REFUSAL OF MEDICAL TREATMENT IN "CAPTIVE" CIRCUMSTANCES

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There is little definitive authority on the extent to which a court may order or authorize medical treatment to be administered to a competent person, who refuses that treatment and, in particular, when that person is in "captive" circumstances. The "captive" circumstances may vary: the person may be held awaiting trial, may be held on the ground that he is unfit to stand trial or pursuant to a verdict of insanity, may be serving a term of imprisonment, may be confined in hospital, either involuntarily through civil commitment or because of physical or mental disability, or may be held while awaiting deportation. The scope of the courts' authority raises a number of questions: what constitutes and the significance of the "competence" or "incompetence" of the person being held; whether the courts should order or simply authorize treatment; the limits which should be placed on the extent of the treatment ordered or authorized; the safeguard procedures which should surround any order that is made. This article explores these questions, primarily in the light of two recent decisions of the courts in Quebec.

Rares sont les décisions qui définissent clairement jusqu'à quel point les tribunaux ont le pouvoir d'ordonner ou d'autoriser un traitement médical pour une personne compétente, qui refuse ce traitement, plus particulièrement quand cette personne est en état de "captivité". Les circonstances de la "captivité" peuvent être très différentes suivant que la personne détenue attend son procès, qu'elle n'est pas en état de subir son procès, qu'elle est détenue suite à un verdict d'aliénation, qu'elle purge une peine d'emprisonnement, qu'elle est à l'hôpital, soit contre son gré (cure fermée), soit à cause d'une incapacité physique ou mentale, ou qu'elle attend son expulsion hors du pays. L'étendue du pouvoir des tribunaux soulève un certain nombre de questions. Quelle est la teneur et la signification des termes compétence et incompétence tels qu'appliqués au détenu? Le tribunal doit-il ordonner un traitement ou simplement l'autoriser? Peut-on limiter le traitement qui a été ordonné ou autorisé et jusqu'à quel point? Quelles mesures de protection devraient accompagner l'ordonnance du tribunal? Ce sont là les questions que l'auteur examine en se basant surtout sur deux décisions récentes des tribunaux québécois.

Introduction

In *Institut Philippe Pinel de Montréal* c. *Dion*[1] and in *Procureur Général du Canada* c. *Hôpital Notre-Dame et un autre (défendeurs) et Jan Nie-*

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[1] (1983), 2 D.L.R. (4th) 234, [1983] C.S. 438 (Que. S.C.).

miec (mis en cause)[2] (the *Niemiec* case) courts in Quebec authorized physicians to administer medical treatment to a person in captive circumstances, despite the person's refusal of the treatment. The outcome was similar in the much-publicized *Bouvia* v. *County of Riverside*[3] case in California. On the other hand, in *Attorney General of British Columbia* v. *Astaforoff*[4] the British Columbia courts refused to order treatment of a prisoner hunger-striker. The approach taken in this article is to examine the Quebec cases in detail, and, where appropriate, to compare them with these other two cases.

Although the situations encountered in the four cases may constitute the exception in terms of daily medical practice, they raise some of the most vexing issues currently being faced with respect to consent to or refusal of medical treatment and have important general ramifications in this respect. This is true, because, as is often the case, the full content and import of rules of more general application may only be fully delineated in extreme circumstances.

I. *The Quebec Cases*

The Quebec case are similar in several important respects: first, both the patients refused consent to medical treatment that was necessary to prevent, in one case, a serious deterioration in the patient's health and, in the other, probable death; second, neither patient was terminally ill, in the sense that either with or without treatment he would die within a short time; third, both patients were in captive circumstances, although the legal justification for this captivity varied, in that, in one case, it was criminal in nature and, in the other, non-criminal; fourth, in both cases the patients were legally competent (that is, they were adults and not under a court order of interdiction or incompetency); fifth, in the *Niemiec* case, and possibly in *Dion*, the patient was factually competent in that he at least understood the basic nature of the proposed treatment which he refused and the consequences of giving or refusing consent to it; sixth, each patient's decision to refuse treatment seems to have been characterized as irrational; seventh, although each patient was legitimately incarcerated, it was expressly held in both cases that court intervention was necessary to override the patient's refusal of treatment; and, eighth, in both cases the court gave an order authorizing treatment.

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[2] [1984] C.S. 426 (Que. S.C.).

[3] *Bouvia* v. *County of Riverside*, Docket no. 159780 (Super. Ct. Riverside, Calif., Dec. 16, 1983).

[4] *Attorney General of British Columbia* v. *Astaforoff*, [1984] 4 W.W.R. 385, (1983), 54 B.C.L.R. 309 (B.C.C.A.), aff'ing [1983] 6 W.W.R. 322, (1983), 47 B.C.L.R. 217 (B.C.S.C.).

A. *The Dion Case*

In *Institut Philippe Pinel de Montréal* c. *Dion*,[5] the respondent-patient, Dion, had threatened to kill the Premier of the Province of Québec, the Honourable Réne Lévesque. Dion had been found "not fit to stand trial" and was being held in "Pinel", a psychiatric prison hospital, on a Lieutenant-Governor's warrant, issued pursuant to the Criminal Code.[6] Dion had been diagnosed as suffering from paranoid schizophrenia with megalomania and persecution complex. The medical evidence was to the effect that Dion needed psychotropic drug therapy to prevent deterioration of his mental state. He refused treatment. The evidence also established that it is typical of such an illness that the person afflicted refuses to recognize the illness and is convinced that he is completely normal. Consequently, Dion believed that he had no need for treatment, and, further, that trying to persuade him to submit to treatment was also part of a plot against him. The Superior Court of Quebec authorized the psychiatrists at "Pinel" to give treatment.[7]

(1) *Competence*

The first matter which needs to be addressed in any case involving an issue of consent to, or refusal of, medical treatment, is whether the patient is competent or incompetent. There are two forms of competence relevant to the law, legal and factual competence. The latter is the more important with respect to the law of informed consent to medical treatment.

(a) *Factual competence—Functional assessment*

Modern approaches to assessing factual competence adopt a functional definition; that is, competence depends upon the patient being able to perform the function in question, namely, to give an informed consent

[5] *Supra*, footnote 1.

[6] R.S.C. 1970, c. C-34, as amended, s. 543.

[7] Dion appealed this ruling. Before the appeal was heard, Dion was found fit to stand trial, although he had not been forcibly medicated with psychotropic drugs. He pleaded guilty to the offence charged and was convicted without the issue of insanity being raised. He was subsequently released from "Pinel". The Court of Appeal then held that the matter before it was no longer justiciable. This information was provided by Dion's lawyer, Me Jean-Pierre Ménard. It is important to make the distinction, in analyzing the judgment of the Superior Court of Quebec, between, on the one hand, the facts as presented to and found by the Court and predictions based upon these facts, and, on the other hand, events as they subsequently evolved. However, it is worth noting that the Superior Court made no mention of even the possibility that Dion might improve without treatment (in fact they expressly found the converse, that he would deteriorate without treatment) and, apparently, did not consider that there was even a slight chance of this occurring. It is suggested that courts should make an express finding in this respect, because the chance of spontaneous improvement is clearly most important in assessing the risk-benefit ratio of various courses of action and in determining the overall justification of ordering treatment despite a person's refusal of it.

to, or informed refusal of, treatment. This would require that Dion be capable of understanding the nature and consequences of the proposed treatment and its alternatives, including having no treatment, and the risks run by giving or withholding consent to any given course of action. It is not clear from the judgment whether the Court found Dion to be factually competent or incompetent. The Court described him as being "incapacitated" ("un majeur incapable"),[8] but stated that he could not be interdicted under the Civil Code of the Province of Quebec.[9] This makes it clear that Dion could not be declared legally incompetent, but leaves doubt as to the Court's finding with respect to his factual competence.

It is important for a court to indicate what it holds regarding factual competence, because very different principles are involved depending on whether the issue is one of overriding a competent, adult patient's refusal of treatment, or one of a court making a decision for an incompetent person, whether adult or child.[10] The power of a court to override a competent person's refusal of treatment will be discussed later. In the case of an incompetent person, the court can exercise its *parens patriae* power, be it inherent or statutory in origin.[11] In such cases, a court's decision-making can be based on either the "best interests" of the incompetent person (a more objective approach), or on a "substituted judgment" standard, which requires the court to stand in the shoes of the incompetent person and decide according to what the court believes he or she would have decided if competent to do so (a more subjective approach). The court in the *Dion* case was of the opinion that decision-making, pursuant to the *parens patriae* power, would be governed by a "best interests" standard when a child was involved and by "substituted judgment" when it concerned an incompetent adult.[12] In all probability, the reasoning behind this approach is that if "substituted judgment" is possible, it should be the standard used, but, if not, "best interests" will apply. The choice between these two standards is not always neutral in terms of outcome. Moreover, it can be particularly important in situations where the interests or wishes of other parties could be taken into account in reaching a decision and might be in conflict with those of the incompe-

[8] *Supra*, footnote 1, at pp. 237 (D.L.R.), 440 (C.S.).

[9] *Ibid.*, at pp. 239 (D.L.R.), 441 (C.S.).

[10] It should be noted that a court will not necessarily be involved in medical decision-making regarding incompetent persons. Further, it should be recognized that any practice of allowing the same physicians, or even different ones, to determine both competence and, in the case of incompetence, what treatment will be given, lacks adequate safeguards from the incompetent patient's point of view. Moreover, such a practice, (and, in Quebec, decision-making concerning treatment, even by the incompetent person's family) is, theoretically, legally invalid; see, *infra*, pp. 79-80.

[11] See, infra, pp. 63-64. For an extensive discussion of the *parens patriae* power see *Re Eve* (1981), 115 D.L.R. (3d) 283, at pp. 302-305, 311-318 (P.E.I. C.A.); an appeal to the Supreme Court of Canada is set down for hearing on June 4, 1985.

[12] *Supra*, footnote 1, at pp. 238 (D.L.R.), 441 (C.S.).

tent person. Such situations can occur, for example, with respect to decision-making concerning the withdrawal of life support treatment from irreversibly comatose persons.

Another important issue raised by the *Dion* case, with respect to the requirements for factual competence, is the relevance of a patient's *beliefs* concerning certain facts, as compared with his *understanding* of those facts. For instance, in order for him to have been judged factually competent, would it have been necessary for Dion to believe that he was mentally ill? Or, would it be enough if he understood that the psychiatrists thought him to be mentally ill, although he denied this? Or, is his belief as to his state of illness or health irrelevant to assessing his factual, cognitive competence, because this information is an "additional belief",[13] that is, not part of the legally required disclosure of information which the patient must apparently understand, in order to consent to or refuse treatment. Or, once a patient understands the medical diagnosis relevant to his case, is any belief with respect to his diagnosis or his need for treatment, relevant to his emotional, rather than to his cognitive, competence?[14]

Whether a patient must be aware of his illness in order to be judged competent is an important issue. It is relevant to consent to, as well as refusal of, treatment. Many patients deal with their illnesses psychologically, especially serious or terminal illnesses, by a process of denial. If psychotic patients are held to be factually incompetent because they lack insight into the fact that they are mentally ill, would consent to treatment given by a person who was physically ill, but in a state of denial, be invalid? Or, can the latter situation be distinguished on the basis that it is enough that the patient at some time understood that he was ill, although he subsequently denied it? Or, is repression through denial different from failure to acknowledge illness due to psychosis, because in denial there must be some minimal consciousness of the illness always present in order to maintain the denial,[15] whereas, in psychosis it is symptomatic of the illness that the person entirely lacks insight into the fact that he is ill. The same point can be made in another way: should a distinction be drawn, for the purposes of assessing competence to consent to, or to refuse, treatment, between what could be called "closed mind" unawareness of illness (when it is due to denial) and "blank mind" unawareness (when it is due to psychosis)?

In the *Dion* case, one indication that the court might have been treating Dion as factually incompetent is that it relied on its *parens patriae* jurisdiction. Traditionally, "*parens patriae*" is the inherent jurisdiction or power of the court, derived from the power of the King, to look

[13] See *infra*, pp. 66-67.

[14] See *infra*, p. 65 *et seq.*

[15] I am indebted to Dr. P. Appelbaum, of the University of Pittsburgh School of Medicine and School of Law, for raising this point.

after those persons unable to look after themselves.[16] This is the same power that the British Columbia Supreme Court used in the *Stephen Dawson* case[17] to order treatment, against the wishes of his parents, for a severely mentally retarded, six year old boy, who was, undoubtedly, both legally and factually incompetent. In Canadian common law jurisdictions the *parens patriae* power tends to be reserved for decision-making involving incompetent persons and, hence, its use could indicate that the court regards the person as incompetent. This can be contrasted with another possible approach in which the *parens patriae* power could be given a broader interpretation, more in the nature of a general power of beneficence, rather than being limited to avoidance of harm, and, as a result, as not necessarily being limited in its exercise to protection of legally or factually incompetent persons.[18]

It should also be noted, here, that the finding that Dion was "not fit to stand trial" (that is, not able to understand the nature of either the charge made against him or the proceedings, or not able to assist in his

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[16] There is even an argument as to whether Quebec courts have a true, inherent *parens patriae* jurisdiction, or whether any such power that they have can only be derived from legislation. In the latter respect, in the appeal in the *Dion* case the appellant had argued in his appeal factum, that the judge at first instance erred in holding that art. 31 of the Code of Civil Procedure of the Province of Quebec could be the legislative source of a *parens patriae* power vested in the Superior Court: appeal factum of the plaintiff-appellant Guy Dion, submitted at the Quebec Court of Appeal, No. 500-09-001356-831, p. 19 *et seq.*

It is also interesting to note, in this respect, a recent judgment of the Manitoba Court of Appeal, *Re Director of Child Welfare and Simeon* (1984), 4 D.L.R. (4th) 406, which held that the inherent *parens patriae* jurisdiction of a court would only be ousted by clear and express legislative provision to this effect.

[17] *Re Superintendent of Family and Child Service and Dawson et al.*, (1983), 145 D.L.R. (3d) 610, *sub. nom. Re S.D.*, [1983] W.W.R. 618,(1983), 42 B.C.L.R. 173 (B.C.S.C.).

[18] Cf. *Reference Re: Section 6 of the Family Relations Act* (1982), 131 D.L.R. (3d) 257 (S.C.C.), at pp. 291-292, where Estey J., states that "[i]t is worthwhile to note that Story [Story's Jurisprudence, 12th. ed., (1877), at para. 1333] saw the *parens patriae* jurisdiction as extending to those who had no other lawful protector, an indication that that jurisdiction has a more limited scope than that contended for it by the proponents of a broad general jurisdiction". The issue will only be raised here, but it could also be questioned whether, historically, the "parens patriae" power is limited to giving a court jurisdiction over minors and that jurisdiction over mentally incompetent persons, in the form of the "lunacy jurisdiction", had a different basis and, hence, possibly different parameters. The recent Supreme Court of Canada decision in *Ogg-Moss* v. *R.* (1984), 11 D.L.R. (4th) 549i, is interesting in this respect, because the court held that mentally incompetent adult persons could not be equated to children, for the purposes of the Criminal Code, *supra*, footnote 6. It remains to be seen whether this holding will give rise to a general precedent, that mentally incompetent persons and children should be distinguished for the purposes of determining what the law allows with respect to imposing medical treatment on them. See also *Re Eve, supra,* footnote 11; *In re Infant K,* Vancouver, A842616, January 31, 1985, unreported (B.C.S.C.).

defence),[19] does not necessarily indicate that he was incompetent to refuse medical treatment. These are two different functions and an accused person could be able to function with respect to one, but not the other, and, consequently, be competent with respect to one, but not the other.[20] This functional approach to assessing competence means that a concept, which incorporates the possibility of partial competence, is adopted. Such a graduated or continuum view of competence and incompetence can be compared with the more traditional, legal approach, which espoused a doctrine that required choosing between two poles, those of global competence and global incompetence.

(b) *Cognitive and Emotional Competence*

A further competence issue raised by the *Dion* case is whether the law needs to develop a distinction between cognitive and emotional competence for the purposes of determining competence to consent to, or to refuse, medical treatment. It may well be that Dion was cognitively competent, but emotionally incompetent. In general, because the test for factual competence is based on *ability to understand* the consequences and risks of any given course of conduct relevant to a decision-making situation, the law looks only to cognitive functioning in assessing competence.[21] Emotional disturbance, at least in theory, would only be relevant to an assessment of competence, if it were of such a nature or degree as to affect the person's cognitive functioning or understanding. There are arguments for and against including assessment of a person's emotional state as part of a determination of his competence for legal purposes.

Arguments in favour of such an approach would be that decision-making depends not only on an understanding of the essential factors involved in making a choice in any given situation, but also on a person's emotional reaction to this knowledge. Consequently, if that emotional reaction is far outside any range that could be considered normal, the person should be adjudged incompetent. One of the advantages of adding an emotional component to the assessment of competence, would be to allow one to explain why, in some cases, a court will override a cognitively competent patient's refusal of treatment and, in others, it will not, and to satisfactorily reconcile or distinguish these cases. For instance, a court's refusal to order a life-saving blood transfusion for a Jehovah's

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[19] This test represents the kind of criteria addressed by courts in determining the issue of fitness to stand trial; see, for example, *R.* v. *Hubach* (1966), 55 W.W.R. 536, 48 C.R. 252 (Alta. C.A.). The Criminal Code, *supra*, footnote 5, does not define the terms "unfit to stand trial" or "capable of conducting his defence" found in s. 543(1).

[20] See the discussion of functional assessment of competence, *supra*, p. 61 *et seq.*

[21] See, in general, M.A. Somerville, Consent to Medical Care, Study Paper prepared for the Law Reform Commission of Canada (1979); M.A. Somerville, Structuring the Issues in Informed Consent (1981), 26 McGill L.J. 740.

Witness patient could be distinguished from a court's ordering psychopharmacotherapy for a psychiatric patient, on the grounds that, although both were cognitively competent, only the former was also emotionally competent and, therefore, while the former's decision should not be overridden, the latter's should be.[22]

The availability in the law of a concept of emotional competence could also provide a legal basis for dealing with another troubling situation. This occurs when a patient understands all the information relevant to giving or refusing consent to treatment, but has some *additional* belief (for instance, Dion's belief that treating him in order to render him fit to stand trial was part of the plot against him)[23] which affects his decision concerning treatment, but which is not, in itself, indicative of any disordered cognitive functioning. One possible way of handling this situation is to argue that the additional belief affects the patient's understanding of the legally required disclosure of information and, therefore, the patient is not cognitively competent, that is, he is factually incompetent in law. But, this approach could lead to awkward and uncertain precedents with respect to which "additional beliefs" are relevant to cognitive competence and when they will render a person incompetent for legal purposes. This would be especially troubling if it were found, as may well be the case, that many people may have potentially relevant "additional beliefs". Further, such an approach is inconsistent with a rule that only understanding of the legally required disclosure of information, and not rationality, is required for legally valid decision-making.[24] In comparison, the use of a concept of emotional competence to deal with such situations would allow recognition that the person is cognitively competent according to the usual rules governing this assessment, and, hence, would avoid distortion of this concept, and, at the same time, would provide a possibility for overriding the refusal of treatment by a person whose decision was unduly coloured by "additional beliefs".[25] But there is a problem inherent in such an approach. What a person believes is, primarily, part of his cognitive functioning, yet, it is being proposed that "additional beliefs" should be treated as affecting emotional, and not cognitive, competence. Consequently, in order to maintain the integrity and consistency of the legal concept of cognitive competence, it would be

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[22] It should be noted that there is no intention to imply that mental illness can be equated, automatically, to either cognitive or emotional incompetence. In any given case, it will be necessary to investigate the nature, seriousness and extent of any psychopathology that a patient displays and to determine whether it affects his cognitive or emotional functioning, or neither or both.

[23] *Supra*, footnote 1, at pp. 236 (D.L.R.), 439 (C.S.).

[24] M.A. Somerville, Structuring the Issues in Informed Consent, *loc. cit.*, footnote 21.

[25] See, *infra*, pp. 67-68, for discussion of the procedural safeguards suggested with respect to overriding a refusal of treatment on the basis of emotional incompetence.

necessary to postulate that "additional beliefs" are pertinent to assessing competence, when they cause emotional reactions to the cognitively comprehended information of such a nature and degree that the person can be regarded as emotionally incompetent.

A number of arguments can be made against a requirement that a person exhibit a "normal" emotional reaction, in order to be held competent. These include that it could be open to abuse. There is some indication of this possibility in the fact that, in the past, physicians have sometimes simply equated refusal of treatment with incompetence.[26] In such cases, the finding of incompetence becomes just a convenient mechanism for overriding the patient's wishes. It may even be that the court in the *Dion* case drew an inference of incompetence from Dion's refusal of treatment:[27]

> The court feels that the respondent's refusal to accept the recommended treatment condemns him to detention in perpetuity and the eventual loss of all contact with reality. The court does not believe that a man of healthy mind would do this voluntarily.

Further, introducing a requirement of emotional competence may affect the present situation in which a competent person can make a legally effective and binding decision, although it is based on irrational reasons, because irrationality may be equated with emotional incompetence. The degree to which we should trespass on another person's liberty of decision-making concerning himself or herself, particularly on the grounds of irrationality, is a delicate matter. Apart from other factors, what is considered to be irrational can be a value judgment. It can be argued, also, that the real test of freedom is whether we are free to make decisions, whether rational or irrational, with which others may disagree, because, if there is consensus as to the proper outcome, no liberty issue is raised. Moreover, consent could quickly become a meaningless formula, rather than a protection of a person's rights to autonomy and inviolability, unless a person is free to reach a decision on the basis of whatever reasons are of importance or relevance to him or her.

There is also a possibility of adopting a "middle course" with respect to the role that emotional competence should play, in the overall determination of factual competence, within the law governing consent to or refusal of medical treatment. It could be proposed that the *Dion* case is an example of an approach which requires that the decision of a cognitively competent person regarding medical treatment must be respected, but that it is open to physicians to seek a court order to override this decision on the basis of emotional incompetence. Such an approach has, it is suggested, desirable features. It allows emotional incompetence to be taken into account in exceptional circumstances, but subject to a safe-

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[26] L.H. Roth, A. Meisl, C.W. Lidz, Tests of Competency to Consent to Treatment, Am. J. Psychiatry 1977; 134:279.

[27] *Supra,* footnote 1, at pp. 241 (D.L.R.), 443 (C.S.).

guard and control mechanism—the requirement of court authorization. At the same time, it does not allow emotional incompetence to become generally available as a factor in assessing competence.

Within this context it is worth noting that some factors, including a person's emotional state, could be relevant within the doctrine of informed consent, not only to assessment of competence, but also to that of voluntariness. Voluntariness is the requirement that consent to or refusal of medical treatment be free of undue influence, coercion or duress. It should be stressed, in this respect, that it is important to assess separately the requirements of competence and voluntariness, in order not to confuse or overlook some of these factors. Further, it is suggested that, in general, factors which can be regarded as more intrinsic with respect to the patient go to competence, and those that are more extrinsic in this regard, to voluntariness. Pursuant to such an approach, if an emotional state of the patient were to be taken into account as part of the doctrine of informed consent, its *cause* would be relevant in determining whether it should be considered in relation to competence or voluntariness, or both. The more endogenous its origins, the more it would be relevant to competence (assuming, for the moment, that the patient was only affected emotionally, and not in his cognitive function, and emotional competence was relevant to assessing competence). In comparison, the more exogenous the cause of the "abnormal" emotional state of the patient (for instance, if it were due to pre-operative medication) the more it might be considered as affecting, if any requirement of informed consent, that of voluntariness. Alternatively, rather than looking to the cause of the patient's emotional state, its *effect* on him could be examined in order to determine whether it affected competence, or voluntariness (for instance, pre-operative medication could leave a patient competent, but highly vulnerable to coercion and, hence, only affect voluntariness), or neither requirement, or both.

(c) *Power of a Court over Competent Captive Persons*

Assuming Dion to have been factually competent, a further question raised by this case, is the extent of a court's power to override a competent person's refusal of medical treatment. Further, does this power differ, and is it more extensive, when the person is legally incarcerated? And does it make a difference whether the person is being held pursuant to a criminal proceeding, as in the *Dion* case, as compared with his being held in non-criminal detention, either pursuant to a deportation order under the Immigration Act, 1976[28] or under a civil commitment order, that is, involuntarily hospitalized under an Act such as the Mental Patient's Pro-

[28] S.C. 1976-77, c. 52. See the discussion, *infra*, p. 81 *et seq* of the *Niemiec* case, *supra*, footnote 2.

tection Act[29] of Quebec (the Quebec Act), or the Mental Health Act[30] of Ontario (the Ontario Act)? In answering these questions, the exact source of the court's power, in any given circumstances, needs to be identified and its nature and scope analyzed.

The starting point for this analysis is to determine whether a court, under its *parens patriae* power, should order medical treatment for a competent adult who is not subject to any order of incarceration. Regardless of the theory of powers of courts in this respect,[31] the practical reality is that should a court authorize the overriding of a non-incarcerated, competent person's refusal of treatment, in practice the persons acting pursuant to that authorization would be immune from legal liability, as would the judge, save for the most exceptional circumstances.[32]

Then, the proper role of a court with respect to overriding a refusal of consent by a competent person who has been involuntarily hospitalized can be explored as an example of a court's power with respect to authorizing treatment of a person who is subject to non-criminal incarceration. Such an enquiry also throws light on the proper scope of courts' powers to authorize treatment of non-incarcerated persons.

The grounds for involuntary hospitalization under the Ontario Act include that the person is dangerous to himself or herself or others, or is in danger of imminent and serious physical impairment.[33] Commitment on the ground of dangerousness to others is predicated on the "police" power of the state, whereas that on the basis of likelihood of harming oneself probably depends on the *parens patriae* power.[34]

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[29] R.S.Q., c. P-41.

[30] R.S.O. 1980, c. 262.

[31] The judgment of the Court of Appeal of British Columbia, in the *Astaforoff* case, *supra*, footnote 3, is of interest in this respect, because it demonstrates a court addressing the issue of the proper technical legal basis for both the order which is sought and the one it proposes to give. The court examined its power to order the Attorney-General of British Columbia to force-feed Astaforoff, as contended for by the Attorney-General of Canada. The court held that it had "no power to make that kind of mandatory order" (388 (W.W.R.), 312 (B.C.L.R.)), but that it could "make a declaratory order as to the existence of the duty contended for by the Attorney-General of Canada" (388 (W.W.R.), 313 (B.C.L.R.)). In the result, the court found no statutory or common law duty to this effect. The Court of Appeal pointed out that it was "here concerned primarily with a dispute between two levels of government" (389 (W.W.R.), 314 (B.C.L.R.)) and that it was "not concerned with the power of the corrections authorities, or indeed of any other prison authorities, to forcibly feed prisoners under their care and control . . . [that is,] we are not concerned with power, but rather with the existence of a duty" (388 (W.W.R.), 312 (B.C.L.R.)).

[32] H.P. Glenn, La responsabilité des juges (1982-83), 28 McGill L.J. 228. See also *Stump* v. *Sparkman*, 98 S. Ct. 1099 (1978).

[33] Mental Health Act, *supra*, footnote 28, s. 9(1).

[34] The use by the state, through the legislature, of a power of the nature of *parens patriae*, should be distinguished from situations in which this power forms part of the

Does the legitimate scope of any authorization of treatment of a competent, involuntarily hospitalized patient[35] by a court, vary depending on which power is used to justify the involuntary hospitalization and, likewise, to justify the involuntary treatment?[36] It could be, for instance, that a court has wider powers to protect other members of the community from a person than to protect him from himself, or wider powers to prevent harm than to confer benefit. On the other hand, a court may be able to order treatment only pursuant to an exercise of the *parens patriae* power (the source of which may be its own inherent power in this respect, or legislation which confers a power of this nature on the court) and not pursuant to the "police" power, which (unless there is express legislative provision to the contrary) may be limited in its exercise to avoiding dangerousness to others through incarcerating dangerous persons, and its use to this effect justified only when incarceration constitutes the least restrictive, least invasive alternative reasonably available. Investigation of relevant legislation is essential to any such analysis and is instructive, on a more general level, with respect to the power of a court to intervene and order treatment.

First, any statutory right of a patient to refuse treatment would be determinative of the parameters of any power of a court to override a patient's decision. Moreover, although the Ontario and Quebec Acts, referred to above, deal only with involuntarily hospitalized, psychiatric patients, the rights of competent, voluntary, psychiatric patients, or non-psychiatric patients, to refuse treatment, should be at least as extensive. The Quebec and Ontario Acts differ with respect to their articulation of such a right.

The Ontario Act makes it clear that a competent patient's refusal of treatment, or the refusal of treatment by the relatives of an incompetent patient, cannot be overridden, except on the authority of a Regional Review Board.[37] This provision could be interpreted as giving rise to several, alternative, implications with respect to the general law of informed consent to medical treatment. It is suggested, however, that the

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inherent jurisdiction of a court. The latter is usually more limited in scope and may, for instance, unlike the legislature's power, only be applicable to incompetent persons. See *Re Eve, supra,* footnote 11; M.A. Somerville, Changes in Mental Health Legislation: An Indicator of Changing Values and Policies, to be published, M. Roth and R.S. Bluglass (eds.), Psychiatry, Human Rights and the Law, forthcoming.

[35] It should be noted that involuntarily hospitalized patients may or may not be competent; a person can be dangerous to himself or others, but competent to consent to or refuse medical treatment. That is, dangerousness and incompetence are not necessarily linked.

[36] The grounds on which any involuntary treatment of a patient is justified might or might not be the same as the grounds justifying that patient's involuntary hospitalization.

[37] *Supra,* footnote 28, s. 35(2).

preferable, and most likely, interpretation is that the provision recognizes the right of all competent patients to refuse treatment, but establishes an exceptional mechanism for overriding such a refusal in the case of involuntarily hospitalized, psychiatric patients. The Ontario Act provides, also, that decisions of a Regional Review Board can be appealed to a court,[38] but only, it would seem, as to jurisdiction and form, and not as to merit, at least not if they are within any reasonable exercise of the Board's discretion. This leaves open what the proper powers of a court are with respect to overriding a refusal of treatment by a competent adult patient, who is not involuntarily hospitalized. The stringent criteria which must be fulfilled before a Regional Review Board can override a refusal of treatment by a competent, involuntarily hospitalized patient[39] would indicate that if it were to do so at all, a court should only override a non-incarcerated, competent patient's refusal of treatment in circumstances where the refusal threatens that person's life and when the benefits of treatment clearly outweigh any of its harms and risks. Such overriding might be justified, from a theoretical legal perspective, on the basis of a doctrine of necessity,[40] in common law systems, which, in comparison with civil law jurisdictions, do not have an articulated doctrine of "abuse of rights",[41] which could constitute an alternative justification for such overriding.

In comparison with the Ontario Act, the Quebec Act is silent as to whether or not a competent involuntarily hospitalized patient has the right to refuse treatment. But it could be assumed, according to the usual rules of statutory construction, that such an Act will be interpreted so as to infringe least on rights which otherwise exist. Such rights include those of autonomy and inviolability.[42] Consequently, a competent patient, even if involuntarily hospitalized, would have a right to refuse treatment, at least

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[38] *Ibid.*, s. 33f, and see *Re T and Board of Review for the Western Region et al.* (1983), 44 O.R. (2d) 153 (Ont. H.C.).

[39] Mental Health Act, *ibid.*, ss. 35(4),(5).

[40] It is interesting to speculate whether a court has a power based on a concept of necessity, as compared with its being able to uphold a defence of necessity or, even, to grant an immunity to an applicant, which could be analyzed as being in the nature of a declaratory judgment that a defence of necessity would exist in certain circumstances. That is, can a court contravene a right of a person (in one sense, commit a "wrong" with respect to that person), in order to avoid a greater harm or "wrong"? In general, necessity operates as a defence for a defendant or accused, but it is true that courts often implement their value judgments through such concepts and always exercise discretion through their findings as to whether or not the defence, though available, has been fulfilled in the particular circumstances of a given case. For discussion of the use of the defence of necessity in medical treatment cases, see M.A. Somerville, Medical Interventions and the Criminal Law: Lawful or Excusable Wounding? (1981), 26 McGill L.J. 82; M.A. Somerville, Therapeutic Privilege: Variations on the Theme of Informed Consent (1984), 12 Law, Medicine and Health Care (1) 4.

[41] See *infra*, p. 81 and footnote 79.

[42] Civil Code of the Province of Quebec, article 19.

with respect to any treatment which was not necessary in order to preserve his life.[43]

Do these rules concerning rights to refuse treatment, differ when a person is incarcerated pursuant to a criminal process? In the *Astaforoff* case[44] the British Columbia Court of Appeal affirmed the decision of the trial court, which held that an elderly woman prisoner, who had undertaken a hunger strike and was in danger of death, could not have her refusal to take nourishment overridden and could not be subjected to force-feeding. It should be noted that the prisoner was found by the court to be "rational" (competent) and there were also serious risks to her health and, even, life, in force-feeding her. There is nothing in this case to indicate that prisoners' rights to refuse treatment are any different from those of non-prisoners and it could be argued, on the basis of this case, that there is an absolute right to refuse treatment, at least while the patient remains competent,[45] under the law of British Columbia.[46] However, in this respect, the Court of Appeal of British Columbia emphasized "that we are here concerned solely with the existence of the duty . . . [of] the Attorney General of Canada [to act] . . . [W]e are not concerned with the power of the corrections authorities, or indeed of any other prison authorities, to forcibly feed prisoners under their care and control".[47] Consequently, the extent to which there would be legal immunity for imposing treatment on persons despite their refusal (at least upon prisoners, if not on other persons), remains an open question.

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[43] See *infra*, p. 81 *et seq.* for a discussion of the *Niemiec* case, *supra*, footnote 2, in this respect.

[44] *Supra*, footnote 4.

[45] The British Columbia Supreme Court stated:

> If she [Astaforoff] becomes unconscious or incapable of making a rational decision, that is another matter. Then she will be unable to make a free choice. But while she is lucid no law compels the provincial officers to apply force to her against her will. (*supra*, footnote 3, at pp. 327 (W.W.R.), 222 (B.C.L.R.)).

It is interesting to note, in this respect, that the court would seem to be prepared to ignore the patient's wishes, expressed while competent, as to how she was to be treated if she became incompetent. The trial judge made the above finding while being aware that:

> She [Astaforoff] informed the correctional officials that she does not want any medical attention. She said this is to remain in effect even if she loses consciousness or becomes incapable of making a rational decision. (*Ibid.*, at pp. 324 (W.W.R.), 219 (B.C.L.R.)).

This could be taken as an indication that a "living will" (a declaration made by a person while competent, which is intended to govern his or her medical treatment should he or she become terminally ill and incompetent to consent to or refuse treatment) may not be upheld by a Canadian court. Cf. Legal Advisors Committee, Concern for Dying, The Right to Refuse Treatment: A Model Act, Am. J. Pub. Health 1983; 73(8): 918.

[46] This, of course, leaves open the issue of the extent, in other Canadian provinces, of the right of a competent person to refuse medical treatment.

[47] *Supra*, footnote 4, at pp. 388 (W.W.R.), 312 (B.C.L.R.).

But, could it be that the situation is different, again, with respect to a person held under a Lieutenant-Governor's Warrant, as Dion was? And further, would it make a difference whether the Lieutenant-Governor's Warrant authorizing the incarceration of the person was issued pursuant to a finding of unfitness to stand trial, as compared with its being issued pursuant to an acquittal on the grounds of insanity?[48]

These are complex questions which have not been explored, as yet, by Canadian courts. There is, however, some American case law and legal writing which has addressed similar issues.[49] It can be argued that the state interest involved in having a person stand trial[50] justifies medicating him, despite his refusal of treatment, when he would otherwise be unfit to stand trial. Such cases can also be compared with those involving refusal of treatment by persons involuntarily hospitalized within the civil commitment system. Gutheil and Appelbaum suggest that the courts tend to give greater emphasis to the negative effects of anti-psychotic treatment when it is proposed to involuntarily medicate persons who are civilly, as compared with criminally "detained", and, as a result, are more ready to authorize treatment of criminally, as compared with civilly, committed persons.[51]

Another difficulty, which could arise with respect to persons held on Lieutenant-Governor's Warrants, is that there may be a tendency to treat them as incompetent; that is, "unfitness to stand trial", or a finding of legal insanity, may be automatically equated to incompetence, which would not necessarily be a correct finding. The juridical basis of the Lieutenant-Governor's Warrant could support such an approach: its use

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[48] R. Anand, G. Czuka, The Canadian Charter of Rights and Freedoms and Provincial Human Rights Legislation: Tools to Strengthen Rights of Psychiatric Patients and Ex-patients, Discussion paper prepared for Canadian Mental Health Association (1984), p. 33, distinguish warrants issued on these two different bases on the grounds that in the latter case, but not the former, there should have been "evidence presented upon which the court could conclude that the accused has committed some serious social harm", to justify the court issuing the warrant.

[49] See T. Gutheil, P. Appelbaum, Mind Control, Synthetic Sanity, Artificial Competence, and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication (1983), 12 Hofstra Law Rev. 77, in which the relevant case law is also cited, at footnote 65.

[50] It should be noted that this state interest will vary from jurisdiction to jurisdiction. For instance, in a jurisdiction where a person found "not fit to stand trial" must be released within a reasonable time, the state interest in bringing him to trial in order to prevent his release, if he is dangerous, will be stronger than in a jurisdiction, such as Canada, which has no such limitations. See also the discussion of synthetic competence, *infra*, p. 75 *et seq.*

[51] For an up-to-date discussion of the rights of civilly committed psychiatric patients to refuse treatment in the context of American Law, see B.R. Furrow, Public Psychiatry and the Right to Refuse Treatment: Toward an Effective Damage Remedy (1984), 19 Harvard Civil Rights—Civil Liberties Law Rev. 21.

has been described as "exercising the Royal Prerogative of parens patriae in the custody of an insane acquittee. . .".[52] However, in this regard, at least with respect to persons acquitted on the grounds of insanity, two points should be made: first, a finding of legal insanity does not mean, necessarily, that a psychiatrist would judge the person to be insane under medical criteria;[53] secondly, the legal finding relates to sanity at the time of the offence, not at the time of trial or any future time. Consequently, it would be possible, theoretically, to find a person both "legally" insane and "medically" sane, or *vice versa*. It might be useful, sometimes, to distinguish these two concepts. For instance, such a distinction would allow one to recognize that a person acquitted on the grounds of insanity was "legally" insane until the Lieutenant-Governor's Warrant under which he was held was validly terminated and, hence, his continued detention could be justified formally, despite the fact that he might, at the same time, be adjudged "medically" sane.

With regard to persons held pursuant to a Lieutenant-Governor's Warrant, care needs to be taken, also, to distinguish duties to make treatment available[54] (which may be owed to a person, whether competent or incompetent), from any rights to impose treatment on a competent prisoner. The latter, it is suggested, would exist only where expressly authorized by either legislation or where a court exercises a valid power to do so. The *Astaforoff* case, again, is interesting in this respect. It was argued, in support of force-feeding the prisoner, that section 197 of the Criminal Code,[55] established a legal duty to treat and, therefore, supported a right to impose treatment. So far as relevant, section 197(1) reads:

> Every one is under a legal duty . . .
>
> (c) to provide the necessaries of life to a person under his charge if that person

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[52] *R.* v. *Saxell* (unreported) Ont. Prov. Ct., June 24, 1980, referred to in M.E. Schiffer, Psychiatry Behind Bars: A Legal Perspective (1982), p. 5. This description of the source of the power of the Lieutenant-Governor in issuing his warrant, should be compared with that in the judgment of the Court of Appeal in the same case: "That right [to the custody of an accused person who has been acquitted on account of insanity] has now been assumed by Parliament in criminal cases, and by it delegated to the Lieutenant-Governor, so that he derives his authority from the Code and not from any vestige of the Royal Prerogative"; *Regina* v. *Saxell* (1980), 123 D.L.R. (3d) 371, at p. 377, 59 C.C.C. (2d) 176, at p. 183 (Ont. C.A.). See, also, *supra*, pp. 64-65 for discussion of the distinction between a finding of 'unfitness to stand trial" and incompetence.

[53] This situation can occur because legal insanity, as defined in s. 16 of the Criminal Code, *supra*, footnote 6, is a technical legal concept and does not necessarily parallel medical concepts of insanity.

[54] The trial court in *Saxell, supra*, footnote 52, in referring to such duties, stated that "one must assume that the Lieutenant-Governor . . . will act properly and in a seemly manner . . . and that [a prisoner held under his warrant] . . . will be humanely dealt with and treated for illness while in confinement"; cited in Schiffer, *op. cit.*, footnote 52, p. 5, at p. 40 of the original judgment.

[55] *Supra*, footnote 6.

(i) is unable, by reason of detention, age, illness, insanity or other cause, to withdraw himself from that charge and

(ii) is unable to provide himself with the necessaries of life.

The trial court rejected this argument, holding that it was sufficient to avoid criminal liability under this section, that the necessaries of life (which include medical treatment) had been offered to the prisoner and that they need not be "forcibly provide[d]". The court goes on to say that to allow the latter "sort of conduct could lead to all kinds of abuse",[56] which would indicate that treatment not only need not, but should not, be imposed. This approach can be compared with that taken by the Ontario Court of Appeal in *R.* v. *Saxell*,[57] which is more ambiguous in this respect:

> Society has a legitimate social interest in persons who have committed some serious social harm, but who have been found not to be criminally responsible on account of mental disorder; it is justified in subjecting those persons to further diagnosis and assessment, in exercising appropriate control over them, if necessary, and in providing them with suitable medical treatment.

(d) *Synthetic Competence*

A further consideration with respect to refusal of treatment by prisoners, is that of "synthetic competence". This concept contemplates treating mentally ill persons for the purpose of making them competent to stand trial, in order to convict and sentence them. Is this justified? Perhaps it could be when the harms involved in being convicted and sentenced would be less than the harms of being incarcerated without trial. This appears to have been the situation in the *Dion* case in that, as it was thought at the time,[58] the almost certain acquittal on the grounds of insanity which would result were he able to stand trial, was believed to be, not only therapeutically desirable, but also less harmful in terms of its impact and consequences, than not standing trial.[59] In short, from several perspectives, standing trial was seen by the court as a therapeutic manoeuvre, in that it could have the effect of reducing Dion's paranoia. Moreover, the court in the *Dion* case, in authorizing treatment, relied heavily on the point that the benefits of treatment outweighed its detriments, that is, the inevitable consequences and risks of the proposed treatment.[60] Further, as mentioned previously, the court stressed that

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[56] *Supra,* footnote 4, at pp. 326 (W.W.R.), 220-221 (B.C.L.R.). The Court of Appeal did not deal expressly with s. 197, but it did state that there was no statutory justification for imposing treatment.

[57] *Supra,* footnote 49, at pp. 381 (D.L.R.), 187 (C.C.C.).

[58] In fact, the defence of insanity was not raised at Dion's eventual trial, because he pleaded guilty and was given a sentence of six months probation. See *supra,* footnote 7, for a description of events as they subsequently ensued.

[59] *Supra,* footnote 1, at pp. 241 (D.L.R.), 442 (C.S.).

[60] The *Dion* case can be compared with the *Astaforoff* case in this respect. In the latter, the trial court went to some pains to describe "the grisly business of force-

treatment avoided the serious detriments of non-treatment, in that the patient's refusal to accept the recommended treatment condemned him to detention in perpetuity and eventual loss of all contact with reality.[60a] But the benefits of treatment may not always outweigh all its detrimental consequences or risks of harm, and an issue can arise as to what may be characterized as a detriment to be weighed in the risk-benefit calculus. For example, in some American cases, where a charge of murder is involved and the death penalty could be imposed, would one be justified in treating a mentally ill patient against his will, in order to make him "synthetically competent" to stand trial, in order to convict and execute him?[61] And could such a consequence be taken into account as a "detrimental" effect of treatment, with the result that, in taking it into account, the detriments of treatment would outweigh its benefits, whereas the converse would otherwise be true? This issue may seem to be largely irrelevant in Canada, but it has application in the next case which will be discussed, the *Niemiec* case.

There is also a combined legal-pharmacological-psychiatric enquiry required in relation to synthetic competence. In order to determine the legal effect of synthetic competence, it is necessary for courts to have some idea of the effect of psychotropic drugs on a person's mind. Should these drugs be described as restoring competence and the cause of that competence ignored, that is, should restored competence constitute legally valid competence? Or should the action of psychotropic drugs be described as suppressing abnormal emotional reactions and allowing the cognitive part of the brain to function, in which case cognitive competence could be regarded simply as being permitted to operate, rather than being restored or directly affected in any way? Or do these drugs give some restoration of competence, but at a reduced level, and should an accused person be allowed to stand trial in such a state? Further, if these drugs do not inhibit mentation and restore "normalcy", could any of their secondary effects, for instance, extra-pyramidal symptoms, be regarded as inhibiting competence? Or, could it even be that some drugs could be regarded as reducing the level of competence that would otherwise be present? It might be thought that the distinctions suggested in these enquiries are simply a matter of semantics, but that is not so. For instance, the more it could be shown that a person's cognitive incompe-

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feeding"; the risks of this to the patient—in that it could even cause death; the physical and psychological pain and suffering it would involve for the patient; that it might not be ultimately effective, because the patient could induce vomiting; and that it would have to be carried out for an indeterminate period, which might be prolonged; *supra*, footnote 4, at pp. 325 (W.W.R.), 219-220 (B.C.L.R.).

[60a] This, in fact, proved not to be true; see, *supra*, footnote 7.

[61] See *State of Tennessee* v. *William Early Stacy*, 556 S.W. 2d 552 (Crim. App. Tennessee, 1977) and a discussion of the case in G.C. Grober, F.H. Navoh, Ought a Defendant be Drugged to Stand Trial? (1979), 9 Hastings Center Report (1)8.

tence is due to some biochemical malfunctioning and that a certain drug does nothing other than remedy this, the easier it would be to argue that the action of that drug is to restore competency. Then, is it fair to an accused person to have him appear before a judge and jury with the symptoms which may have precipitated his criminal behaviour and which may give rise to a defence, artificially suppressed? Is a synthetically competent accused person, competent for the purposes of the law? And, the most important issue, which is a separate one, is should synthetic competence be allowed to be induced, despite an accused person's refusal of medication? These questions[62] show the need for in-depth medical knowledge (and, sometimes, further medical research), which must be carefully factored into any decisions reached by courts in these respects. It is not sufficient for courts to make an uninformed or intuitive decision that psycho-pharmacotherapy either restores, or leaves unaffected, or inhibits competence. Precise consideration both of the pharmacological mode of action of any given drug and its psychological and physiological effects and of the legal requirements of competence are necessary. Then, on the basis of these analyses, a decision can be taken as to the presence or absence of competence, in relation to fitness to stand trial, in any given case.

(2) *Decision-Making Mechanisms*

The court held in the *Dion* case that the Institut Philippe Pinel de Montréal could proceed with the necessary psychiatric treatment and therapy without risk of liability, under compulsion if necessary, provided a special medical committee was established to review the patient's care regularly. This is an interesting and novel approach for a Canadian court, although there are some similar, but far from identical American precedents, for instance, the *Quinlan*[63] and *Colyer* cases.[64] One can only hypothesize as to what the court anticipated that this committee would do, although, in requiring that it be established, the Court cited Dr. Leonard Béliveau, Director General of "Pinel", who was one of the witnesses, to the effect that "we [Institut Pinel] will do everything necessary to provide treatment while respecting the rights of the individual".[65] It could be that

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[62] Many of these questions are raised by Gutheil and Appelbaum, *loc. cit., supra,* footnote 49.

[63] *In re Quinlan,* 70 N.J. 10, 355 A. 2d 647 (N.J.S.C., 1976); *cert. den., sub nom. Garger* v. *New Jersey,* 429 U.S. 922 (1976).

[64] *Matter of Welfare of Colyer,* 660 P. 2d. 735 (Sup. Ct. Wash., 1983). It is interesting to compare the composition of the committee recommended by the court in *Quinlan, ibid.*—namely an "ethics committee" with multidisciplinary representation—with that favoured by the court in *Colyer*—a "prognosis committee" composed only of physicians. The latter appears to be closer to the approach taken by the Quebec Superior Court in the *Dion* case.

[65] *Supra,* footnote 1, at pp. 242 (D.L.R.), 443 (C.S.).

inclusion of this statement in the judgment constitutes recognition and adoption by the Court of a "least invasive, least restrictive, alternative course of conduct" approach. More invasive, more restrictive treatments would be justified if they were both the only alternatives which were reasonably available and likely to be effective. One could then hypothesize that the court envisioned the role of the committee as being to ensure that such an approach was actually implemented in giving treatment to the patient, Dion.

The petitioner-hospital also asked the court to determine whether it (the hospital) had:[66]

> The authority and the power to force *any person* detained therein by virtue of an order of the Lieutenant-Governor to undergo psychiatric treatment and therapy as required by his condition, and to impose such treatment and such therapy.

The court, in reply, stated that "it should be pointed out that neither the judge's order, nor that of the Lieutenant-Governor, authorizes Pinel to treat the accused, but only to provide care".[67] Moreover, the court held that it "cannot grant this request, not only because its decision here is based on an exceptional case, but also because the Court believes that each similar case must be considered individually and the medical decision to disregard the accused's refusal must be examined by the Courts".[68] In formulating this requirement of judicial intervention, the Court relied on Massachusetts' case, *Superintendent of Belchertown State School* v. *Saikewicz*. [69]

In short, a custodial order does not authorize the giving of any treatment, or certainly not when the patient refuses this, but only care. Further, a court order is potentially available and necessary to impose treatment against the will of a person held pursuant to a Lieutenant-Governor's Warrant on the basis that he is not fit to stand trial. This raises many issues.

First, it is interesting that the court relied on the *Saikewicz* case in order to support its holding that judicial intervention was necessary to override Dion's refusal of treatment, because, apart from the fact that the ruling to this effect in *Saikewicz* has since been modified in other cases, in terms of any universality of its application,[70] this case can be distin-

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[66] *Ibid.*

[67] *Ibid.* One issue which arises here is what is the distinction between care and treatment. Such a distinction could be relevant, for instance, to rights to refuse artificial or forced feeding. If artificial or forced feeding were regarded as care, and prisoners, or at least those held under Lieutenant-Governor's Warrants, did not have the right to refuse care, a prisoner would not have the right to refuse food, even though he would have the right to refuse treatment.

[68] *Ibid.*

[69] 370 N.E. 2d 417, at p. 434 (Mass. S.C., 1977).

[70] See W. Probert, Ethics and the Law of Dying (1984), 8 Death Education (1) 70.

guished on several important factual grounds from the *Dion* case. In *Saikewicz*, the issue was whether physicians were justified in withholding chemotherapy from an institutionalized, severely mentally retarded man, who had developed acute leukaemia, when the treatment would only marginally prolong his life and would, in itself, entail suffering from side-effects which he would be unable to comprehend. The *Saikewicz* court held that, in the circumstances, there was no obligation to treat, but that a court order to this effect was necessary. In comparison, in the *Dion* case, the issue was giving treatment despite the patient's refusal, in a situation where the patient was not terminally ill, and, possibly, was competent or, even if not, "[w]ith the exception of his psychosis . . . is a man of ability, of superior intelligence, without express conceptual disorders. . .".[71] Further, the court in *Saikewicz*, as the passage from this case cited in *Dion* states, rejects entrusting any decision-making regarding the patient to, *inter alia*, a committee. This raises even more speculation as to the role that the court envisioned that the committee, which it ordered to be set up in the *Dion* case, would play.

Secondly, the fact that a court order was held to be necessary to override Dion's refusal of treatment could indicate that the court found him to be competent. If he were incompetent his refusal, likewise any consent he gave, would be of no legal effect and, in general, the Public Curator is the appropriate person, under Quebec law, empowered to make decisions on behalf of an incompetent adult person who has no court-appointed, private curator.[72] The presence, in Quebec law, of the institution of "public curatorship", which provides for "automatic" guardianship of factually incompetent, adult persons,[73] can be contrasted with the absence of such an institution in Massachusetts' law, which only contemplates the equivalent of the institution of "private" curatorship under Quebec law. The difference raises a further issue with respect to the Court's reliance, in the *Dion* case, on the *Saikewicz* case to support its holding that judicial intervention in decision-making concerning Dion's treatment was necessary, because one reason the Massachusetts' court was involved was that there was no legislatively provided, non-judicial, alternative, decision-making mechanism. This is not meant to indicate that a Quebec court should never be involved in medical decision-making.

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[71] *Supra*, footnote 1, at pp. 239 (D.L.R.), 441 (C.S.).

[72] See the Public Curatorship Act, R.S.Q. 1977, c. C-80. The Public Curator is the counterpart of the Official Guardian in the common law provinces, where the next-of-kin, rather than the Official Guardian, is treated, almost invariably, as the legal representative of an incompetent adult person for the purposes of consent to, or refusal of, medical treatment. However, except where there is statutory provision that the next-of-kin shall be the legal representative of an incompetent adult (as, for instance, in the Ontario Mental Health Act, *supra*, footnote 29, s. 35(2)) the legal validity of this well-established practice could be challenged.

[73] *Ibid.*

As in all jurisdictions, sometimes it should and sometimes it should not and what is needed are guidelines indicating, in any given situation, whether court intervention is appropriate, or unnecessary, or, even, inappropriate. Moreover, it could be that a court should intervene in some decisions which fall within the jurisdiction of the Public Curator and, hence, was "rightfully" involved in the *Dion* case. But, what is surprising, is that the Quebec Superior Court not only made no reference to the Public Curatorship Act, but held, expressly that "[i]t would appear that there is nothing in statutory law, in the doctrine or the jurisprudence which would directly apply to the respondents case".[74] It is possible that the Court took this approach either because it was of the view that Dion was competent and, hence, the Act was not relevant, or because Dion was being held on a Lieutenant-Governor's Warrant which is an exercise of the federal criminal jurisdiction and, hence, application of a provincial Act could be ousted, or, simply, that the Act did not apply to incarcerated persons.

This leads to the question of whether court intervention was necessary, not because Dion was competent, but because he was being held in "criminal custody". It is true that prisoners may often need special protection, because they are more than usually vulnerable. But, it would be surprising if court approval of the giving of standard, therapeutic, medical treatment to any incompetent person, whether prisoner or non-prisoner (as compared with withholding medical treatment from such a person), were required. The only circumstances in which this could be true is where a competent person either would, or would not, be likely to have the proposed treatment and the opposite course of conduct, in either respect, was being anticipated in relation to the incompetent person.

(3) *Scope of Authorization of Treatment*

The final questions raised by the *Dion* case are to what extent were the psychiatrists authorized by the court to give treatment to Dion despite his express refusal and, if the court did override his refusal on the grounds that he was incompetent, what situation would prevail when the treatment he was involuntarily given rendered him competent? Would his refusal then have to be respected? It is suggested that the purpose of the order which was sought, namely to give Dion treatment to render him fit to stand trial, should govern the extent of the treatment which would be justified.[75] Consequently, although the treating psychiatrists might think

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[74] *Supra*, footnote 1, at pp. 238 (D.L.R.), 441 (C.S.).

[75] I am indebted to my colleague, Professor R. Sklar, of McGill University for raising this point. He pointed out, however, that this is likely to be more a theoretical, legal construct than a practical, medical possibility, because it would be almost impossible to determine whether many treatment interventions went beyond simply producing "fitness to stand trial".

that, in the interests of Dion's overall health and well-being, more extensive therapy was desirable, this would not be justified pursuant to a treatment authorization aimed at rendering him fit to stand trial. Likewise, such an approach would mean that continuation of treatment after trial would have to be justified on some other basis. There is no indication, however, in the *Dion* judgment that the court imposed any such limitations. Finally, in this respect, there is always the possibility that the treatment will be ineffective, or cause serious side effects, or that the patient will continue to refuse it. With respect, it would seem desirable for a court to place some limits on the period for which treatment is authorized,[76] at least without further review of the situation by a court. Articulation by the court of the conditions under which treatment must be discontinued before any such time limit expired, would not be necessary where, as in the *Dion* case, the court did not order treatment, but simply authorized the physicians to treat.[77] This is true, because the giving of treatment, where it clearly became contra-indicated due to side effects, would constitute conduct that was unethical, unprofessional, malpractice and, possibly, criminal.

B. *The Niemiec Case*

The second Quebec case to be discussed is *Procureur Général du Canada* c. *Hôpital Notre-Dame et un autre (défendeurs) et Jan Niemiec (mis en cause).*[78] Niemiec had been refused immigrant status in Canada and was being held in non-criminal custody awaiting deportation. He swallowed a piece of wire which he took from the mattress in his cell. The wire lodged in his oesophagus. He was taken to hospital, where he refused all treatment and nourishment. He declared that he would rather die than be deported to his country of origin. The medical evidence was that he was at major risk of serious complications, that there was an urgent need to intervene and that he was in a critical condition.

Niemiec was, without doubt, legally competent and appeared to be factually competent. Could his refusal of treatment be overridden? The court held that the principle of inviolability of the person is not absolute, but is a right given to enable the person to preserve his integrity and his life; it could not be invoked to achieve the opposite result.[79] Further,

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[76] I am indebted to my colleague Professor R.A. Kouri, of the University of Sherbrooke, for suggesting the need for this limitation.

[77] See *infra,* pp. 88-89.

[78] *Supra,* footnote 2.

[79] This is to invoke an "abuse of rights" doctrine, which is more explicit in civilian, than in common law, legal systems. For a discussion of whether the right of inviolability could be limited by a concept of "abuse of rights", see A. Bernadot, R.P. Kouri, La responsabilité médicale (1980), para. 204, pp. 135-136; and see M.A. Somerville, Experimentation on the Person: A Comparative Survey of Legal and Extra-Legal Controls, Doctoral Thesis, McGill University (1978), pp. 65-68, vol. 2, p. 878, note 31.

respect for life took precedence over respect for the person's will, that is, his right of self-determination. Moreover, all persons "have an obligation to protect the life and security of others and, according to the circumstances, to provide for those others the necessities of life".[80] Then, citing the *Bouvia* case,[81] as standing for the same principle, the court held that individuals cannot use the law or the courts in order to realize an aim of destroying their own lives. For these reasons, the court authorized the carrying out of the operation to remove the wire and all necessary ancillary measures to prepare the patient for the operation, including his nutrition.

Among the issues raised by the *Niemiec* case, is that of the limits, if any, to the broad precedent it sets, that the refusal of treatment by a competent, adult patient can be overridden, at least by a court. With respect, it is unfortunate that the judge failed to articulate or even hint at any such limits, because, apart from other considerations, the question is left open as to how a court would act regarding refusals of treatment on the grounds of religion, such as refusals of blood transfusions by competent adult adherents of the Jehovah's Witness faith.[82] Some of the distinctions which could be drawn, in order to define precisely and limit any precedent set by the *Niemiec* case, will now be examined.

(1) *Limiting the Niemiec Precedent*

One assumes that the urgency and necessity of the intervention (in that Niemiec's refusal of treatment was life-threatening) were important factors in this respect. Was it also important that Niemiec was not "free-living", that is held in captive circumstances, although not pursuant to a criminal jurisdiction, which makes the situation more like involuntary hospitalization[83] than incarceration under a Lieutenant-Governor's Warrant or imprisonment? Further, how important was it that Niemiec was willing to have the required surgery if the Immigration authorities would agree not to deport him? Could one argue that he was not refusing the treatment itself, but only doing so in order to achieve some further end, that is, to manipulate the Immigration authorities and that a refusal on such grounds could be overridden? There are serious policy considerations involved in determining the degree to which legally incarcerated

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[80] Author's translation. *Supra*, footnote 2, at p. 427. This approach can be compared with that taken in the *Astaforoff* case. See discussion, *supra*, pp. 74-75.

[81] *Supra*, footnote 3.

[82] There are no reported Quebec cases, that could be found, dealing with this point. However, there is doctrine (R.P. Kouri, Blood Transfusions, Jehovah's Witnesses and the rule of inviolability of the human body (1974), 5 R.D.U.S. 157) which proposes that refusals of transfusions by such persons should be respected under Quebec law and, in practice, some physicians and hospitals do respect them.

[83] See discussion, *supra*, pp.

persons can be allowed to manipulate the prison system.[84] And, Annas has proposed that, in some circumstances, "motives do matter",[85] in determining whether to respect or override a refusal of medical care by prisoner hunger-strikers.

For instance, it may be relevant in deciding whether a person's refusal of treatment should be respected, whether it is primarily motivated by suicidal or manipulative considerations, in comparison with religious ones. This is to postulate that there are acceptable and unacceptable motives for the same decision outcome. But, what constitutes a relevant motive and should only primary motives be taken into account? For instance, when a person refuses treatment on religious grounds, should it be held that there is no motive of seeking death, but only one of upholding religious beliefs? Should a person's refusal of treatment be respected when his motives for refusal are acceptable, but be allowed to be overridden when his primary motive or motives are all unacceptable and at least one primary aim of refusing treatment is death?

Then, to what degree was it relevant to the court's decision to authorize the surgery on Niemiec, that his condition was deliberately induced and treatment was required as a result of an attempt to commit suicide on his part? Would treatment always be ordered when it was needed as a result of a suicide attempt? Or, was Niemiec's suicide attempt judged to be irrational and this irrationality provided both a necessary and sufficient reason for the court to authorize a non-consensual intervention? In that case, what if his suicide attempt had been considered rational, either in the particular circumstances of his case, in that he preferred death to deportation, or if the circumstances were different, for example, he was terminally ill and in great suffering and wished to end his life? Would the court still have authorized the surgery? There is nothing in the judgment to suggest that this would have changed the court's decision and, in fact, the nature and breadth of the reasons given to justify authorizing the surgery suggest that, no matter what the circumstances, a person's life would be preserved, contrary to his wishes, if this were possible. Such cases are of extreme difficulty. Even among those who fully support individual freedom and liberty, many do not acknowledge either a right to take one's own life or that there is no right on the part of another to intervene to prevent this result. One approach to finessing this dilemma is to propose that irrational decisions need not be respected and that all persons who try to commit suicide are irrational, that is, the act proves the irrationality, and, therefore, intervention is warranted. But, even if such an approach were accepted, in general, can the situation of a person who seeks to die through refusing medical treatment be distinguished from

[84] *Commissioner of Correction* v. *Myers*, 399 N.E. 2d 452 (Mass. S.C., 1979).

[85] G.J. Annas, Prison Hunger Strikes: Why the Motive Matters (1982), 12 Hastings Center Report (6) 21.

other means of achieving death[85a] and, further, should such a refusal never, or sometimes, or always be regarded as suicide? Does it make a difference in this respect, whether or not the treatment is needed to avoid, on the one hand, serious consequences of a deliberately induced threat to his life by the patient or, on the other hand, life-threatening consequences of a fortuitous, or apparently fortuitous, event? Moreover, how, if at all, should factors such as terminal illness, quality of life, intense pain or suffering be taken into account by a court in deciding whether or not to override a competent adult patient's refusal of treatment?

The *Astaforoff* case[86] is, again, of interest, by way of comparison with the *Niemiec* case. The court held expressly that the prisoner, Astaforoff, was attempting to commit suicide by starving herself to death. However, while aiding and abetting, counseling or procuring a person to commit suicide is a criminal offence,[87] as the trial court stated in *Astaforoff*:[88]

> . . . idly standing by without encouraging a person to commit suicide is no crime. Nonetheless, it is the duty of every person to use reasonable care in preventing a person from committing suicide. What is reasonable depends upon the facts.

Further, the court has a "responsibility . . . to preserve the sanctity of life. It is a moral as well as a legal duty".[89] But the court held that here "the facts are against" compelling the giving of medical treatment and, in the circumstances, there was no legal duty on the province of British Columbia, (although, as mentioned before there may have been a power),[90] to treat the prisoner. This is a much more individual and precise approach than that taken in the *Niemiec* case and, while it leaves open the possibility of a court overriding a competent patient's refusal of treatment, it shows that this will certainly not always be done, even when the result could be death and this could have been avoided. Further, the British Columbia court seems to start from an initial presumption of requiring that the imposition of the non-consensual treatment be justified, that is, an initial presumption of individual autonomy, rather than from a

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[85a] See H. Kushe, A Modern Myth, That Letting Die is not Intentional Causation of Death: Some reflections on the trial and acquittal of Dr. Leonard Arthur (1984), 1 Jo. of App. Phil. (1) 21, who discusses this point in relation to defective new born babies. Such situations may be compared and contrasted with those where a competent adult seeks death through refusal of treatment.

[86] *Supra*, footnote 4.

[87] Criminal Code, *supra*, footnote 6, s. 224.

[88] *Supra*, footnote 4, at pp. 326 (W.W.R.), 221 (B.C.L.R.). It is suggested that here the court is using the term duty in the sense of either moral duty or privilege, rather than legal duty. This would mean that any person who intervened to prevent suicide would have immunity from legal liability for having done so, but, would not incur legal liability for failure to intervene in a situation in which there was no pre-existing legal duty relationship between the parties.

[89] *Ibid.*, pp. 327 (W.W.R.), 221 (B.C.L.R.).

[90] *Supra*, p. 72.

presumption of a right and duty to preserve life, which appears to be adopted in the *Niemiec* case.

With respect to overriding refusals of medical treatment that could be regarded as suicidal, it is worth noting, again, that, in legal theory, any power to override an adult's refusal of treatment, *without judicial intervention,* depends on finding him incompetent and any finding of irrationality is irrelevant, except in so far as it could indicate incompetence. Whether a court has wider powers in this respect, including the power to override a competent adult's refusal of treatment, and under what conditions (for instance, it could be suggested that this power is only present when the refusal would constitute suicide), is a separate issue. It is difficult, however, to contemplate what the theoretical basis of such powers could be if the *parens patriae* power were excluded (as it probably would be in the case of at least a "non-captive", competent adult), because a court can only enforce a valid claim of right on the part of some party and there would not appear to be the possibility of any such claim in these cases. But, if such powers are held to exist, or, simply, are exercised in practice despite the absence of a theoretical basis for them, any overriding of the refusal of treatment by a competent adult, as in the *Niemiec* case, ought to be justified on carefully delineated grounds, which may then be able to be distinguished or applied in future cases, as appropriate. Failure to adopt such an approach risks creating a situation of uncertainty as to whether and, if so, which refusals of treatment by competent patients can be overridden. This could create problems, not the least being to know when an approach should be made to a court and to predict how a court may decide in any given circumstances. Further, it is worth noting that although the requirement of a court order is a procedural, rather than a substantive, limitation on overriding a competent patient's refusal of treatment, it would act as a regulating device and restrictive safeguard in terms of any wholesale disregard of a patient's wishes concerning treatment. The danger in this respect is that the court order could become nothing more than a "rubber stamp", simply endorsing any decision taken by a physician, as has allegedly occurred in some jurisdictions with respect to court approvals of involuntary civil commitment, or donation of tissue or organs by young children.[91]

It is also interesting to note that the court authorized Niemiec's nutrition, although as an adjunct procedure in preparation for surgery. This can be compared with the British Columbia courts' refusals to order force-feeding as a primary treatment in the *Astaforoff* case.[92] Further, does the fact that the Quebec Superior Court expressly authorized the nutrition, indicate that such nutrition was regarded as treatment, rather than care,

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[91] P. Déschamps, D. Sauvé, Aspects juridiques de la transplantation de moelle osseuse, M5decin du Québec 1981: 16(q): 51-60.

[92] See *supra,* p. 72.

because in the *Dion* case the court indicated that its authorization of care would not be required. Or is it that imposition of care need not be authorized for a person held under a Lieutenant-Governor's Warrant, but would be required with respect to other prisoners or non-prisoners? Moreover, depending on the circumstances could nutrition sometimes constitute care and sometimes treatment, and, if so, what are the distinguishing criteria? The answers to these questions have important ramifications, in particular, with respect to rights to refuse and duties to continue to provide artificial feeding to terminally and non-terminally ill, competent and incompetent patients. The most publicized recent example, in this respect, has been the case of Elizabeth Bouvia.[93] The ways in which this case differs from both the *Dion* and *Niemiec* cases highlights, still further, the complexity of the issues raised by the Quebec cases and of the whole area of refusal of medical treatment.

II. *Comparing the Bouvia Case*

Elizabeth Bouvia, a victim of cerebral palsy, with virtually no motor function in any of her limbs or other skeletal muscles, desired to starve herself to death in a hospital setting, where she would be given palliative care during the process of dying. She was admitted as a voluntary psychiatric patient on the grounds that she was suicidal and her lawyer then applied for a court order restraining the hospital from either discharging or force-feeding her. The court held that Bouvia could discharge herself from the hospital, but that, if she stayed, the hospital could force-feed her. Among the points raised by a comparison of the *Bouvia* case with those of *Dion*, *Niemiec* and *Astaforoff*, are the following.

First, unlike in the *Dion* and *Niemiec* cases, the application to the court was made by the *plaintiff patient* seeking to have the hospital ordered to desist from intervening. One can only speculate as to why the hospital was not the primary applicant, but one possibility is that it did not consider that it needed to be authorized to give medical treatment, despite the refusal of that treatment by a competent adult.

Secondly, Elizabeth Bouvia was seriously physically handicapped and institutionalized (although voluntarily), which resulted in her being subject to a form of captivity, which can be compared with the captivity resulting from judicial orders in the *Dion* and *Niemiec* cases. In theory, and to some extent in practice, Bouvia had an option to leave the hospital,[94] which Dion and Niemiec did not. The court held that she could discharge

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[93] *Supra*, footnote 3.

[94] Bouvia's option to leave the hospital was dependent on someone outside the hospital being willing to take her in and look after her. In fact this happened and she went to Mexico and commenced eating and, as last reported, may have changed her mind regarding starving herself to death. (See: Death-wish woman changes her mind, The Gazette, Montreal, April 24, 1984, p. A-11.).

herself from the hospital, but, if she stayed, she could be force-fed. Did the court rely on the presence of this choice to justify its ordering of treatment, in that there is some pretence that treatment is not being imposed, because it could be avoided? The approach taken by the trial court in the *Astaforoff* case[95] makes an interesting comparison in this respect. The fact that Astaforoff was free to leave the prison under a form of parole, but "chose . . . to remain there and starve herself to death",[96] was a reason given by the court for not ordering her force-feeding.

This leads to the third point, that there may be an implication of a "take it or leave it", "package" approach to medical treatment in the holding in the *Bouvia* case. To what degree can patients consent to or refuse the modalities of their treatment, as compared with the treatment itself? Did the judge, even if covertly, interpret Bouvia's request for palliative care and pain relief as a request for treatment and, therefore, find that the rest of the treatment "package", which included nutrition, could not be refused? There is a fine line between respecting a patient's right to consent to or refuse treatment and allowing the patient to manipulate unduly and unacceptably the treatment situation. But it is necessary to be sensitive to the fact that there may be undue coercion in some situations where patients clearly need and want some treatment, but not other treatment which the physician considers to be essential. There are also associated problems related to the manner in which treatment is given, when more than one alternative is available and the patient demands one form and the physician considers another preferable. Such conflicts can arise because the physician considers a form of treatment refused by the patient to be preferable from the patient's point of view or, sometimes, from a cost-saving perspective in a situation in which the much less expensive alternative is equally as safe and effective, or, possibly, even more so.[97] This is a particularly important issue when the patient has no real alternative but to be treated, for example, if he needs haemodialysis for terminal renal failure and want this treatment, but only in a certain form or designated circumstances.[97a] Such issues need in-depth, comprehensive and careful research in order to try to carry out the delicate balancing act that is involved in, as far as possible, respecting patients' rights to autonomy, but, at the same time, giving due weight to the multiple other legitimate demands arising within all health care systems.

Fourthly, the court in the *Bouvia* case, unlike the courts in the *Dion* and *Niemiec* cases, considered harm to others resulting from a failure to

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[95] *Supra,* footnote 3.

[96] *Ibid.,* at pp. 327 (W.W.R.), 222 (B.C.L.R.).

[97] M. Kaye, J. Lella, R.F. Gagnon, B. Mulhearn, G. Low, Dialyzer re-use. A study in applied medical ethics, Faculty of Medicine, McGill University (submitted for publication).

[97a] In this latter respect see *Commissioner of Corrections* v. *Myers, supra,* footnote 84.

override the patient's refusal of treatment as a factor in reaching its decision to order treatment; it took into account, ". . . the interests of third parties involved in the case . . . [including] other patients in the hospital, other persons similarly situated who suffer from chronic disabling diseases and health care professionals employed by Riverside General Hospital who would have to assist in the Plaintiff's death".[98] In particular, the court found that allowing Bouvia to starve to death in Riverside Hospital would "have profound effect on the medical staff, nurses and administration" of the hospital and "would have a devastating effect on other patients within Riverside Hospital and other physically handicapped persons who are similarly situated in this nation".[99] Because Bouvia was not terminally ill, it was held that "[t]he established ethics of the medical profession clearly outweigh and overcome her own rights of self-determination".[100] Yet again, the *Astaforoff* case offers an interesting comparison. The British Columbia Supreme Court, in its judgment, notes that "[t]he provincial medical practitioners employed by the prison officials object to participating in the affair because they say their code of ethics restricts them from invading the body of a patient in this way when it is against her will".[101]

III. *Nature of the Court Order*

Finally, there is one important aspect in which the *Dion* and *Niemiec* cases are identical. In neither case did the court order treatment of the patient; rather, it authorized the physicians to treat each patient despite his refusal.[102] The same outcome resulted, indirectly, in the *Bouvia* case through the court's refusing the plaintiff patient's request for an injunction against the defendant physicians to prevent them force-feeding her. This approach can be compared with that taken in the *Dawson* case where the court expressly ordered the treatment.[103]

Adoption of an "authorization of treatment", rather than an "ordering of treatment", approach has important legal ramifications and implica-

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[98] *Supra*, footnote 3 at p. 1245 of the transcript.

[99] *Ibid.*, p. 1243.

[100] *Ibid.*, p. 1246.

[101] *Supra*, footnote 4, at pp. 325 (W.W.R.), 220 (B.C.L.R.). The holding of the Supreme Judicial Court of Massachusetts in *Commissioner of Correction* v. *Myers*, *supra*, footnote 84, is also interesting in this respect and can be contrasted with the *Bouvia* decision. Relying on the *Saikewicz* case, *supra*, footnote 69, at p. 149, it stated, at p. 458, "[t]he governmental interests in maintaining the ethical integrity of the medical profession and in permitting hospitals to care for those in their custody are not controlling, since a patient's right of self-determination would normally be superior to such institutional considerations".

[102] I am indebted to Professor Julius Grey, lawyer for Niemiec, for bringing this point to my attention.

[103] *Supra*, footnote 17, at pp. 623-624 (D.L.R.), 633 (W.W.R.), 187 (B.C.L.R.).

tions. First, if the treatment had been ordered and the physicians had refused to give it they would have been in contempt of court—a serious offence.[104] Secondly, such an approach leaves the decision-making power regarding treatment in the hands of the physicians, not the state authorities, who cannot demand that treatment be undertaken by the physicians. In legal terms, the court placed no duty on the physicians to treat, but simply gave them a power to treat despite the refusal of treatment by the patient. Consequently, if the treating physician thought that treatment were contra-indicated, because, for instance, the circumstances had suddenly changed (and there was no negligence involved in holding such an opinion, in that a reasonable and competent physician in the same circumstances could be of the same opinion), the physician would not only have no duty to treat, but would have a duty not to treat, breach of which would constitute medical negligence or malpractice.

Conclusion

The issues involved in refusal of medical treatment are complex and need detailed analysis. Factors which must be taken into account include: whether the patient is an adult or a minor, competent or incompetent, and, if incompetent, whether he or she has ever been competent in the past and expressed wishes regarding treatment in circumstances similar to those which have arisen. It is also relevant whether there is a refusal of treatment or simply a situation of no consent; whether the person is terminally ill or not terminally ill; whether the condition necessitating treatment is deliberately induced; and whether the patient has some reasonably available option or options for avoiding the treatment. Finally, one must always consider whether the patient is in "captive" circumstances.

This list is nowhere near exhaustive. Further, no one factor operates in a vacuum, but will vary in importance in any given set of circumstances and, in particular, with the presence or absence of the other factors listed. It could even be said that multivariant analysis is needed. This demonstrates what is probably the most important consideration in this area: that any decision regarding refusal of treatment by a patient, whether taken by a court or some other person or body, and whether to respect or to override the refusal, must be carefully structured, and reached on the basis of precisely identified principles, applied in carefully delineated fact situations. To do less is to risk both an inappropriate decision in the immediate case and the setting of unfortunate and uncertain precedents.

Moreover, both these risks may be augmented by any attempt to solve the problems raised by the refusal of medical treatment through a "blanket" approach, such as legislation might necessarily comprise. Certainly,

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[104] See the Code of Civil Procedure of the Province of Quebec, arts. 49-54; and the Criminal Code, *supra,* footnote 6, s. 116.

to grossly understate the matter, it would be regrettable if legislation were passed, as seems could happen in Quebec,[105] detracting from rights to autonomy and inviolability, without at least ensuring that any given instance of such detraction was subject to the most stringent safeguards. Such safeguards are more likely to be procedural, than substantive, in nature, and one approach would be simply to legislate the present position, as shown by the cases discussed in this text, in which recourse is had to a court. But, whether this or other forms of safeguard are adopted, steps must be taken to ensure that account is taken of the full range of delicate and nuanced factors involved in any decision to override a refusal of treatment, especially on the part of a competent patient. To do less is to risk both a return to the harms of medical imperialism and paternalism, any benefits of which have already been lost, and destruction of carefully developed legal requirements which promote respect for patients as persons.

[105] See Legislative Assembly of Quebec, Bill 106, 1982 (in particular art. 12), which was withdrawn, but will be re-presented in 1985, as it stands at present, unaltered in respects relevant to this text.