circumstances. The conflict is between honouring a competent refusal of treatment and protecting the patient from the potentially lethal consequences of that choice. If, faced with such hard choices, physicians decide in good faith, and within particular parameters to be taken up later, that they have a duty to treat to preserve life, then that choice should be protected.

The law is nevertheless very widely understood to be otherwise. It is otherwise because of the apparently absolute authority which a competent person has over medical treatment decisions, at least when the interests of no other person are substantially harmed. Clearly it is right and appropriate that competent, self-determination be presumed, and respected most of the time. The three chapters which follow lay the foundation for the proposal that the autonomous value of self-determination should not however always rule. Rather, sometimes the patient's even competent preferences should be overridden for the sake of his or her own good.
6. A CHARACTERIZATION OF PATIENT AUTONOMY

Overview

The common law defence of necessity then, as an answer to a civil suit for battery or criminal charge of assault in a case of intervention with a decision to die, holds some promise. The most substantial impediment to its application is that the person sought to be saved from death does not apparently see death as a harm, and in any event has either refused such assistance, or might reasonably be expected to do so. Even in the right circumstances, how can necessity be invoked to permit a medical practitioner to save a person who denies the necessity - who sees the unlawful intervention as offering no benefit?

It might be that necessity is justified by a favourable balance of benefits and harms, that interfering to save the suicide's life creates benefits or avoids harms which outweigh the lesser harm caused by such interference. Even so, why should the judgment of the medical practitioner as to this balancing be preferred to that of the person him or herself? The subject of the intervention has made the decision to die and therefore has presumably concluded that life is not worth having and that the benefits of carrying on are overcome by its drawbacks. Further, it is that person who must live with the consequences of unrequested interference. Even granting that the suicide might be mistaken in assessing the prospects for a satisfactory future life, who is better positioned to make that assessment? If the suicide may be making a mistake, is he or she not less likely to be doing so than anyone else? And if so, should a decision about the balance of utilities not be left within the (albeit imperfect) judgment of the one most directly affected?

Much U.S. jurisprudence has characterized the defence as arising from the unavoidable necessity to make a "choice of evils" between, first, tortious interference with the privacy and self-determination of another and second, allowing another to die. How can it be necessary to interfere, thereby committing a battery, when the person interfered with does not view death as an evil? On what basis is allowing a person to take their own life counted an evil when it
is chosen by the person for him or herself?

Finally, if necessity is based upon the need to choose between conflicting, legally recognized duties, how can a medical practitioner appeal to a duty to intervene to protect life when the owner of that life rejects intervention? How can a duty to interfere arise, which the beneficiary of the duty rejects? And what of the autonomy rights of the person contemplating suicide? Even if there is a balance of good created by intervention, does not the right of self-determination override the balance of harms or conflicting duties? After all, no other person is being harmed, or in any event, harmed sufficiently as to justify interference on that basis alone.

The problem is clear enough. The prospective suicide has taken a decision for and about him or herself. To interfere is to usurp the decision-making authority of another. The interest in exercising autonomy, or self-determination in one's own decision-making, is deeply felt. At least as adults, we feel that we have a right to decide for ourselves. It seems an affront to our dignity to take away the opportunity to map out and govern our own lives, in accordance with the goals and values which we accept. If this is so, how much more so when the decision involves the very continuation of our life.

While the value of autonomy and self-determination are not seriously doubted, the concern is to determine the limits of autonomy in the context of interference with a particular kind of decision - that to end one's own life. The intuitive moral objection, reinforced by strong judicial opinion, is that such interference violates the autonomy of the individual. The common law speaks warmly of the right "...to be let alone - the most prehensive of rights and the right most valued by civilized man." As a constitutional matter, courts in Canada have placed a high value on the Charter right of security of the person. In the U.S., similar protection is found in the constitutional rights of privacy and liberty.

1 Olmstead v. United States, 277 U.S. 438 (1928) at 478 (per Brandeis, J.)


3 Found in the 5th and 14th Amendments.
The law regulates, by both civil and criminal means, autonomous decision-making in a great many ways. However, such legal regulation typically is in issue only when another is being harmed by individual choices or where otherwise legitimate choices among or between persons conflict. The present discussion addresses cases where the interests of the person seeking death are acknowledged to be paramount. Interference is proposed out of concern only for the person him or herself, and not by virtue of harm to, or the competing claims of, any other person.

Of course, the interests of others are commonly touched by an individual decision to die. Family members, friends, health care providers and others may be profoundly affected. For these purposes however, it is assumed that, in making a decision to die, it is the interests of the person him or herself which are most important and that only in extraordinary cases would the interests or claims of others be sufficiently great as to be relevant to the ultimate decision whether interference is justified. Anyway, as Narveson points out, leaving aside particular fiduciary duties, we are not generally thought to owe any person, or society generally, all of the good things which it is possible for us to offer. Accordingly, others have no general right to insist that we stay alive to contribute to society. In any event, the point of this assumption is to focus consideration on the nature and value of autonomous decision-making and possible justifications for interference.

In order to understand the circumstances under which autonomous decision-making may be overridden, it is necessary first to survey the notion of autonomy. This is because autonomy provides the fundamental objection to intervention in any treatment decision, including life-ending decisions. Therefore, it raises the most troubling difficulty about applying the defence of necessity in such circumstances.

What is Autonomy?

Many commentators have noted the difficulties inherent in framing a comprehensive

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characterization of the notion of personal autonomy. Dworkin suggests it is unlikely that there is a core meaning which underlies all of the various uses of the term. He sees "autonomy" as a term of art, introduced to attempt to make sense of a tangled net of intuitions, conceptual and empirical issues and normative claims. Accepting these difficulties, and acknowledging that the notion can have subtly or profoundly different references to different people and in different contexts, no all-encompassing conception of autonomy will be attempted. Rather, the conception and justification of autonomy will be considered primarily in the medical context. Certainly, even so restricted, ambiguities in the conception of autonomy will be found. However, a more focused examination of the concept should make for a more manageable project with a greater likelihood of yielding helpful analysis.

**Autonomy and Liberal Theory**

Notions of autonomy may be seen as fundamental to post-Enlightenment ideals of liberalism. Much is written about liberalism and indeed the topic has enjoyed something of a rebirth in recent times. Nevertheless, it is difficult to locate a clear statement of just what liberalism is, or what liberal theory entails. Michael Sandel, no friend of liberalism, describes its "core thesis" as follows:

> [S]ociety, being composed of a plurality of persons, each with its own aims, interests and conceptions of the good, is best arranged when it is governed by principles that do not themselves presuppose any particular conception of the good; what justifies these regulative principles above all is not that they maximize the social welfare or otherwise promote the good, but rather that they conform to the concept of right, a moral category given prior to the good and independent of it.

John Gray isolates four elements to the liberal tradition: Liberal theory is:

...*individualist*, in that it asserts the moral primacy of the person against the

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claims of any social collectivity; egalitarian, inasmuch as it confers on all men the same moral status and denies the relevance to legal and political order of differences in moral worth among human beings; universalist, affirming the moral unity of the human species and according a secondary importance to specific historic associations and cultural forms; and meliorist, in its affirmation of the corrigibility and improveability of all social institutions and political arrangements.  

Liberalism is seen as a theory of right, not a theory of the good. It emphasizes the importance of the individual and rejects a political philosophy that society's role is to determine what is good for people, and provide it to them. Rather, the role of society is to facilitate each individual in his or her pursuit of their own good, individually conceived. One chooses the best for oneself, and it is the role of law to foster such self-rule to the extent that the autonomy of others is not hindered.  

The pluralism implied by liberal theory extends also to requiring tolerance of others pursuing their own good. Therefore, an important aspect of liberal theory is its presumption against interference. The ends and goals that people pursue are, in an objective sense, fundamentally value neutral. Or rather, they are valuable for an individual by virtue simply of the individual having them. S.I. Benn characterizes the classic liberal man as the "self-governing chooser."  

Liberal theory requires respect, both for the individual as such and for the individual's distinct goals, values and ambitions. This is not to say that liberal theory is inconsistent with showing compassion or doing good for another. It is to say simply that an important element of liberalism is to respect peoples' right, within constraints having to do with the rights of others, to do as they please. A political and moral structure based on respect for the individual, and which is tolerant of individual differences, is most likely to yield a stable and

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8 J. Gray, Liberalism (Minneapolis: University of Minnesota Press, 1986) at x.


relatively peaceful society. S.I. Benn suggests that the principle of non-interference constitutes a type of normative judgment, placing the onus on one who proposes to interfere with another, to provide reasons justifying such interference. Without the acceptance of the principle of non-interference, each would act without restriction in their own perceived interests and life would be a series of prisoners' dilemmas. The respect we claim for our own natural personality commits us to extending that respect to others.

A classic liberal defence of freedom of action, within a personal sphere, is found in J.S. Mill, in particular his *On Liberty*. It is perhaps surprising that a utilitarian moral theorist such as Mill should argue so firmly for the rights of the individual:

> The object of this essay is to assert one very simple principle... That principle is that the sole ends for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number is self protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so [or] because it will make him happier, because, in the opinions of others, to do so would be wise or even right.

What is referred to here as "autonomy" is a notion closely related to what Mill referred to as "individuality:"

> The liberty of the individual must be thus far limited; he must not make himself a nuisance to other people. But if he refrain from molesting others in what concerns them, and merely acts according to his own inclination and judgment in things which concern himself, the same reasons which show that opinion should be free prove also that he should be allowed, without molestation, to carry his opinions into practice at his own cost.

Although it is problematic to characterize Kant as a straightforwardly liberal thinker.

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12 S.I. Benn, "Freedom, Autonomy and the Concept of a Person" (1975-76) 76 Proceedings of the Aristotelian Society 109-30 at 120.


14 *Ibid.* at 68.
his view of autonomy contrasts interestingly with that of Mill.\textsuperscript{15} For Kant, autonomy is a property possessed by all minimally rational persons, an unconditional requirement of reason. Moral obligation is grounded in the fact that the human will has autonomy, which implies a commitment to certain rational constraints. Acceptance of the importance of the autonomy of the individual leads rationally to the acceptance of the supreme moral law, the categorical imperative, and as such is imposed not from without but from within oneself, necessarily so as a requirement of reason. Liberalism, as a theory about right conduct, gets its clearest expression in Kant in his statement of moral obligation, that is, others are to be treated as ends in themselves, and not as means to the ends of another.\textsuperscript{16} This obligation arises from an acknowledgement of the autonomy which all possess, necessarily, by virtue of possessing a rational will.

In the literature of medical ethics, this liberal view is developed by Engelhardt, in his *The Foundations of Bioethics*, particularly in its first edition. For him, autonomy is not simply equated with the value of freedom, it is rather respect for freedom, the necessary condition for the possibility of mutual respect, which is in turn the necessary condition for morality. Accordingly, he argues that the fundamental moral limit of action is to avoid force to which the innocent have not consented. Such fundamental moral limit grounds a doctrine of respect for autonomy and allows us to live in a tolerably peaceful, secure, pluralistic society.\textsuperscript{17}

**Psychological vs. Normative Autonomy**

In characterizing the notion of autonomy, the following distinction is crucial: Autonomy may be seen either as a certain kind of capacity to make decisions (psychological autonomy); or as the entitlement to decision-making authority, free from the interference of others (normative autonomy). The *ability* to make decisions autonomously is distinct from the


authority to make decisions for oneself, free from interference. These two senses of "autonomy" are commonly conflated. This may be because it is assumed that the presence of psychological autonomy (the ability to decide in a particular way, which we describe as "autonomously") gives one, in general, the right to make such decisions without interference (gives one "autonomy"). Of course, to deduce that one should be allowed to decide for oneself, from the premise that one is able to decide for oneself in a specified way, commits a kind of naturalistic fallacy. Nevertheless, although the presence of autonomous decision-making capacity does not strictly imply decision-making authority, it seems at least intuitively clear that the connection is strong. Conversely, the absence of autonomous capacity does not logically imply a lack of decision-making authority. But again, the two seem closely related. In any event, such relation must be justified on the basis of public policy or moral theory.

The connection between the ability to decide and the right to decide is addressed in Chapter 7. In assessing the autonomy claim of one seeking death, the distinction drawn is clear enough. In assessing whether interference with such a decision is justified (contrary to a normative claim for autonomy as non-interference), appeal is typically made to the person's ability or capacity to make that decision in an autonomous way (psychological autonomy). To the extent that psychological autonomy is absent, or diminished, the claim for authority to decide for oneself is likewise diminished and the normative justification for interference is stronger. In light of this important connection between psychological and normative autonomy, it should also be clear that the way psychological autonomy is characterized will impact profoundly on the normative claim of freedom from interference. This chapter focuses on the requirements for psychological autonomy - the capacity to make decisions in a particular sort of way. It turns out this particular way is difficult to characterize, and has a variety of dimensions.

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Requirements for Psychological Autonomy

While no satisfactorily comprehensive characterization of the requirements for psychological autonomy have yet been developed, certain important themes emerge in its analysis. It will become clear that autonomy, even psychological autonomy, is a richly ambiguous notion. First: a distinction is drawn between an autonomous person, or an autonomous life viewed as a whole, and a sense of autonomy which describes a particular act or choice as autonomous. While it may seem initially that in examining a particular act or choice as autonomous, it has been suggested rather that a meaningful assessment of the autonomy of a particular choice is shallow if abstracted from the context of the individual's life viewed as a whole. Robert Young argues that what he calls this "occurent" sense of autonomy cannot itself capture what an autonomous choice would be like for any particular individual. 20

There is much to be said for the view that in examining autonomy, the appropriate focus is the individual choice rather than the individual agent in some global sense. For a particular person, the degree of autonomy required or present in making one choice at a given time, in given circumstances, may be quite different than that required or present in the making of another. For this reason, whether a choice is autonomous or not, or even whether the person is autonomous to a particular degree with respect to a particular choice, may depend importantly on the surrounding circumstances.

At the same time, looking at individual choices in isolation from the larger context of a person's life also seems inadequate. Certainly the autonomy of a particular choice cannot be assessed except in light of a more comprehensive understanding of the person's values and history. No resolution of this apparent tension is offered, and it may be that none is possible. However, the ambiguity is troubling and the potential conflict between a judgment about the global autonomy of a person, and that concerning the autonomy of a particular choice is one which will be become relevant later.

Intentional, Voluntary and Informed: Whether occurrent or global, there is some

agreement about certain required aspects of psychological autonomy. Its core is found in a
certain kind of ability or capacity to be self-governing. The minimal conditions of
autonomous choice that it must be intentional, voluntary and adequately well-informed are
relatively uncontroversial. There is little doubt that autonomous choice must be in some
sense intentional. Faden and Beauchamp see intentional action as action "willed in accordance
with a plan," that is, action which is not accidental. While there is some divergence of
opinion as to whether one intends to do that which is an unwanted, though foreseen
consequence of one's act, it seems clear enough that acts which are the result of autonomous
choice must be those which we intend or mean to do. Further, while choices may be more
or less voluntary, choices which are the result of manipulation, coercion or threats cannot
sensibly be seen as autonomous. Dworkin conceives this condition as one of "procedural
independence," autonomous choice is not unduly influenced by forces which subvert the
reflective and critical faculties employed in choosing. That is, the decision is not manipulated
or coerced. Further, while choice will never be perfectly informed or made with perfect
understanding, choice which is inadequately informed, or substantially based on
misinformation cannot qualify as autonomous. At least with respect generally to these
conditions, there is little debate in the literature.

Authenticity: However, the characterization of autonomous choice as intentional,
voluntary and adequately well-informed fails to take account of certain other qualities of
autonomous choice which also seem to be essential. Among these is the sense in which an
autonomous choice is one which is reflective of the individuality or identity of the actor. The
idea that autonomous choice is, in a significant sense, one's own has proven difficult to define.
However, a description of the personal or individual element of autonomous choice has been
conceived in a number of plausible ways under the general requirement that autonomous

21 For example, T.L. Beauchamp and J.F. Childress, Principles of Biomedical Ethics, 4th ed. (New York: Oxford
University Press, 1994) at 123ff.


choice must be "authentic."

Central to autonomous choice is that it be personal to oneself, that choice be one's own. The notion of authenticity seeks to give expression to this intuition by requiring that autonomous choice reflect or be expressive of one's own values, goals, history and individual ends and preferences. Checkland and Silberfeld see authentic decisions fundamentally as an expression of who one really is, of an enduring character.24 Dworkin initially characterized autonomy as authenticity plus independence.25

Dworkin's account of authenticity as a condition for autonomy has drawn substantial critical comment. For Dworkin, authenticity is found in either the congruence between first- and second-order desires (his earlier view)26 or in the capacity to question the congruence between first- and second-order desires (his more recent view).27 First-order desires are the straightforward desires and preferences which we have in fact, and feel on a basic level. Second-order preferences are preferences about first-order desires. That is, a person may very strongly desire to smoke a cigarette (a first-order desire) but at the same time wish to stop smoking and so wishes that he did not have the desire to smoke (a second-order desire). Roughly speaking, if one's first order desires are consistent with one's second order preferences, the first order desire is authentic. So, the desire to smoke in the above example would not be authentic. A variant of this view holds that if one can assess, or identify with, one's first-order desires in light of one's second-order desires, then the choice which results is authentic. The idea of identification with second-order preferences may also be seen as reflecting a long-term identification with oneself over time. That is, second-order preferences reflect both the history and development of goals and values as well as one's wishes, plans and

24 Checkland and Silberfeld, "Competence and the Three A's" supra note 18.


26 Ibid.

expectations about the future.28

At the same time, authenticity entails certain positive things about the process of decision formation. Richard Double analyzes the autonomy of choice in terms of its conformity with one's own "independent management style" - the way one makes choices and lives life. Choice is autonomous if it both conforms with and is caused by one's independent management style.29 Others have suggested that choice is authentic when one identifies with, or adopts as one's own, the choice that is made. This is a view which is strongly related to the first- and second-order preferences conception of authenticity. A central aspect of an autonomous person lies in the set of standards, the beliefs, preferences and values by which he or she lives.30 Presumably one's values, history and individual goals determine the second-order (or higher order) preferences, on the basis of which first-order preferences are evaluated. It is perhaps also in this process that one creates oneself, by reviewing and shaping one's preferences, self-creation being an important liberal autonomous value.31

However authenticity is conceived, it is compelling that choice, to be autonomous, must be in some sense authentic to one's broader values and history, that it be personal to the individual. However, the requirement of authenticity in autonomous choice has been challenged on several fronts. First, it is suggested that very few people would be able to identify, in a satisfactory way, their fundamental goals and values, in order to test their congruence with presently occurring choices. A conception of one's authentic self is typically quite vague. If deliberation and reflection about our core values is necessary then very few of our day-to-day decisions would qualify as autonomous. Worse, we may rarely know whether a particular decision is autonomous, since we can never be sure that it is consistent with our elusive values. If so, authenticity is too onerous a condition which would render too


30 Benn, "Freedom," supra note 12.

many choices non-autonomous.\(^\text{32}\)

Second, the requirement of authenticity appears to rule out, as autonomous, decisions which are precocious or experimental to the individual. Why is a choice which is "out of character" not autonomous? If eccentric or experimental choices conflict with deeply held values, and if the consequences of such choices are great, our response may be that such choices are not autonomous or, in any event, that they should not be respected.\(^\text{33}\)

Third, persons are constantly developing and changing. Accordingly, it seems fair to say that our authentic self evolves. In requiring that authenticity be present for autonomy, we run the risk that a decision of the evolving or developing self will not be respected as autonomous. A person facing a life-ending decision may, because of changes and stresses in his or her own life, be subject to quite radical changes in outlook, goals and values. The life changes brought about by the illness, trauma or disability which often accompany a decision to die, may radically affect one's authentic self. Accordingly, if the authenticity of decision-making is judged against that person's values prior to a drastic re-orientation of his or her life, the truly and presently authentic ends of such a person may fail to be considered.\(^\text{34}\)

As to this last objection, in principle, there is no difficulty. If one's authentic self has in fact changed, and fundamental goals and values have been realigned, then surely it is the presently existing goals and values which determine the authenticity of a particular decision and against which the autonomy of choice may be tested. Checkland and Silberfeld suggest that, "[w]e change, all right. But change is measured and identified against much that endures." Although people may change, the authentic self is the baseline from which one changes.\(^\text{35}\) However, in practice, it may be difficult to differentiate between genuinely developing values and goals and those which are inauthentic because skewed by the effects of

\(^{32}\) Faden and Beauchamp, *A History and Theory of Informed Consent*, supra note 22 at 262-266.

\(^{33}\) D. Checkland and M. Silberfeld, "Mental Competence and the Question of Beneficent Intervention" (1996) 17(2) *Theoretical Medicine* 121-134.


\(^{35}\) Checkland and Silberfeld, "Competence and the Three A's," *supra* note 18 at 464.
crisis, trauma or depressive illness. In this light, the objection may be seen as a significant practical difficulty.

In ordinary discourse about everyday matters, little turns on whether autonomy, as a psychological notion, requires authentic choice. However, when the discussion turns to a normative justification for autonomy seen as freedom from interference in medical decision-making, the presence or absence of authenticity plays a vital role. This is because if the moral imperative of autonomous choice requires such individuality or authenticity, the moral imperative of respect for autonomy (as non-interference) depends at least to some extent on the presence of such authenticity in choice. If authenticity is absent, then the case for non-interference is weakened. If one's choices are not, in some significant sense, one's own, then it is difficult to see why they are strongly presumed to be worthy of respect. If they are not individual and personal to the agent, then the high value associated with autonomy may be misplaced.

**Critical Reflection:** Aside from the authenticity of autonomous choice, it is proposed that some element of consideration or deliberation is also important. Autonomous choice must be, at least to some extent, a considered choice. Consideration or reflection supplies the nexus between the individual's history, goals, aims and values on one hand, and the choice itself on the other. For Benn, the interplay between authenticity and critical reflection is key. A central aspect of an autonomous person lies in the set of standards by which he or she lives. However, one's beliefs, preferences and choices do not belong to oneself accidentally, but as a result of a continuing process of criticism and re-evaluation. An autonomous person has the capacity for deliberation to discover and test principles and values in light of new reasons and circumstances.36

It may be however that a condition of critical reflection is overly stringent. The word "reflection" may be deceptive in that very often plans or values become translated into action by force of habit or instinct or, in any event, with very little conscious consideration. It may be, for example, that a person will, perhaps unconsciously, decide how a particular type of

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situation is to be handled and thereafter not revisit those decisions already made. In our lives the vast majority of decisions are simply not the product of deliberation and reflection about personal goals and values. Checkland and Silberfeld warn against requiring that a decision be specifically reflected upon in order to be considered autonomous. They identify both a strong and a weak sense of autonomy. The weak sense entails only that the agent claims ownership of a particular decision. The stronger conception requires that a choice be in conformity with some rational plan, order or more or less coherent set of values. Decisions arising from this strong sense of psychological autonomy, which require reflectively considered decisions, would be rare, presumably since we rarely reflect carefully on our choices. Things are just done and choices are just made without the soul-searching that appears to be implied by a requirement of critical reflection. If such reflection is required to justify non-interference with a particular decision, then there would be a great deal more intervention in people's lives than is generally accepted.

Dworkin too recognizes that the identification of first- and second-order preferences is not typically a conscious, fully articulated or explicit process. Less educated or reflective individuals can still act autonomously. This is why, for him, what is important is the capacity of the individual to change their first order desires, to make them effective in action as a result of reflecting upon them.

But, if the hard sense of autonomy is too exacting, the weak sense (a mere claim of ownership of the choice) seems generally insufficient. It is counter-intuitive to suppose that choice may be autonomous even if made blindly, or in an unconsidered way. Decisions can be made in accordance with one's authentic goals and history even if deliberation and reflection about those goals does not take place or the subject is not able to identify such goals in a reasonably comprehensive way. Indeed, decisions which we make out of habit or otherwise without much thought usually are made in accordance with what is important to us. In any event, at least according to Benn, an autonomous person need not make a conscious...


38 Dworkin, Theory and Practice, supra note 6, ch. 1.
decision prior to every choice. What is important is that a decision will be more or less coherent with a set of principles having some sort of internalized, but not necessarily articulated existence, and be open to critical assessment.39

While it may seem that most of our decisions are made without reflection or consideration, it would be counter-intuitive to suppose that particularly important decisions could be autonomous if taken without consideration of whether the choice and its consequences reflect one’s ends or preferences. Certainly a decision to end one’s life could not reasonably be seen as autonomous if not carefully reflected upon. In the absence of critical reflection, the psychological autonomy of a decision is compromised, and with it the moral force of claims to non-interference.

**Rationality:** A requirement of at least some degree of rationality or logical coherence seems also to be a part of our notion of autonomy. It is sensible to suppose also that, in order to be autonomous, a choice itself must be to some extent rational. Not only must one reflect upon choices, but one must be rational in doing so. Christie and Hoffmaster assume that it is a condition of autonomous choice that such choice be rational.40 By extension, a rule against non-interference will be much less persuasive if the decision interfered with is irrational in some significant sense.41 Christman agrees that it would be counter-intuitive to urge that an utterly non-rational decision is autonomous.42

This notion is expressed in a number of ways. For Bruce Miller, attaching non-rational weight to some or all of one's risks or preferences compromises autonomy.43 For Stephen Wear, it is necessary that one have the ability to appropriately evaluate the information

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40 Christie and Hoffmaster, “Patient Autonomy,” supra note 19.


42 Christman, “Introduction,” supra note 5.

relevant to decision-making, that is, not have a skewed conception of causation. Double views the quality of logical reflection as essential to autonomous choice. Dworkin agrees, and sees procedural independence, which is the capacity to employ the reflective or critical faculty in choosing, as a condition of autonomy. For him, logical consistency is a natural requirement for a satisfactory theory of autonomy.

In addition, as a normative matter, the absence of rationality seems to supply a good reason to override choice. Dworkin argues that paternalistic interference is justified where a person lacks the emotional and cognitive capacities required to make fully rational decisions. On its face, this is not particularly controversial. After all, it is primarily out of a concern for their ability to make rational decisions that we interfere with the decision-making of children and the mentally disordered, at least about serious matters. And, to the extent that children or the mentally disordered become increasingly capable of making rational choices on their own, we are less inclined to interfere.

However, there is a tension between autonomy and rationality which is missed by this analysis. The tension may be exposed by examining the nature of rationality in this context. How is the notion to be conceived? Rationality may be a purely instrumental notion. That is, what is rational is that which will most effectively promote the ends of the individual, whatever they may be. For example, Benn argues that autonomy requires a minimal rationality, some ability to effectively connect resources with goals. On this view, it does not matter what these goals are. Ends or goals themselves are neither rational nor irrational, it is the means chosen to satisfy such ends that may be rational or not. This conception of

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45 Double, "Two Types," supra note 29.
46 Dworkin, Theory and Practice of Autonomy, supra note 6, ch. 1.
49 Benn, "Freedom," supra note 12 at 110-112.
rationality fits well with classical liberal theory which emphasizes an individual conception of the good. Social or communal structures have no place determining or imposing a view of the good on any of its individual members. Society's role rather is to facilitate, equally for all of its members, the individual pursuit of the good, as each individual conceives it. Means which further such pursuit are rational inasmuch as they are effective in bringing about the good sought. On one level, these notions of rationality and liberal theory tie in nicely with a common-sense view of autonomy. Valuing autonomy implies valuing the particular personality and choices of the individual. Autonomy gives expression to respect for authentic choices made by individuals, that is, choices made in accordance with their own values, goals and history.

A notion of rationality which simply approves those actions which give effect to individual ends may seem simplistic. A more sophisticated view of rationality acknowledges that in fact people have goals and ends both of which exist on various levels of abstraction and which come into conflict with one another. First, it is recognized that a goal of getting a cup of coffee is, in some sense, on a different level than a goal to stay awake over the next few hours which is in turn found on a different level than completing a particular project, getting a raise in pay or wishing for world peace. Second, the agent's various goals may also conflict both because we have logically inconsistent goals and because of a scarcity of time or resources. Therefore, we must pick and choose among our goals. Third, whether we will be able to satisfy particular goals is very often a matter of probability. That is, satisfaction is rarely a sure thing and the attainment of some goals is more likely than that of others. Accordingly this notion of economic rationality acknowledges that we must prioritize goals and abandon some because they will frustrate the attainment of others. We must make decisions about the amount of resources we will expend in satisfying some goals given their importance to us and the likelihood of their being attained. This conceives rationality as a more complex matter.\footnote{L. Haworth, \textit{Autonomy: An Essay in Philosophical Psychology and Ethics} (New Haven: Yale University Press, 1986) ch 2.}
However, this more refined analysis still gives no account of how our goals are validated. Presumably again one must be as valid as any other. More important, this account gives no sense of how the process or prioritizing and selecting of goals is rationally achieved. Accordingly, economic rationality is also fundamentally an instrumentalist view.

It may be that certain ends are rational even apart from their being accepted by the individual. But, how could an end or goal itself be rational? Culver and Gert suggest that acting in the knowledge that certain types of outcomes, such as death, pain or loss of liberty, will likely arise is irrational unless some acceptable justifying reason can be offered. That some person(s) will be benefitted by the act, or harmed by the failure to take the chosen course, are factors which would count as valid reasons. Reasons are adequate to render an act rational if they would be adequate to a significant group of competent people. Others suggest that it is rational to pursue those goals which give expression to man's "true" nature, for example, the development of intellectual or self-creative capacities and the improvement, by exercise of reason, of man's self-transforming nature.

There is an additional difficulty about a rationality condition for autonomy. That is, a requirement of rationality seems to deny the significance of emotion or sentiment in forming decisions which count as autonomous. It need hardly be pointed out however that emotional or affective factors form an important, perhaps essential, part in human decision-making. Indeed, choices relying solely on reason, made in the absence of emotional considerations would seem decidedly inhuman. It must be then that autonomy cannot require a purely autonomous decision.

This concern may be answered by requiring only that autonomous choice be made by one who has the capacity for rational thought and deliberation, even if such capacity is not fully exercised in the particular situation. This move might be helpful, but it does have drawbacks. First, it focuses the judgment as to autonomy on the person and not on the

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51 Culver and Gert, "The Inadequacy of Incompetence," supra note 47.

individual decision. This recreates the difficulties, raised earlier, between conceiving autonomy as a global judgment about the individual, or as a property of choices - the so-called "occurrent" sense of autonomy. Second, it allows that a wildly irrational decision is autonomous, if made by a person capable of exercising reason. If an important aspect of the purpose of assessing autonomy is to help determine which choices ought to be honoured, the irrational choice of a rationally capable person poses problems, particularly if the choice carries serious or grave consequences. If death is the predicted result of such an irrational, but autonomous choice (autonomous since the person is capable of exercising rational thought, although he or she did not do so in this case) the autonomous character of the choice may not be sufficient to dictate non-interference. This consideration militates in favour of assessing the autonomy of individual choices, and not the global autonomy of persons, at least in this context.

**Independence:** There seems to be fair agreement that, under certain circumstances, autonomous choice is consistent with a strong acceptance of the guidance, leadership or direction of another. For example, an autonomous person may be strongly committed to some religion or cause, and follow the precepts or directions of its leadership faithfully. Double suggests that we may autonomously choose simply to accept the views of others or to emulate them uncritically. We may choose autonomously who we respect and whose views we are prepared to accept. For Double, the test is whether such choices correspond with one's individual management style.

While choice which is coerced or manipulated is not autonomous, it is not required that choice be uninfluenced, or the product only of one's own judgment. Autonomy is consistent with choosing to be influenced by, or even dedicated to a certain kind of life or set of beliefs.

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56 Double, "Two Types," supra note 29.
If one arrives freely and upon reflection at the decision to follow his mother's advice in all things, then he is doing what he wants and is living his life in accordance with a plan freely chosen by himself. He is autonomous. A person with a commitment to a cause or loyalty to a person may be less free than one who has no such ties. There is a sense in which the command of his will is, to this extent, external to him. But the devotional sentiment is his own - it is chosen by him.

Indeed, it seems that autonomy must be consistent with binding ourselves to promises or undertakings, or committing to act in certain ethical or professional ways. So long as the promise, commitment or obedience is consistent with the type of person the agent wishes to be, and is arrived at with procedural independence, resulting choices should be autonomous. This is just to say that autonomy need not be associated with a thorough-going individualism. However, since the autonomous person practices procedural independence, he or she will tend to be sceptical of authority and will question his own values and commitments. Presumably, he or she will seek to discover his "true" needs, which Dworkin describes as needs the genesis of which does not tend to undermine one's acceptance and identification with that need.57

The Will: Both Haworth and Frankfurt argue that autonomy requires more than rational, voluntary, informed and authentic decision-making. It requires also a will, the capacity to act in accordance with one's choices. It is not enough that one has second-order preferences against which first-order desires may be tested. One's second-order preferences must be effective - they must move one to action. For Frankfurt, to be autonomous, not only must one be able to desire or prefer a particular course of action, one must be moved to act toward the fulfilment of that course. One wills a choice when he or she is actually moved to bring the choice about.59

The notion of a will includes the capacity for self-control, or the ability to act in

57 Dworkin, Theory and Practice of Autonomy, supra note 6.


accordance with choices autonomously made, even when doing so involves overriding one's immediate desires and preferences.\textsuperscript{60} Related to the requirement of will, and to the requirement of rationality discussed earlier, is the view suggested by Benn, that autonomy requires that one be autarchic, that is, one must be a chooser. The notion of autarchy identifies a family of capacities, including: the ability to identify oneself as a single person corresponding over time; the capacity for making decisions, when confronted by options, in light of one's own preferences, and acting on them; and the capacity to formulate projects or policies. One must be able to make decisions at one time for the sake of a preferred state of affairs at a future time. In addition, being autarchic includes the capacity to recognize what qualifies as evidence and inferences warranting changes in beliefs, and to make appropriate changes to decisions and policies in light of such changes in beliefs. An autarchic person is not compelled by outside forces to choose, but chooses for reasons that he or she acknowledges to be relevant in making an appropriate choice.\textsuperscript{61}

**Autonomy and Freedom**

The notion of autonomy is closely related to notions of freedom and liberty. Nevertheless, acting freely and acting autonomously are distinct activities. For Christman, the two concepts are distinguishable on the following basis: autonomy is properly viewed as a property of *preference formation*. "Freedom, on the other hand, is a property of human *action* - a characteristic of the relation among desires, bodily movements, and restraints that may be facing the agents...\textsuperscript{62} Benn views freedom as the absence of constraints to objective and subjective conditions of choice. By contrast, autonomy requires such absence of constraints, but it requires also both a coherence among preferences and an autonomous process. The autonomous person, beyond freedom, seeks coherence in the set of values he

\textsuperscript{60} This notion is closely related to Kant's exercise of practical reason, see *Foundations of the Metaphysics of Morals*, trans. L.W. White (Upper Saddle River, N.J.: Prentice Hall, 1995) 1st Sec.

\textsuperscript{61} Benn, "Freedom, Autonomy," *supra* note 12 at 112-117.

\textsuperscript{62} Christman, "Introduction" *supra* note 5 at 13 (italics added).
or she has internalized, and which informs his or her acts and choices. In addition, the process of choosing is a rational one, involving reflection in the making of choices.\(^63\)

It may be that a full account of the notion of freedom will necessarily include an account of autonomy (seen as a process of preference formation of a particular kind). However, Dworkin points out that one can act autonomously in accepting restrictions on his or her own freedom. For example, in giving oneself over to a cause or a set of religious precepts, one may lose some freedom of action, or even of thought, but can remain autonomous.\(^64\) McMahon agrees that it is sensible, and does not violate autonomy, to give at least some authority over one's choices to another whose judgment is accepted to be superior to one's own, at least within the subject matter of the choice.\(^65\) For Dworkin, this is because autonomy is fundamentally a procedural, not a substantive notion.\(^66\) That is, there is no substantive content to the choices which an autonomous person will make. However, to qualify as autonomous, a person must make choices in a particular way. By agreeing to abide by the teachings or direction of another, we relinquish some freedom of action, but not autonomy, so long as the decision to become so directed is taken in a procedurally independent way.

People accept the authority of laws, choose to be loyal to particular persons, relationships and groups and ally themselves with particular causes. Again, while doing so restricts their freedom, it does not necessarily restrict their autonomy. If autonomy required complete freedom to make every decision afresh, without reference to prior commitments and important relationships, it is a poor excuse for a human or moral value. Such autonomy would be inconsistent with loyalty, commitment, benevolence and love. If autonomy requires that one never give up control of decision-making, then promising, obedience to command and conformity to law are all inconsistent with autonomy.

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\(^{63}\) Benn, "Freedom, Autonomy," supra note 12.

\(^{64}\) Dworkin, Theory and Practice, supra note 6, ch. 2. Also, Feinberg, Harm to Self, supra note 55.

\(^{65}\) McMahon, "Autonomy and Authority," supra note 55.

\(^{66}\) Dworkin, "Autonomy and Behavior Control," supra note 23.
Willard Gaylin sees the core of freedom and that of autonomy as similar and characterizes each in Kantian terms as being or reflecting an ability to act contrary to one's desires or instincts. Man has freedom in that he has the power to choose between right and wrong, to accept obligations and to obey or refuse to obey his compunctions and longings. Lawrence Haworth sees autonomy as logically prior to freedom. This is because freedom is of no value without the opportunity to genuinely make one's life one's own, and to be responsible for it. Bruce Miller analyzes autonomous action as requiring that such action be free, that is voluntary and intentional, but requiring more; namely authenticity, effective deliberation and possibly moral reflection. For Miller then freedom is a necessary component of autonomy. Robert Young agrees that autonomy simply as freedom from the governance of others is too restrictive a model. Freedom is part of the notion of autonomy but there is more. In his "occurrence" sense of autonomy, in order to be autonomous, one must act in a way which is expressive of one's own preferences and aspirations.

Autonomy and Justice

Closely related to its role in liberal theories, the notion of autonomy is also tied to that of justice. Lacking some notion that individuals have interests and claims which are in some sense their own, principles of distributive or retributive justice lose their foundation. For example, the existence of rationally autonomous agents is fundamental to Rawls' development of principles of justice. The essential equality among persons implied by a notion of normative autonomy lies at the core of, and gives meaning to, justice. The moral imperative of respect for others' autonomy is founded upon the principle of justice that like cases must


68 Haworth, Autonomy: An Essay, supra note 50, ch. 8, esp. at 145.


70 Young, "Autonomy and Socialization," supra note 20.

be treated alike. Because one's own autonomy is important, and given this justice principle, the autonomy of others must be worthy of respect - hence the ethical foundation for non-interference in autonomous choice.

**Autonomy and Competence**

While more is said about this in Chapter 3, it is worth noting that autonomy is distinct from the legal notion of decision-making competence, sometimes called "capacity." The latter provides a test by which medical or other decisional authority is allocated for legal purposes. Competence is most like normative autonomy inasmuch as it is intended to provide a basis to determine the circumstances under which the individual decides for him or herself, and when authoritative decision-making by another is required.

A significant difference is that competence, as a legal allocation of decisional authority must be, at least in respect of a particular decision, either present or absent. In cases of unresolved conflict, judges must ultimately determine whether the patient has the authority to decide, or whether another must decide instead. In general, anyone who exceeds a particular threshold is competent, no matter by how much or little they surpass the standard. The reverse is, of course, also true. A person is incompetent, and therefore may not generally make authoritative decisions, who fails to meet the legal threshold, by however little they may fall short. Autonomy, on the other hand, is a relative concept. People are autonomous (in the descriptive or psychological sense) to varying degrees. One may be more or less autonomous, as distinct from autonomous or not.

**Autonomy and Informed Consent**

The application of liberal principles to medicine is natural. Decisions about individual health and well-being are among our most important and intimate. If self-government and non-interference are generally important, then they must be of particular importance in the context of health care. In interrelations with medical practitioners, especially physicians, patients find themselves relatively uninformed, dependent and vulnerable. Medical practitioners are granted privileged access to probe, examine and look at the bodies of their
patients, and to perform often painful, uncomfortable and embarrassing invasions of their physical and emotional selves. In light of this privilege, it is natural to expect particular vigilance in respect of such touching, whether by medical treatment or examination, of patients by practitioners.\textsuperscript{72}

In the history of medicine, patient autonomy is a relatively recent development. While the common-law tradition has long recognized the tort of battery, that is, the wrongful character of unconsented touching, it was only in the early 20th century that a clear judicial statement of its application to the medical context is found.\textsuperscript{73} Further, it is only within the last thirty years that the notion of informed consent has been recognized and given content in our law.\textsuperscript{74} The liberal ideal of patient autonomy is expressed through the caregiver's obligation to secure informed and voluntary consent for any medical treatment and in the obligation to respect the patient's refusal of consent. As a general matter, these are developments which have gained broad acceptance both among patients and health care providers.

The primary goal of health care in general is to maximize each patient's well-being. However, merely acting in a patient's best interests without recognizing the individual as the pivotal decision maker would fail to respect each person's interest in self-determination - the capacity to form, revise, and pursue his or her own plans for life. Self-determination has both an instrumental value in achieving subjectively defined well-being and an intrinsic value as an element of personal worth and integrity.\textsuperscript{75}

The autonomy of the patient is respected by giving him or her the final say in whether and which of alternative medical examinations, tests and treatments are to be performed.

\textsuperscript{72} J. Berger, \textit{A Fortunate Man} (New York: Random House, 1967) at 68.

\textsuperscript{73} Schloendorff v. Society of New York Hospital, 105 N.E. 92 (N.Y.C.A. 1914); Mohr v. Williams, 104 N.W. 12 (Minn. 1905) and Pratt v. Davis, 79 N.E. 562 (Ill. 1906).


Autonomy and Decisions to Die

Consider then a medical practitioner facing a person seeking to give effect to a decision to die. It should be clear that it will be highly relevant for the practitioner to know whether that decision is psychologically autonomous. Based on the foregoing discussion, making that determination may be a complex matter. First, there is no broad agreement just what autonomy means, or how it is to be applied in particular cases. It involves reaching a satisfactory resolution with respect to a number of questions, all of which are to some extent problematic.

The question whether a particular choice is autonomous raises the following interrelated subsidiary issues: Is the decision intentional? The question of intention is typically associated with acting wilfully, or that which is “willed in accordance with a plan.” While the intention associated with a decision may often be clear enough, it will not always be so. For example, if a decision to die results from “giving up” out of fatigue and a sense of helplessness, is the action that follows “intentional?”

Is the decision adequately voluntary? Whether a particular choice is voluntary is a relative matter. No doubt, some decisions are so clearly manipulated or coerced that choice cannot be said to be autonomous. Conversely, in the context of some decisions, such forces are so clearly absent or minimal that the decision must be acknowledged to be voluntary. For many decisions however, particularly in the circumstances in which the person is contemplating death, the matter will not be so clear. How strong must an influence be such that choice is rendered involuntary? The English Court of Appeal in Re T. held that the influence of a mother, exercised at a time when T. was in hospital, fearful, dependent and vulnerable, was sufficient to vitiate her refusal of treatment. Along a continuum of voluntariness, lines in particular cases may be difficult to draw.

Is the decision adequately well informed? Again, this is a relative matter in which the sufficiency of information, or the extent of misinformation, might render choice non-

\footnotesize{\textsuperscript{76} Faden and Beauchamp, A History and Theory of Informed Consent, supra note 22.}

\footnotesize{\textsuperscript{77} [1992] 4 All E.R. 649; [1992] 3 W.L.R. 382.}
autonomous. Whether the person is sufficiently well informed in a particular case, or when a persistently false belief vitiates autonomy, may be difficult to ascertain.

Is the decision sufficiently authentic to the individual? While authenticity of decision-making is important, the ambiguities surrounding this notion, canvassed earlier, will often make for substantial difficulties in arriving at a helpful resolution of this question.

Has the person given adequate consideration and critical reflection to the decision? While we may be hesitant to accept that an unconsidered decision is autonomous, in a particular case how much reflection is necessary? In the context of life-ending decision making, we would not wish to describe a rash, thoughtless or even spontaneous decision as autonomous. At the same time, at some point, thinking must cease and choice must be given effect.

Is the decision sufficiently rational? While it is natural to suppose that autonomous choices must be at least to some degree rational, difficulties about rationality arise along two dimensions. First, as noted above, there is no consensus about what rationality means or how it may be tested or applied to specific cases. Second, even if we did have such a notion of rationality, we are left to ponder how much is enough. An utterly irrational decision should not qualify as autonomous. However, even people who lack doctoral degrees from esteemed universities may act autonomously. In between extremes of irrationality and perfect rationality (even assuming we can make sense of these concepts) lies a point of sufficient rationality, with no clear guide to locate such a point.

With respect to these matters and others as well, a determination as to the autonomy of a particular choice is a very uncertain matter. This is troubling because the liberal democratic ideal is premised upon persons having the capacity to make psychologically autonomous choices. Therefore, confusion or uncertainty about whether a particular choice is autonomous creates problems for the determination of whether that choice should be honoured.

In the next chapter, this latter question is addressed. That is, even granting that psychological autonomy is an important aspect of the ethical imperative of honouring individual choice, it is argued that the situation is even more complex. While in general,
choice which is psychologically or descriptively autonomous should be honoured, choice may be overridden because the autonomy of the choice itself is suspect or when autonomy itself is not the only relevant consideration. Fundamentally, whether choice should be honoured is a question which involves factors other than the autonomy of the agent.
7. THE VALUE OF PATIENT AUTONOMY

Overview

Although the notion of autonomy, as a psychological concept, is not as straightforward or univocal as may be wished, a sketch of the concept, particularly in the medical context, is possible roughly on the lines suggested in the previous chapter. As was noted in the latter part of Chapter 6 however, not only is the notion of autonomy conceptually ambiguous, but it will often be difficult to know when a particular choice is or is not autonomous. Most of the significant elements of autonomy are relative matters, and line drawing is difficult. No adequate standards are offered to judge how much is enough. In addition, difficulties about characterizing choice as autonomous arise when the characterization is being made by someone other than the chooser. The inherent uncertainties in knowing whether choices made by others have these particular qualities leave them with at best an imperfect judgment about the autonomy of another’s choices.

However, even assuming that we do have the conceptual tools to identify a particular choice as autonomous, there remains the further question: What justifies non-interference with respect to that choice? Assuming that a particular choice is autonomous, how does it follow that the person should be left alone to exercise that choice? In short, wherein lies the compelling moral force of autonomy? Since normative autonomy refers to the right not to have one’s choices interfered with by others, the focus is on others’ responses to choice-making. Therefore, the value at issue is really respect for individual autonomy.

An assessment of the moral value of respect for autonomy is important to this project because the individual interest in protecting autonomy is by far the most substantive objection to the application of a defence of necessity to cases of suicide intervention. The purpose of this chapter is twofold. First, it is argued that respect for autonomy, while a very important value, cannot be absolute or overriding in all cases. Sometimes competing considerations are sufficient to override even autonomous choice. Second, autonomy is always compromised to
some degree. Accordingly, an individual decision to take steps with the expected result of death may be overridden on the basis that such decision has been made in an inadequately autonomous way. In either case, the fact that the individual has rejected interference in a decision to die need not be the determinative factor. If in some cases autonomy may be overridden then, in such cases, the availability of the defence of necessity cannot be dismissed. This is because the medical practitioner has a *prima facie* duty to treat the person to preserve life. This duty is weighed against the patient’s interest in controlling his or her own medical care and is, in some cases, more compelling. On this basis, a lawsuit for battery should be successfully defended.

**Why is Autonomy Valuable?**

In order to see when autonomy may be overridden, it is important to survey the value of respect for autonomy, as well as its limits. As a normative concept describing obligations to honour others’ choices, the principle of respect for autonomy could be valuable in itself, or it could be valuable inasmuch as it promotes some further good. In the former case, it would be said to be inherently or intrinsically valuable. In the latter, autonomy would be instrumentally valuable. Clearly, autonomy is valuable. But is it inherently or instrumentally valuable, or both? This question is important because the answer would tell us something very important about the notion of normative autonomy. If autonomy is instrumentally valuable, then it is good inasmuch as it tends to produce good of another kind. In a particular case, if autonomy fails to produce such good, then respect for autonomy may be overridden, since that which gives it value is absent. If however, respect for autonomy is inherently valuable, then it is good without reference to its consequences. Presumably, in that case, it would be unintelligible to ask what autonomy is good for. It is just good.

**Justification of Autonomy as Instrumentally Good**

Normative autonomy, that is, the authority to make and give effect to choices without interference, may be seen as good because it advances some more fundamental good. If respect for autonomy is instrumentally good, two questions arise. First, what further good is
autonomy aiming to produce; and second, is autonomy in fact effective in producing such good? Neither of these questions has a clear answer.

As to the first question, the liberal ideal is that each person chooses his or her own good. If this is the case then, as an instrumental notion, respect for autonomy aims at maximizing the particular preferences of the individual. By contrast, ideal notions of the good assert instead that what is good is so apart from its being valued by any individual.¹ So, hard work, self-fulfilment and artistic beauty (as examples) may have *objective* moral value, that is, value apart from being desired by anyone. Utilitarian values such as happiness and other pleasurable states, are thought to be good in themselves, although perhaps because it is assumed that all persons seek happiness. Needless to say, there is no widespread agreement as to what constitutes the good. This creates a difficulty in assessing autonomous choice, at least as an instrumental matter. Unless we agree about the good that autonomy seeks to promote, it will be impossible to assess the value of autonomy itself, because we will be unable to test whether autonomy is effective in producing such good.

An answer to the second question, as to whether respect for autonomy is in fact effective at producing good, might throw some light on the first. Autonomy as the right to make decisions for oneself, free of the interference of others, would seem to be most effective at promoting one's own preferences or ends. This being the case, respect for autonomy does, at least in general, seem like a pretty good strategy for allowing the satisfaction of one's own individual preferences. It makes sense that the individual will know his own preferences best, and will be in the best position to assess how they may be achieved in an optimal way. On the other hand, autonomy may not be particularly successful in promoting ideal goods, at least those not chosen by the individual.

John Stuart Mill, as a utilitarian philosopher, saw happiness as the sole good. This conclusion was based on his psychological conclusion that happiness is the only ultimate good to which people tend. For Mill, it is always wrong to interfere with another's autonomous

decisions, in Mill's terms, the exercise of one's "individuality,"\(^2\) at least on grounds of the person's own good. However, his justification for this very strong principle is consequentialist. Inasmuch as persons tend to know their own good better than others, it will generally serve a person most effectively to respect their choices. Leaving others unhindered in the pursuit of their own good is the best way of ensuring that such good will be maximized. Therefore, it is reasonable to conclude that, for Mill, respect for autonomy is at least instrumentally valuable inasmuch as it tends to promote the individual's non-moral good.

In any event, as Mill points out, people will naturally feel paternalistic interference as an affront to choice making and will rebel against such interference. Therefore, even in cases where another \textit{does} know what is best, the good of another is nevertheless effectively served by a general policy which prohibits interference to bring about that good. Therefore, for Mill, autonomy is both contingently and instrumentally good, but practically speaking in any event, is always good. If this is the case however, then good is logically prior to autonomy, and if good is not in fact always best promoted by autonomous choice then, whenever it is not, autonomous choice need not be respected.\(^3\)

Of course, this assumes that the promotion of non-moral good in ourselves and others is itself morally valuable. As a general matter, such assumption is not objectionable. However, this type of justification for autonomy presents the difficulty of determining just what things are and are not good, such that it is morally valuable to seek their promotion, and how conflicts between the promotion of various goods are resolved.

If respect for autonomy is instrumentally valuable, it follows that its value is dependent upon its being effective in promoting a more fundamental good and further, upon some agreement about the good which respecting autonomy seeks to promote. The notion is problematic at a practical level because there is no agreement about the nature of the good toward which choice and action should tend. Difficulties arising out of conflicting notions of


\(^3\) \textit{Ibid.}, ch. 1. Mill would disagree, arguing that in such cases, it is still a socially desirable policy that autonomous or individual choice be respected, notwithstanding the exceptions.
the good which respect for autonomy promotes are canvassed in later sections of this chapter. But, even if the nature of the good could be agreed upon, respect for autonomy as an instrumental notion should be overridden whenever that good is not in fact promoted by autonomous choice.

**Justification of Autonomy as Intrinsically Good**

These difficulties may be resolved if respect for autonomy is inherently and not instrumentally valuable. Attempts to show that autonomy is inherently valuable succeed not by pointing to something that it is good for, but rather by showing that autonomous choice is in some sense essential to the nature of personhood or to a core of human dignity. If either of these can be demonstrated, then the inherent value of respect for autonomy follows, and its normative force may fairly clearly be demonstrated.

**Man's Essential Nature:** The value of respect for autonomy, of self-determination free from interference, may arise out of the fact that the exercise of individual choice is fundamental to the nature of persons. Persons may be characterized as having the capacity to imagine the world as different than it is, and be motivated to mould or change the world, its course of events, and his or her place in it. If this is so, then reflection, judgment and considered choice are themselves valuable, apart from whatever good they may produce.

S.I. Benn sees autonomy as valuable inasmuch as it gives expression to a higher degree of one's ontological status as a natural person. That is, a person more fully creates himself, and constitutes his own personality in the exercise of autonomous reflection and judgment. To be a natural person is to have some awareness of self, as an initiator of events which will turn out differently depending upon the choices one makes. Natural persons have "reflective appreciations of situations in the light of their own sets of preferences." Persons generally have a "normal consciousness of self and so regard their decisions as making a difference."

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4 S.I. Benn, "Freedom, Autonomy and the Concept of a Person" (1975-76) 76 Proceedings of the Aristotelian Society 109-130 at 117.

5 Ibid. at 118.
Accordingly persons entertain goals, make projects and engage in enterprises.

It is sensible to suppose that others also are persons in this sense, with projects and goals that are important to them. Without the collective acceptance of a principle of non-interference, each would be out for themselves, without restriction, and life would be unacceptably competitive and violent. There would be no love or friendship among people as equals and no "...reactive feelings and attitudes that belong to involvement or participation with others in interpersonal human relationships." Since we claim a moral respect for our own natural personality, we are committed to extending that respect to others. Charlesworth sees autonomy as more than a precondition for moral value, rather seeing it as the well-spring of moral value itself. Such value arises out of the intrinsic goodness of individuality and the obligation of the state to promote individuality to the degree possible. It is through autonomy that individual differences are expressed.

Harry Frankfurt, in his search for a conception of a "person" looks for elements of personhood beyond simple membership in a species. For him, it is freedom of the will that makes persons. This in turn is characterized by the having of second-order volitions - the capacity to be moved to choose in a certain way arising out of a desire to do so. Autonomy then is valuable inasmuch as it is essential to personhood. Willard Gaylin sees autonomy, which he describes as "...freedom from instinctual fixation" as unique to persons, and therefore inherently valuable. He posits an obligation to improve ourselves arising out of our uniquely human ability to do so. Norman Dahl suggests the related view that an

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6 Ibid. at 120.

7 Ibid.


instrumental conception of good should be abandoned in favour of an Aristotelian acceptance that there are certain natural ends of persons.

By reflecting on their own actions and the actions of others, people can make inductive inference to what it is that they are aiming at by nature, thus inferring the ends they should consciously be aiming at.12

Haworth agrees that autonomy is a defining characteristic of human personhood. The capacity for reflective self-evaluation and for normal autonomy are uniquely human. Humans are by nature autonomous and autonomy emerges as the development of a pre-existing trait, although the development of autonomy may be stunted or thwarted in some cases. Autonomy must be inherently valuable since it precedes both utility (analyzed as preference satisfaction) and liberty. Autonomy precedes utility since, in order to be considered valid, preferences must be autonomously chosen. It precedes liberty since freedom is wasted without the opportunity to genuinely make one's life one's own - to make oneself responsible for it. Therefore autonomy is a fundamental value that conditions and precedes other values such as freedom and utility. The development of autonomy constitutes a central element of the development of personhood. Only persons have the capacity for reflective self-evaluation and accordingly, this is a defining characteristic of personhood. He does not argue that all people are autonomous. Rather, given favourable conditions, persons become autonomous as a natural process, albeit one which is fallible. The motive to be competent, to make choices for oneself and to strive to make changes to one's world effective, are essential aspects of mankind.13

Kronman agrees that what separates man from other animals is his purposive activity, the ability to conceive of a future state of affairs and to plan to bring about that state. This ability distinguishes technology from instinct and permits action in conscious accordance with rules. For particular persons, individuality is essential to their nature. To plan one's life and

12 Dahl, "Paternalism and Rational Desire," supra note 1 at 266.

make it one's own is an essential, not accidental aspect of being human. Rachels and Ruddick see liberty (which in this context is closely related to autonomy) as essential to having a life, which in turn is what gives moral worth to persons. Having a life is a condition beyond being alive. It is constituted by certain types of actions, attitudes, emotions and social relationships. One such attitude is that one be self-referring, that is, one figures in the contents of one's own thoughts and plans.

The argument is that the types of qualities which we associate with autonomous choice are roughly (or precisely) those which represent the unique characteristics of mankind. It is appealing to conclude that since it is natural or essential to personhood that we act autonomously, others must be morally obliged to permit us to do so, and society's laws should protect such activity. Nevertheless, this does not follow logically, and a proponent of this view is obliged to explain how we can derive the ought of moral obligation from the is of personhood. For the purposes of showing the moral availability of interference, it is enough to show that autonomous choice can sometimes be overridden, not that it always can. Even if it is true that autonomy is natural, it does not follow that autonomy is the sole or ultimate value.

Human Dignity: Alternatively, autonomy is thought to be intrinsically valuable if it either gives expression to, or arises from the dignity or inherent worth of individuals. This suggestion reflects the Kantian notion that persons are to be treated as ends in themselves and not as means to the ends of others. If the individual is inherently valuable, then the particular choices made by individuals and which give expression to that dignity must also be, in themselves, valuable. To rob one of independent decision-making robs them of that fundamental element of human worth. Haworth goes further in arguing that respect for


autonomy is inherently valuable as inseparable from our own sense of self. Losing autonomy is a losing of oneself. Without autonomy, we are not persons — not individuals. The value one places on life is connected to the value one places on autonomy. The individual is inherently valuable, and the particular choices made by individuals, and which give expression to that individuality must also be, in themselves, inherently valuable. To rob one of independent decision-making robs them of that fundamental element of human worth.¹⁸

It cannot be however that autonomous action should never be interfered with, since the law quite rightly regulates much autonomous action. The question is whether the law may regulate autonomous action that does no significant harm to another. Even if it is the case that autonomous activity expresses such fundamental human worth, it does not follow that autonomy is the only source of value. That is, autonomy could be inherently valuable, without being the only human good, and without being overriding of other goods in all cases. There is more to human worth than autonomous choice making, and more to the moral life than respecting others’ autonomous choices.

Challenges to the Supremacy of Autonomy

The fundamental challenge is to identify the circumstances, if any, under which the putatively autonomous choices of another may be interfered with. Certainly if an individual’s choices cause harm to or compromise the interests of another, social forces may appropriately be brought to bear. But this is not the case here. Again, in the context of suicidal or life-ending decision-making, the question is primarily one of paternalistic interference, that is, interference for the person’s own good and not to avoid harm to others.

It might be thought that in the context of such paternalistic interference at least, autonomous choice should always prevail, both ethically and legally. This could be true whether autonomy is inherently valuable or instrumentally so. On an intuitive level, the value of autonomous choice to persons is clear enough. Autonomy stands for self-determination, self-rule - it expresses the central place of personal liberty in our lives. Who should make

¹⁸ Haworth, Autonomy: An Essay, supra note 13, ch. 11.
decisions for us about profound individual matters, if not ourselves? In the context of life-ending decisions, how can one person choose for another about life, death and fundamentally about their own well-being?

Joel Feinberg points out that paternalistic intervention has a distinctly pejorative connotation. It is something that one is accused of.\textsuperscript{19} This reflects a strong visceral feeling about autonomy, at least in Western societies. We do not simply disapprove of interference, we become indignant, and consider ourselves violated when someone attempts to impose their view of our own good. Challenges to the primacy of autonomous choice must account for this response, if paternalistic intervention is to be in some circumstances permissible or obligatory. Challenges of this kind take a number of different forms:

**Preference vs. Welfare:** Which is more important, promoting a person's welfare or respecting that person's preferences? On its face, the question is simplistic. A sensible response is that it depends both on the magnitude of the welfare for the person (including the harm avoided) and the strength and importance of the person's preferences. But this response, at least as far as it goes, assumes that a person's welfare and a person's preferences are both important, and as with so many conflicts in life, their relative importance in the particular circumstances must be balanced before we can decide what to do. It would be extreme to suppose that one should never interfere with another's choices, for their own good, no matter how catastrophic the consequences of such decision. Therefore, at least some balancing of respect for autonomy and best interests is indicated.

Childress agrees that respect for autonomy, while an important moral value, is at best a *prima facie* value which must, in the circumstances, be balanced against other important values, such as beneficence and care. Sometimes, respect for autonomy is outweighed by these other factors. In determining whether autonomy may be overridden, the following factors are relevant: proportionality - whether the competing values are stronger; effectiveness - whether violating respect for autonomy would likely be effective in protecting the competing interest; last resort - whether infringing upon choice is the only means available of protecting

the competing interest; and least infringement - whether the infringement of autonomy is the least intrusive means consistent with protecting the competing value.\(^\text{20}\)

It was noted in Chapter 6 that Dworkin saw autonomy as a formal or procedural notion and not a substantive notion. That is, the presence or absence of autonomy in choice is not dependent upon the substance of the choices made. The process does not determine the content of the outcome and autonomous choices may be good or bad for the chooser. What is important is how the choice is made.\(^\text{21}\) Since the process, or formal element which characterizes autonomy, says nothing whatever about the good produced by the resulting choice, it must be that the process of choice has value apart from its outcome. However, this is not to say that, even when considering the agent's own good, personal choice must always trump personal well-being. Both choice and welfare are valuable, and in the particular case, some balancing is required. However, such a balance is particularly difficult for a number of reasons, not least that choice and good are qualitatively different notions. How does one balance the value of the dignity and respect which comes of honouring the freely made choice of another against the harm to be suffered or the benefit to be foregone as a result of such choice?

Further, the assumption of an essential incongruence between choice and welfare may itself be simplistic. As noted earlier, Mill argues that overriding a person's preferences in order to promote their welfare is ultimately self-defeating. This is because people naturally rebel against such intervention and this resistance, coupled with the feeling of affront to the person, would usually negate any balance of good that may be achieved by interfering.\(^\text{22}\) Indeed, this may often be the case. However, there is no reason why, in principle, the good achieved by interference may not in some cases exceed the good achieved by permitting individual choice, even taking into account the negative effects of such feelings of affront. Since for Mill the ultimate test is that of utility, the primacy of individual welfare over


\(^{21}\) Dworkin, Theory and Practice of Autonomy supra note 9, ch. 1.

\(^{22}\) Mill, On Liberty, supra note 2.
individual preference appears by him to be acknowledged. But is there not something more to choosing for oneself than the good it will produce?

Howarth points to our intuition that it seems better to satisfy preferences which are chosen autonomously, that is, as a result of reflective choice, consistent with one's values, goals and history, than preferences which are non-autonomous in this sense. For example, we may think less important those preference induced by the subtle but powerful effects of advertising by profit-motivated corporations, than those chosen in a more self-conscious way. If the welfare of the person is primary, then this should not matter. This intuition suggests that developing and expressing autonomy has value independent of the welfare for the individual which it may produce.

But even this balance portrays an overly simplistic view of the place of autonomy in individual decision-making. The challenges to autonomy run much deeper than the common sense observation that sometimes people choose badly for themselves. The contrast between honouring another's choices, and doing what is in their best interests, reflects a contrast between autonomy and welfare. That is, an obligation to respect another's autonomy will conflict, in a large number of instances, with an obligation to do what we believe to be the best for him or her. It seems just false that one always knows their own good better than anyone else, particularly when they are sick or suffering emotional despair. Accordingly, giving moral dominance to respect for autonomy will sometimes entail standing by and allowing another to act in a way which will not promote their best interests, and may do them harm. Conversely, a substantive obligation of beneficence entails that autonomous choices must sometimes be overridden, and paternalistic intervention undertaken.

This conflict becomes particularly acute where the nature of the relationship creates special duties on the part of one person to attempt to ensure the promotion of the welfare of another. Parents are in such a relationship with respect to their children, and medical professionals are similarly placed with respect to their patients. Practically, how is this conflict resolved? On one hand, society's acceptance of the all-knowing paternalistic

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23 Haworth, Autonomy: An Essay, supra note 13, ch. 7.
physician, who feels no obligation to seek his patient's advice with respect to treatment, or even to discuss the medical situation, is rightly rejected. At the same time, a physician is not merely a technician, informing and then executing, without question, the instructions of the patient. It has been suggested that there need be no such sharp conflict between the medical responsibility to promote the patient's welfare on one hand and the obligation to respect the patient's autonomy on the other. It is possible for practitioners to find a third way by becoming involved in a patient's life such that personal growth and development is enhanced without contravening the patient's genuine wishes. Pellegrino and Thomasma characterize the medical obligation to patients as one of "beneficence-in-trust." They reject both a contractual analysis of the medical relationship and one, like a strict autonomy model, which focuses on the rights of the parties to the exclusion of other considerations. The obligation of the physician is to act for the benefit of the patient in a way which expresses neither a pure autonomy nor a pure paternalistic relationship. Respect for autonomy and paternalism are alternative models, but beneficence is not necessarily grounded in paternalism. Rather, beneficence is a "mediating principle" between autonomy and paternalism. Therefore, both strict autonomy and paternalism may be rejected.

According to them, beneficence, as an obligation of the medical practitioner, is grounded in the suffering and vulnerability of the patient. Respect for autonomy, seen as focusing on individual choice or preference, is intimately intertwined with a beneficent response. Because of the illness, vulnerability and suffering of the patient, a physician's obligation of beneficence necessarily entails an obligation to empower and foster the patient's autonomy. It is wrong to suppose that doing good for a patient can be separated from respect for his or her authentic and autonomous choice.

If this is the case then the question of whether to intervene paternalistically to promote

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24 Christie and Hoffmaster, Ethical Issues in Family Medicine, supra note 16, ch. 4.

a person's welfare, in violation of the person's own preference, is more subtle than it initially appeared. This is because, for Pellegrino and Thomasma, autonomy is an essential element both of one's personhood and of one's welfare. It is naive to suppose that the welfare of a particular individual can be analyzed in the absence of his or her own particular choices and preferences. No doubt, enhancing another's autonomy is an important aspect of promoting their good.

It does not follow, however, that there is no "true" conflict between doing good for another and respecting their autonomy. Consider the decision to intervene in a life-ending decision. The patient may choose to die and seeks to do so immediately. The practitioner believes that the death would be a tragic and irretrievable mistake. In the practitioner's view, stopping the suicide would benefit the patient. It may also be that taking the time to counsel and empower the patient, thereby fostering the patient's autonomy, would also be to his or her benefit. Nevertheless, either would be a violation of the patient's choice, since the patient does not wish to have the death impeded or delayed. Therefore, in these circumstances, the conflict between the welfare of the person and honouring his or her choice is real. Autonomy and welfare do conflict. Although promoting a person's autonomy will very often promote his or her welfare, it would be simplistic to suppose that a true conflict cannot arise. In such cases, it should not be assumed that autonomous choice must be respected no matter the consequences for the welfare of the person.

**Temporal Nature of Persons:** Childress and others have pointed out that persons are essentially historical or temporal beings. That is, we exist through time and, more importantly, make choices which change through time. Focus on the primacy of autonomy gives preference to present individual choice which may change in future. In principle, it is by no means clear that a person's present choice should be preferred to a later, or even earlier,


If we have some reason to suppose that an individual may choose differently in future, what does respect for his or her autonomy require?

Hardin sees an identification with oneself over time as central to the notion of autonomy. Such identification is expressed in our second order desires, as the core of the person, which is to some extent enduring. At one extreme, if this core is constantly being re-created, then autonomy is weak, since relatively fleeting. However, at the other extreme, an autonomous will that is strong and which creates itself in an enduring, uncompromising and resolute way, makes for a very unattractive autonomy, and makes strong respect for autonomy a very unappealing moral theory.

A person then who seeks to give effect to a decision to die may be acting autonomously at the time. It may be however, that at some future time, if the suicide is not completed, that person may decide differently, thereby exercising their autonomy at that later time. While it is true that we can be more certain of the contents of a present choice, we know in many types of situations that there is a fair likelihood that self-destructive feelings will change. The question is at least raised whether the present exercise of autonomy should be preferred over a predicted future choice when the two are inconsistent. Nothing in the nature or justification of autonomy gives us any reason to prefer the individual’s exercise of autonomy at any given time, including the present.

Summary: These challenges to the supremacy of respect for autonomy suggest not that autonomy is an unimportant value, but that it cannot be the sole moral framework for decision-making, decisive in every case. These considerations may apply to limit autonomy even where no other person, or their interests, are harmed. Primarily, it is neither irrational or morally blameworthy, at least in some circumstances, that the welfare of a person be sufficient to override his or her autonomous choice. Mill suggested that overriding another’s autonomy will generally result in doing more harm to the person. This is because the

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individual naturally will know what is best for him or herself, and because of the feelings of outrage which result from such interference. While this may generally be true, it is not universally so. When the decision is that life is no longer worthwhile and death is the only solution, it is easy to conclude that such decision will not always be for the good of the individual, particularly in light of its irrevocable nature and the possibility of error. At some point, the welfare of the person is sufficient justification to override his or her choice.

As noted earlier, the value of autonomy must either be intrinsic or instrumental. If autonomy is instrumentally valuable, then it is valuable inasmuch as it is effective in promoting some further good. If this is the case, then, since the good aimed at is separate from and more fundamental than autonomy, such good must override where autonomy is not in fact the best means to bring it about. Therefore, if the good for a person is to any extent other than being free to choose as they please, in an autonomous way, then such further good provides grounds to override autonomous choice. So, if autonomy is instrumentally valuable, it may sometimes be overridden.

If autonomy is essentially or inherently valuable, then it is good in itself and not good only to the extent that it promotes some further and more important good. But we have good reason to believe that autonomy is not valuable in this way. It is implausible to suppose that autonomous capacity is the only aspect of human nature worthy of moral consideration or which provides a basis for moral obligation. Even assuming that autonomy is inherently good, there are competing or alternative goods, in particular beneficence, or concern for individual well-being, which must be taken into account. But if other values are to compete meaningfully with autonomy then, on some occasions, they must be overriding. If this is so, then autonomy, even if inherently valuable, is not the only such value, and so must sometimes give way when conflicts arise.

**Compromised Autonomy**

Even if it is accepted that, in general, autonomous choices are to be respected, it may sometimes be the case that individual autonomy is compromised, or constrained, such that intervention may be justified on the basis that choice is not *sufficiently* autonomous. The
easiest examples of these are the lack of sufficient autonomy possessed by children or the mentally disordered. Dworkin suggests that we justify paternalistic interference with children because they lack the emotional and cognitive capacities required to make fully rational decisions. In these circumstances, paternalistic intervention is justified. The same could no doubt be said of the mentally disordered. Children and the mentally disordered are classed incompetent to make significant decisions for themselves, and therefore, interference with their decisions is ethically permitted and even required. Indeed, Dworkin argues that in doing so we are not really opposing their will, because, if they could act out of reason, they would agree with the coerced choice. Haworth suggests that the incompetence of children and the mentally disordered gives rise to an obligation on the part of others to attempt to foster and nurture their autonomous decision-making capacity.

However, there are constraints and conditions which compromise autonomous decision-making even in those who are, for legal purposes, competent. Such constraining influences come in a variety of forms, any one of which may potentially rob one of effective autonomous decision-making. It was suggested earlier that, as a psychological matter, autonomous decision-making capacity is a relative concept. That is, one may be more or less autonomous. Accordingly, a number of factors may be seen as diminishing one's autonomous decision-making capacity, but need not deprive one altogether of autonomy or decisional competence. At the same time, the presence of these factors, in the individual case, need not reduce autonomous decision-making capacity to a large degree, or indeed at all. However, the existence of these factors is relevant to one's capacity for autonomy and may provide a basis for intervention in particular decisions. This is because, if one's psychological autonomy is compromised, it is plausible to suppose that one's normative autonomy, one's authority to choose free from interference, should likewise be called into question.

Effects of Physical Illness or Disability: Pellegrino argues that illness always compromises autonomy to some degree. Illness brings about a state of "wounded humanity"

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30 G. Dworkin, "Paternalism" (1972) 56(1) The Monist 64-84.

31 Haworth, Autonomy: An Essay, supra note 13, ch. 7.
which necessarily compromises decision-making as a whole person. Ackerman sees the sick person not simply as a well person who happens to have a disease, but rather as a qualitatively different person, socially, emotionally and even cognitively. Cassell agrees that the sick are qualitatively different than the well. Authenticity is impaired in a seriously ill person and illness or disability tends to compromise the ability to reason. There are typically large gaps in the person's understanding, and illness interferes with the ability to act as one chooses. These states may be quite crippling to one's capacity to choose autonomously. An overriding desire to be rid of symptoms may interfere with the person's ability to make rational decisions. Illness can give rise to an inordinately sensitive emotional state, an assault on the unity of one's life and self, withdrawal, introversion and regression. All of these compromise autonomous decision-making, but need not render one incompetent. Of course, not all people suffering from illness are compromised in these ways. These effects are usually felt most strongly by those with serious illnesses, but generalizations are dangerous. It is enough however that these effects are relatively common and that it may be difficult for practitioners or others to assess the degree to which they affect autonomous decision-making in a particular case.

Terrence Ackerman argues that liberal theories of autonomy rely on two "dogmas" which neglect certain psychological realities about people suffering from serious illness. First, that patients have a ready-made ability to act autonomously; and second, that non-intervention (upon adequate disclosure of information) is the best way to protect patient autonomy. Patients facing serious illness undergo profound changes to family relations, work, recreation and other aspects of life. In light of these changes, the patient's plans, goals, values and expectations may all need to be re-examined to reflect their altered medical condition.


35 Christie and Hoffmaster, Ethical Issues in Family Medicine, supra note 16, ch. 4.
Without working through this process, the authenticity (and therefore autonomy) of decision-making may not be genuinely re-developed. Disclosure and non-interference are not sufficient, in such circumstances, to ensure autonomous decisions.36

Since autonomous action issues from plans of action formulated through deliberation and reflection, based upon one's own life plans, intervention may be justified when cognitive, psychological or social constraints impede autonomous behaviour. Illness may give rise to any or all of such constraints. When the aim of paternalistic intervention is to help the patient regain autonomous capacity, to help remove impediments to autonomy, intervention can enrich autonomy.37

Effects of Psychiatric Illness: Psychiatric illness may also compromise one's ability to make satisfactorily autonomous decisions. Particularly combined with physical illness or disability, a person suffering from depression or other affective disorder may lack insight into their own condition, may exaggerate the hopelessness of their situation and underestimate the prospect of an acceptable future quality of life. Such a state is not necessarily inconsistent with decision-making competence.38 The natural course of depression may be from six months to two years and persons suffering from depressive illness may in fact be ambivalent and conflicted in their attitude towards life. Such people rarely see that the meaning or experience of their suffering can change. Self-love is often missing, but restoration of feelings of self-worth are by no means impossible.39 Edwards suggests that mental illness should be conceived as involving primarily an extreme and prolonged inability to know and deal in a rational and autonomous way with oneself and one's social and physical environment.40

37 Ackerman, "Why Doctors Should Intervene," supra note 33.
Persons who are ill, in hospital and contemplating death may exhibit a number of other types of impairments and obstacles to genuine and authentic decision-making. Under such conditions, patients may exhibit withdrawal, introversion and even regression. Robert Young suggests that such patients' inner selves may become disordered, or lack integration in any of four distinct ways. First, the patient may exhibit signs of neuroses, acting in a self-defeating manner by reacting to anxiety-producing impulses with repression or other defences. Choices are not authentic, since not in accord with a coherent motivational life plan. Second, self-deception robs one of autonomy since such deception renders impossible an understanding and control, at least in a rich sense, of one's authentic motivational structure. In either case, evidence as to the state of the world is distorted and misconstrued. Third, a person suffering from *anomie* manifests a lack of inner coherence when, although recognizing the greater significance or importance of a particular authentic course of action, will nevertheless allow less important actions to intervene. Again, by not acting in accordance with such inner order or coherence, the anomic person fails to carve out a truly autonomous existence. Fourth, weakness of the will manifested in illness can be a significant autonomy-constraining factor.41

Dworkin suggests that persons under these circumstances may exhibit signs of cognitive delusion, irrationally believing things that are not so, or refusing to believe that which is clearly true. But a person may also suffer from what he terms "evaluative delusion," characterized as failing to calculate appropriately the risks and benefits of particular courses of action.42 Steven Wear agrees that those contemplating death may have a skewed conception of causation, perhaps the result of an unreasonable evaluation of available information.43 Jackson and Youngner point to the effects of ambivalence and emotional or physical fatigue.

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42 Dworkin, "Paternalism," supra note 30 at 82.
in impairing decision-making capacity.44

**Effects of Emotional Factors:** Emotional factors and psychological disturbance may also compromise one's autonomous capacity. The pain and suffering of physical, psychological or emotional difficulties, inevitably associated with decisions to die, give rise to a myriad of impediments to autonomous decision-making. The fear, dependence, confusion and vulnerability associated with being sick, particularly in a disorienting institutional environment surely may, at least to some extent, rob one of effective decision-making capacity. In addition, the presence of physical and/or emotional fatigue may compromise decision-making.45

**Effects of Insufficient or Mistaken Information:** It is generally conceded that choice is not autonomous if not reasonably well-informed. Someone with an illness or serious disability who is contemplating their own death will typically be deciding based on substantially imperfect information. Facts about diagnosis, the nature of the illness or disability itself, prognosis and a reasonably sophisticated understanding of the likely consequences of various proposed treatments will tend to be very poorly understood by an individual without medical training.

Autonomous choice may also be compromised by the presence of a persistent and false belief about some aspect of medical care upon which a treatment decision is made. Faden and Faden report the case of a 57 year-old woman diagnosed with cervical cancer. The cancer was "almost certainly" curable by a hysterectomy. The woman refused consent to the operation because she did not believe that she had cancer. In her mind, people with cancer feel sick and lose weight. She felt reasonably well, and despite the physicians' best attempts to convince her otherwise, she held fast to the view that she did not need the operation.46 In doing so, she

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46 R.R. Faden and A. Faden, "False Belief and the Refusal of Medical Treatment" (1977) 3 Journal of Medical
could not be said to be making an autonomous choice about her own care even though her medical situation was fully explained to her, and she understood perfectly well what the medical team was telling her. Unless there is good communication between practitioner and patient, the medical team may be unaware of the presence of a false or idiosyncratic belief affecting a decision.

Effects of Other's Attitudes: Apart from the disorienting effects of fear, vulnerability and dependence, the environment within hospitals and within families can have profound effects on the autonomy of decision-making. These constraints are manifested in a number of different ways. First, and perhaps most obviously, the emotional dynamics of family interrelation may substantially compromise autonomy. For example, guilt and the pressure of family members' expectations may create powerful stresses upon individual choice. Practically speaking, this may manifest itself in a perhaps misfounded view that the family would be "better off" without him or her. More subtly, feelings of alienation or abandonment from family may tend to poison feelings of self-worth and autonomous decision-making. Cassell points out that autonomy itself is exercised in relation to others and may be encouraged or defeated by the attitudes and actions of others. Even the most loving can be turned away by the ugliness, pain and suffering associated with serious illness. The injury which may be done to families by the damaged authenticity of the patient is destructive of autonomy.

Just as some patients may accept blindly the recommendations or direction of their physician, some patients suffer from an unreasoning mistrust of their physician, or physicians and health care providers generally. Such mistrust is very often well-founded. However, an environment of mistrust and bad faith in the medical relationship is genuinely counter-therapeutic. Further, an atmosphere where trust is missing or attenuated may tend unnecessarily to reinforce feelings of hopelessness or despair.

An atmosphere which is destructive of hope and good feeling in the medical

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*Ethics* 133-136.


relationship need not be the result of conscious indifference by family members or medical team members. Robert Burt describes the treatment (recorded on videotape) of Mr. G., who was horribly burned, over most of his body, in an automobile accident. He describes in particular the treatments for G.'s burns which included daily immersion in a chemical bath and the application of various ointments to his burned skin. Both of these treatments were excruciatingly painful. Burt notes particularly the attitude of the technicians and care-givers all of whom, we have no reason to doubt, were competent, caring and thoughtful practitioners. However, perhaps because G.'s situation was so desperate, his burns so disfiguring or because their care offered so little chance of cure, effective treatment or even satisfactory outcome, these care-givers tended to turn away and avoid warm human contact with him. Burt speculates that it was uncomfortable for care-givers to face the extreme pain and suffering felt by G. and that such feeling was reinforced by their own failure, and that of medical science, to deal effectively with his pain and suffering.

Burt suggests that such coldness or distance demonstrated by his care-givers, and their (albeit unintended) expressions of revulsion toward him, could not but affect G.'s attitude toward himself and his own recovery. This story suggests that the attitude of care-givers, be they family or professional, may have profound effects on the decisions made by those who are the recipients of care. If the medical situation appears hopeless, or, worse, if it appears that medicine is failing, (because success is characterized by cure) such feelings of failure may be adopted by the patient.

Conclusion - The Limits of Respect for Autonomy

At the close of Chapter 4, which discussed the nature and availability of the defence of necessity to a lawsuit brought in respect of a practitioner’s intervention in another’s decision to die, the profoundest objection was that the patient him or herself does not share the view that intervention is necessary. This led to a discussion of the nature of autonomous decision-


making in Chapter 6, and to the issue of its normative force in this Chapter. In order to justify the application of the defence of necessity to cases of suicide intervention, it must be shown that even competently made autonomous decisions may sometimes be overridden for the welfare of the individual.

That competent, autonomous choice may be overridden is suggested by two broad types of reasons: First, while autonomy is a very important value, it cannot be the only value relevant to whether choice will be respected. Indeed, this should not be a contentious suggestion. In describing the four “traditional” principles of bioethics, namely, respect for autonomy, beneficence, non-maleficence, and justice, the common view is that these principles are all prima facie of value, and in case of conflict must be balanced against one another. Therefore, it should not be surprising that, on some occasions, an obligation to respect another’s autonomy must give way to the obligation of beneficence - to promote the welfare of that other person.

In addition to showing that respect for autonomy may sometimes be overridden, it is also suggested that a person’s decision to die may not be respected because it is not sufficiently autonomous. Autonomy itself may be compromised by inadequate or mistaken information, psychological or psychiatric illnesses, the effects of physical illness or disability, emotional factors and the responses of others. Since autonomy lies along a continuum, the question whether a particular decision made by an individual at a particular time is sufficiently autonomous may be a matter of substantial uncertainty.

In arguing for the availability of a civil defence of necessity for one who intervenes by providing medical treatment to a person who has attempted suicide, the primary problem is that doing so overrides that person’s autonomy. The project of this chapter has been to show that while autonomy and self-determination are important values, they are neither ultimate nor overriding in all cases. The justification and limits of paternalistic intervention will be taken up more fully in the next chapter. It seems clear enough however that sometimes autonomy

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may be overridden to promote the good, or best interests, of the person, or to save them from serious harm.

This is not to say that the good of the individual will always constitute sufficient justification to override individual choices. However, when the good to be promoted or the harm to be avoided is sufficiently great, autonomy must give way. The insight that respecting autonomy is an important element of promoting the welfare of a person, or acting in his or her best interests, should make us cautious about ignoring others' choices. In addition, predictions about the outcome of honouring or interfering with a person's choices are uncertain and prone to error. That is, it will often or usually be at best an educated guess whether the welfare of a person is best served by honouring or overriding choice. And, Mill is correct that a person will generally know best their own interests. Therefore, the judgment of another about one's good may be a precarious one. Mill's observation that people will naturally rebel and feel aggrieved at interference with their decisions is also relevant, and dictates caution.

However, even taking these factors into consideration, it just seems wrong to suppose that a person's interests will never conflict with their preferences. Sometimes such conflict really should be resolved in favour of violating individual choice. Further, non-interference with current preferences entails respecting the autonomy only of the present. The various justifications for autonomy as non-interference do not account for the preference of present choices over different ones which may have been made in the past, or which may be made in the future.

Accordingly, it would be extreme to urge that respect for another's autonomy constitutes the only or overriding moral obligation to others. When Beauchamp and Childress argue that autonomy is one value among others and that such values are to be balanced in the particular circumstances, it may fairly be implied that our obligations to others extend beyond simply respecting their informed, voluntary, authentic choices. Dworkin suggests that we should also respect other's welfare, liberty and rationality, and identify sympathetically with

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52 Principles of Biomedical Ethics, supra note 51.
In short, the unsurprising conclusion is that there is more to morality than autonomy. But giving autonomy a privileged place in medical decision-making raises as well a different kind of problem. That is, even if autonomy were unassailably valuable, it is present in any particular choice to a greater or lesser degree. Autonomy cannot be said simply to be present or absent. It is, except in the most extraordinary of cases, always present to some extent, and always lacking to some extent. Autonomous decision-making capacity is compromised in innumerable ways by the effects of physical illness or disability, psychiatric illness or affective disorder, false belief or the want of adequate or reliable information, emotional factors attending the particular circumstances of the decision, and the attitudes and emotions which others bring to human interaction surrounding the decision.

In themselves, none of the limits to autonomy necessarily justify overriding autonomy. In any particular case, to the extent that individual choice may be overridden on paternalistic grounds, nothing heretofore has suggested the circumstances under which this may acceptably be done. However, if it is correct that autonomy may sometimes be overridden, that is, interference with others' choices is not always out of bounds, the next step is to lay a foundation for the application of a defence of necessity, rendering such otherwise unlawful interference either justified or excusable. What remains is to develop some principled sense of when such paternalistic intervention is acceptable, and how these principles may be applied to unconsented medical treatments intended to save the life of someone who has chosen to die. The justification for paternalistic intervention will be taken up in the next chapter.

33 Dworkin, *Theory and Practice*, supra note 9, ch. 2.
8. PATERNALISTIC INTERVENTION - OVERRIDING AUTONOMY

Overview

In Chapters 6 and 7, the nature and value of respect for autonomy is addressed. While the nature of autonomy is not unambiguous, a rough characterization is possible. Autonomous decisions are to some extent intentional, reasonably voluntary and informed as well as personal to the individual and the product of critical and rational reflection. However, there are limits to the value of respect for autonomy, both because competing considerations are important and sometimes overriding of autonomy; and because it is often unclear, in particular cases, whether psychological autonomy is in fact sufficiently present to justify self-determination.

When a person makes an autonomous treatment decision which will predictably result in his or her death, and a medical practitioner interferes, that person’s autonomy is violated. If death is prevented, then self-determination is not respected. When such intervention is motivated solely or substantially by the good or welfare of that person, it is said to be paternalistic. The term “paternalistic” commonly carries a negative connotation. In interfering with the choice and self-determination of another, one may be acting in a patronizing, officious and overbearing way. Perhaps more fundamentally, paternalistic interference is said to evidence a lack of respect for the individual.

Of course, the law commonly interferes with individual autonomy when the autonomous action harms another, or conflicts with another’s interests. This is not the type of interference addressed here. Interfering with another’s decision to die, in this context, is interference that is undertaken solely for the welfare of the person interfered with, paternalistic interference. As such, it requires particular justification.1 If a civil defence of necessity is to be sensibly applied in the circumstances, it must be shown that there is some duty, or strong

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justification for preserving the life of someone who has chosen to end it. This duty, or reason justifying paternalism, must be balanced against the admitted value of individual self-determination to decide whether intervention may be justified in the circumstances. In this context, the justifications for paternalistic interference are explored.

Characterization of Paternalistic Intervention

In order for interference in another's choices to be purely paternalistic, it must be undertaken not for the good of society as a whole, or for that of the person interfering, or indeed any other person. Pure paternalistic intervention is undertaken solely for the good of the person whose choice is interfered with. Accordingly, criminal and regulatory statutes, although they interfere with people's ability to act on certain kinds of choices, are not typically paternalistic. Laws which restrict activities to protect others from harm or to protect or promote the larger social good are not paternalistic laws. An example is the Supreme Court decision in the case of Rodriguez v. B.C. (A.G.). There, the court upheld the criminal prohibition against assisted suicide primarily on the basis that permitting some persons the right to even autonomously chosen assistance in dying would expose vulnerable others to abuse by being pressured or manipulated to make an insufficiently voluntary decision to die. The interests of those who can make the choice to die appropriately are sacrificed for the broader social good. While paternalistic laws also subsume the individual's autonomous right to choose, they do so not for the collective good, but for the welfare of the person him or herself.

Impure paternalism is undertaken to benefit both the person whose choice is constrained, and others or some broader social good. For example, legislation requiring the use of seatbelts may be motivated by a paternalistic desire to protect persons riding in cars from the harmful consequences of failing to use seatbelts, a paternalistic good. However, it may also be motivated by the non-paternalistic consideration that health care or other social

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2 G. Dworkin, "Paternalism" (1972) 56(1) The Monist 74-84 at 76.
cost savings will predictably be realized by reducing injuries caused by motor vehicle accidents.

However, like autonomy, a comprehensive characterization of paternalistic interference is elusive. In the medical context, paternalism is associated with the physician's beneficence. That is, paternalistic treatment of patients is undertaken by medical practitioners because, in their judgment, to do so is in the patient's best interests. Christie and Hoffmaster suggest that medical paternalism can occur in three different ways. First, the patient's expressed decision may be overridden; second, a patient may not be permitted to make a decision; and third, information given to a patient may be manipulated such that the patient's decision corresponds with that thought best by the physician. Buchanan agrees that withholding information about diagnosis or other matters relevant to the patient's health status is also paternalistic. Dworkin suggests that the definition is broader still and offers the example of a husband who hides his own sleeping pills from his suicidal wife. Such act is paternalistic even though no moral rule is broken, no overt coercion is used and no misinformation or deception is employed. This leads Dworkin to conclude that paternalism is found in the usurpation of another's decision-making either by preventing them from doing what they have decided to do, or by interfering with the way in which they arrive at a decision as to what to do. Any influence may be paternalistic, so long as one is substituting one's own judgment for that of another. The other is used as a means to one's ends, although the ends relate to the well-being of the other, not one's own.

For these purposes, drawing subtle distinctions about the definition of paternalism is unnecessary. It is enough that treatment without the patient's consent, or in the face of refusal, is paternalistic when done primarily for the welfare of the patient. “Soft paternalism”

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5 A. Buchanan, "Medical Paternalism" (1978) 7(4) Philosophy & Public Affairs 370.


is the view that paternalistic interference may be justified only when the action which is the subject of such intervention is not truly autonomous. "Hard paternalism" holds that such interference is sometimes justified even if the choice is substantially informed, voluntary and competent. The defence of necessity could not be justified unless hard paternalism is sometimes acceptable.

Against Paternalism

J.S. Mill argued that hard paternalistic interference can never be justified for three fundamental reasons: First, it is natural that a person knows what is best for him or herself. While others may think they know best, the safer assumption is that the individual is more familiar with his or her own good and therefore paternalism cannot be justified on the basis of promoting the welfare of another. Second, paternalism is an affront to the choice-making ability which is central to a unique personhood. This argument isolates both the choice-making or purposive inclination of persons as well as the importance of the uniqueness of the individual expressed in his or her individual choices. Third, since people will naturally rebel against interference, it is generally self-defeating to attempt to act paternalistically in another’s interest. This consideration appeals to our inclination to feel aggrieved at another’s intervention in our choices, and suggests that such feeling would frustrate the good sought to be done by interfering. If these arguments are determinative, a strong anti-paternalistic stance is dictated. That is, where competent choice conflicts with the individual’s welfare, autonomy trumps and no interference is legitimate.

However, the discussion in the previous chapter sought to show that respect for autonomy, while giving expression to an important value, has substantial limits as a

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*ibid.*


straightforward model for responding to life-ending decision-making. Briefly, the argument is summarized in responses to Mills' three objections to paternalistic interference. First, while it may be true that one generally knows his or her own good better than others, it seems simply false to suggest that this is always the case. Dworkin argues that the premise that a man will always know his own good better than others is almost certainly false, and with respect to "higher" goods sought by unsophisticated persons, Mill acknowledges that this will often be the case. Also, when the good contemplated is distant from one's immediate experience, man may tend to make errors about how best to ensure the satisfaction of such good. In any event, as Feinberg points out, the fact that people generally are more familiar than others with their own welfare raises at best a rebuttable presumption that coercion should not be used. In particular, for one who is ill, possibly in some pain and suffering and requiring medical care, it is clear that, at least sometimes, the individual does not choose best for him or herself.

As to the essential choice-making capacity of persons arising out of their unique individuality, the positive moral force of such essential nature, even assuming that we have such, is by no means clear. Our individuality and choice-making essence may be expressed in selfishness, cruelty, and violence as well as in compassion, generosity or courage. That is, so long as autonomy is a procedural notion and not a substantive one, we can say nothing about the moral value of the particular autonomous decision made.

As to the view that persons will naturally rebel against having their own choices overridden and that such affront may dilute or frustrate the good produced, again, we have no reason to suppose that this will always be the case. While such feelings may be taken into account in deciding whether paternalistic interference is indicated, it appears likely that in

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12 Mill in, On Liberty, supra note 10, acknowledges this point in his discussion at 102ff.


14 Feinberg, "Legal Paternalism," supra note 1.

certain circumstances feelings of affront or betrayal may be outweighed by the good produced by interference.

The feeling of moral outrage which commonly accompanies having one's choices overridden may or may not be instructive. It may be that this sense of outrage suggests a strong intuitive feeling that we are rightfully entitled to our autonomous choices. That is, while it may be acknowledged that such right can be overridden in cases of harm to others, when it comes to purely self-referring decisions, the individual is rightly the final arbiter. If so, it is positively unjust that such authority be usurped. This would mean that there is some element of choice-making which must be honoured apart from the good that the individual thereby creates for him or herself. Of course, such a feeling of outrage may also reflect the belief that we have such a right, but this belief is mistaken. Such feeling may entail no moral consequences, and simply be an emotional expression of anger or resentment that another would have the temerity to assert that our own judgment is faulty and the other's is better.

Christie and Hoffmaster suggest that, at least in the medical realm, unacceptable paternalism is found not in interference per se, but in interference of particular kinds. So, while it is acceptable for physicians to persuade, cajole or attempt to shape the patient's attitude by the use of appropriate information and reasoning, acts which are coercive or manipulative are unacceptable. Presumably the same would be said of deception or deliberately withholding the truth. This is a very weakly paternalistic stance, indeed one which may not be paternalistic at all. Few would see persuasion by rational argument or even cajoling in a more or less honest and straightforward way as paternalistic interference. Such acts do not threaten autonomous choice as ordinarily conceived.

But the paternalism sought here to be justified is hard paternalism. That is, an apparently competent person has made an apparently voluntary decision to seek his or her own death. Interference means overriding that person's choice on the basis not that others would be harmed (although it is likely that some will), but rather because it is in that person's interests to do so. No doubt the presumption is in favour of respect for autonomy. So,

16 Supra note 4.
paternalistic interference must be justified. Proposed justifications for paternalistic interference have taken a number of forms.

**Justifications Consistent with Rights**

**Diminished Autonomy:** The first basis upon which paternalism may be justified is so-called "soft paternalism," and is relatively uncontroversial. Intervention is justified when the person is incompetent, misinformed or if the choice in question is not truly voluntary. It is argued in Chapter 4 that the legal notion of competence is not particularly helpful in determining when intervention in a life-ending decision should take place, at least in doubtful cases. Nevertheless, it is sensible to suppose that if autonomy is substantially compromised, or other conditions of valid consent are compromised, then intervention is justified, particularly when the consequences of non-interference are serious.

Paternalism may be justified when choice is informationally deficient or substantially involuntary. Faden and Faden, while rejecting any stronger notion of paternalism, affirm a physician's responsibility to make substantial efforts to disabuse a patient of errors respecting his or her medical condition or prognosis. Intervention, at least to this extent, is justified because voluntariness requires adequate information and autonomy requires voluntariness. Regan agrees that ignorance or insufficient information is a variety of unfreedom. So, paternalism may be justified when the patient lacks relevant information about the consequences of his or her choices.

Stephen Wear sees the physician's fiduciary obligations as extending to test the autonomy of patient's decision-making with respect to their understanding of the situation (whether there are false beliefs or skewed conceptions of causation) and whether the patient can appropriately evaluate the information. If those conditions are met, then patient choice must rule. Otherwise, (soft) paternalistic intervention may be justified.

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Further, when one lacks the ability to meaningfully appreciate such information, paternalism may also be justified. For example, the person may be subject to psychological compulsion or unusual social pressure.\textsuperscript{19} For Feinberg, the test appears to be that of voluntariness. If a choice lacks sufficient voluntariness, then paternalistic intervention is justified. In such cases, the decision is not truly that of the subject, and therefore interference may be warranted. Nevertheless, interference is not warranted on the basis of the good of the subject, in the face of his or her competent choice.\textsuperscript{20}

Gruzalski suggests the necessary condition for paternalistic intervention is that the person be "not fully competent."\textsuperscript{21} This he describes as the state when, because of stress or other emotional incapacities, the patient is unable to assess the future and their options. For such person, an expressed wish is not truly an expression of their will because of delusion, inadequate information, false belief or the overpowering effect of emotional factors. Dworkin warns however that paternalism is never justified unless the subject is being treated as a "moral equal."\textsuperscript{22}

This framework, which focuses on justification being found in the lack of autonomy of the subject, is also theoretically consistent with a strong rights framework. Persons who have the ability to exercise it meaningfully have a right to have their choices honoured. If psychological autonomy were present, then paternalistic interference would not be justified. The consequences of interference or non-interference, that is, the good which may be promoted by interference or the harm produced by non-interference, would not be relevant.

Few would argue that intervention is not justified where choice is misinformed, involuntary or compromised in some substantial way. More difficult are those cases in which legal competence is arguably present, relevant information has been imparted and apparently


\textsuperscript{20} Feinberg, "Legal Paternalism," supra note 1.

\textsuperscript{21} Gruzalski, "When to Keep Patients Alive Against Their Wishes," supra note 29 at 179.

\textsuperscript{22} Dworkin, "Paternalism: Some Second Thoughts," supra note 7 at 107.
understood, and the decision is voluntary or at least substantially uncoerced. What justification may be found for intervention in such cases?

**Contract with Physician:** Another proposal is that the physician’s paternalistic interference is justified on a contractual basis. On this view, when seeking medical services, the patient implicitly agrees to give management of his or her treatment and care to the physician to undertake as judged best. The physician agrees to use reasonable skill, judgment, and effort to protect the patient from harm, to relieve suffering and if possible to effect a cure. On this model, if the physician determines that therapeutic ends will best be achieved by withholding information thought to be counter-therapeutic or by failing to give effect to the patient’s straightforward expression of wishes, this is justified by the agreement implied in the contract for medical services.23

The view that the model of the medical relationship is ultimately contractual and that such contract includes the terms just described is unsatisfactory. Both in law and medical ethical theory, the characterization of patient and physician solely as contracting parties is rightly rejected.24 The patient is not simply purchasing goods or services as he or she would buy a car or engage a plumber. Although involving elements of contract, the medical relationship imposes upon the physician a family of fiduciary and other obligations apart from those bargained for in a market transaction between independent contracting parties. And again, even if the medical relationship is like a contract, it cannot be supposed that the patient impliedly agrees to renounce the right to decision-making authority. Such contractual terms, if made explicit, would be unacceptable to most people and it would be unreasonable for a physician to rely on them. In any event, paternalistic intervention cannot be implied as a contractual term if it has been specifically refused. Here, we imagine cases where the patient has decided to die and so has refused life-sustaining treatment.

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23 A. Buchanan, “Medical Paternalism,” *supra* note 5.

At least in theory, there is a way in which a previous consent could bind a patient, notwithstanding a present refusal. This is by the so-called "Ulysses Contract," whereby a person may, at a given time, empower others to ignore his or her instructions under certain future circumstances. The idea is modelled on the classic myth of Ulysses. While returning home from the Trojan War, Ulysses passes by an island inhabited by the sirens, whose singing was known to be so beautiful that sailors were lured onto the rocks to the death. Fearing that he would be so lured, but wishing to hear the beautiful music of the sirens, he commanded his men to fill their ears with bees' wax and tie him to the mast while they sailed past. He ordered his men not to obey any order he may make to release him until the danger had passed.

The argument would be that there may fairly be implied what Dworkin terms "a social insurance policy." That is, society reasonably assumes the implied consent of all its members to accept life-saving treatment when needed, notwithstanding a current refusal. Such consent may be implied because it is a rational strategy to protect oneself against the possibility that we may, like Ulysses, make dangerously misguided decisions in a moment of weakness.

While interesting, this social insurance policy theory is not persuasive, at least in this context. Even accepting the controversial view that a Ulysses Contract may be applied against the person who has since changed his or her mind, it is too great a reach to suppose that there is anything like reasonably universal acceptance of that implication, such that it may fairly be applied to any given individual. It is simply too much to suppose not only that the Ulysses Contract is morally valid and cannot be rescinded, but also that reasonable people may generally be assumed to be amenable to being bound by its terms with respect to life-sustaining treatment.

Consent: Related to the justification based on implied contract is the view that

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26 Dworkin, "Paternalism," supra note 3 at 81.
paternalism is justified by the prior, future or implied consent of the person. In the cases we are concerned with, consent has been refused. Implied consent is clearly absent since consent cannot be implied if it has been expressly refused. Ex hypothesi, present consent is lacking. Any previously given consent would be overridden by the more recent refusal. What remains is future consent.

Future consent refers to the retroactive approval or ratification of paternalistic intervention, expected at some time in the future. So for example, Rosemary Carter sees future consent as a necessary and sufficient condition for paternalistic intervention, so long as the paternalistic act itself did not cause the consent; the person’s desires, values, preferences and beliefs are not distorted; and the person is not lacking relevant information. The question whether a person will, or is likely to retrospectively approve of the interference, when viewed from some future time, depends upon a number of factors: (1) whether the interference is in accord with the person’s permanent aims and goals; (2) whether the person is in a state of temporary incompetence; (3) whether the person lacks relevant information; (4) the nature and weight of the benefits created and harms avoided; (5) whether the harmful consequences of not intervening are irreversible; and (6) whether there exists relevant social understandings to which the person, either expressly or impliedly, would be expected to assent. Bart Gruzalski agrees that one necessary condition for paternalistic intervention is the expectation that the patient would later welcome the intervention. While predicting future consent is an inherently uncertain exercise, one is presumably justified in intervening where, on a good faith basis, it appears reasonable to suppose that such retrospective consent will be given.

Van De Veer argues however that this notion of subsequent or future consent is more problematic than Carter suggests. Fundamentally, this justification rests unhelpfully upon a fiction. Consent is not given (indeed, it is refused) and there is at best the expectation or prediction that the intervention will be ratified at some later time. It strains the meaning of

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the word to refer to such subsequent approval as "consent" at all. The factors which Carter proposes do seem relevant to the question of whether intervention is justified. However, with the exception of the condition of temporary incompetence, these factors relate to the consequences of intervention, that is, whether the patient will benefit from paternalistic treatment, rather than to the presence or quality of consent. This is telling, because it indicates that the person's predicted future ratification may be seen really as a way of identifying whether intervention is likely to be in the person's long-term interests. If it seems likely that the person will come to be grateful for having been rescued, it is sensible to suppose that the intervention really did promote his or her welfare. We assume that one would ratify the intervention only if they at least thought it was for the best.

A justification for paternalistic intervention which is analyzed in terms of contract or consent are consistent with a strong rights model for decision-making. Indeed, it is altogether consistent with the overriding or ultimate nature of autonomous decision-making. It is a strong liberal view which assumes that, although a decision may be temporarily befuddled, ultimately it is the individual's own past binding or future consent which decides how they are to be treated.

Justification Based on Consequences

Promoting Future Autonomy: The next proposed justification involves a mixture of rights and consequences. It is argued that paternalistic intervention with another's present autonomy is only justified when the future autonomy of that person will thereby be promoted. Autonomy and the right of self-determination remain the primary values, but the paternalist calculates that intervention will, on balance, create more autonomy by allowing or creating conditions more conducive to future autonomy, or by acting to avoid, for the agent, a loss of future autonomy. For example, according to Christie and Hoffmaster, the stark dichotomy between autonomy and paternalism is in fact false. Autonomy may be promoted and fostered by beneficent intervention only if undertaken with a view to enhancing the personal growth

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and autonomous decision-making capacity of the patient.\textsuperscript{31}

This idea is illustrated most clearly by the very extreme case of the prohibition against selling oneself into slavery. A law which deems such contracts unenforceable is arguably paternalistic. However, it is paternalistic only inasmuch as it denies the freedom to alienate forever that same freedom.\textsuperscript{32} No doubt there may be difficulties predicting when intervention will yield an increase rather than a diminution of autonomy or liberty. Nonetheless, such uncertainty need not be fatal to this justification. It is enough that some present autonomy may be sacrificed for the sake of future autonomy, in some circumstances.

**Averting the Consequences of Irrational Choice:** It has been suggested also that paternalistic intervention is justified when the act or choice in question is irrational. Intervention averts an irrational choice on the part of the person, or rather, seeks to protect the person from the potentially harmful consequences of irrational choice. This may be because autonomy only protects rational choice, or at least not seriously irrational choice. This is a plausible and tempting suggestion. In the context of suicide, Margaret Battin has argued that intervention to prevent a suicide is justified when that attempt is irrational and characterizes rationality in that context. She isolates five elements to rationality:\textsuperscript{33}

First, in order to act rationally, one must have the ability to reason. That is, one must employ valid logic, moving in a reasoned way from premises to conclusion, and must have a reasonable appreciation of the consequences of different choices. Benn also views the ability to effectively connect resources with goals as an aspect of a minimal rationality.\textsuperscript{34} Second, the actor must have a realistic world view. A decision to die which is based upon a skewed conception of reality could not be said to be rational. Third, rational choice must be based on adequate information.

\textsuperscript{31} Christie and Hoffmaster, "Patient Autonomy," \textit{supra} note 4.

\textsuperscript{32} Feinberg, "Legal Paternalism," \textit{supra} note 1 and Mill, \textit{On Liberty}, \textit{supra} note 10, ch. 5 at 125.


\textsuperscript{34} S.I. Benn, "Freedom, Autonomy and the Concept of a Person" (1975-76) 76 \textit{Proceedings of the Aristotelian Society} 109-130.
To these three cognitive conditions for rationality, Battin adds two others: Fourth, an action, to be rational, must accord with the agent's own interests in the protection of his or her person and body from harm. On this view, it is rational to attempt to avoid displeasure, dissatisfaction, pain or suffering. Of course, it cannot be said that failing to avoid harm will always be irrational. Sometimes, sacrifices of this kind are sensibly made. Culver and Gert argue that an irrational decision is one which will result in death, pain, loss of liberty and similar basic harms, without adequate reason for the sacrifice. While it is not clear what constitutes adequate reason, the general response is that an adequate reason exists where the gains accrued or harms avoided in accepting the harm are sufficient to compensate for it. While this is vague, it is intuitively appealing that acting so as to create physical or emotional harm to oneself, without adequate justifying reason, is paradigmatically irrational.

Fifth, to be rational, acts must accord with what Battin refers to as "ground-projects" or basic interests which themselves arise from one's most abiding fundamental values. This is to say that in order to act rationally, one must act authentically, or in accordance with one's own goals and values. It is assumed that acting in furtherance of one's deeply held goals is rational and that acting in a way which will frustrate such goals is irrational.

Norman Dahl also suggests that the ends or goals of action may or may not be rational. In a view reminiscent of Aristotle, he suggests that certain ends are natural to humans and one may act irrationally in pursuing goals which are contrary to such natural ends, even if such pursuit is well-reasoned, informed and effective in bringing them about. Suggestions as to such natural ends include the avoidance of physical and emotional harm and suffering, as well as the development of those qualities which are uniquely human, commonly thought to be rational pursuits, and personal growth and fulfilment through purposive activity.


Beneficent Intervention: Alternatively, it may be that the justification for paternalistic interference, at least in the medical setting, arises out of the physician's obligation of beneficence. At the extreme, paternalism based on medical beneficence is an unappealing view. Inasmuch as the physician is the medical expert, or at least has much more medical expertise than does the patient, the physician should decide, in choosing a course of treatment, how the medical ends of the patient should best be accomplished. So, if in the expert opinion of the physician, the goals of healing are best served by deception, incomplete disclosure or overriding patient choice, then the physician's fundamental obligation of beneficence requires that, regrettably, this be done. This obligation does not arise out of contract or the implicit agreement of the patient. Rather, it arises out of the physician's overriding obligation to use his or her skill and expertise for the good of the patient.

There are (at least) two fundamental difficulties in simplistically justifying paternalistic intervention on this basis. First, it fails altogether to take account of the importance of self-determination as such to the individual. If individual autonomy is not the ultimate or only moral consideration, it must nevertheless be accounted for in determining medical decision-making.

More importantly it assumes, mistakenly, that the medical good of the patient can best be judged by the physician in virtue of his or her medical training and experience. It misses the simple point that the welfare of an individual, even that associated with medical goals, are to a significant degree particular to the patient. The patient's specific goals, values, and history may affect substantially the medical approach which will best foster his or her own welfare. Complete and honest disclosure of relevant medical information, together with a process of decision-making in which the patient participates, helps to ensure that the particular goods and goals of the patient may be applied to his or her particular medical situation in order to fashion a clinical approach which is most likely to serve his or her welfare. Accordingly, the physician's beneficent paternalism will often be self-defeating in that the welfare of the patient.

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patient will not, under those conditions, be most effectively achieved.

These considerations argue not that paternalistic acts should never take place, but rather that they should only be undertaken in clear cases. Accordingly, a number of commentators have focused on the seriousness of the consequences in considering whether paternalism is justified. Susan Sherwin sees great potential for abuse in paternalistic interference and argues that the potential for serious harm is required to justify it. Charlesworth would require that the long-term benefits outweigh the short-term interests of the agent. Gert and Culver argue that the justification of such interference requires two things: (1) significantly more evil to the person must be prevented by such an intervention than is caused, where benefit to the person is seen as the prevention or relief of death, pain, disability or loss of freedom, opportunity or pleasure; and (2) one must be able to universally allow the violation of the rule in the circumstances. In application, it must be that all rational persons would agree that the evils avoided outweigh the evils attaching to the moral violation of the paternalistic intervention and that one could publicly advocate such violation generally.

In a later piece, Culver and Gert refine these requirements to suggest that the choice in question must be “seriously irrational.” A seriously irrational decision is one which would result in death, pain or loss of liberty, and the like, without adequate reason. There will sometimes be disagreements about the adequacy of reasons offered, but in practice the acceptability or otherwise of reasons will generally be tolerably clear. The structure of this justification is fundamentally consequentialist. Intervention to avert irrational choice and to avert choices having bad consequences are strongly related if rationality is seen as effectiveness in meeting ends, and one’s ends do or should involve the avoidance of harm without adequate compensation in welfare.


41 Gert and Culver, “The Justification of Paternalism,” supra note 1 at 203.

42 Culver and Gert, “The Inadequacy of Incompetence,” supra note 35 at 632.
Dworkin takes the mixed view that paternalism is justified in any of three types of cases: First, for decisions that are serious and relatively irretrievable; second, decisions made under extreme psychological or sociological pressure; and third, decisions posing dangers not fully understood or appreciated by the agent.\textsuperscript{43} The justification for intervention in each of these cases is strengthened where the danger sought to be averted is severe or far-reaching and if the intervention is relatively minor, or does not interfere substantially with the other choices the person makes. Also, in order to justify interference the harm must be clearly shown and must involve no more than the least possible disruption of freedom. That is, if there is a less disruptive interference possible, which would avert the harm, it must be preferred.\textsuperscript{44}

There is strong intuitive appeal to the view that paternalism is justified when the breach is small and the harm averted is great. That is, it seems sensible to trade off a certain amount of autonomy for a clear net gain in utility. The difficulty is, as Haworth has pointed out, that no theoretical framework is offered to resolve conflicts, in a principled way, between respect for autonomy and beneficent interference.\textsuperscript{45} There is no straightforward common reference between utility or welfare on one hand, and autonomy or non-interference in choice, on the other. If one were to argue that benefits to the individual should never be traded off against that person's autonomy, what would count as a valid response?

Donald Regan addresses directly the conflict between the value of paternalistic interference when utility will be maximized, and the value of freedom of choice.\textsuperscript{46} He suggests that a bridge may be found between the value of choice and the intuitive appeal of intervening paternalistically where the benefits are great, by allowing for intervention only where freedom for the agent itself will be maximized. This is a view, like one discussed

\textsuperscript{43} Dworkin, "Paternalism," \textit{supra} note 3 at 81-84.

\textsuperscript{44} Pellegrino and Thomasma agree that treatments which are of clear benefit, and treatments clearly consistent with the patient's own values may not be refused: E.D. Pellegrino and D.C. Thomasma, \textit{For The Patient's Good: The Restoration of Beneficence in Health Care} (New York: Oxford University Press, 1988) ch. 3.

\textsuperscript{45} L. Haworth, \textit{Autonomy: An Essay in Philosophical Psychology and Ethics}, \textit{supra} note 37, ch. 10.

earlier, in which both autonomy and welfare are important elements. The balance then is not to reconcile autonomy with welfare; rather, the balance is between present and future freedom of choice. While this balance may be, in practice, difficult and inherently uncertain, the values compared are at least of the same general kind. This response pays attention to the importance of temporal personhood and may be consistent even with Mill's strong anti-paternalistic framework. Even Mill allowed that one could not sell oneself into slavery. 47 This is because it is contradictory to exercise one's freedom for the purpose of depriving oneself permanently of freedom - becoming a slave. By extension, Regan suggests that others are entitled to interfere where the exercise of our present freedom will predictably result in a diminution of our future freedom.

Regan offers the example of a cyclist who is required by law to wear a helmet. Suppose that the cyclist is apprised of all relevant risks and benefits of not wearing a helmet and voluntarily chooses to accept them. Suppose further that at some future time the cyclist crashes and is badly injured as a result of not wearing the helmet. Regan argues that we may owe a duty at the present time to act to protect the cyclist as a person at the later time. 48 And, the injured cyclist might, in retrospect, agree that forcing her to wear the helmet was a good idea. Presumably, since the violation of a present or current free choice is more certain and less subject to contingency than predictions about freedom gains in the future, present freedom of choice should be weighted more strongly. However, the point remains that if a relatively small violation of the freedom of a person at a given time will predictably avert a greater loss of freedom for that person at some future time, such violation may be justified by the promotion of freedom itself.

It is important to see that all of these writers, by implication or otherwise, accept that there are circumstances in which paternalistic intervention may be justified. Indeed, although there may be wide disagreement as to the conditions under which intervention is justified, it is an extreme position that paternalistic interference is always wrong. In broad terms, two


48 Ibid. at 123ff.
kinds of consequentialist justifications are offered. Paternalistic interference is permitted (1) when the consequences of not interfering would be that the person’s welfare is seriously adversely affected; and (2) where interference will in fact promote autonomy by creating conditions under which the individual will be able to exercise autonomy more effectively in future.

Justification of Paternalism in Suicide Intervention

A variety of justifications then are proposed for paternalistic intervention. It is the thesis of this work that, under certain circumstances, paternalistic intervention in another’s decision to die is acceptable, or at least, should not expose the intervenor to an action for battery. For reasons canvassed more fully in Chapter 3, it is not suggested that such circumstances can helpfully be restricted to those in which the person choosing to die is decisionally incompetent. Further, although in many cases a decision to die is taken in the context of compromised information, voluntariness or autonomous capacity, interference is sometimes justified where these factors are absent. Therefore, the paternalistic intervention defended here includes cases of hard paternalism, that is, intervention for the good of the subject notwithstanding apparently competent choice. Can such intervention be justified on any of the grounds canvassed in this chapter?

Such intervention cannot be justified on the basis that the person has impliedly contracted or consented to a health care practitioner exercising such paternalistic discretion. It is artificial and wrong to suppose that a person contracts with his or her physician on the basis that the physician may act only as he or she thinks fit in their care and treatment. No doubt patients would generally be surprised to be told that such were the terms of their medical relationship. In any event, the “contract” between patient and physician is always alterable, at least with respect to those treatments that are unacceptable to the patients. For obvious and quite desirable policy reasons, no patient may contract away his or her right to refuse unwanted medical treatment, and surely no patient expects that he or she is doing so when placing themselves under the care of a doctor.

Similarly, deemed, implied, or future consent do not give sufficient warrant to the
doctor to override the patient’s expressed wishes about treatment. Certainly there can be no implied consent in the face of an expressed refusal. To proceed on the basis of a predicted future consent is artificial, since no consent is or indeed may ever be given. It is also misleading because a future expression of gratitude or ratification of intervention is not meaningfully a consent at all. Discussions of consent and contract in this regard attempt to frame the intervention in terms which do not imply a violation of the “right” of autonomous decision-making of the patient. Such attempt is not successful or particularly helpful.

More persuasive is the view that autonomy may be violated in order to promote the longer-term or future autonomy of the patient. While such justification is generally insufficient to justify paternalistic interference, it serves tolerably well in cases of lifesustaining treatment in the case of a refusal. This is because the decision is grave and irreversible. If the patient dies, then no future exercise of autonomy or liberty is possible. Saving that person’s life allows greater future autonomy while not generally foreclosing the patient’s option to attempt again to end his or her life at some future time.

The most powerful justification for such paternalistic intervention, however, is found in the positive consequences for the person’s welfare, which predictably result. The harm avoided by saving life is great, at least in most cases. When a person on a street corner steps out in front of a passing bus, we assume he is making a mistake in calculating the consequences of crossing the street at that time. Being unaware of the threat posed by the passing vehicle, the person assumes that it is what he or she wants, and that crossing is in his or her interests at that time. But such person is mistaken, and the passerby, who intervenes without consent to avert the tragic consequences of that mistake, even by seizing the person bodily, obviously is not blameworthy in so doing. The rescuer does not act on the basis of expected future consent, or contract, or even on a theory about increasing future autonomy. The passerby acts to avert a predictable tragedy.

So it is with the physician or other medical practitioner who gives needed medical treatment and care to one in danger of dying. The practitioner may strongly believe that, in deciding to bring death about, or in allowing death to come, the patient is also making a tragic mistake. If the person seeking to die is making a mistake - is miscalculating as to his or her
prospects of, or possibility for, a sufficiently satisfying life, even on their own terms, then the interference must be justified, since the harm averted is so great. If it is the case that at some future time that person would look back upon the rescue and be glad, and agree that a tragedy had been averted, then the intervention was justified not on the basis of future consent, but rather on the basis that a serious harm had been avoided, and the person has come to realize this.

But, it may fairly be responded, the doctor cannot know for certain whether the patient is making such a tragic mistake. If indeed the patient has calculated roughly correctly that his life can never be sufficiently fulfilling or satisfying to justify its continuation, and if that person would never look back with gratitude or contentment upon the intervention, then the physician will have interposed him or herself in a particularly burdensome way. Clearly, care must be taken in interfering paternalistically with the choices of another. In particular, a decision to rescue another should not be taken lightly. However, the uncertainty inherent in intervening does not mean that such intervention is never justified. It does mean that the circumstances and context of the intervention are important in assessing its justification in particular cases. The considerations relevant to a decision whether paternalistic intervention is justified will be taken up in Chapter 10. These considerations will focus on the question whether it is likely that a mistake is being made by the person proposing to die, and the consequences both of intervening in the absence of mistake and those of failing to intervene in case of mistake.

Of course, these assessments are all subject to uncertainty. Little in life is certain, and most important decisions are taken on the basis of probabilities and expectations which we hope are reasonable. This is particularly true in medicine. The fact that a surgeon cannot guarantee a good outcome from surgery is not by itself sufficient reason not to proceed. While an internist may not know with certainty that a particular course of antibiotics will successfully treat a particular infection, he or she is nevertheless justified in proceeding on the basis of the best judgment and information available at the time. So it is also with an intervention to preserve life. That a medical practitioner may be wrong in doing so, may be in fact meddling in a sensible and well-considered choice of the individual, is not by itself determinative that
no such intervention should ever take place. Sometimes he or she is justified in proceeding nevertheless on the basis of the best judgment which can be made at the time, in the circumstances.

It is not argued that such paternalism to promote future autonomy is justified as a general policy to be applied by practitioners. In the course of day to day practice, the practitioner should, in all but extraordinary circumstances, strive to respect the autonomy and self-determination of those in his or her care. In Chapters 9 and 10 however it is argued that the special nature of the decision to die, specifically its grave and irreversible character, justifies a more interventionist stance, at least in some circumstances.

It is also this special nature of a decision to die which provides the basis to override another's interest in making their own mistakes - a right to be wrong. Part of the justification for allowing people to make mistakes is the hope that they will learn from them. If the purpose of allowing people to make their own mistakes is that valuable lessons are thereby learned, then this object is defeated by allowing one to make the mistake of dying unwisely. Once dead, there will be no opportunity to reap the benefits of such lesson. If however the position is simply that all autonomous choices must be honoured, no matter the consequences for the person's welfare, it is the project of this thesis to argue that this view, as an absolute, is not morally defensible. Acknowledging the importance of respect for autonomy, the challenge is to develop adequately concrete, but ethically sensitive guidelines as to the appropriate exercise of paternalistic intervention.

**Paternalism and the Law**

Even if it is granted that, as a matter of ethics, paternalistic intervention in a life-ending decision may sometimes be justified, is it practical to suppose that such intervention may be *lawful* as well? After all, the law requires stability and certainty and, in a society which aims at tolerance and a pluralistic respect for others, its concern is mainly with protecting peoples' rights. In this context, the most fundamental right in question is the right of self-determination and in avoiding unwanted medical treatment. Given these well-established legal rights, can the law, at the same time, permit individuals to override those
rights, even for that person's own benefit?

Certainly such intervention is not to be undertaken lightly. The circumstances or conditions under which intervention may be permitted should be closely constrained. Restrictions and limitations on such intervention are important and must reflect primarily the fact that it is the patient who bears the consequences of interference. Nevertheless the suggestion that the law may permit paternalistic intervention in the rights of another is far from novel. Further, permitting such interference is, in appropriate cases, proper and just. The law appropriately endorses paternalistic intervention in a number of significant ways.

Allowing others to make decisions in the place of children and other persons judged incompetent is clearly paternalistic. The fact that such persons are not able to exercise judgment and reason in an effective way does not explain why the law allows others to violate their preferences and make decisions on their behalf. The reason, of course, is that persons without these abilities are at great risk of making both small and great mistakes of judgment with potentially very serious and harmful consequences. The law allows intervention for that person's own good. Of course, in the case of children or mentally disordered persons, the tension between that person's autonomous choice and their own good is less stark, since autonomous choice is absent, or in any event, compromised. The law in such cases acts paternalistically nonetheless, even though it is not doing so in violation of a mature autonomy.

Further, all jurisdictions have laws respecting civil commitment. While terms vary, such laws typically empower authorities to hospitalize, and sometimes treat, persons who pose a threat to themselves, usually even if they are not a threat to others. This aspect of such civil commitment laws is clearly paternalistic. While the presence of some psychiatric disorder is generally required, the presence of psychiatric disorder does not necessarily entail a lack of decisional competence. Such laws protect not just others who may be harmed by those sought to be civilly committed, but protect also those persons themselves. These laws


are paternalistic and necessary.

Laws which require new drugs to gain regulatory approval prior to sale or distribution are clearly paternalistic, as are those which prohibit the sale of prescription medications without the approval of a physician. One can buy any number of harmful products, such as bleach and drain cleaners, without permission. However, people who are sick, or think they are sick, are particularly vulnerable to suggestions about possible cures, and drugs can be very dangerous. The clear purpose of such laws is to protect people from using potentially harmful drugs without proven benefit and acceptably limited harm - a paternalistic purpose.

In addition, the law restricts in a variety of ways even competent persons from entering into a certain types of contractual relations. These restrictions exist even when such contracts are entered into freely and with adequate information. Duncan Kennedy argues for example that laws regulating financial institutions and the sale of securities have a hard paternalistic component. They do so by rendering unenforceable certain kinds of purchases of securities or other financial products for the purpose of protecting individuals, at least to some extent, against their own greed, gullibility and foolishness. Further, laws which mandate a "cooling off" period, such as in certain door-to-door sales transactions, and those which limit the ability to marry and divorce, all protect persons from over-hasty and imprudent choices. While these laws restrict individual liberty and to some extent frustrate the exercise of autonomy, few would argue that laws of this kind are in principle improper.\footnote{D. Kennedy, "Distributive and Paternalist Motives in Contract and Tort Law" (1982) 41(4) Maryland Law Review 563-649.}

It is true that laws with paternalistic effect may be impurely paternalistic. That is, such laws may be seen as motivated in part by their positive consequences for others or for society as a whole. For example, securities regulations, it may be argued, serve the purposes also of promoting efficient markets and remedying asymmetries of information or inequalities of bargaining power. While the argument can be made that such laws are enacted without regard to their paternalistic effects, and entirely with a view to the good of others or the broader social good, Kennedy views such a comprehensive account as implausible. In considering
such laws, the sense is strong that the contractor is being saved from himself, or his own potential folly. 

Consider business contracts with restrictive covenants found void for public policy. When the terms of a contract restrict the contractor's opportunity, either during or for a period following the currency of the contract, to carry on a competing business or employment, the restriction on trade or inability to earn a living may be found void and unenforceable. The law reasons that such loss of livelihood is a consequence too harmful to be permitted. It is simply too unwise for one to agree to restrict the earning of one’s livelihood to such a degree, and the law does not allow it. Explanations focusing on economic efficiency and distributional factors seem artificial compared to this intuitively apparent one.

Kennedy views such legal paternalism as justifiable where the beneficiary of the paternalism seems particularly at risk of making a significant mistake, with serious consequences. They occur, for example, where persons might be prone to underestimate the seriousness of risk of financial or bodily injury, or where the long-term consequences of a particular choice tend to be mistakenly calculated. People may have preferences which are particularly dangerous or harmful. For this reason, we have seat belt and motorcycle helmet laws, as well as laws and regulations which require safeguards for those seeking to skin- or sky-dive. Arguments pointing to the health and other social costs saved by such regulations do not seem to capture the true motivation for such laws.

The other reason which Kennedy isolates, aside from the problem of mistake on the part of the beneficiary about his or her real interests, is what he terms “false consciousness.” In this context, false consciousness amounts to a cognitive bias or systematic tendency to misinterpret or ignore relevant information or to repress unwanted information. In certain types of situations, people are prone to evalutational errors and non-adaptive behaviours. While imperfect, paternalistically-based laws seek to protect persons from the most serious

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52 Ibid. at 632.

53 Ibid. at 634.

54 Ibid. at 638ff.
effects of such mistakes and false consciousness.

As Robin West points out, the case for a strong anti-paternalism rests on two assumptions. The first is that our revealed preferences are generally rational, that is, we prefer what is in our own best interests. The second assumption is that persons have privileged access to their own best interests which are in some sense fundamentally unknowable by others. Both of these assumptions are, to some extent, questionable. As to the first, it should be clear enough that people commonly fail to act in furtherance of their own interests, even those interests which are authentic and expressive of the individuality of that person. Second, while a necessarily imperfect exercise, it is overly delicate to suppose that we can never gain a tolerably accurate sense of another's good.55

Indeed, as Kennedy observes, the law has developed and defined quite finely detailed trustee, fiduciary, guardian and parental relationships which impose very specific obligations on some people to act in the best interests of others. A parent is legally obliged to act in the best interests of her child, a trustee is similarly obliged with respect to his beneficiary, and a physician must act in furtherance of the good of his or her patient. In these cases, and a myriad of others, the law does not throw up its hands in despair that the true welfare of a beneficiary is fundamentally unknowable by his or her fiduciary. While of course a parent, trustee, guardian or other fiduciary cannot know perfectly the good of the one under their care, the law recognizes sensibly that such knowledge is reasonably possible.56

Accordingly, it is simply not the case that paternalism is foreign to the law or beyond its proper bounds. If it is appropriate for the law to permit interference with one's purchase of stocks, pharmaceuticals or vacuum cleaners, or with one's livelihood, recreation, marriage and divorce, how is it improper that the law should intervene to allow the saving of one's very life? The consequences of mistake or false consciousness may be small or great, and may be easy or difficult to repair. If paternalism is ever to be countenanced, it seems a decision to end one's life is the most obvious circumstance in which the law may appropriately intercede.


56 Kennedy, "Distributive and Paternalist Motives," supra note 51 at 636-637.
In this chapter, it is proposed that hard paternalistic intervention may be justified on a variety of grounds, and that intervention in a life-ending decision will in some cases be an appropriate instance of justified paternalism. This will be the case when paternalism is based on promoting the future autonomy of a person seeking to die, or where the result of interference would be to avert a much greater harm than the good produced by honouring the person's self-determination. In Chapter 5, it is proposed that a common-law basis for paternalistic intervention may be found in the civil defence of necessity. There, it is argued that the most persuasive bases for such defence lie either in the avoidance of a greater harm to another, or when a legally recognized duty to intervene conflicts with, and outweighs, the duty to respect a refusal of life-sustaining treatment. These bases are in general supported by the philosophical justifications for paternalism. Obviously the justification for paternalism based on avoiding serious harm and promoting future autonomy is related to the proposed requirement for necessity that a greater harm be averted. The conflict of duties analysis also requires an assessment of the consequences of intervention weighed against those of respecting choice. In Chapter 9, the justification of paternalistic interference is discussed specifically with respect to decisions to die.
9. PATERNALISM AND LIFE-ENDING DECISIONS

Overview

It is argued in Chapter 5 that the common law civil defence of necessity could in theory be invoked by a medical practitioner who is sued for battery for giving life-sustaining treatment notwithstanding a refusal of consent. From a policy standpoint, the obvious impediment is that such treatment violates the important liberal democratic value of self-determination, or autonomy. In Chapters 6 and 7, autonomy is described and some of its limitations are canvassed. Because of these limitations, it is suggested that respect for autonomy cannot be the sole guiding moral principle in general or in medical practice. In Chapter 8, the philosophical basis for the justification of paternalism is addressed. There it is argued that even "hard" paternalism may sometimes be justified and that in fact the law is already paternalistic in a variety of ways.

In this chapter, it is suggested that the justification for paternalism in life-ending decisions is particularly strong. The final and irretrievable nature of a life-ending decision makes the case for intervention more compelling, or at least compelling in special ways. It will be important to sketch just how such life-ending decisions are different from others, to see how rules about paternalistic intervention should be shaped in this context.

Paternalism - The Immorality of Suicide Intervention

Self-Determination and Ownership: One approach to the question of paternalistic intervention in health care is to see such intervention in a decision to end life purely as a wrongful violation of liberty and a battery against the person. It is urged that, if the person has, while competent (or when the medical practitioner has no reason to think the person not competent) expressed the desire not to be rescued, then this desire should be respected. The medical practitioner who interferes and treats the person, despite his or her refusal, does so
wrongfully. It is not relevant that the situation is urgent, or that the person’s life is in danger, since no emergency exception to the informed consent requirement exists where consent has been competently refused.

The above view reflects a fundamentally libertarian position which prizes autonomy as the overriding value. That is, our lives (and deaths) are our own. To interfere with a suicide attempt, which harms no one else, is an unjustifiable intrusion - an affront to one’s autonomy and liberty. Eliot Slater writes:

We must become sensitive to the predicament of those human beings who come to a settled and firm conviction that they want no more of this life and would prefer to end it. This is especially the case when such decision has been reached on sound principles, when all the most obvious obligations to himself, his family and to society have been discharged, and full consideration has been given to the feelings of others.

Sartorius argues that the liberty of the individual is of primary importance. For him, what gives meaning and value to life is the freedom to choose one’s own life plan and to live as one sees fit. Accordingly, if a person freely chooses not to live at all, this is his or her right, and such choice should not be interfered with.

Szasz views the freedom to grant or withhold consent to treatment as a basic human freedom. That a person may choose to share suicidal thoughts and feelings with others does not justify depriving that person of the basic human freedom to act on them. On what grounds does a physician interfere when a person decides to end his own life? Szasz rejects the view that the suicidal person must be ill or that preventing suicide amounts to the treatment of some underlying disease which is causing the person to wish to die. Fundamentally, a suicide is the act of a person, responsible for his or her own life. It is odd, Szasz notes, that the physician

1 Malette v. Shulman (1990), 72 O.R. (2d) 417 (C.A.)
4 R. Sartorius, "Coercive Suicide Prevention: A Libertarian Perspective" (1983) 13(4) Suicide and Life-Threatening Behavior 293-303.
appears to value the patient's life more highly than does the patient him or herself. The fact that one is disturbed does not show mental illness, nor in any event does being mentally ill justify psychiatric hospitalization and treatment. The routine practice of suicide intervention wrongly treats what is an act as something which happens to the patient. Suicide has become medicalized to the point where psychiatrists, "by force and fraud," impose their views and values on their suicidal patients. Feinberg sees the question as one of ownership. That is, we own our own lives and so are justified in destroying what is our own property if we so choose. Heyd and Bloch also worry that suicide intervention usurps the fundamental importance of an individual's jurisdiction over his or her own life.

The difficulty about prohibiting all interventions in suicidal choice is that it can only be justified if autonomy is the only or always overriding consideration. It depends on the assumption, which is at best an article of faith, that the presence or absence of any other factors could not be relevant to a determination of whether, in a particular case, intervention may be justified. In Chapters 6 and 7, it was argued that while the value of autonomy is strong, there are abundant reasons to suppose that it cannot be determinative in every case. Indeed, in Chapter 8, it is proposed that paternalism can sometimes be justified and that a significant part of our law operates from paternalistic motivation and with paternalistic effect. It may be that such intervention does constitute an affront to one's autonomy and liberty. If so, this is regrettable. However, liberty is not the only value which operates in our law, and it is trite to say that it is overridden in countless, quite justifiable ways.

Arguments in favour of suicide intervention need not rely on the medicalization of suicide. Indeed, it is a central aspect of this dissertation that paternalistic intervention might be justified even in case of an apparently competent and healthy person.

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Suicide need not be itself an illness for suicide to be justified. It is no contradiction to claim that a person who is responsible for his or her own suicide decision nevertheless ought to be rescued.

**Alleviation of Suffering:** In addition to the argument that autonomy or individual self-determination requires non-intervention in life-ending decisions, some argue that such interference should be forbidden because it typically has the effect of prolonging the misery of the suicidal person. The appeal here is to compassion or fellow feeling. In an early paper on suicide, Mary Rose Barrington urges that there is little natural or praiseworthy about extending a painful, suffering life. Even animals are spared such suffering. In a civilized society, suicide ought to be considered a perfectly normal and acceptable manner for people to end their lives.\(^8\) The price of forcing the patient to continue to live against his will is a prolongation of this psychological and physical misery, in addition to a serious deprivation of liberty.\(^9\) Further, intervening to prolong another's death may be deforming and destructive both to his or her dignity and to affected others.\(^10\)

It is tragic, although true, that death may be a welcome and compassionate release from suffering, pain and disease. It may also be true that sometimes the continuation of life is deforming and robs one of dignity. It is not suggested here that suicide must always be avoided or that intervention in decisions to die is always justified. Arguments which focus on compassion for a suffering individual remind us that intervention may be officious and harmful, as well as caring. But if the well-being of the person is relevant to a determination whether suicide ought to be permitted, it must also be relevant to the questions whether and when decisions to die should not be permitted. Such determinations can only be made in the context of the circumstances and experience of the individual him or herself. In the absence of its context, suicide intervention can be neither ruled in or ruled out.

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\(^9\) Heyd and Bloch, "The Ethics of Suicide," *supra* note 7.

Other Objections: There are other reasons why suicide prevention is problematic. Margaret Battin points out that suicide can be, in some circumstances, dignity-promoting, or in any event, the least worst death possible in the circumstances. Rescuing someone from a suicide attempt may result in a greater affront to the dignity of that person than allowing them to see their project through to its lethal conclusion. If, as a result of the attempt, their condition is worsened, the lack of success may be particularly bitter.11

Paternalistic interference of any kind carries with it a number of risks, any of which may be substantial. Generally speaking, there are strong reasons to avoid acting paternalistically. First, the judgment of the intervenor that the suicide is a mistake, or not otherwise in the best interests of the person, may itself be incorrect. That is, it could be that the person attempting suicide is perfectly justified in his or her beliefs and suicide is the most rational course for that person to adopt. The future may really be as bleak as the person imagines. Second, it may be that the suicide is based not on the mistake which the intervenor sees, but on some larger plan which was not understood. The suicide may have intentions which are not readily apparent, and in light of these intentions, the choice to die is perfectly sensible. If one who intervenes is wrong in either of these ways, intervention makes things worse rather than better.12 Alan Stone worries that if we presume too quickly the incapacity of those attempting suicide, on the basis that autonomy is always or almost always lacking in such cases, we risk replacing the "myth of autonomy" with a "myth of psychiatric omniscience." The assumptions that a psychiatrist is capable of telling when their patient’s reasoning is skewed, and further that he or she is able to repair it, may both be unwarranted.13

In addition, the paternalist is aggressive. The other's projects are frustrated, often by force. The subject is likely to feel anger and resentment against perceived unjust treatment, and they


may be right. 14

The foregoing general concerns about paternalism and the fallibility of the paternalist's judgment are important cautionary considerations. Certainly a decision to intervene in an important aspect of another's life should not be undertaken lightly. Again, however, this is not to say that such intervention will always turn out badly. This is not to say either that the consequences of intervention are not to some extent predictable. Certainly no guarantees are available that intervention will in fact help the situation. Nevertheless, certain factors about a suicidal decision render it more or less likely that paternalistic intervention will have salutary results. The tragic and irrevocable nature of a mistaken decision to die warrants rescuing even when there is some likelihood that intervention may be misguided. Uncertainty of result need not dictate inaction. In appropriate circumstances it would be fair and reasonable to suppose that intervention is for the best.

The Morality of Suicide Intervention

Incompetence: Even those who take a strong libertarian approach to intervention, focusing on the injustice of interfering with the autonomy and self-determination of the person choosing or allowing death, agree that intervention is justified when the patient is decisionally incompetent. That is, few would deny the "soft paternalist" view. This accords with relevant legal principles. Consent to medical treatment which constitutes intervention in a suicide is not validly refused by a person who lacks competence. Rather, it is the lawful surrogate decider who is authorized to give a legally valid consent to, or refusal of, treatment. Clear cases of incompetent persons contemplating suicide are easy enough to imagine. Persons suffering from severe depression or other psychiatric illness, those experiencing strong delusions or having a severely skewed understanding of their own situation or prognosis, may be incompetent. Under those circumstances, an informed, rational and voluntary decision to suicide cannot meaningfully be made. Accordingly, others are justified in interfering to stop the attempt.

It is of course right that refusals of life-sustaining treatment by clearly incompetent persons should not be honoured. That decision lies with a surrogate, and the law clearly reflects this. In Chapter 4 however, it is argued that, except in clear cases, the notion of competence as the tool for assessing suicide and refusals of life-sustaining treatments is not particularly helpful. Incompetence should not be the only ground upon which such refusals should not be respected. There are other grounds than incompetence for intervening in another's decision to die.

**Irrational Suicide:** It is claimed also that intervention in a suicidal decision is justified when the decision itself is irrational, formulated in an irrational way, or as part of an irrational process. This could be the case even if the patient is decisionally competent. Because of the irretrievable nature of a decision to attempt suicide, it is appealing to suppose that we may interfere, and the law will protect such interference, when a decision is irrational, even if not clearly incompetent. Powell and Kornfeld believe that rational suicide occurs only in a very small number of cases - when the patient is overwhelmed by pain and suffering, has exhausted all other options and for whom death offers the only possible relief. However, the characterization of a suicide as rational or irrational is, to say the least, problematic.

The traditional and perhaps most straightforward view is that suicide is rational when realistic, well-considered, deliberate, and clear-headed. The rational suicide considers carefully the value or utility which he or she can reasonably expect from life, and balances this against the value or utility of no life at all. In the case of suicide, this amounts to a calculation about the harm which may be avoided by suicide balanced against whatever happiness or satisfaction may reasonably be expected if life continues. In these terms, the decision results from a sort of risk/benefit calculation. R.B. Brandt sees the decision process as making a

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17 D.J. Mayo, "Contemporary Philosophical Literature on Suicide: A Review" (1983) 13(4) *Suicide and Life-Threatening Behavior* 313-345.
choice between future world courses. One chooses between the future world course which includes oneself alive in the best or happiest circumstance which it is possible for one to achieve, with the future world course which includes one's own more or less immediate death. Of course, a number of factors will be significant. Certainly the intensity of suffering which one is experiencing and may expect to continue to experience will be significant, as will one's ability to withstand suffering. The likelihood of improvement and the potential for meaningful relationships and activities in the future will also, of course, be relevant to a rational assessment of the value of living, as opposed to dying.\(^\text{18}\)

Skewed reasoning and failures of logic may profoundly affect the rationality of a suicidal decision. Brandt warns against the "plain errors" that may beset a person contemplating suicide, and which may affect autonomous decision-making of any kind. Brandt proposes that another sort of irrationality may be introduced when facing a choice whether to live or die. Events distant in the future tend to carry less weight than do more immediate events. Therefore, present unpleasant states affect us more profoundly than a rational calculation might dictate, and probable future pleasant states tend to count less. The future does not elicit motivation, desire or preference in relation to its true effects. Also, we tend to overvalue that which has been lost. This may make the lifestyle losses associated with illness or disability seem greater than they are in fact.\(^\text{19}\)

Many writers have pointed to the transforming effects of illness,\(^\text{20}\) creating a state of "wounded humanity,"\(^\text{21}\) a dynamic largely ignored by the autonomy model, which may attenuate the rational process of decision-making. Those who are ill or suicidal may lack a realistic world view and may conceive only a limited range of possibilities for their own life.

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The presence of stress and various other pathological states may cause an individual's perceptions to become distorted.\textsuperscript{22} Suicidal feelings are commonly associated with self-hatred and a sense of one's own worthlessness or the presence of acute denial. Sick people may lack insight into their own condition, which can prevent them from making validly informed decisions, even without lacking the competence to consent to or refuse treatment.\textsuperscript{23} Such emotions could profoundly affect a rational choice to die, and could ground justifiable intervention.

It will also be important to judge whether the continuing life that is available is in accordance with or promotes one's fundamental or authentic interests. Is a continuation of life consistent with the value system of the individual? Are alternative life plans available which are reasonably likely to promote one's goals and fundamental interests? In this regard, Seneca notes that we must sometimes choose between living long and living well. In this he means that it may sometimes be necessary to live a shorter life, and terminate it at a particular point, in order that one's life be meaningful and satisfactory.\textsuperscript{24} If rational action seeks to further one's own goals and values, then continuing life may be irrational if such a life is no longer possible.

**Constraints Upon Decision-Making Abilities:** In Chapter 7, a number of impediments to autonomous decision-making were canvassed. Even granting the value of individual autonomy and self-determination, autonomous decision-making may be constrained in many ways. This was to show that the goals of autonomy and the virtues of self-determination may not always be realized by simply allowing others to choose for themselves. Such limitations to autonomous decision-making may be particularly pronounced when one is ill and even more so when one is in circumstances such that ending life is contemplated.

\textsuperscript{22} J.A. Motto, "Clinical Implications of Moral Theory Regarding Suicide" (1983) 13(4) Suicide and Life-Threatening Behavior 304-312.


Illness clearly may interfere with the ability to act authentically. Since many of these constraints tend to address the rationality of an individual’s decision-making generally, it will be no surprise that such constraints may skew the rationality of a decision to suicide. On this basis, intervention may be appropriate. For example, a decision which is based on misinformation, a lack of information or delusions cannot be seen as either autonomous or rational. Martin sees four classes of false desires: mistaken information as to what suicide will bring, false or incomplete information about our own circumstances, false or incomplete information about the alternatives available to us, and fleeting desires, not representative of one’s authentic or enduring personality. In any event, where the quality or quantity of the information founding a decision is inadequate, intervention may be justified.

Much has been written about the effect of depression and psychiatric illness on the quality of decision-making. Studies show that suicidal feelings are strongly correlated with the presence of clinical depression. Chochinov found that the reasoning processes of depressed patients are characteristically biased by negative mental sets that may affect their capacity to make well-considered life and death decisions. Depression is known to primitivize intellectual processes and restrict one’s ability to see the range of possibilities for life. Depression also tends to repress memories and evidence which supports non-gloomy predictions about one’s future life and conversely exaggerates the memory or evidence of a

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negative conception of the future. In addition, depression tends to seriously affect judgments of probabilities. Bad things seem worse and good things seem less than they are.\(^{30}\) However, depression is a largely treatable medical disorder. Anti-depressant medication, psychotherapy and behavioural treatments have proven to be highly effective.\(^{31}\) There is no doubt that depression clouds the ability to choose rationally and is associated with empty, hopeless and helpless feelings.

**Genuine Wish to Die:** Intervention to stop a decision to die would be justified when the decision was not substantially voluntary, that is, made in the presence of coercion or other improper influence.\(^{32}\) Further, treatment refusal could not realistically be seen as genuine if that refusal was not firm, clear and unwavering. Ambivalence in a decision should be grounds for intervention on the basis that, without a settled conviction, the authenticity of a decision, and therefore its voluntariness, is in doubt.\(^{33}\) The helplessness, demoralization and lack of assertiveness typically attending illness may render patients more vulnerable to suggestion or abuse.\(^{34}\) As such, the authenticity or voluntariness of a decision to die, or to accept death, may be undermined in ways that are not apparent to practitioners or others.

But other types of justification for intervention exist. It is argued that suicide intervention is justified when the person does not really wish to die. There seems little doubt that many suicide attempts do not express a genuine desire to die, but are rather a "cry for

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\(^{34}\) Admittedly, this vulnerability may also be exploited by practitioners to encourage that patients accept treatment. While this is of course problematic, an inauthentic or involuntary decision to accept treatment is less tragic than one to decline life-sustaining treatment because of the serious and irretrievable nature of an insufficiently autonomous decision to die.
help," a desperate wish to gain sympathy, a desire to take revenge or a hope to be relieved of pain.\textsuperscript{35} A person may, subconsciously or otherwise, attempt suicide as the only way they can see of marshalling resources to have others attend to strongly felt needs.\textsuperscript{36} If such an attempt should be successful, then a lack of intervention would be a sadly lost opportunity to help someone making a tragic and irretrievable mistake. In such cases, forbearing from intervention amounts not to a respect for autonomy or self-determination but rather respect for a misfounded "...state-dependent, time-limited impulsivity."\textsuperscript{37} In such cases, intervention would not violate autonomy, since the act does not represent the suicide's true wishes. A fixed, firm and unshakable decision to commit suicide is relatively rare.\textsuperscript{38} More often, such a decision is ambivalent and uncertain. Studies show that suicidal feelings are commonly transient and very often respond well to medical or psychiatric interventions.\textsuperscript{39} Ignoring the reality of such common ambivalence surrounding suicidal decision-making may frustrate, not promote, the fundamental interests of the individual.

The foregoing types of justifications: where suicide is irrational, when autonomous decision-making is compromised and where suicide is not really intended, each ground interference in some sense on the autonomy or self-determination of the individual. Interfering with an irrational suicide is arguably an attempt to preserve the patient's freedom to make rational, autonomous decisions in future. If the patient's wish to die is not genuine, or if autonomy is significantly compromised, then interfering in fact promotes autonomous decision-making.

**Expectation of Future Ratification:** Intervention in suicidal decision-making may also be justified by the expectation of a future feeling of approval or gratitude. Self-

\[\text{\textsuperscript{35} Heyd and Bloch, "The Ethics of Suicide," supra note 7.}\]


\[\text{\textsuperscript{37} H. Bursztajn et al., "Depression, Self-Love, Time, and the 'Right' to Suicide" (1986) 8 General Hospital Psychiatry 91-95 at 94.}\]

\[\text{\textsuperscript{38} Chochinov et al., "Desire for Death in the Terminally Ill," supra note 28.}\]

\[\text{\textsuperscript{39} Murphy, "Suicide and the Right to Die," supra note 31.}\]
destructive feelings may be transient and it is often not expected that suicidal feelings will persist. The fact that we have some reason to suppose that the person would, at some future time, be grateful for intervention provides a justification for such intervention.\textsuperscript{40} We live our lives through time and our feelings, beliefs, desires, circumstances and view of the world constantly changes. Our desires, aversions and preferences may be very different at a future time and the passage of time may reverse desperate or sorrowful feelings. In principle, there is no reason to give special weight to present preferences.\textsuperscript{41} If one decides at a particular time that their strongest wish is to die, should that wish be respected if at some future time these desires may well be different? What reason do we have to prefer the wishes of a present self over those of the self at a different time? Of course, if the wish to die at the present time is satisfied, then there will be no future person whose interests or wishes need be addressed or satisfied. Surely however, prolonging the life of someone who later will be glad to have it must be ethically acceptable.

This is not to say however that expected future ratification qualifies as autonomous consent to treatment. Rather, intervention is justified currently by the reasonableness of the expectation that the person's attitude toward ending life will change in future. This justification is not dependent upon the change in attitude actually coming about, although if the expectation is reasonable, such change should usually occur. The moral force of the expectation of future endorsement of the decision to intervene then is that it provides a way of analyzing whether the intervention is in the person's best interests. That is, if the person ratifies the intervention, then it will be reasonable to suppose that intervention was, after all, in the person's interests. The crisis will have passed, the person's life and future will have become clearer and will likely be reflected upon in a more realistic way.

If the person him or herself comes to think that intervention was good for them, then it likely was. Therefore, the question whether the person would ratify the intervention in

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\textsuperscript{41} Brandt, "The Rationality of Suicide," supra note 222.
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future is really a proxy for, or another way of making a reasonable prediction about, the person's medium or longer term interests, which in turn is highly relevant to the justification for intervention.

**Authentic Best Interests:** The most compelling justification for suicide intervention however, arises not out of a respect for autonomy, but rather out of compassion or caring for the suicidal individual. This justification is at the heart of a hard paternalism - overriding individual autonomy is justified on the basis simply that it is for the individual's own good. The paternalist argument is strongest when the harm sought to be avoided is most serious. On this view, suicide intervention arises out of our general obligation to render aid to one in serious distress. If, as has been suggested, suicide is in many cases a cry for help, a strategy by the suicide to attempt to get others to help change his or her life, then the interventionist response is precisely what the suicide is really requesting and really needs. Sakinofsky and Swart point out that others are often in a better position to understand the true needs of the patient. If this is so, then others, particularly health care practitioners, have a particular responsibility to meet those needs at a time when the suicide him or herself may be having difficulty seeing clearly.

On a more basic level, perhaps our most natural drive is to save or preserve life, reflecting a sense of the inherent value of life. Dougherty sees the protection of life as a natural moral first principle. Life is precious and intervention both affirms and values life, both in itself and for the individual suicide. Ringel urges that every human life is important and the purpose of suicide prevention is to affirm or revalue life, by extending the help which medical science and crisis intervention now make possible. The inhumanity of allowing or forcing someone to carry on living when they strongly wish to die is found not in the resulting frustration of that person's wishes, but in the failure to help and care for the person, and to

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42 Brandt, “The Rationality of Suicide,” supra note 18.


alleviate his or her suffering, that life may be made worthwhile.\textsuperscript{45}

**The Social Dimension and Context of Suicide**

There is another sense in which the discussion of suicide in terms of rights and autonomy misses a quite significant aspect of lives as they are truly lived. First, it assumes, or at least appears to assume, that suicidal decision-making takes place in a way abstracted from the interactions of others. That is, a person contemplating suicide assesses his or her own situation apart from the effects which the actions of others may have on that situation. This characterization of the decision-making framework ignores the very profound effects which others have upon our choices and indeed our willingness to go on living. It is trite to say that a person who feels abandoned, worthless, without emotional support or other resources will be much more likely seriously to contemplate suicide than a person who is treated warmly, supportively, caringly and respectfully. To a significant extent, the presence or absence of these supports is a matter in the hands of others and includes the responses and actions of spouse, family, friends and health care practitioners. Suicide prevention constitutes the implementation of the human and social responsibility to care for one's fellow person.\textsuperscript{46}

Suicidal feelings may very often be addressed by evaluating and treating depression or pain, or by addressing other emotional and physical needs.\textsuperscript{47} Clinical experience indicates that most depressed and suicidal people can be helped and are not persistently suicidal, if clinical and emotional factors are addressed.\textsuperscript{48} At a more basic level, by helping and caring for others, suffering can be alleviated and suicidal urges reduced, at least in a great many cases. Such caring includes not only psychological and emotional counseling by professionals but also the human and personal responses of family members and health care practitioners treating the


\textsuperscript{46} Ringel, "Suicide Prevention and the Value of Human Life," *supra* note 45.

\textsuperscript{47} Powell and Kornfeld, "On Promoting Rational Treatment, Not Rational Suicide," *supra* note 15.

\textsuperscript{48} Sakinofsky and Swart, "Suicidal Patients and the Ethics of Medicine," *supra* note 27.
Paternalistic intervention is justified if the person can be helped to regain a life-affirming attitude. Doing so includes an obligation to examine how care may best be offered to the suicidal person. This in turn requires taking account of the entire context of the person's life including, most importantly, the relationships and responsibilities in the context of which the patient lives. With this approach, the focus is not on rights or autonomy, at least as understood in the traditional liberal way, but rather on the most effective way to care for the person. Appropriate care is context-specific. Suicide is not simply an individual decision made independently of the decisions and interactions of others. Suicide is a decision with profound social causes and consequences. With respect to terminally ill patients, Bender sees the issue as how best to care for the person.\textsuperscript{50}

But there is another, perhaps deeper sense in which suicide is a social matter. The social dimension of suicide is demonstrated by judicial and social responses to particular kinds of suicides and refusals of life-sustaining treatment. The decision to attempt suicide, or to have life-sustaining treatments withdrawn seem, to courts and others, to be particularly compelling where there is not long to live and where life seems to be particularly burdened with untreatable pain or suffering. In such circumstances, the choice of death seems rational and perhaps acceptable. However, if we contemplate the no less competent wish of a younger, relatively healthy person who chooses a course of action which will likely result in death, judicial and social feelings about suicide or refusing life-sustaining treatment become increasingly ambivalent. The enthusiasm for honouring the life-ending decision wanes.

But why is this so? If the fundamental value is the self-determination of the individual, then the particular circumstances, whether the patient was terminal or how and to what extent the patient was suffering, should be irrelevant. Courts appear to wish to limit cases in which life-sustaining treatment may be refused to those where there is not long to live, where the


treatment itself, or the life extended by the treatment, seems particularly burdensome or where the patient is in permanent coma or PVS. In particular, notwithstanding their strong rhetoric, if reasonable health can be restored, courts have proved hesitant to sanction a choice to die. But if the relevant moral or legal consideration is the patient’s right to choose, the court should not be enquiring into such circumstantial factors.\(^{51}\)

The fact that a patient’s circumstances do make a difference to our willingness to accept their life-ending decision, indicates at bottom that we make judgments about the quality of other’s lives. If this is true then autonomy is not absolute and the individual context matters. We typically do not stand by while others, even if apparently competent, make choices based upon their own conception of the good, when disastrous results are predictable. It is right not to do so. If we are prepared to allow intervention with any of the life-ending choices made in the narratives related in Chapter 1, and it is a fair guess that most people would,\(^{52}\) then we must admit candidly that some deaths are to us more acceptable than others. Indeed, this is not only a decision which society does make, but it is a decision which society morally ought to make.

While paternalistic laws in general may be justified in appropriate circumstances, laws respecting paternalistic interference with decisions to die are particularly so. In the next chapter, conditions under which such intervention are justified are proposed. By taking account of the nature of decisions to die, and the requirements of acceptable legal paternalism, the reach and limits of such paternalism is analyzed. In this context, the balancing of harms and duties required by the defence of necessity can be given some concrete substantiation.


10. FAITH, DEATH AND SUFFERING

Overview and Summary

It would be helpful to take the opportunity to summarize the argument of this thesis as it has been developed to this point. Initially, it was suggested that, at least on an intuitive level, circumstances may arise in which one may ethically intervene in another’s apparently competent decision to die, by giving life-sustaining treatment. The cases of Allan, Betty and Kenneth were offered as examples. The response of hospitals and medical practitioners to those brought in following a suicide attempt is pretty much universally to treat and preserve life if at all possible. However, if the person has specifically refused treatment, or left a note attesting to the genuineness of his or her intention to die, then it would seem that he or she has instructed medical personnel, and others, not to administer treatment. It could even be that the fact of the suicide attempt itself evidences a desire to die, and therefore a refusal of treatment which would frustrate that desire could reasonably be inferred. The broad question of this thesis then is the justification of practitioners’ administration of life-sustaining treatment in the face of an explicit or implied refusal of such intervention.

In Chapter 2, the judicial response to competent persons’ claims to a right to refuse treatment is canvassed. In general, treating a person despite their refusal is a common law battery, and may also be a violation of the individual’s constitutionally protected rights to security of the person in Canada and liberty or privacy in the U.S. However, although the legal prohibition is strong, it is not absolute. Courts in Canada and the U.S. have acknowledged the existence of important state interests in preserving life, preventing suicide,

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protecting innocent third parties and promoting the integrity of the medical professions which must be balanced against these rights. Any of these might, in appropriate circumstances, override the right to refuse treatment. While these interests have generally been found insufficient, particularly in the more recent cases, it is difficult to find cases where a right to refuse life-sustaining treatment has been endorsed where the health of the patient could predictably be restored, aside from cases of religious objection to treatment, of patients requiring limb amputation, or of patients suffering from quadriplegia.

In Chapter 3, it is argued that the supposed distinction between suicide and refusing life-sustaining treatment is not morally relevant. That is, in considering whether intervention in the face of a refusal of consent is permitted, it does not matter whether death would be brought about by an overt act of suicide, or by the underlying disease process. It may generally be true that cases in which intervention is appropriate are more often cases of rescuing a person from an overt act of suicide. This is because such persons will tend to be healthier (at least medically) and their health is more likely to be restorable by intervention. However, the categories of suicide and refusal of treatment are not appropriate proxies to identify the truly relevant considerations. It is argued that the presence or absence of such relevant considerations are generally reasonably accessible and may apply either to overt acts of suicide or to refusals of treatment for an underlying medical condition.

A common response by practitioners when faced with a refusal of life-sustaining treatment which seems particularly unwise or inadequately supported by rational reasons, is to argue that the person is decisionally incompetent to make medical treatment decisions. On this basis, treatment may be given either on the basis of the emergency exception to the requirement of consent, or by appealing to an available surrogate decider. It could be argued

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4 Malette v. Shulman (1990), 72 O.R. (2d) 417 (C.A.)

5 Lane v. Candura, 376 N.E.2d 1232 (Mass. Ct. App. 1978); In re Quackenbush, 383 A.2d 785 (N.J. 1978); State Dept. of Human Services v. Northern, 563 S.W.2d 197 (Tenn. Ct. App. 1978); Re C., [1994] 1 All E.R. 819 (Fam. Div.) Indeed, where there is any doubt about the prior wishes of an incompetent patient, the courts have been hesitant to order amputation - In re Dept. of Veteran's Affairs Medical Center, 749 F.Supp. 495 (N.Y. Dist. Ct. 1990).

that no additional legal mechanism is necessary to address patient's troubling decisions to die because those persons whose choice ought to be interfered with can in any event be found incompetent.

It was argued in Chapter 4 however that this is not a satisfactory response or strategy. Briefly, the existing legal-medical notion of competence is, conceptually and practically, too ambiguous to provide a reliable test of whether intervention in the face of such refusal is appropriate, particularly in light of the potentially grave consequences of a failure to intervene. In addition, the considerations relevant to justified intervention are not adequately captured by the accepted tests for incompetence. Accordingly, the strategy of searching for some incompetence-making features of the patient, or his or her choice, will tend to be artificial. It would be preferable to address squarely the considerations which are relevant to interference, and non-interference, rather than to use incompetence as a proxy or marker for the presence or absence of such relevant considerations.

In light then of the legal prohibition against involuntary treatment, if it is accepted that such intervention is sometimes justified, the concern is that a practitioner may act morally appropriately in rescuing a suicidal person, but be liable in battery to the patient for doing so. If the practitioner does indeed act ethically in treating, it is problematic that he or she could be successfully sued. For this reason, in Chapter 5, the common-law civil defence of necessity is proposed as an appropriate legal shield against such liability. The defence of necessity requires a balancing of the harm averted or benefits gained by violating the law (in this case, by treating without consent) against the harms and benefits which may be expected to result from complying with that law (refraining from treatment).

The values given effect by respecting a refusal of treatment, such as individual autonomy or self-determination and protection of the individual's bodily integrity are, no doubt, important. In order then to give some framework for the balancing which the defence of necessity requires, the medical-philosophical notion of autonomy is reviewed in Chapters 6 and 7. Broadly speaking, the conclusion is that autonomy has significant value, but self-determination cannot be absolute or overriding in all cases, both because it does not comprise a comprehensive or self-sufficient moral system, and because the psychological qualities which
give autonomy its normative force are often compromised.

The other side of the balance required in applying the defence of necessity is a consideration of the benefits gained and harms averted by intervening notwithstanding treatment refusal. Inasmuch as such intervention is motivated solely or substantially for the good of the individual whose choice is overridden, intervention is ultimately paternalistic in the hard sense. Accordingly, in Chapter 8, the broad philosophical justification for paternalism is examined and Chapter 9 addresses the justification for paternalism in the particular case of decisions to die. The conclusion is that paternalistic interference is justified, at least in some circumstances, where the good of the individual is thereby promoted or in order to promote the individual's future autonomy.

The purpose of this Chapter then is to attempt to apply the defence of necessity to cases of refusal of life-sustaining treatment, including those expressed or implied in the context of a suicide attempt. In particular, it will review the basis upon which such intervention is undertaken and will propose guidelines to determine when such intervention is appropriate and when a refusal of treatment ought to be respected. From these guidelines, more concrete proposals may be made about the application of the defence of necessity to particular cases. It is hoped that greater certainty about the application of the defence of necessity to particular cases will be helpful as a guide to practitioners in making difficult choices about their obligations when attending to a person refusing life-sustaining treatment.

The Legal Basis for Intervention

Emergency: It is assumed that intervention is justified in the cases related in Chapter 1, or at least in some others where the patient is apparently competent, reasonably informed and making a decision which will result in his or her death in a reasonably voluntary way. It remains to explain the basis upon which such intervention may be undertaken. The urgency or life-threatening nature of the patient's condition would typically obviate the need for consent because the common law principle of emergency provides an exception to the
requirement of consent in such circumstances. However, where the patient makes a competent prior or contemporaneous refusal of the treatment in question, and the patient is presumed to be competent, courts have been clear that medical urgency does not justify treatment.

**Informed Refusal:** It might be proposed alternatively that, at least in some cases, a lack of informed refusal justifies life-saving treatment. The argument would be that the patient does not have adequate information about the consequences of refusal to allow him or her meaningfully to exercise that choice. Just as a consent to treatment must be informed in order to be valid, a refusal of treatment should likewise be informed. Unless the patient is adequately informed, neither consent nor refusal should be considered genuine and, on that basis, treatment may be given on the basis of emergency.

While this argument is tempting, it presents a number of difficulties. The most important problem, from a legal standpoint, is that the Ontario Court of Appeal rejected precisely that argument in the *Malette v. Shulman* case. In that case, Georgette Malette, a Jehovah’s Witness was found to have refused a blood transfusion, required as a result of a serious automobile accident. She was unconscious when brought to the hospital and incapable of giving verbal consent or refusal to treatment at that time. Her refusal of blood was expressed on a card which she carried in her handbag. Clearly, the doctor had ample reason to doubt whether Mrs. Malette understood the risks and consequences of refusing blood in the particular circumstances. Nevertheless, he was found to be obliged to respect her refusal notwithstanding unanswered questions about the adequacy of the information underlying her refusal.

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8 See cases in notes 15 and 16.


10 *Supra note 4.*
refusal.\textsuperscript{11}

In any event, in most cases, the argument that refusal was inadequately informed will be inapplicable on the facts. This is because the risks and consequences of refusing life-sustaining treatment, or of refusing treatment following a suicide attempt, will be perfectly obvious. The risk is death, and it is either intended or expected by the patient at the time of treatment refusal. Betty and Kenneth both knew and apparently accepted the consequence that they would die without mechanical ventilation. Allan took an overdose with precisely that expectation. Accordingly, the absence of informed refusal, as a justification for treatment without consent, is both legally unsupported and, in any event, almost always factually inapplicable to these types of cases.

**Presumed Incompetence:** It may be argued next that such intervention is justified on the basis of the presumed incompetence of the patient.\textsuperscript{12} That is, a person who attempts to take his own life, at least in circumstances where the reasons and context are uncertain, or where reasons seem inadequate to care-givers, should be presumed to have been incompetent at the time the life-ending decision was made, and treatment given on that basis. This might be seen as a useful fiction to allow intervention when judged necessary while remaining within the basic framework of the existing law of consent. Since deemed to be incompetent, any prior refusal would be ineffective, and the case may be treated as an emergency.\textsuperscript{13}

The difficulty here is that such presumption is artificial. Clearly, some refusals of treatment should be honoured, and a blanket presumption of incompetence would be over-inclusive. In such cases, a presumption of incompetence would clearly result in unjust treatment. No method is apparent to distinguish cases in which treatment refusal is acceptable

\textsuperscript{11} In *Werth v. Taylor*, 475 N.W.2d 426 (Mich. Ct. App. 1991), the court held that a refusal of a life-sustaining blood transfusion by a Jehovah's Witness may be disregarded if not fully informed and expressed contemporaneously. In addition, in that case, it was not clear from earlier discussions with the patient whether she was refusing blood even if needed to preserve her life.


and ought to be respected. Considerations of this kind are vital because they address directly the question which is in issue.

More important, again there is no basis in law for such presumption. Quite the contrary, judicial, legislative and critical opinion is clear that incompetence must be proved in every case, and although Canadian courts have not taken up this question, U.S. courts have held that incompetence must be shown by clear and convincing evidence. Provincial legislation, to the extent that such exists on the subject, has embodied this presumption. An additional difficulty is that if the patient is to be treated as incompetent, then if a legally authoritative surrogate is available, that person's substitute decision about treatment would be controlling. If the surrogate also refuses to consent, practitioners remain without valid legal authority to treat, at least if presumed incompetence is the basis for treatment.

**Actual Incompetence:** Could it be then that, although while the persons in such cases may not be presumed to be incompetent, they are nevertheless actually incompetent. That is, appearances to the contrary, for a person to make the decision to die, on what appear to be irrational grounds, is itself evidence of lack of decisional competence. This too is an attractive argument. If the decision seems unwise or one which carries seriously harmful consequences, apparently without satisfactory prudential justification, then there must be some failure of understanding or appreciation, even if such failure is not apparent.

Unfortunately, this approach too is unsatisfactory. It would be extreme to argue that a person must be incompetent who wishes to die, or who would accept an avoidable death. Therefore, the fact that death is chosen or expected could not be, in itself, sufficient to discharge the burden of proving that the person was incompetent in rendering that decision.

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16 U.S. v. Charters, 829 F.2d 479 (4th Cir. 1987).

17 For example, Health Care Consent Act, S.O. 1996, c. 2, s. 3(2).
In addition, there is widespread judicial and critical acceptance that a person may be depressed, or suffer from cognitive or affective disorder, and still be competent.\textsuperscript{18} Indeed, a person who is civilly committed may still be competent,\textsuperscript{19} and one court found that a person who is unfit to stand trial on a criminal matter could nevertheless be found competent to consent to medical treatment.\textsuperscript{20} So, a finding of incompetence on the basis that the patient has chosen to die, or of the patient's psychiatric status, would be improper, at least if there is no severe or crippling psychiatric illness.

If however, a finding of incompetence is made purely on the perceived imprudence of the decision, or its lack of adequate justifying reasons, then the determination of competence becomes a quite different process than has been heretofore understood. The assessment of competence based on the outcome of the decision has been widely rejected.\textsuperscript{21} The point of evaluating competence, at least we are given to understand, is not to ensure that the right decision is made, but rather to ensure the person has the requisite decision-making capacities such that his or her right of self-determination may be exercised in a valid and meaningful way. Deciding that one is incompetent by looking to the decision itself, rather than to cognitive or affective decision-making capacities demonstrated by the patient, confuses what a competence determination seeks to establish. As a number of writers have noted with disapproval, it is typically the case that the same person would easily be found competent if they had consented to, rather than refused, the life-sustaining treatment offered.\textsuperscript{22} Therefore,


\textsuperscript{20} U.S. v. Charters, supra note 16.


\textsuperscript{22} M.R. Wicclair, "Patient Decision-Making Capacity and Risk" (1991) 5(2) Bioethics 91-104 at 103.
it seems out of bounds to make a determination of incompetence based largely or solely on the content of the particular decision made.

Further, it seems just mistaken to conclude that Allan, Betty, Kenneth or others refusing life-sustaining treatment must have failed to meet the legal or medical standard for competence. It is not difficult to imagine that Allan understood what it meant to him (at least medically) to take an overdose of pills, and that he had a reasonable appreciation that doing so might well mean that he would die. But the fact is that hospital personnel pretty much always treat attempters of suicide, even against their stated wishes.23

An Alternative Basis - The Likelihood of Mistake

In any event, it is artificial to seek for some source of incompetence in cases where death will be the result of treatment refusal and it is at least apparent that the person has decision-making capacity. What is really going on is simply that the choice to refuse treatment seems to be disastrously unwise and intervention is justified, if at all, on the basis that the decision predictably carries grave consequences without adequate rational or prudential justification. When we feel impelled to step in to rescue or treat someone in danger of dying, such as Allan, or to continue medically indicated treatment, such as for Betty or Kenneth, it makes more sense to suppose that we do so because the matter admits of great uncertainty. We know that such a person might be incompetent, or they might not be, but it does not really matter, at least for the purposes of a decision whether to intervene. The uncertainty is whether the patient is in fact mistaken that being dead is truly in their own best interests, judged on their own terms, that is, in terms of their own goals, values, and individual personality.

Mill tells us that people generally know, better than anyone else, what is truly in their own authentic best interests,24 and this may usually be true. But we recognize that it is not always true. People have in some sense privileged access to their own best interests, but they do not have perfect access, they might be mistaken. There are a number of reasons why a

23 Cassell, "The Function of Medicine," supra note 1 at 239.
person might be mistaken about a decision which will result in their own death. Some of these reasons are the same as those outlined in Chapter 7 as compromising autonomous decision-making. The person might be inadequately or wrongly informed about relevant matters, or may be confused, seriously ill, in pain or suffering, feeling pressure from others, or suffering from cognitive or affective disorder. Margaret Battin suggests that several factors may contribute to the,

...backfiring of right-to-die choices. First, and perhaps most obvious, patients may misjudge their situations in refusing treatment, or in executing a natural death directive; refusal may be precipitous and ill-informed, based more on fear than a settled decision to die.25

None of these conditions is necessarily inconsistent with the person being decisionally competent.

The question may be approached in another way. A number of writers have argued that intervention in a suicide is acceptable when the suicide would be irrational.26 But what if, as is understandably usually the case, the rationality of a particular decision is unclear? To the extent that there is significant doubt about the rationality of a suicidal decision, it seems appropriate to intervene, particularly in light of the serious and irretrievable nature of a completed suicide.

At bottom, the question is whether the patient is evaluating appropriately either their ability to withstand the present suffering, or the possibility that they may regain an adequately satisfying life.27 There are a number of reasons to suppose that a suicidal person may be mistaken about these matters, or be deciding in an irrational way. Persons considering ending their lives are very often depressed, and depression may confound effective decision making in a number of ways. However, depression is not, by itself, inconsistent with decisional


competence. Indeed, some depression may be quite understandable in those circumstances in which suicide is contemplated. Powell and Kornfeld note that it may in any event be difficult to distinguish clinical depression from an appropriately sad reaction to a poor prognosis. A disproportionate pessimism is a natural response in these circumstances. Depression “primitivizes one’s intellectual processes and restricts the range of one’s survey of the possible.” It affects one’s judgment about probabilities and tends to repress one’s memory of evidence that supports a non-gloomy prediction about one’s future.

Brandt notes that even if one is not depressed, our future prospects may be misjudged in a number of ways. This is because events distant in time, such as the possibility of future happiness, tend to feel small and do not have their due effect on our motivational processes. Conversely, present unpleasant states tend to affect us more powerfully and weigh more heavily in our calculations than probable future pleasant ones. Things we have lost may appear, in retrospect, to have been more valuable to us than they in fact were. So, the loss of abilities or capacities which may at first appear to be unendurable, may in fact be losses which will come to be satisfactorily assimilated. Also, we tend to give insufficient weight to the fact that sorrowful feelings can change and the passage of time may find us feeling very differently about our situation. For example, Carol Gill points out that people who become disabled generally adjust to their disabilities, even if such adjustment may appear to them


32 Brandt, “The Rationality of Suicide,” supra note 26 at 120-121.
initially as impossible.\textsuperscript{33} Bursztajn \textit{et al.} note that suicidal persons rarely see that the meaning or experience of their suffering can change.\textsuperscript{34} Ganzini \textit{et al.} note that while some suicidal persons have the ability to understand and appreciate the relevant medical information, feelings surrounding the suicide may alter their "...equation for weighing the risks and benefits of medical treatment." The person is temporarily not his or her authentic self.\textsuperscript{35}

David Mayo argues that people in a state of despair are apt to go astray when they undertake to make a rational decision on the basis of the future consequences of their actions. A person in this state may simply abandon any serious commitment to making rational decisions. Rationality may cease to be an important consideration. Such persons then will not even attempt to think clearly about their prospects for a minimally satisfying future life. Feelings of hopelessness, typically attending suicidal feelings, will tend to alter the person's perception of his or her own life and future prospects.\textsuperscript{36} To cooperate with such feelings, according to George Murphy, would be to violate an important responsibility of the physician.\textsuperscript{37} According to Jerome Motto, exaggerated feelings of guilt and diminished self-worth may confound a realistic assessment of one's future.\textsuperscript{38} Heyd and Bloch argue that even if life has lost meaning, part of the value of life lies in the fact that so long as there is life, new

\textsuperscript{33} C.J. Gill, "Suicide Intervention for People with Disabilities: A Lesson in Inequality" (1992) 8(1) \textit{Issues in Law \\ & Medicine} 37-53.

\textsuperscript{34} H.J. Bursztajn \textit{et al.}, "Beyond Cognition: The Role of Disordered Affective States in Impairing Competence to Consent to Treatment" (1991) 19(4) \textit{Bulletin of the American Academy of Psychiatry and Law} 383-388 at 386.


\textsuperscript{38} J.A. Motto, "Clinical Implications of Moral Theory Regarding Suicide" (1983) 13(4) \textit{Suicide and Life-Threatening Behavior} 304-312.
meaning may be created. 39

In addition, a decision to die may be very complex. Feelings surrounding ending one’s life will often be conflicted and subject to pressures from a variety of sources which may not be readily apparent to the patient. Although it is not necessary that a decision to die be complex, the powerful psychological, emotional and often physical forces at play render it more commonly so. The uncertainties attending such decision are enormous. This is partly because one’s future happiness or misery is so difficult to predict, as is the nature of what awaits us, if anything, after death. Philip Devine notes the profound imaginative and intellectual difficulties attached to envisaging the end of one’s existence. 40 Heyd and Bloch point to,

... the asymmetry between the two choices of life and death. The prolongation of life does not mean the shortening of death, and cutting life short does not imply having more of the other state (death). Therefore, even if we could assign ‘values’ to life and death they would typically be incommensurable. How can we compare the state of conscious experience of an identifiable subject with the complete loss of consciousness and personal identity? 41

Whether life is really worth living is a question complicated not only by the fact that we cannot know what happiness or misery awaits us, but also because it is difficult to predict what sorts of things we might come to find productive of happiness or misery. A suicide will very commonly arise from a blend of essentially good reasoning, at least from the person’s point of view, applied to non-rational motives. It is a complex web that resists disentanglement. 42

Overall, it would be mistaken to assume that choices in this context are governed by plans of action developed on careful reflection after acquiring and sifting information


dispassionately. Normally one hopes that such behaviour is fully volitional and based on a realistic assessment of the person's life plans and values. However, a pervasive sense of pessimism, hopelessness and helplessness is often associated with decisions to die and may be destructive of thoughtful consideration about such a choice. And there is an additional source of uncertainty. Not only must it be acknowledged that the suicidal person may be mistaken, but the practitioner considering intervention will also typically be uncertain as to whether a mistake is being made. Heyd and Bloch note that the intentions and other internal states of the patient are difficult to discern and, in principle, impossible to know with certainty.

According to Motto, society accepts that intervention is sometimes acceptable and a number of factors are relevant. He offers as examples, intensity of pain, individual threshold of pain tolerance, likelihood of relief, capacity for rational thought and autonomous activity, the religious meaning of death for the individual, the value system of the individual, the suicide's potential impact on others and the person's potential for meaningful relationship and activities. However, a practitioner has no reliable instruments to measure these considerations, aside from his or her own intuitive judgment. In principle, there is no concrete way to answer how rational or autonomous the suicidal decision must be. How much pain must the person be suffering? What constitutes an adequate likelihood of recovery, and to what level of functioning? How satisfying must be the prospects for the person's future life, and how probable must they be? In short, the conceptual and practical uncertainties are profound.

At least in many cases it will not be unreasonable to question whether a mistake of this kind is being made. And if, in the circumstances, it is not unreasonable to suppose that a mistake might be made, it is morally allowable, or even obligatory, for a practitioner to

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44 Heyd and Bloch, "The Ethics of Suicide," supra note 39 at 253.

45 J.A. Motto, "Clinical Implications of Moral Theory Regarding Suicide," supra note 38 at 311.
intervene to provide needed treatment. It is proposed further that the default, or presumption, should be to treat in such circumstances, notwithstanding refusal. Accordingly, although paternalism has acquired a bad name, it should be acknowledged that in some circumstances, we may act paternalistically, in the best interests of the patient, to rescue them from what, it is reasonably believed, might be a tragic mistake. Indeed, such acknowledgement simply reflects a plausible characterization of the current reality of medical decision-making where treatment refusal seems unwise. In such circumstances, a search for decisional incompetence appears to be merely a way of finding an appropriate legal or ethical category through which intervention may be justified.

The Nature of a Suicidal Decision

In light of the present state of the law and ethics with respect to the right to refuse treatment, a presumption of paternalistic intervention may seem a strong conclusion. It is supported, however, by the common sense observation that, if it is a mistake, a decision to die is a particularly tragic kind of mistake to make. This is so for a number of reasons:

First, psychiatric or medical illness, pain, personal grief and skewed decision-making, as well as other sources of compromised decision-making, make the likelihood of mistake in this regard more significant. These are canvassed in some detail in Chapter 7, and it is important to note that such sources of compromised decision-making need not be such as to render the person incompetent. Briefly, the effects of physical illness or disability, psychiatric illness, powerful emotional factors and insufficient or mistaken information may all have profound effects upon one's ability to act in an appropriately autonomous way. Such effects are more likely to be playing a role in the decision-making of a person in circumstances in which suicide is contemplated than in others. In addition, the attitudes displayed and the support offered by others will have profound effects on a decision about suicide.

Second, studies show that suicide attempts and other expressions of a decision to die are often ambivalent, and indeed commonly do not express a well-considered or stable resolution. Suicidal expressions or acts may be instead a "cry for help," a strategy which might be in fact a quite rational appeal to others for support, resources, love, fellowship,
validation, or some other human need. Heyd and Bloch note the,

...well-recognized observation that explicit expression of suicidal intention is, in many cases, really a cry for help, a desperate wish to gain sympathy, a desire to take revenge, or a hope to be relieved from pain, and so forth.

Bursztajn et al. note that the suicidal person may be seeking an interaction that will help to either confirm or deny a decision ambivalently made. If this is so, no unambiguous suicidal intention is evidenced by the attempt. Gill notes that "...[a]ny deliberate act of self-annihilation is suicide and all suicidal behaviour is motivated by need, not reason alone." Glanville Williams isolates three kinds of suicidal acts. First there are genuine attempts at suicide, which may or may not succeed, but will typically succeed eventually if they are genuine. Second, there are what he terms "suicidal demonstrations," where what appears superficially to be an attempt at suicide is not seriously meant. This second class comprises suicides which constitute a gesture, calling upon others to take notice of his or her misery. In such cases, there is no intent to die. The third class, intermediate between the other two, are suicidal acts that are consciously an attempt at suicide, but unconsciously a gesture. In this third sort of suicidal act, the patient gambles his life, running the risk of death, but subconsciously hoping that it will turn out to be merely a successful gesture, resulting in an improvement of his or her circumstances. Clearly, it may be very difficult for another to determine with confidence to which class of suicidal act a particular attempt belongs. And, if a particular attempt constitutes either a conscious or unconscious gesture, the expressed or implied refusal of the treatment will not in fact be what is truly sought by the person.

Erwin Stengel sees suicide attempts fundamentally as a kind of risk-taking behaviour.

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47 "The Ethics of Suicide," supra note 39 at 253.

48 H. Bursztajn et al., "Depression, Self-Love, Time, and the 'Right' to Suicide" (1986) 8 General Hospital Psychiatry 91-95.

49 Gill, "Suicide Intervention for People with Disabilities," supra note 33 at 39.

at least in the absence of serious mental illness. The goal of the suicide attempt is to make an appeal to others for recognition or attention.

Because of its effects on other people, the threat of suicide acts as one of the regulators of human relations in all societies in which suicide is dreaded and disapproved. The only way to deprive it of its appeal effect is to make the appeal unnecessary.51

While not denying that some suicides are motivated sincerely by a desire to die, Stengel sees these as exceptions. Misinterpreting such expression as representing a "true" choice to die, or to allow death to come, would be particularly tragic.

Third, in part because death forecloses all possibility of future happiness or satisfaction, death feels like a very great harm, and for most people, most of the time, it is a great harm. Our criminal law reserves its most extreme punishment for the crime of taking a life, but even so, we forbid the state from killing, even in answer to this horrible crime. The grief and sadness we feel at the death of another, even of one we do not know well, or like very much, is very natural. News of a death is almost always bad news. When we learn of a suicide, the response is rarely one of relief that the person has finally achieved the peace and dignified demise which he or she has sought. Rather, the response, with some exceptions, is that the suicide is a tragic human waste. The high value placed on life seems entirely appropriate, both as an expression of caring for the individual and as an affirmation of the hope which can give life meaning. For Dougherty, life is a "...natural moral first principle."52 The instinct for survival seems very deeply embedded in the psychology of humans and other creatures. Studies show that even most terminally ill persons do not wish to die, and indeed cling to life.53

It is perhaps trite to attempt a description of the value of life. Edward Keyserlingk, in his report to the Law Reform Commission of Canada on the sanctity of life, writes, "...the

51 E. Stengel, Suicide and Attempted Suicide (Hammondsworth, Middlesex: Penguin, 1964) at 109.


53 D.C. Clark, "Rational' Suicide," supra note 28 at 160.
sanctity of life principle is probably the single most basic and normative concept in ethics and in law...” and,

It is rightly claimed that the starting point, the foundation for any formulation or reformulation of biomedical laws, codes or consensus should be the sanctity of life principle. That principle has, after all, been the one most fundamentally and continually appealed to in our western culture as the justification for moral rules, laws, human rights and social policies.54

Edward Shils bases a secular belief in the sanctity of life in,

...the primordial experience of being alive, of experiencing the elemental sensation of vitality and the elemental fear of its extinction. Man stands in awe of his own vitality, the vitality of its lineage and of his species. The sense of awe is the attribution and therefore the acknowledgment of sanctity.55

Keyserlingk notes that human life is precious and worthy of respect and protection. It cannot be defended merely by subjective or utilitarian concerns. Rejection of the sanctity of life principle would endanger all human life.56

Fourth, and most important, a decision to die is irrevocable. This aspect of the act of suicide creates another kind of asymmetry between the two responses to suicide.

The irreversibility of non-intervention places a particularly heavy burden of moral responsibility on the psychiatrist. By contrast, a decision to intervene can always be reversed.57

In deciding whether to intervene, the practitioner risks making one of two kinds of mistakes. He or she could intervene when the person had in fact made a realistic decision that life is not worth continuing. In that case, intervention would be misguided and burdensome to the patient. Alternatively, the practitioner could fail to intervene in a decision resulting in death, where the potential exists that the person may in fact be able to salvage an adequately

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56 *Supra* note 54 at 17.

satisfying future, even on his or her own terms. If the first kind of mistake is made, then death is stopped wrongly when it really is for the best. Of course, it is possible to correct this sort of mistake. However, if the other kind of mistake is made, a person is allowed to die needlessly, and the failure to intervene cannot be repaired.

Perhaps because of these reasons, the traditions and expectations of the medical professions strongly incline toward saving life wherever possible. Heyd and Bloch argue that, for practitioners, the underlying assumption of intervention is, “the instinctive drive to save other people’s lives plus the professional duty and practice of doctors to do so.” While prolonging life at all costs is acknowledged not to be a necessary or appropriate role for practitioners, medical professionals have a strong presumptive legal and ethical duty to preserve life, which may be deferred only in extraordinary circumstances. Singer and Lowy note the traditional medical practice to err on the side of life when faced with uncertainty. As applied to life-ending decisions, the present law which presumes the validity of the patient preference to refuse life-sustaining treatment reverses this default position. Given the nature of a decision to die, the traditional presumption in favour of life is more compelling when the authenticity or autonomy of choice is uncertain.

Faith, Death and Suffering

A default in favour of treatment in response to a choice to die supports the view that others, most particularly medical practitioners, have an important presumptive duty to intervene to save life. This presumption of treatment notwithstanding refusal is justified by the significant likelihood of mistake on the part of one attempting suicide, coupled with the tragic and irretrievable nature of such mistake, if it is being made. However, this presumption is not absolute, and may be rebutted. Three factors relevant to displacing this presumption - faith, death and suffering - are proposed. Medical practitioners should have a limited privilege

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58 Ibid. at 257.

to impose treatment reasonably needed to save life, unless any one of these three conditions is present.

**Faith:** To the extent that the proposed treatment itself is contrary to the person's deeply held religious, cultural or personal beliefs, then the existence of such beliefs should displace the presumption that a refusal of life-sustaining treatment not be honoured. A person should be permitted to refuse treatment on the basis that their strong and abiding convictions prohibit the particular treatment. Where fundamental beliefs about the treatment are tolerably clear, they will likely not be mistaken, since the refusal is more transparently in accordance with deeply-held values. Also, because the person has no wish to die *per se*, it may be expected that the unwanted consequence of death will be carefully considered, and less likely to be mistaken. In such circumstances, the consequences of treatment are, at least in the experience of the patient, very grave indeed. The strongly-felt belief is that accepting treatment will be answered with everlasting consequences, or, in any event, a lost opportunity at salvation or paradise. For example, the Jehovah's Witness patient in the *Osborne* case told the judge that if the court ordered him to be transfused, he would be deprived of everlasting life.

Accordingly, refusals of life-sustaining treatment based on strongly-held and stable personal or religious belief should outweigh the practitioner's duty to preserve life. While this duty is strong, cases of refusal based on faith will, as a general matter, be stronger. The likelihood of the patient misjudging his or her own authentic welfare, taking account of their values, goals and history, is greatly reduced.

In addition, the consequences to the patient of overriding autonomy, and imposing treatment, are much greater than in other cases of treatment refusal. This is because once treatment is given, that religious infraction cannot be repaired, or at least so it is believed by many of the Jehovah's Witness and Christian Scientist faiths. The reason for the refusal

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is clear and reasonably unambiguous. So, the effects of affective or cognitive disturbance, inadequate information and so forth, are unlikely to be playing an inappropriate role in the making of this decision. It is important also that when religious belief is deeply felt, the practitioner can be more confident that there is less likelihood that the person would change his or her mind in future if treatment were imposed. Therefore, overriding the religious adherent’s refusal is less likely to be autonomy-preserving, at least with respect to the person’s views about the medical treatment in question.

This view about respecting strongly-held religious belief is consistent with both Canadian and U.S. constitutional guarantees of freedom of religion. Both countries afford great respect to individual religious belief, seeing it is a special kind of free expression afforded particular rights and protections. Justice Robins, in the *Malette* case, adopts the words of the trial judge, Donnelly, J., as follows:

> However sacred life may be, fair social comment admits that certain aspects of life are properly held to be more important than life itself... Refusal of medical treatment on religious grounds is such a value. ⁶³

The attitude of the U.S. Supreme Court is captured by Chief Justice Burger:

> The essence of all that has been said and written on the subject is that only those interests of the highest order and those not otherwise served can overbalance legitimate claims to the free exercise of religion. ⁶⁴

This is not to say that such constitutional and common law protections of religious expression by themselves justify special rights of non-interference with religiously-based treatment refusals. Such protections do however point to a social, legislative and judicial recognition of the powerful role of religious belief in people’s lives, which underscores the very serious nature of a decision to involuntarily treat a person in a way which is offensive to such belief.

The condition of faith, however, should not be restricted to deeply-held religious views alone. The considerations which militate in favour of a special respect for religious belief count as well for other deeply-held cultural or even individual beliefs relating to the treatment

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⁶³ *Malette*, supra note 4, quoted at 422.

itself. For example, suppose a person feels very strongly about the rights and welfare of animals, and could not accept that he should be treated with any drug which was tested using live animals, even if necessary to preserve his life. If the practitioner was aware that such belief was long and deeply held, then an obligation to honour a refusal of that drug would be justified on the same basis as if the drug were the subject of a strongly-felt religious prohibition. Or, a Holocaust survivor may have extraordinarily powerful beliefs about certain kinds of treatment arising from their experiences in a concentration camp. Clearly, the practitioner in question must be aware both of the particular belief in question and that such belief is of a strong, enduring and stable nature.

**Death:** The presumption in favour of intervention to treat to preserve life should also be displaced when death is imminent. For these purposes, death must be reasonably expected to occur fairly quickly, whether or not the life-sustaining treatment is given. If death will come soon anyway, then concerns about preserving future autonomy are much reduced. The person’s future liberty is reasonably expected to be of very short duration in any event. Seneca argues that a wise person contemplating death near the end of life, "...does not regard it with fear, as if it were a great loss; for no man can lose very much when but a driblet remains."

With death drawing near, there is less potential for the person to find a satisfying life or, to put it another way, it becomes more likely that the patient’s own estimate of the possibilities for life and its quality in any continuation is roughly accurate. The probability of mistake by the patient concerning the future course of his life is much reduced, since the future which must be imagined is shorter. In such cases, others are properly required to stand aside and allow the patient’s own judgment to prevail.

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65 I am grateful to Wayne Sumner for offering this example.

66 For example, Dr. Ed Etchells describes the case of an elderly concentration camp survivor, who refuses a medically indicated amputation of her great toe in part because of fear brought on by her exposure to medical inhumanities in the camp.

Earlier, we discussed the distinction, apparently accepted by the court in *Quinlan*, between preserving life and prolonging death. This was the view that at some point, the body is simply overtaken by disease and its various systems are in the process of giving out. While the person may be alive, the process of death has begun and cannot be stopped. By the application of various medical interventions, it may be possible that such a life be extended, but this would only have the effect of prolonging the process of dying, already begun. The condition that death must be near acknowledges that at some point life is approaching its end and further treatment, particularly unwanted treatment, serves no valid purpose.

**Suffering:** The third alternative criterion is that if the practitioner reasonably believes that the suffering felt by the patient is not amenable to relief, then honouring a decision to die is appropriate. This condition is based importantly on the value of compassion. If suffering cannot be relieved, it is cruel to refuse to take steps to end such suffering when called upon to do so, or to interfere with the person's choice to end that suffering by imposing treatment which will have the effect of prolonging it. If suffering is reasonably judged to be untreatable, it seems far less likely that the patient is making a mistake about whether his or her life could at some future point be satisfying, since it seems clear that it can no longer be so. In these circumstances, the patient's judgment that continuing life will no longer serve his or her own aims and goals is likely to be correct. For this reason, the patient is less likely to have a change of heart at some later time, and the importance of preserving future autonomy is absent, or in any event much reduced.

Suffering will also displace the presumption of treatment when the treatment itself will inflict more or less permanent and unremediable suffering on the patient. For example, the burden of a ventilator, needles, tubes, CPR and other ICU care may be very great. When it is improbable to suppose that the patient will ever leave the ICU, such interventions may be withdrawn. Accordingly, when unremediable suffering is caused by the medical treatment or devices themselves and the patient is unlikely to survive their withdrawal, then refusal should

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be honoured.

A helpful characterization of “suffering” is elusive and the concept has not been adequately studied. Cassell views suffering as resulting from an injury or destruction of some aspect of the self, construed broadly. While greater precision will not be attempted here, it is clear that pain may cause suffering, but that suffering may also have emotional, psychological or existential causes. Therefore, for these purposes, suffering is not limited to that caused by pain. It is fair to say that feelings of loneliness, loss, helplessness and other sources of personal distress can all bring about profound suffering. It is not intended that the reach of the notion of suffering be limited in this discussion.

However, it is important to note that for the condition of suffering to be satisfied, suffering must be reasonably judged to be beyond relief. The person’s own subjective appraisal that suffering is permanent will not necessarily be determinative. The recuperative powers of the human spirit can be remarkable, and a practitioner should be slow to conclude that psychological or existential suffering cannot be remedied, particularly if, with treatment, the person is expected to live a reasonably long time. As to physical pain, whether the suffering which results cannot be alleviated will ideally be a matter of appropriate medical judgment, based on the available clinical information.

It may be that the three separate conditions of faith, death and suffering are in fact instances of a more general condition of avoiding disproportionate and unremediable suffering. That is, the theme which is at work in these conditions is that giving treatment in each case will fairly clearly result in acute and untreatable suffering. Because of the severity of suffering entailed by the proposed treatment, the likelihood of mistake is much reduced because the suffering inflicted by treating will clearly and predictably be greater than that which would come of honouring the refusal of treatment. With respect to the condition of faith, involuntarily imposing a treatment which is by its nature abhorrent to the religious,


cultural or personal beliefs of the patient will predictably impose lasting suffering on that person. The sense of betrayal of firmly-held belief will endure and may not be remedied. As to the condition of proximity to death, for a person who is anyway in the process of dying, treatment which prolongs that process may inflict suffering either directly from the treatment itself, or by extending a painful but faltering existence.

Suffering may be inflicted either directly by the treatment itself, or indirectly if the treatment prolongs untreatable suffering associated with the underlying illness. In either case, if there is some reason to suppose that the suffering may be amenable to relief, then a decision to give temporizing treatment should be protected. That is, in either situation, the suffering from which the patient may demand to be relieved must be unremediable.

However, even if suffering is a helpful unifying theme encompassing the important considerations in each of the conditions, faith, death and suffering, it is nevertheless helpful to retain these categories to help give some structure to the application of the defence of necessity. As will be argued later, for legal purposes it is preferable that the applicable principles be laid out with more rather than less specificity.

The proposal then is that medical practitioners should have a limited privilege to impose treatment required to preserve life, notwithstanding a refusal, unless any of the three conditions, faith, death or suffering, are present. This is not to say that a practitioner is required to provide life-sustaining treatment in every case other than those. However, should a medical practitioner be sued in such circumstances for providing life-sustaining treatment without consent, or in violation of a refusal, he or she should be protected from liability because the necessity of preserving life, founded in the legally recognized duties attaching to the medical professions, and reflected in the law's interest in preserving life and preventing suicide, should be a shield against liability. Medical practitioners are entitled to the comfort

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of knowing that, unless certain more or less clearly delineated conditions are present, they are entitled to act compassionately to save or sustain life in accordance with their best medical judgment and the important obligations and expectations which society rightly imposes upon those practising the medical professions.

Application of the Defence of Necessity

It is in this context that the defence of necessity applies. In Chapter 5, it was suggested that the common law civil defence of necessity, although rarely applied, may be used to justify otherwise unlawful conduct when the policy goals of deterrence, compensation or punishment would not be met by imposing liability. Relevant to civil wrongs, necessity may provide a defence in two types of cases: First, necessity may be a defence when the harm which is averted by committing the otherwise unlawful act outweighs, or substantially outweighs, the harm done by the otherwise unlawful act itself. The second and preferable formulation is that necessity applies when the purported wrongdoer is faced with a conflict of legally recognized duties. In this context, the practitioner’s duty to honour the patient’s right not to be treated without consent comes into conflict with the practitioner’s duty to treat or not to abandon a patient requiring life-saving intervention. The basis of the duty to treat to preserve life is discussed in detail in Chapter 5.

For the purposes of either formulation, balancing is required. This is because of the requirement of proportionality found by the Perka case. Necessity will afford a defence only when the good created or harm averted by performing the otherwise unlawful act outweighs the harm created or benefit frustrated in doing so. In this context, the harm done by the unlawful act, that is, by treating without consent, has a number of dimensions. First, there is the affront and indignity of imposing involuntary treatment upon the patient. There also may be the unwanted continuation of life which the patient had sought to avoid. In this regard, the patient may have been correct about the prospects of his or her regaining a fulfilling or reasonably satisfying life. It could be that the patient is making no mistake and

it is the practitioner who is mistaken about the patient’s future prospects. Added to this will be the feelings of anger and affront which the patient will naturally feel at experiencing what is perceived as unjust treatment. The practitioner risks doing the patient not only an injury, but an injustice by imposing treatment without consent.74

Involuntary or forcible treatment may impose suffering on suicidal persons in other ways as well. Giving blood to a Jehovah’s Witness patient who has refused it may result in life-long grief or psychic suffering of a particularly acute kind.75 Disfiguring or mutilating surgery, such as limb amputation, may impose long lasting, harmful effects and suffering on the patient. Treatment which needlessly prolongs the life of a person who is dying and suffering from untreatable physical or psychological pain has the same effect of inflicting avoidable suffering on the patient.76

Against this must be placed the benefits, including the harms which may be averted, which may result from treatment notwithstanding a refusal. The first of these, as suggested above, is the possibility of averting a mistaken decision about dying, coupled with the special and irrevocable nature of a decision to die. On this side is the tragedy which may be averted if the person choosing death is in fact mistaken about his or her prospects or future or is misguided in his or her assessment of future happiness and misery. It is important also that if treatment is imposed and it turns out there was no mistake, it is usually the case that the choice to end life may be given effect at a later time.

In addition, intervening to treat and thereby to sustain life preserves at the same time future freedom or autonomy. That is, the value of autonomy and liberty which is violated at present by failing to honour a refusal, must be balanced against the gain in future autonomy resulting from allowing or forcing life to go on. Balanced against the patient’s right to refuse is the likelihood that the patient will, at some future time, ratify or approve of the decision to

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75 Malette v. Shulman, supra note 4.

ignore his or her refusal. As discussed earlier, there is in principle no reason why the present autonomy or preferences of an individual should be preferred to those of the person at some future time.\textsuperscript{77} We know that desires, aversions and preferences may be very different at a future time and that the passage of time may reverse desperate or sorrowful feelings.\textsuperscript{78} Therefore, the predicted preferences of the patient in future, while not necessarily determinative, should weigh in the balance against his or her present preferences.

It is important to say however that this argument does not justify a \textit{general} practice by practitioners of overriding patient wishes on the basis of a medical judgment that present autonomy may be sacrificed for the sake of a predicted preferable future autonomy. The benefits and importance of current autonomy are acknowledged and a general policy of medical paternalism would be harmful to the doctor-patient relationship in a variety of ways. However, the decision to die, or to accept an avoidable death, raises special issues canvassed earlier in this chapter. The rationale for a narrow and closely circumscribed paternalistic exception to the general obligation of respect for autonomy lies in the very serious and irreversible nature of a decision to die. Inasmuch as the consequences are grave, the medical practitioner’s conditional duty to preserve life reaches so far as to justify what would otherwise be inappropriate disregard of the patient’s wishes.

Accordingly, where a practitioner is sued for battery for giving life-sustaining treatment despite a refusal, the defence of necessity should be available to the defendant practitioner. Indeed the presumption should be that such treatment was necessary and so, the defence should succeed. If however the plaintiff can show that any of the conditions, faith, death or suffering, were present to the reasonable knowledge of the practitioner, then the presumption of necessity would be rebutted and liability for battery could follow. If any of these conditions were present, but not reasonably knowable by the defendant, then the practitioner should likewise be free of liability.

As noted in Chapter 5, the defence is subject to a number of other limitations, the most

\textsuperscript{77} Brandt, “The Morality and Rationality of Suicide,” \textit{supra} note 29 at 129-130.

\textsuperscript{78} Brandt, “The Rationality of Suicide,” \textit{supra} note 26 at 121.
important being the requirement of proportionality. That is, the harm inflicted must be less than the harm sought to be avoided. This is a reflection of the need to balance the harms resulting from honouring or failing to honour the refusal of treatment. The requirement of proportionality is satisfied by reference to the harm potentially averted by the likelihood of mistake and by the very serious consequences attending a successful suicide. At the same time, if the suffering to be inflicted, or allowed to continue as a result of the treatment is substantial and not remediable, then it may be that the harm imposed by treatment is greater, and the defence should fail. So long as these conditions are not present, the practitioner’s good faith assessment that treatment ought to be given on this basis should be sufficient.

The second pre-condition to the applicability of the defence of necessity is that the needed intervention must be urgent and immediate. If the unlawful conduct, in this case giving the refused treatment, is not required immediately then it should be delayed. When the proposed life-sustaining treatment has not yet been started, and is required immediately, then its urgency will be clear enough. The application of this condition to a failure to honour a request that such treatment be withdrawn is satisfied by the fact that the treatment is continuously required to preserve life. Therefore, its urgent nature arises any time the treatment is sought to be withdrawn.

A third proviso is that there may be no reasonable legal alternative by which the harm in question may be avoided, absent the unlawful act. In cases of this kind, it will virtually always be the case that the only way to sustain life is by giving the treatment in question. However, in principle, if there is some other lawful means of preserving the life of the suicide, aside from administering the treatment which has been refused, then it must be adopted.79

A fourth limiting condition to the application of the defence of necessity, that the intervention must be reasonably designed effectively to prevent the threatened greater harm, that is the person’s death, will also typically be satisfied. This is just to say, in this context, that the treatment proposed must be reasonably believed to be effective to preserve life. The

79 Perka, supra note 73 at 252, 253.
final condition is that the proposed intervention must create the least possible interference, consistent with achieving the ends sought by intervention. So, if there is some alternative treatment or course of action which is less intrusive or objectionable to the patient, and which would be as effective in preserving life, then it should be given instead. Again, so long as the treatment proposed is medically reasonable, this condition will also typically be satisfied.

It is true that each of the elements weighing in favour of intervention admit of some uncertainty. Whether the patient is making a mistake in calculating as to his or her prospects for a satisfying life is a matter about which the practitioner cannot be certain. Similarly, whether violating the patient’s present autonomy will, on balance, produce positive gains to the patient’s future autonomy is also a matter which cannot be known, in any strong sense, in advance. Finally, it is uncertain whether the patient would, at some future time, approve of or be thankful for the intervention. Indeed, it is precisely this uncertainty, together with the irrevocability of death, that gives necessity its moral force. If we typically could know, with a fair degree of accuracy, whether life could be satisfactory for a suicidal person, there would be less need for the defence. In the case of Re T., it was argued that,

It is well established that in the ultimate the right of the individual is paramount. But this merely shifts the problem where the conflict occurs and calls for a very careful examination of whether, and if so the way in which, the individual is exercising that right. In case of doubt, that doubt falls to be resolved in favour of the preservation of life for if the individual is to override the public interest, he must do so in clear terms.\textsuperscript{80}

The difficulty is that such clear evidence will rarely be available. This being so, there will commonly be some significant doubt, and such doubt should be resolved in favour of preserving life.

The fact that these matters are uncertain does not by itself mean that they should not be undertaken. Predictions may be reasonable or unreasonable, and a reasonable estimate of the probabilities is sufficient. Although absolute certainty is impossible, we should proceed on reasonable grounds nonetheless. It is possible to isolate certain elements of the context of a refusal which lessen the uncertainty involved in predicting whether intervention will, all

\textsuperscript{80} Supra note 13 at 661 (per Lord Donaldson of Lymington, M.R.)
things considered, be in the patient's own interests. The risks attending such paternalistic intervention are not to be lightly dismissed. It is for this reason that the criteria of faith, death and suffering are proposed to assist the balancing between the harm done and the harm averted by intervention.

But even aside from the dangers of paternalistic intervention and the uncertainties involved in weighing its appropriateness to a particular case, there is another reason why criteria or conditions are required. Courts are concerned that if a defence of necessity is left to the unguided discretion of the individual, the rule of law would be weakened. In short, it is not acceptable or sustainable that persons be permitted to judge for themselves whether compliance with a particular law is, in all the circumstances, really preferable.\textsuperscript{81} Stability, certainty and predictability of law are vital to its functioning and credibility.

However, in the context of refusals of treatment, if more or less concrete conditions are established which constrain, in an orderly way, the exercise of the practitioner's discretion in considering whether to impose treatment, the interests of the law in preserving life and promoting the fiduciary character of the medical relationship, along with its interest in maintaining the authority of the law, may all be upheld. The conditions of faith, death and suffering provide a tolerably concrete and reasonably operationalized guide as to when intervention is morally appropriate and when the defence of necessity may properly be applied.

None of this is to say that suicide is never rational. The claim is not that suicide must be irrational, but rather that the rationality of suicide is, in most cases, not known with adequate certainty to the patient him or herself, or to the practitioner who is in the position to render life-sustaining medical assistance. Because of this fundamental uncertainty, the presumption should be to treat to preserve life, even notwithstanding a refusal. Neither is this to say that the practitioner must treat unless any of the conditions, faith, death or suffering, are satisfied. This thesis is about the conditions under which an action for battery may be resisted and does not address the limits to a claim for breach of a duty to treat or not to abandon the patient. That the practitioner has a discretion not to treat in circumstances of

\textsuperscript{81} Perka, supra note 73 at 248 (per Dickson, C.J.C.)
uncertainty may or may not imply an obligation to treat under those same circumstances. It might, but it need not.

Medical practitioners, and others, feel impelled to use the impressive resources and training which they command in the service of saving or sustaining lives when possible. This feeling is entirely appropriate and desirable, and is one which gives expression to the very valuable traditions and internal morality of the medical professions. The law is rightly concerned about protecting individual autonomy and integrity, including bodily integrity, and so has established important rights which act to protect these intuitively powerful interests. These protections of course have been extended to include autonomy with respect to medical care, even that given from essentially good motives.  

However, at least when treatment is required to preserve life, other considerations come importantly into play. In the context of a terminally ill person, alone and close to death, racked by untreatable physical, psychological and emotional suffering, the right to refuse lifesustaining treatment accords well with the dignity- and autonomy-promoting assumptions of these laws. However, as the circumstances become farther removed from the most awful conditions of suffering and dependence, a “right” to refuse life-sustaining treatment becomes less compelling.

There is some reason to think that a presumption against respecting a refusal of treatment in these circumstances accords with the common sense moral intuitions of a majority of Canadians. In a 1992 cross-Canada study, 85% of respondents would deny patients the right to forego life-sustaining treatment, if they were likely to recover. Of course, the condition of being likely to recover at best only approximates the absence of the conditions, faith, death and suffering as they are described here. However, it is interesting that the response of a broad cross-section of the population is fairly strong that, where health is reasonably judged to be restorable, treatment should be given notwithstanding a refusal.

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The observation that we tend to be more hesitant to permit someone to choose death as their health and emotional well-being appear to be increasingly recoverable is significant. It is significant because the question of consent in this regard is more complex than simply adopting a rule prohibiting interference in others' competent decisions. As an expression of concern for others, normative judgments about quality of life and the prospects for an adequately satisfying life are also in play. It is desirable that such value judgments be made and that the law give them some expression.
11. CONCLUSION

Overview and Summary

The defence of necessity then supplies an ethically appropriate and legally available mechanism whereby a medical practitioner may, in proper circumstances, resist an action for battery for administering life-sustaining treatment without consent. The defence should be available except where any of the three conditions, faith, death and suffering are present because where the patient's life is at stake, the practitioner's duty to preserve life is balanced against his or her acknowledged duty to respect an apparently competent refusal of treatment. Owing to the uncertainties attending another's judgments about the competence, authenticity, voluntariness and quality of information underlying a decision to die, and because of its grave and irreversible nature, a practitioner's good faith assessment of this balance ought to be accepted, except in the three special types of circumstances. When any of these three limiting conditions are present however the likelihood of mistake or misjudgment is greatly reduced. In addition, in those types of circumstances, the suffering felt by the patient, either by the treatment itself, or by the continuation of life which is permitted by the life-sustaining treatment, will typically be acute and unrelievable. Therefore, in these types of circumstances, the balance favours honouring the patient's refusal of treatment.

In addition, these considerations are relevant to the determination of a court, in proceedings brought in advance, whether such treatment ought to be given. Clearly, in urgent cases, there will not always be sufficient time to seek a judicial determination that life-sustaining treatment may or may not be given. Nevertheless, there will often be enough time, and in difficult cases, it would be prudent for a practitioner, or a health care institution, to seek a court declaration as to the legality of treatment, and insulation from civil liability when acting in accordance with the court order.

In making this determination, either prior to the event or afterwards, courts should take account of more than the practitioner's obligation to respect a competent refusal of treatment,
together with an assessment of the patient's competence. For reasons outlined in Chapter 4, the assessment of competence is both conceptually and practically muddy, and in any event, incompetence is not a sufficiently accurate marker of those for whom paternalistic intervention is ethically appropriate. In practice, the question of whether paternalistic intervention to override a refusal of treatment is appropriate typically becomes conflated with the question of the patient's competence. Such conflation is unhelpful because it confuses a reasoned and morally defensible assessment of either of these questions. The straightforward issue is whether the practitioner should intervene paternalistically and administer treatment notwithstanding that it has been refused. It makes better sense to address this question directly by a consideration of the situational factors relevant to justified paternalism in the context, rather than indirectly, through a conceptually uncertain and practically difficult determination of incompetence.

Certainly the self-determination, or autonomy, of the patient is an important and highly relevant consideration. The potential harm and the undeniable personal violation which results from overriding personal wishes is by no means a small matter. Others are typically less well situated to say what is in one's own best interests. Given the strong intuitive and empirical appeal of autonomy, of the right to make one's own choices for oneself, it is an important question: On what basis may a hard paternalistic intervention in treatment decisions be justified? That is, why may treatment be imposed paternalistically, for the good of the patient, but against their wishes? In this thesis I have proposed three broad responses:

First, as argued in Chapter 7, autonomy is not, and cannot be, the only relevant moral value. Other values must play a part in moral reasoning and are sometimes controlling. In the context of paternalistic intervention, the value of beneficence cannot be ignored. Sometimes promoting a person's welfare will outweigh respecting that person's choices, even if no other person is adversely affected, and even when this choice is apparently competent.

The second type of response acknowledges the importance of autonomy, but takes note of the fact that a myriad of factors may compromise autonomy without rendering the person

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incompetent. That is, a person may retain the ability to understand and appreciate the relevant information concerning his or her medical condition, prognosis and treatment options, whose autonomous capacity is compromised to an extent which renders their choice to die a perilous one, even on their own terms. Some writers have argued that the normal standard of competence may not provide sufficient protection for a person whose choices about medical treatment risk serious harm or death.² As argued in Chapter 7, medical or psychiatric illness, powerful emotional influences, affective disorders, insufficiencies of information and the effects of the attitudes of others may all affect one’s ability to make decisions in an adequately autonomous way. These factors may tend particularly to be present in a person facing a life crisis such as may be created by those circumstances in which one contemplates their own death.

The answer however is not to raise the standard of competence such that no one for whom intervention seems appropriate could possibly be found to be competent. This move is clearly artificial and defeats the purpose of an assessment of competence, which has traditionally focussed on the decision-making abilities of the patient. The decision to die is a particularly perilous one, and therefore it should be treated in a way which takes account of its special dangers. A more sensible response, in light of the threat of compromised autonomy, is to make a further assessment of the person for the presence or absence of considerations rendering life-sustaining intervention reasonable. In this regard, it matters that the choice to die is liable to be mistaken, particularly in light of the presence of these autonomy-compromising factors. It matters also that a decision to die is final and irreversible.

The third response points to the value of future autonomy. If we have some reason to expect that at some future time the person would, if rescued, change their mind and choose to go on living, this provides some reason to intervene to rescue. Intervention preserves future autonomy which, in principle, is no less valuable than one’s present autonomy.³ Certainly the


expectation that a suicidal person may change his or her mind, and come to endorse or be thankful for a decision to intervene is at best uncertain and probabilistic. The practitioner's judgment as to that person's possibility for a future satisfying life, as a proxy for the determination that future autonomy will be preserved, is at best a guess. Nevertheless, the serious and irretrievable nature of a decision to die is relevant, as is the fact that a choice to die can usually be given effect again at a later time. If a choice to die is honoured, then there can be no future autonomy. Preserving autonomy permits the person the opportunity to re-formulate a connection to his or her own personal goals, projects and life plan. It allows relationships to be re-established and more positive emotions and experiences to be rediscovered. While it is certainly to be hoped that the suicide who is rescued will go on to live an acceptably contented life, preserving autonomy permits the person also to exercise that autonomy to end his or her life at a later time.

When the case for autonomy is made in the context of life-ending decision making, it is often framed in terms of a patient who is nearing death and suffering from a painful and incurable terminal illness. The treatments required to sustain this person's life are burdensome and undignified. In such cases, the emotional pull may be strongly in the direction of non-interference with a choice to die. If, however, the case is more like that of Allan, Betty or Kenneth, we become less sure that their wishes ought to be honoured. There appears to be so much more at stake. The situation is uncertain and fluid. When in future the person might come to have a reasonably satisfying or fulfilling life, it seems wrong to give in to the present self-destructive wish. The suicidal person may believe that they have no future prospect for a satisfying life, but we know that very often this judgment is simply incorrect. Feelings of hopelessness and helplessness can cloud the judgment of a person contemplating suicide in a number of ways. Honouring such a choice seems more like abandonment than respect.

In this light, it becomes clear how the paternalist may respond to the question: On what basis does the practitioner interfere with another's informed, voluntary and competent choice to die? The question assumes that information, voluntariness and competence are matters which are clearly present or clearly absent. But of course this is not the case at all. People act with varying degrees of these qualities. People are driven to a greater or lesser extent by
logic and valid reasons. It is neither necessary nor desirable that they do so. However, the
model of the well-considered, rational choice to die, unaffected by undue emotional or
affective forces, is at best a liberal construct. The question really is whether a person
choosing to die acts with sufficient information, voluntariness, and competence. No doubt
sometimes people do. However, these matters will always be to some extent uncertain, both
to others and to the person him or herself. What justifies intervention is the uncertainty and
liability to error of the choice?

The challenge to the paternalist is sometimes framed in another way, and it has to do
with the authority of the individual paternalist to interfere. Who are you, it may be asked, to
interfere and deprive another of this most intimate and personal of choices, when it is the
person him or herself who must bear the continuing suffering, and live with the consequences
of your decision? Without the permission of the person most directly affected, wherein lies
the moral authority to substitute your own judgment?

The response by the paternalist to the question, “Who are you to decide?” is
straightforward. “We are the ones who are in a position to offer care.” Empathy and concern
for others is not an affront to autonomy or officious meddling, it is a highly desirable social
response. It is easy enough to sympathize with a patient’s sense of hopelessness and
perception of an ever-contracting universe. We may see all too clearly their loss of self-
esteeem, their feeling that life is nothing but a burden and that he or she is a drain on family
and community. In light of these sympathies, it does seem that the patient’s assessment that
the choice to die is logical in the context of the reality in which he or she lives. No doubt the
patient deserves our compassion. But what compassion is deserved? Does compassion involve
supporting the right to withdraw from life, celebrating the patient’s “control” over death, or
his or her triumph over a miserable, wretched existence? Rather, do we not have a duty
before the patient dies and loses all of his or her rights, personhood and interests, to inquire
whether a caring community might still help?

An obligation of care and support is not negated by the lack of permission expressed

by the subject of such care. George Agich argues that we can see the role of autonomy in ethics as recognizing the importance of a sense of self, or individuality, without implying a claim for complete independence, or on an absolute right of non-interference.\(^5\) This is in large part because the attitudes demonstrated by others may have a profound influence on the choice itself. Except where the conditions of faith, death and suffering are present, a choice to die may be profoundly affected if the patient's caregivers, family and community either encourage a decision to die or express caring by continuing to advocate for life by their compassion, love and constant reinforcement of the patient's worth. It is the vulnerable and the sick that are particularly in need of protection.

Before cooperating with a decision to die, a number of questions must be addressed: What would the patient want if the medical professionals within the facility, responsible for promoting his or her quality of life, would strive to do a better job of supporting and encouraging the patient, instead of validating their choice? What would he or she want if the medical care were more effective in terms of good pain, symptom and psychological management? Is the suicidal person seeking a triumphant victory over their own fate, or for some caring response to feelings of helplessness and abandonment? Until we have a good sense of the answers to these questions, the fundamental human obligation of care and compassion requires that death be at least delayed. Once the patient is in the grave, we will never know the answers. To the extent that an exercise of autonomy fails to take account of the responses of others, it is a deficient description of, and justification for, individual choice. This is not to say that persons would never choose to die if they received optimal medical and supportive emotional care. It is to say that where the acts and responses of others could make a difference to a suicidal outlook, we should hesitate to endorse that feeling.\(^6\)

Irwin Ringel argues that the inhumanity of allowing or forcing someone to carry on

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\(^6\) Many of the sentiments expressed in this and the previous four paragraphs were inspired by Rabbi Lowell S. Kronick, of the Parker Jewish Institute for Health Care and Rehabilitation, New Hyde Park, N.Y., posting to the Medical College of Wisconsin Bioethics Discussion Forum in October, 1996. I am grateful to Rabbi Kronick for these insights.
living, when they strongly wish to die, is found not in the frustration of the person's wishes, but rather in the failure to help and care for that person, to alleviate their suffering and help make life worth while, which is evidenced by the wish to die. He urges those within communities to feel responsible for the fate and well-being of others. Intervention in a decision to die is the implementation of this human responsibility towards one's fellow human beings. It is not inhuman to reject a demand for suicide or for the planned termination of life. It is important also to help and guide the despairing to enable them to make their lives happier and more worthwhile. A strong urge to end one's life is by no means inconsistent with the right of others to intervene to meet the spiritual needs of those whose life is at stake.  

David Mayo is concerned that the acceptance of a notion of rational suicide, which others may not interfere with, may increase the number of tragic, irrational ones as well. If suicide becomes a realistic option, it may come to be encouraged even when not rational. Albert Gunn worries that a right to die may lead to a duty to die. Further, if the question is whether it is rational to end one's life, people in a state of despair are particularly apt to go astray when they undertake to make a moral decision on the basis of an assessment of the future consequences of their actions.

Application to Allan, Betty and Kenneth

In this context, it is possible to see why intervention in the decisions of Allan, Betty and Kenneth to die is ethically justified and should be lawful. When Allan was brought to hospital, the emergency medical team had very little information about Allan, and no

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information whatever about his underlying medical or psychiatric health, his frame of mind, his reasons for the apparent suicide attempt, or the circumstances under which the attempt was made. Although Allan’s refusal of their intervention is unambiguously expressed, and there is no adequate reason to suppose that he was incompetent when taking the overdose, the profound uncertainties attending the case justify treatment. The duty to respect a refusal of treatment is balanced against the possibility that Allan was mistaken in judging that, even on his own terms, the burdens of life were, and would continue to be, too great to justify carrying on. So many questions require answers: Does Allan suffer from any medical or psychiatric illness such that his estimate of his prospects for a reasonably satisfying life are realistic and well-founded? Is it really true that it is not possible for him to recapture a worthwhile life? In attempting suicide, did Allan really intend to die, or was the attempt more like a “cry for help?” Are there family, friends or other community resources which could be accessed by or on behalf of Allan, which could cause him to change his mind about wanting to die? Is his suicide attempt driven by powerful emotional forces such as fear, loneliness, vulnerability, helplessness or hopelessness which counselling or other support could assuage?

So long as there is uncertainty surrounding these questions, and a host of others, it is not unreasonable to suppose that Allan might be making a tragic and irreversible mistake. This being so, he should be treated and cared for, not allowed to die. The medical team has no reason to suppose that the treatments they propose to give are the subject of any deeply-held religious, cultural or personal prohibition. It seems sensible to assume that, aside from the effects of the overdose, Allan is not in the process of dying. While the medical staff admittedly do not know whether Allan’s emotional or physical suffering is amenable to relief, they have no strong indication that it is not. For these reasons, it is not unreasonable to judge that the harm averted by rescuing Allan in these circumstances outweighs the harm inflicted by treating him involuntarily. Accordingly, such treatment should be sanctioned, both ethically and legally.

Similar questions arise with respect to Betty’s demand that ventilatory support be withdrawn. While her powerful feelings of despair are understandable, and her situation naturally inspires great sympathy and compassion, the medical team may rightly be sceptical
of her belief that her life cannot now become worth living. The hurt is too fresh and the emotions at play are too powerful for others to have any confidence that her judgment about the future course of her life is realistic. In judging that her life is not, and cannot become, worth living, Betty is gravely at risk of error. So, again the balance weighs in favour of intervention, notwithstanding the wrong that is done her by failing to honour her wishes. There is no faith or strong personal objection to the treatment per se, and, with treatment, Betty could live a long time. Whether her emotional suffering can be relieved is uncertain, but experience indicates that it is possible notwithstanding such horrible personal tragedy.

Most of the same things may be said about Kenneth. His condition is not terminal and he has no objection to the particular treatment he seeks to have withdrawn, aside from the fact that it will keep him alive. The question is whether it is reasonable to suppose that Kenneth is correct in his belief that the loneliness and suffering which he will endure after the death of his father may not be relieved. This is a difficult question because Kenneth is very familiar with the consequences of his disability, having lived with them for many years. So, while he has managed to have an acceptable quality of life for this period of time, will the loss of his father create an irremediable void in his life? On one hand, it might be argued that Kenneth could well be mistaken that his life would not be worth living without his father. He does not know what other sources of emotional support may be available to him and how he would respond, given time, to establish fresh supportive relationships and different habits of life. On the other hand, the treatment which Kenneth seeks to have withdrawn, the ventilator, will be with him for the remainder of his life, at least in the absence of some medical miracle. It may be that this constant reminder would cause unremitting suffering to him. On balance, however, it is not unreasonable to suppose that Kenneth in future may be able to recover an acceptable quality of life. Accordingly, if in all the circumstances the medical team should make a good faith judgment that their duty to preserve life was stronger than their duty to respect his refusal, based on their judgment that Kenneth might regain a meaningful and adequately contented life, then the decision not to withdraw the ventilator should be legally protected.
Some Related Issues

This thesis does not address the ethical issues surrounding potentially life-shortening palliative treatments. There is a concern that certain kinds of treatments, the intention of which is to make the process of dying more comfortable, may have the effect of bringing on the patient’s death sooner than would otherwise be expected. There is a concern that pain-killing medications such as morphine, in sufficient amounts, may depress respiratory function and speed the death of the patient in some cases. The primary difficulty seems to be in determining the intent of the parties and applying the doctrine of double effect. These questions do not arise here.

However, it might be thought that this issue is connected to that of refusals of life-sustaining treatment in the following way. The project of this thesis is to develop a theory of when a medical practitioner may administer life-sustaining treatment to a competent person who is refusing such treatment and is apparently willing to accept the consequence of his or her own death. In such appropriate circumstances, the practitioner may give the treatment free of liability for battery. By parallel reasoning, however, must it be said that in the absence of such circumstances, life must be allowed to go on and therefore potentially life-shortening treatments may not be given. This would be a powerful objection because if the framework developed here is inconsistent with compassionate pain control at the end of life, something would be seriously wrong.

Fortunately however, the existence of a defence of necessity, as here conceived, does not have that implication. What is proposed is a privilege to treat but not a duty to treat. Therefore, there is no implication that, in the absence of the limiting conditions, life must be preserved at all costs. Accordingly, whether the paternalistic use of potentially life-shortening opioids is morally acceptable raises a family of issues quite distinct from those raised here.

Necessity is intended to provide a defence to the practitioner, not a fresh cause of action for the patient. Where life-sustaining treatment is refused, and the qualifying conditions are not present, the practitioner has a legal privilege to treat, founded on the necessity to save life. Nevertheless, no alteration of the law is proposed with respect to the practitioner’s duty to treat in such cases, or the practitioners duties with respect to palliative care. Honouring
such refusal would count as negligence, or breach of the practitioner’s fiduciary obligations, only if it does so on the basis of the existing common law. Indeed, as the cases found in Chapter 2 demonstrate, a practitioner is very unlikely to be found liable for honouring a competent refusal of treatment. Therefore, it is no implication of this thesis that practitioners must do everything to preserve life, except where the qualifying conditions set forth in Chapter 10 are present. As a practical matter, patients receiving potentially life-threatening palliative doses of pain medication will almost always fall within either or both of the conditions of death or suffering. Without adequate pain medication, suffering would typically not be relievable. In any event, such persons are commonly nearing death and arguably in the process of dying.

The same may perhaps be said of the suggestion that necessity as it is here conceived would give rise to a duty to inflict death upon a person where any of the conditions faith, death or suffering are present. If the presence of any of these conditions indicates that life is no longer worth living, then perhaps the practitioner’s fiduciary obligation requires that the patient be mercifully killed. But the conditions of faith, death and suffering are not intended to provide indicia of a life not worth living. Rather, their point is to provide considerations relevant to whether a decision to refuse life-sustaining treatment is adequately informed, voluntary and authentic, and is highly unlikely to be misguided or mistaken in its assessment of the person’s future prospects for a sufficiently satisfying life. Where these conditions are present, if the patient is not requesting that treatment be withheld or withdrawn, it is difficult to imagine that doing so could be ethically appropriate. If, however, the patient is clearly incompetent, for example, in a permanent coma, the patient’s surrogate decider is empowered to direct the withdrawal of treatment, for example, withholding nutrition and hydration, subject to the usual legal requirements. If practitioners sought to withdraw treatment on the basis of medical futility, the issues relevant to such determination are likewise beyond the scope of this thesis.

It might be, however, that the defence of necessity could be applied to a case of mercy killing by a medical practitioner. It is at least conceivable that a practitioner is in a position of conflict between a duty not to inflict death upon the patient and a duty to relieve the
patient's acute and unbelievable suffering. For example, Sneiderman and Verhoef argue that the considerations underlying the Dutch euthanasia policy are closely related to the Canadian common law defence of necessity. It is on this basis in the Netherlands that the physician has a defence to murder for an act of mercy killing.

According to Dutch case law, the defence of overmacht envisions a case of urgency in which the accused is driven by his conscience to commit an offence which amounts to a lesser evil than would have ensued had he permitted events to run their course. It is in effect a "back to the wall" defence: the accused makes the deliberate moral choice to break the law because the force of circumstances precludes delaying action.

Overmacht is thus the Dutch analogue to the common law defence of necessity, which also requires that the accused be driven by the force of circumstances to commit an offence as the only way to prevent a greater harm.11

The proposal that the defence of necessity may permit death to be inflicted, as well as prevented, is interesting but beyond the scope of the present discussion.

In Chapter 3 it was argued that, for the purpose of determining the appropriateness of paternalistic intervention to give life-sustaining treatment in the face of a refusal, no distinction may helpfully be drawn between cases of overt acts of suicide and cases of refusal of treatment in the context of an established medical relationship. While no definitive characterization of suicide was proposed, it requires that the death be brought on by an intentional self-initiated act and not by the withdrawal or withholding of treatment, which allows a lethal underlying condition to cause death. It is urged that this distinction was not morally relevant at least to the question whether a refusal of treatment should or should not be honoured.

Against this suggestion, it is commonly thought that such distinction is morally relevant. While suicide intervention is typically appropriate, even if it involves giving treatment in contravention of the expressed or implied wishes of the attempter, a competent refusal of treatment must always be respected. In suggesting that the two types of cases are relevantly similar, it follows that they should be treated in the same way. The thrust of this

thesis may be construed as urging that refusals of treatment should be treated more like suicides, that is, intervention is justified in a much broader range of such cases than is generally accepted. It might be objected then, that if the two types of cases should be treated the same, does it not make just as much sense to argue for the reverse, to treat suicide cases more like refusals of treatment. That is, perhaps there should be less intervention with suicide attempts, not more intervention in refusals of treatment. Why is it that the two types of cases should be harmonized in one way, and not the other?

The reason is that the usual response to a suicide attempt, that is to presume, in the absence of compelling reason, that death is not in the attempter’s best interests, has it roughly right. For reasons canvassed throughout this thesis, this is a more desirable policy than the conventional response to a refusal of life-sustaining treatment, that so long as the person is judged competent, judgments about the person’s welfare are irrelevant. Consequences for the welfare of the person do matter, and when the consequence is death, they matter a lot. It is misguided to suppose that others have no business making value judgments about the worth of one’s life. For very compelling reasons, it is right that we act with care and compassion to preserve the life of our fellows. The course which best expresses such care is to presume intervention, but be very clear about the conditions sufficient to dislodge such presumption. These conditions are intended to be rationally related to the ethically relevant considerations surrounding paternalistic intervention in decisions to die.

Indeed, the change in perspective which is proposed may not change the outcome of cases substantially. Those persons who refuse life-sustaining treatment will tend to be those who meet at least one of the conditions of faith, death or suffering. Therefore, in many, perhaps most refusals of treatment, the hospital and its practitioners would remain obliged to respect such refusal. Conversely, these conditions tend not to be present in one who makes an overt suicide attempt. Therefore, many, perhaps most suicides, will continue to be the appropriate object of intervention. The difference would be that the two types of cases would cease to be used as markers, or proxies, for those considerations which are relevant to a decision about intervention. The morally relevant considerations are reasonably accessible, and so should be addressed directly.