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EDITOR'S NOTE

Chad Bass-Meldrum *

This issue of the *McGill Journal of Law and Health* reflects our continued efforts to position ourselves as one of Canada's premier health law publications. The issue begins with an article by Jennifer Chandler, which explores whether patients have a constitutional claim to unimpeded medical research under the Canadian *Charter of Rights and Freedoms*. Using the Canadian federal prohibition on human cloning as a case study, the article concludes that a constitutional claim can be made in this context and ought to be available.

The next article by Hilary Young addresses the issues of when medical intervention should cease, and who should be allowed to make such a decision. In light of the Ontario Court of Appeal's recent decision in *Rasouli v Sunnybrook Health Sciences Centre*—which held that physicians can only withdraw certain life-sustaining treatment with the consent of patients or their proxies—the article argues that the law of informed consent should not be interpreted so as to create any entitlement to continued life support. Such an interpretation ignores the interests of physicians and the public interest. Accordingly, the article argues that any entitlement to life-sustaining treatment should flow from laws other than the law of informed consent, such as the *Charter*, or alternatively a new law that can weigh competing interests. In response to Hilary Young's article, an article by Laura Hawryluck seeks both to clarify key issues surrounding the "Hawryluck proposal" as presented by Young, and highlight key challenges facing end of life care for frontline clinicians.

The issue ends with another timely article by Jocelyn Downie and Ben White, which proposes a set of offence specific guidelines for how prosecutorial discretion should be exercised in cases of voluntary euthanasia and assisted suicide in Canadian provinces and territories. This article extends the work of the Royal Society of Canada Expert Panel on End of Life Decision Making.

Once again, I would like to thank the authors, peer reviewers and editors of Volume 6 for their contributions to this Issue of the *McGill Journal of Law and Health*. I would also like to thank the incoming Volume 7 executive, namely Kaitlin Soye, Daniel Mastine, Marie-Laure Tapp, Francesca Taddeo and Adrian Thorogood for their ongoing dedication to making this journal one of a kind. Lastly, I would like to thank our readers—we appreciate your continued support. For more multi-lingual, multi-jurisdictional and multi-disciplinary reading visit us online at <http://mjlh.mcgill.ca>.

À votre santé!

* Editor-in-Chief, McGill Journal of Law and Health, Vol. 6.

DOES A PATIENT HAVE A CONSTITUTIONAL RIGHT TO THE FREEDOM OF MEDICAL RESEARCH? REGENERATIVE MEDICINE AND THERAPEUTIC CLONING RESEARCH IN CANADA

*Jennifer A. Chandler**

Constitutional arguments regarding the freedom of scientific research often focus on the freedom of speech of researchers, with much less attention to the potential constitutional claims that could be made on behalf of patients who may one day benefit from the fruits of that research. This article explores whether patients have a claim to unimpeded medical research under the Canadian *Charter of Rights and Freedoms*, using as a case study the Canadian federal prohibition on human cloning—including “therapeutic cloning” (or the derivation of stem cells that are immunologically compatible with the recipient patient for use in regenerative medicine). The conclusion drawn in this case study is that a constitutional claim can be made in this context and ought to be available as an argument more broadly, although the speculativeness of the eventual benefits of therapeutic cloning research is a significant weakness. The concern over harm to women due to the demand for human oocytes for research and eventual therapy is a credible and compelling one that would justify some restrictions on the research under section 1 of the *Charter*. Nonetheless, the prohibition of all therapeutic cloning research is vul-

Les arguments constitutionnels portant sur la liberté de recherche scientifique mettent la plupart du temps l'accent sur la liberté d'expression des chercheurs, mais beaucoup moins sur les revendications potentielles au nom des patients qui pourraient un jour bénéficier des fruits de ces recherches. Cet article se questionne à savoir si des patients pourraient déposer un recours pour garantir la libre recherche scientifique en vertu de la Charte canadienne des droits et libertés, en utilisant comme exemple l'interdiction fédérale sur le clonage humain, qui inclut le clonage thérapeutique (l'utilisation de cellules souches compatibles immunologiquement avec le receveur pour un usage en médecine régénérative). La conclusion tirée de ce cas de figure est qu'une revendication constitutionnelle est possible et devrait être utilisée de façon plus large, malgré que l'incertitude sur les bénéfices éventuels du clonage thérapeutique constitue une faiblesse importante de l'argument. Les inquiétudes concernant les femmes, compte tenu de la demande pour des ovocytes humains à des fins de recherche et éventuellement à des fins de traitement, sont crédibles et convaincantes et pourraient justifier des re-

* Jennifer A. Chandler, Associate Professor, Faculty of Law, University of Ottawa. I thank the Stem Cell Network (Canada) for support for the research for this paper, as well as my two excellent research assistants, Matt Malcolm and Kiernan A. Murphy.

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nerable to the argument that it is overbroad in that it forecloses lines of therapeutic cloning research that do not endanger women.

strictions sur la recherche en vertu de l'article 1 de la Charte. Par contre, l'interdiction de tout clonage thérapeutique pourrait être perçue comme ratissant trop large, empêchant la recherche sur des types de clonages thérapeutiques ne présentant pas de risques pour les femmes.

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Introduction

Constitutional scrutiny of state restrictions on scientific research usually focuses on the liberty interests of scientists to research, teach and publish as they see fit and the countervailing limits that society is entitled to place on this research where harm to the public interest is feared. Another approach to the constitutionality of state restrictions on scientific research is to consider the interests of the patients who might one day benefit medically from the treatments that medical research makes possible.

This paper explores the question of whether patients have a constitutionally protected interest in unrestricted medical research based on their constitutional right to life, liberty, and security of the person under section 7 of the *Charter of Rights and Freedoms*.¹ Of course, if there is such a right, it will be subject to reasonable limits under section 1 of the *Charter*. Indeed, some forms of restriction on research are now commonplace and easily justified, such as ethical requirements for research involving human subjects. Far less common are government prohibitions on particular research questions or fields of research.

While the focus of this article is the structure and viability of the suggested section 7 claim to medical research unimpeded by government restrictions, it is undeniable that medical research raises questions of broader social and political significance. The choice of research questions, the availability of funds, the likelihood of commercialization of ensuing discoveries, and the eventual access to treatments have socio-political and economic dimensions that are of fundamental importance to patients in need of therapeutic assistance. As a result, an exploration of the proposed section 7 claim against government restrictions on particular lines of medical research can provide only a partial contribution to the more complex problem of balancing liberty, distributive justice, and the public good in the field of medical research. However, the question of whether such a claim can be advanced and what its strong and weak points might be is an important one. It offers a different vantage point upon the way that individual human rights protections might intersect with medical research (beyond a focus on the liberty of researchers). There is also a partial precedent for this type of claim in the American case of *Abigail Alliance*,² where a patient unsuccessfully advanced

¹ *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11, s 7 [*Charter*].

² *Abigail Alliance for Better Access to Developmental Drugs v Von Eschenbach*, 495 F (3d) 695 (DC Cir 2007), rev'g 445 F (3d) 470 (DC Cir 2006) [*Abigail Alliance*].

a constitutional claim to unimpeded access to an experimental drug that had not yet received government approval. A focus on the extent of a patient's section 7 interests at other points throughout the medical research process thus fits within contemporary thinking about constitutional rights related to health care.

There are also good policy reasons to recognize that patients have a potential constitutional right to unimpeded medical research, even if restrictions may ultimately be justified in particular cases. Without such a right, governments might be able to use "upstream" research restrictions to prevent access to treatments that they might find difficult as a constitutional matter to withhold from patients once the treatments come into existence. For example, a government opposed to abortion could decide to prohibit the clinical testing of an experimental abortifacient drug that looks very likely to be an improvement over existing methods in terms of safety and cost-effectiveness.³ If potential beneficiaries of that research were unable to establish a claim, then governments could try to restrict abortion by preventing the upstream research that might improve access to safe abortion.

I have selected as a case study with which to explore this potential section 7 claim, the Canadian criminalization of therapeutic cloning research⁴

³ Canada is one of the few developed countries that has not approved mifepristone (also known as RU-486) for induced abortion. Erdman et al note that no application has been made to approve the drug in Canada, speculating that this is because of inadequate financial incentives for the pharmaceutical company as well as political bias. Joanna N Erdman, Amy Grenon & Leigh Harrison-Wilson, "Medication Abortion in Canada: A Right-to-Health Perspective" (2008) 98:10 Am J Pub Health 1764 at 1764.

⁴ The terminology in this controversial and cutting-edge area of science is contested. The term "therapeutic" is commonly used to distinguish cloning research aimed at generating stem cells from attempts to generate a cloned living organism ("reproductive cloning"). Some question the use of the word "therapeutic," on the ground that it misleadingly suggests that the research is close to supplying therapies (see e.g. Diane Beeson & Abby Lippman, "Egg Harvesting for Stem Cell Research: Medical Risks and Ethical Problems" (2006) 13:4 Reprod Biomed Online 573 at 576; Alexander Morgan Capron, "Placing a Moratorium on Research Cloning to Ensure Effective Control over Reproductive Cloning" (2002) 53 Hastings LJ 1057; Jocelyn Downie, Jennifer Llewellyn & Françoise Baylis, "A Constitutional Defence of the Federal Ban on Human Cloning for Research Purposes" (2005) 31 Queen's LJ 353 at 355). Others object to the term "cloning" to describe therapeutic cloning since it is said to evoke fears of reproductive cloning (see e.g. Robert P Lanza et al, "The Ethical Validity of Using Nuclear Transfer in Human Transplan-

under the *Assisted Human Reproduction Act*.⁵ Therapeutic cloning research, unlike reproductive cloning, is not intended to produce live cloned human offspring. Instead, the hope is that it may offer a way to generate immunologically compatible stem cells for use in regenerative medicine.

This case study offers an excellent context in which to consider this potential claim for several reasons. First, the science of stem cell research is rapidly changing so that the benefits and harms associated with this research are unstable, potentially making it difficult to establish a harmful deprivation if the research is prohibited or to show that such research produces a harm requiring a prohibition on the research. Other contexts might be simpler, but this case study is a good way to explore the complexities on both sides of the argument, and it is typical of the uncertainty in cutting-edge and controversial scientific fields.

Second, there are several types of arguments in favour of the prohibition on therapeutic cloning research. For example, as is discussed later in the article, one of the central reasons for the prohibition appears to be to protect women from exploitation and the health risks associated with hormonal stimulation and surgical removal of the many egg cells (oocytes) likely to be needed for cloning research. In addition to this compelling harm-based concern, other justifications based on moral judgments about the status of the embryo or the instrumental use of reproductive materials are also invoked. As a result, we may consider the effects on a right to unrestricted medical research of both clearly harm-based justifications for the prohibition as well as justifications where the harm involved is much less clear or is contested.

Although the Supreme Court of Canada frequently rejects claims in which patients seek to have the state provide particular medical treatments, it has also found that the state may violate a patient's section 7 *Charter* rights where it impedes that patient's ability to obtain necessary medical treatment.⁶ The argument explored in this paper also takes the form of a negative right-based argument—that is, the claim is based on a prohibition of research rather than a demand that research be conducted. However, the claim being ex-

tation" (2000) 284:24 JAMA 3175 at 3175; Jonathan D Moreno, "The Name of the Embryo" (2006) 36:5 Hastings Center Report 3 at 3). I will use the term "therapeutic cloning research," even though "biomedical cloning research" is preferred by some, because this is the terminology that is most widely used and recognized.

⁵ SC 2004, c 2, s 5 [AHRA].

⁶ See *Chaoulli v Quebec (AG)*, 2005 SCC 35, [2005] 1 SCR 791 [Chaoulli].

plored here does not clearly fit within these precedents because it considers state restrictions on upstream research that might produce new medical treatments rather than state interference with access to medical treatments that have already been established.

Several complexities must be addressed in constructing a section 7 claim to unimpeded medical research in the context of the prohibition on therapeutic cloning research. First, it is unclear whether therapeutic cloning research would generate useful therapies if it were permitted (although many argue that it either will do so or it will at least contribute to the discovery of other useful therapies). As a result, a patient's claim is based on the loss of a speculative benefit. The speculativeness is compounded where the anticipated benefit could potentially be achieved through alternative albeit similarly speculative lines of research that are permitted. As discussed below, there are problems with constitutional rights claims based on speculative harms, although they may not always be insurmountable.

Second, the patient is claiming a violation of a constitutional interest flowing from the restriction of the freedom of a third-party researcher (setting aside the case of a patient who is him or herself a stem cell researcher). Although this seems odd on first glance, a constitutional interest in the freedom of others is typical of claims in the area of access to medical treatment given that patients are usually unable to treat themselves and must rely upon third party assistance.

Third, I anticipate the objection that there can be no right to unimpeded medical research because there is no constitutional right of access to experimental medications, at least under American law.⁷ There is a similarity between these two claimed rights as both involve claims to potential medical benefits and both involve state intervention at points along the path of development of a new therapy. However, as discussed in more detail below, the two contexts are different in that one asserts an interest in research while the other is a demand of access to an existing (albeit experimental) therapy, and the two raise quite different policy concerns. An approach that accepts a right to unrestricted medical research but allows for limitations on that right under section 1 of the *Charter* can accommodate the different reasons for limiting the right in the two contexts of upstream research: prior to the discovery of a therapy and during clinical trials of the therapy once it is discovered.

⁷ *Abigail Alliance*, *supra* note 2.

In addition to these three questions specific to the proposed *Charter* right of patients to freedom of medical research, the constitutional analysis must address two further matters. A violation of section 7 is not established unless the deprivation of the right to life, liberty, or security of the person fails to accord with the “principles of fundamental justice.” If this is the case, a rights violation is established and the analysis turns to the question of whether the violation is justified under section 1 of the *Charter*. These two questions will be the last two issues explored in the constitutional analysis later in this article.

The conclusion drawn in this case study is that a section 7 claim against state restrictions on medical research is available in this context and ought to be available as an argument more broadly, although the speculativeness of the eventual benefit is a significant weakness in this particular context. However, in the context of therapeutic cloning, the concern regarding harm to women is a credible and compelling one that would justify some restrictions on the research under section 1 of the *Charter*. Nonetheless, the prohibition of all therapeutic cloning research is arguably overbroad in that it forecloses lines of therapeutic cloning research that do not endanger women. A preferable approach would be to prohibit cloning research involving oocytes taken from women and girls (apart perhaps from oocytes sourced from ovarian tissue removed for therapeutic reasons).

The outline of the paper is as follows. Part 1 contains an overview of the relevant science. It is important to provide a reasonably detailed overview of the science before moving to the constitutional analysis because these details, such as the level of certainty about whether therapeutic cloning research will produce useful therapies or whether there are alternative routes to similar therapies, are central to the question of whether a future patient is harmed by restrictions on the research. In addition, the overview must provide the factual foundation for assessing the justifications for the governmental restriction on therapeutic cloning research. This scientific review will demonstrate that there is considerable uncertainty over which, if any, of the alternative routes to stem cell therapy will be successful, and that there are various methods in development that would allow researchers to conduct therapeutic cloning research in ways that pose a reduced risk of harm (particularly the exploitation of women for oocytes). Part 2 presents the Canadian prohibition on human cloning, and explores the structure and viability of a section 7 claim against that prohibition brought by patients who might benefit from therapies developed through therapeutic cloning research.

I. The Benefits and Harms of Human Therapeutic Cloning Research and its Alternatives

Many serious human diseases or traumatic injuries involving the loss of cell function may, it is hoped, be cured or their symptoms alleviated using cell replacement strategies in regenerative medicine.⁸ Hematopoietic stem cells derived from bone marrow have been used clinically for decades.⁹ However, researchers hope to find a way to remedy a greater range of conditions with a broader range of cell types. The excitement surrounding stem cells has to do with their capacities both for proliferation and differentiation into multiple cell types.¹⁰ However, not all stem cell types have these capacities to the same degree.¹¹

Pluripotent stem cells are capable of forming every cell type in the adult body. Multipotent stem cells may form a limited set of cell types, while unipotent stem cells can give rise only to one cell type. While all may be useful in particular cases, there is great interest in pluripotent stem cells because of their ability to form any type of replacement cell. Pluripotency is lost as cells differentiate during embryonic development, becoming committed to particular lineages and cell types. Pluripotent cells are found in the inner cell mass of the blastocyst (early embryo). There is some evidence that a small population of pluripotent stem cells may also persist through embryonic development, and thus be available in perinatal tissues, such as cord blood, or even adult tissues. Another source of pluripotent stem cells are the so-called “bioengineered” stem cells, formed by “reprogramming” adult cells. Reprogramming causes the adult cells to regress from their differentiated state back to the pluripotent state, and can now be achieved using several methods, including cloning. Among the key challenges in using pluripotent stem cells therapeutically is that only a pure sample of cells differentiated into the desired cell type should be transplanted, as residual undifferentiated cells may

⁸ K Appasani & RK Appasani, “Introduction to Stem Cells and Regenerative Medicine” in K Appasani & RK Appasani, eds, *Stem Cells & Regenerative Medicine*, (Totowa NJ: Humana Press, 2010) 3.

⁹ Christian Leeb et al, “New Perspectives in Stem Cell Research: Beyond Embryonic Cells” (2011) 44:1 *Cell Proliferation* 9 at 11 [Leeb et al, 2010a].

¹⁰ Appasani & Appasani, *supra* note 8 at 3; Rouven Muller & Claudia Lengkerke, “Patient-Specific Pluripotent Stem Cells: Promises and Challenges” (2009) 5 *Nature Reviews Endocrinology* 195 at 195; Christian Leeb et al, “Promising New Sources for Pluripotent Stem Cells” (2010) 6 *Stem Cell Reviews and Reports* 15 [Leeb et al, 2010b].

¹¹ Leeb et al, 2010a, *supra* note 9.

continue to proliferate following transplantation, giving rise to tumours.¹² Continuing research on cell development is producing strategies to address these risks.¹³ Recently, researchers have also reported having achieved trans-differentiation, or the conversion of one adult cell type to another adult cell type, apparently without having to return to the pluripotent state.¹⁴

Another consideration that arises with cell replacement therapies is the question of immunological incompatibility. This is addressed with immuno-suppressive drugs in the context of organ transplantation. These drugs have harmful effects on patients, including increased exposure to infection and cancer due to the suppression of the immune system.¹⁵ For a time, there was hope that the problem of immune rejection may be less acute for some forms of stem cells. For example, there are signs that embryonic stem cells express lower levels of the proteins leading to immune rejection, although they appear to lose this immunoprivileged status once they are fully differentiated.¹⁶ Some adult stem cells, such as mesenchymal stem cells, were also thought to be tolerated by the immune system, but they also appear to lose this after differentiation.¹⁷ As a result, another hope for future stem cell therapies is that we may find ways to produce immunologically compatible replacement cells, perhaps by sourcing stem cells from the patient's own body or by re-programming a patient's own adult cells. Other proposed solutions to this problem are to attempt to minimize the problem of immune rejection by cre-

¹² Timothy J Nelson et al, "Stem Cell Platforms for Regenerative Medicine" (2009) 2:3 Clinical & Translational Science J 222 at 223; Leeb et al, 2010b, *supra* note 10 at 19-20.

¹³ Nelson et al, *ibid* at 223.

¹⁴ Manuel Masip et al, "Reprogramming with Defined Factors: From Induced Pluripotency to Induced Transdifferentiation" (2010) 16:11 Molecular Human Reproduction 856.

¹⁵ Karen English & Kathryn J Wood, "Immunogenicity of Embryonic Stem-Cell-Derived Progenitors After Transplantation" (2010) 16 Current Opinion in Organ Transplantation 90 at 90; Suzanne Kadereit & Alan Trounson, "In Vitro Immunogenicity of Undifferentiated Pluripotent Stem Cells (PSC) and Derived Lineages" (2011) 33 Seminars in Immunopathology 551 at 553-54.

¹⁶ Junfeng Ji, Bonan Zhong & Mickie Bhatia, "Genetic Approaches in Human Embryonic Stem Cells and Their Derivatives: Prospects for Regenerative Medicine" in Anthony Atala et al, *Principles of Regenerative Medicine*, 2d ed (London: Elsevier, 2011) 179 at 192; English & Wood, *supra* note 15 at 91.

¹⁷ Xi-Ping Huang et al, "Differentiation of Allogeneic Mesenchymal Stem Cells Induces Immunogenicity and Limits Their Long-Term Benefits for Myocardial Repair" (2010) 122:23 Circulation 2419.

ating a stem cell bank sufficiently diverse to ensure a reasonable match with most patients, or to find ways other than the use of immunosuppressive drugs to address the problem of immune rejection.¹⁸

Some of the potential sources of stem cells have given rise to ethical concerns. The chief debates or concerns have to do with sources involving the destruction of the embryo, the instrumental use of the embryo and human reproductive materials for non-reproductive purposes, and the risk to women of supplying oocytes for use in stem cell derivation.¹⁹

We can categorize the main sources of stem cells for therapeutic applications as follows: endogenous stem cells (derived from the patient), exogenous stem cells (not derived from the patient), and bioengineered stem cells (including methods of reprogramming the patient's own cells, such as cloning). The following review will discuss these stem cell sources and their characteristics. The precise characteristics and comparative therapeutic utility of these various types of cells are not fully established.²⁰

1. Endogenous stem cells

The key advantages of endogenous stem cells are their immunological compatibility, and their avoidance of the ethical concerns associated with embryonic stem cells or certain bioengineered stem cells. Endogenous stem cells may be obtained perinatally (e.g. from umbilical cord blood, the placenta or amniotic fluid), although this is unlikely to have been done for every potential patient. They may also be obtained from certain adult tissues.

With respect to differentiation potential, cord blood contains a mixture of adult-like stem cells, as well as embryonic-like stem cells that seem both pluripotent and capable of long-term proliferation.²¹ Stem cells have also been located in various adult tissues. Despite having been thought to be only multipotent or unipotent, rather than pluripotent, and having displayed limited

¹⁸ English & Wood, *supra* note 15 at 93.

¹⁹ Additional concerns may also arise in relation to particular techniques, as is discussed below. For example, the creation of inter-species clones involves the insertion of a human nucleus into an animal oocyte which, for some, involves an unethical blurring of species boundaries.

²⁰ Nelson et al, *supra* note 12.

²¹ *Ibid* at 224; Leeb et al, 2010b, *supra* note 10 at 20.

expansion capacity for lineage-committed adult stem cells,²² researchers have recently discovered rare adult cell populations in various tissues that show greater differentiation potential than was thought possible of adult stem cells.²³ These cells can be expanded *in vitro* (at least in animal studies) and seem to offer a promising source of self-compatible cells for therapy. The number and quality of these highly plastic cells seems to decline with age.²⁴

2. *Exogenous stem cells*

Exogenous stem cells are derived from non-self sources, and create a risk of immune rejection. These non-self stem cells include human embryonic stem cells (“hES cells”), stem cells obtained from perinatal sources (e.g. cord blood), and adult stem cells.

hES cell lines are pluripotent and have now been successfully differentiated into various types of cells.²⁵ These cells are considered particularly promising due to their capacity for indefinite proliferation in cell culture, differentiation potential, and other characteristics suggesting good cell longevity (e.g. long telomere length).²⁶

However, ethical or moral debates continue to surround hES cell research. In particular, the derivation of an hES cell line usually involves the destruction of the embryo. Attempts to address this concern involve one of two strategies. One strategy is to use blastomere biopsy, which involves the removal of a single cell (as in pre-implantation genetic diagnosis conducted during *in vitro* fertilization (“IVF”)), and does not destroy the embryo. The second proposed strategy is to use embryos considered to be non-viable. This strategy might include the use of irreversibly arrested IVF embryos or the deliberate creation of non-viable embryos, such as through parthenogenetic ac-

²² Nelson et al, *supra* note 12 at 225; Jennifer Hipp & Anthony Atala, “Sources of Stem Cells for Regenerative Medicine” (2008) 4 Stem Cell Reviews 3 at 4; Leeb et al, 2010a, *supra* note 9 at 10.

²³ See Donald O Rodgerson & Alan G Harris, “A Comparison of Stem Cells for Therapeutic Use” (2011) 7:4 Stem Cell Rev 782 at 783.

²⁴ *Ibid* at 784, 790; Muller & Lengkerke, *supra* note 10 at 195.

²⁵ Nelson et al, *supra* note 12 at 222.

²⁶ *Ibid*.

tivation of unfertilized oocytes.²⁷ It is not clear, however, that these techniques fully answer ethical objections about the treatment of the embryo.²⁸

3. *Bioengineered stem cells*

In addition to the above-mentioned sources of embryonic, perinatal or adult stem cells, researchers have found methods to bioengineer stem cells with useful properties. In particular, it is possible to “reprogram” adult somatic cells (e.g. skin cells), returning them to a state of pluripotency and proliferative potential similar to hES cells. Whether or not they have the same characteristics and therapeutic potential as hES cells is not yet established.²⁹

²⁷ Muller & Lengkerke, *supra* note 10 at 199; Tiziana AL Brevini et al, “Parthenogenesis as an Approach to Pluripotency: Advantages and Limitations Involved” (2008) 4:3 Stem Cell Rev 127 at 128-30; Ronald M Green, “Can We Develop Ethically Universal Embryonic Stem-Cell Lines?” (2007) 8:6 Nat Rev Genet 480 at 482 [Green, “Ethically Universal Lines?”]; Sayaka Wakayama, Eiji Mizutani & Teruhiko Wakayama, “Nuclear Transfer Embryonic Stem Cells as a New Tool for Basic Biology” in Appasani & Appasani, *supra* note 8, 351 at 358.

²⁸ Brevini et al, *supra* note 27 at 128; Hipp & Atala, *supra* note 22 at 6; Green, “Ethically Universal Lines?”, *supra* note 27; Immaculada de Melo-Martin, Zev Rosenwaks & Joseph J Fins, “New Methods for Deriving Embryonic Stem Cell Lines: Are the Ethical Problems Solved?” (2006) 86:5 Fertil Steril 1330; Svetlana Gavrilov, Virginia E Papaioannou & Donald W Landry, “Alternative Sources of Human Embryonic Stem Cells” in Atala et al, *supra* note 16, 215 at 217.

²⁹ Sayaka Wakayama, James M Cummins & Teruhiko Wakayama, “Nuclear Reprogramming to Produce Cloned Mice and Embryonic Stem Cells from Somatic Cells” (2008) 16:4 Reprod Biomed Online 545 at 547-48; Wakayama, Mizutani & Wakayama, *supra* note 27 at 355-56; Fanyi Zeng & Qi Zhou, “Induced Pluripotent Stem Cells: On the Road Toward Clinical Applications” in Appasani & Appasani, *supra* note 8, 427 at 429-30; Masip et al, *supra* note 14; Muller & Lengkerke, *supra* note 10; Stéphanie Boué et al, “Analysis of Human and Mouse Reprogramming of Somatic Cells to Induced Pluripotent Cells: What is in the Plate?”, online: (2010) 5:9 PLoS One e12664 <www.plosone.org/home.action>; Mark H Chin et al, “Molecular Analyses of Human Induced Pluripotent Stem Cells and Embryonic Stem Cells” (2010) 7:2 Cell Stem Cell 263; Zhumur Ghosh et al, “Persistent Donor Cell Gene Expression Among Human Induced Pluripotent Stem Cells Contributes to Differences With Human Embryonic Stem Cells” (2010) 5:2 PLoS ONE e8975; Elie Dolgin, “Flaw in Induced-Stem-Cell Model. Adult Cells do not Fully Convert to Embryonic-Like State” (2011) 470:7332 Nature 13; Gretchen Vogel, “Reprogrammed Cells Come Up Short For Now” (2010) 327 Science 1191; Rodgers & Harris, *supra* note 23 at 791; AI Marques-Mari et al, “Differentiation of Germ Cells and Gametes From

Nonetheless, the techniques are promising in that they should theoretically produce immunologically compatible cell lines. However, caution is warranted given that the extensive manipulation of these cells could create abnormalities that might trigger an immune reaction, albeit one that is predicted to be less severe than to non-genetically identical cells.³⁰

Among the bioengineering techniques available to reprogram adult somatic cells are “somatic cell nuclear transfer” (also known as cloning) and variants on that approach, induced pluripotency leading to what are called induced pluripotent stem cells (“iPS cells”), and transdifferentiation. Another approach that does not involve reprogramming adult somatic cells but is intended to provide immunologically tolerated pluripotent cells for therapeutic use is the creation of a “universal stem cell line.”

In “somatic cell nuclear transfer” or cloning, the nucleus of an adult differentiated cell is transferred into an oocyte from which the nucleus has been removed. The oocyte appears to contain chemical factors that reprogram the genetic material contained in the inserted nucleus. The cell, once stimulated, develops as an embryo that could, if permitted, lead to a live birth as has been demonstrated in many types of mammals.³¹ If the process aims at or culminates in a live birth, it is referred to as reproductive cloning. This need not be the case, as the embryo may also be used to derive a line of embryonic stem cells in the same way as hES cells are derived from non-cloned embryos. The process of creating cloned embryonic stem cells is commonly referred to as therapeutic cloning. These cloned stem cells are nearly genetically identical to the nucleus donor, with the exception of the mitochondrial DNA, which comes from the oocyte cytoplasm.³² The non-self mitochondrial

Stem Cells” (2009) 15:3 Hum Reprod Update 379 at 387 (“their global gene expression and DNA methylation patterns are similar but not identical to that of [embryonic stem cells]”); Chang-Qing Xie et al, “A Comparison of Murine Smooth Muscle Cells Generated From Embryonic Versus Induced Pluripotent Stem Cells” (2009) 18:5 Stem Cells and Dev 741 (embryonic stem cells and induced pluripotent stem cells exhibit different gene expression profiles for unknown reasons).

³⁰ C Tang and M Drukker, “Potential Barriers to Therapeutics Utilizing Pluripotent Stem Cell Derivatives: Intrinsic Immunogenicity of In Vitro Maintained and Matured Populations” (2011) 33:6 Semin Immunopathol 563; Kadereit & Trounson, *supra* note 15 at 553-54.

³¹ Wakayama, Mizutani & Wakayama, *supra* note 27 at 353 (reporting that reproductive cloning has been achieved in sixteen mammalian species).

³² Kadereit & Trounson, *supra* note 15 at 554.

DNA could theoretically cause an immune response.³³ Researchers have demonstrated that cloned stem cell transplants are not rejected in cattle and mice.³⁴ Indeed, several researchers have demonstrated the successful therapeutic use of cloned stem cells to treat mice with immune deficiency and a form of induced Parkinson's disease.³⁵

As for the use of cloning in humans, the 2004 report by the Korean researcher Hwang Woo-Suk of the successful derivation of a human cloned stem cell line was later retracted over falsified results and breaches of research ethics.³⁶ Since then, researchers have succeeded in creating cloned human blastocysts,³⁷ although the successful derivation of human cloned stem cell lines has not yet been reported.³⁸ Nonetheless, cloned stem cells have been derived in non-human primates.³⁹

Cloning is currently very inefficient although researchers are at work on techniques to improve efficiency.⁴⁰ The derivation, reported in 2007, of two rhesus macaque cloned stem cell lines required 304 macaque oocytes,⁴¹ although another attempt, reported in 2009, demonstrated that cloning was much more efficient with some somatic cell donors than with others. This led

³³ M Drukker, "Recent Advancements Towards the Derivation of Immune-Compatible Patient-Specific Human Embryonic Stem Cell Lines" (2008) 20:2 *Semin Immunol* 123 at 127; Kadereit & Trounson, *supra* note 15 at 554.

³⁴ Heiner Niemann et al, "Somatic Cloning and Epigenetic Reprogramming in Mammals" (2011) in Atala et al, *supra* note 16 129 at 147; Hipp & Atala, *supra* note 22.

³⁵ Wakayama, Mizutani & Wakayama, *supra* note 27 at 361-62.

³⁶ Donald Kennedy, "Editorial Retraction" (2006) 311 *Science* 335.

³⁷ Andrew J French et al, "Development of Human Cloned Blastocysts Following Somatic Cell Nuclear Transfer (SCNT) with Adult Fibroblasts" (2008) 26:2 *Stem Cells* 485; Miodrag Stojkovic et al, "Derivation of a Human Blastocyst after Heterologous Nuclear Transfer to Donated Oocytes" (2005) 11:2 *Reprod Biomed Online* 226.

³⁸ Nelson et al, *supra* note 12 at 226.

³⁹ JA Byrne et al, "Producing Primate Embryonic Stem Cells by Somatic Cell Nuclear Transfer" (2007) 450:7169 *Nature* 497.

⁴⁰ Muller & Lengerke, *supra* note 10 at 198; Satoshi Kishigami et al, "Significant Improvement of Mouse Cloning Technique by Treatment with Trichostatin A after Somatic Nuclear Transfer" (2006) 340 *Biochem Biophys Res Commun* 183; Wakayama, Mizutani & Wakayama, *supra* note 27 at 353.

⁴¹ Byrne et al, *supra* note 39.

the authors to suggest that “[b]ased on our current SCNT blastocyst formation rate of 43% and [embryonic stem] cell isolation efficiency of 29%, as few as 10 or less primate oocytes could be sufficient to derive one cell line. Thus, the continued systematic optimization of SCNT approaches will likely succeed in the efficient generation of patient-specific [embryonic stem] cells for therapeutic applications.”⁴² In cattle and pigs, species for which there is a larger data set than for other mammals, it is possible to see that cloning efficiency has steadily increased as technical skill and knowledge have accumulated.⁴³ Despite these hopeful signs, the fact remains that many oocytes are likely to be required in human cloning research, and, if that research is successful, for the derivation of cloned stem cell lines to treat patients. This leads to one of the central concerns with therapeutic cloning research—the medical risk to women of supplying oocytes for the research.

Recognizing the risk of harm to women, various alternative methods of cloning that do not endanger women have arisen although they are also experimental and they may raise other ethical concerns. These strategies include cell fusion, “stembrids,” inter-species somatic cell nuclear transfer (“iSCNT” or inter-species cloning), the use of failed IVF oocytes, the use of immature oocytes, or the use of oocytes created from pluripotent stem cells.

Cell fusion involves the fusion of a donor cell with an hES cell, which creates a cell that has double the normal number of chromosomes, and that is both unstable and genetically incompatible with the donor.⁴⁴ It is possible to remove the hES cell chromosomes selectively from the hybrid cell to generate a genetically compatible cell.⁴⁵

Stembrids are cells formed when a donor somatic nucleus is inserted into an enucleated hES cell.⁴⁶ A similar approach involves the transfer of the nu-

⁴² Michelle Sparman et al, “Epigenetic Reprogramming by Somatic Cell Nuclear Transfer in Primates” (2009) 27:6 Stem Cells 1255.

⁴³ Niemann et al, *supra* note 34 at 135.

⁴⁴ Muller & Lengerke, *supra* note 10 at 199.

⁴⁵ Leeb et al, 2010b, *supra* note 10 at 17. They note that the continued pluripotency of these cells must still be verified.

⁴⁶ Yury Verlinsky et al, “Cytoplasmic Cell Fusion: Stembrid Technology for Reprogramming Pluripotentiality” (2006) 2:4 Stem Cell Rev 297; Nick Strelchenko et al, “Reprogramming of Human Somatic Cells by Embryonic Stem Cell Cytoplast” (2006) 12 Reprod BioMed Online 107.

cleus into an enucleated zygote.⁴⁷ Supernumerary embryos formed in IVF could be used in this way, although they are also scarce and this technique would still run into the objections related to embryo destruction.

Animal oocytes may also be used for cloning with a human nucleus, producing an inter-species cytoplasmic hybrid.⁴⁸ One report exists of the successful derivation of stem cells using a cybrid formed from the insertion of a human nucleus into a rabbit oocyte, although this has not so far been replicated.⁴⁹ Researchers in the UK have been granted several licenses to pursue iSCNT research.⁵⁰ The utility of iSCNT-derived stem cells for clinical purposes is currently quite uncertain.⁵¹

Oocytes that fail to fertilize during IVF procedures could also be used for cloning without posing additional risk to women, who are already exposed to the risks of oocyte retrieval as a result of fertility treatments.⁵² However, the quality and utility of these oocytes is in question.

⁴⁷ International Society for Stem Cell Research, "Ethics Report on Interspecies Somatic Cell Nuclear Transfer Research" (2009) 5 Cell Stem Cell 27 at 28 [ISSCR, "Ethics Report"].

⁴⁸ Josef Fulka Jr et al, "Cybrid Human Embryos: Warranting Opportunities to Augment Embryonic Stem Cell Research" (2008) 26:9 Trends in Biotech 469.

⁴⁹ *Ibid*; Young Chen et al, "Embryonic Stem Cells Generated by Nuclear Transfer of Human Somatic Nuclei into Rabbit Oocytes" (2003) 13 Cell Res 251; Young Chung et al, "Reprogramming of Human Somatic Cells using Human and Animal Oocytes" (2009) 11 Cloning and Stem Cells 213.

⁵⁰ United Kingdom Human Fertilisation and Embryology Authority, "HFEA Statement on Licensing of Applications to Carry out Research using Human-Animal Cytoplasmic Hybrid Embryos", online: HFEA <www.hfea.gov.uk/418.html>. Françoise Baylis, "Animal Eggs for Stem Cell Research: A Path Not Working" (2008) 8(12) Am J Bioethics 18.

⁵¹ Niemann et al, *supra* note 34 at 147; Fulka et al, *supra* note 48; Zeki Beyhan, Amy E Iager & Jose B Cibelli, "Interspecies Nuclear Transfer: Implications for Embryonic Stem Cell Biology" (2007) 1:5 Cell Stem Cell 502; Chung et al, *supra* note 49.

⁵² Sharon F Sneddon et al, "Gene Expression Analysis of a New Source of Human Oocytes and Embryos for Research and Human Embryonic Stem Cell Derivation" (2011) 95:4 Fertil Steril 1410.

Immature oocytes can be matured *in vitro* for use in cloning, although they appear to be inferior to mature oocytes for this purpose.⁵³ The immature oocytes might come from ovarian tissue removed for therapeutic reasons.⁵⁴ The maturation of immature oocytes from fetal tissues for use in SCNT is also possible, although it may provoke renewed ethical disputes over research using fetal tissues.⁵⁵

Finally, it may one day be possible to cause pluripotent stem cells (such as hES cells or iPS cells) to differentiate into oocytes, providing a source of “artificial” oocytes for use in cloning. Multiple researchers have reported the derivation of primordial germ cells from pluripotent human cells (both hES cells and human iPS cells).⁵⁶ The possibility of producing functional sperm in this way was demonstrated when one researcher reported the birth of live mouse pups conceived using sperm derived from mouse embryonic stem cells.⁵⁷ These results are still some distance from producing functional oocytes *in vitro*, but the research does demonstrate continued progress in this direction.⁵⁸

⁵³ Andrew J French, Samuel H Wood & Alan O Trounson, “Human Therapeutic Cloning (NTSC): Applying Research From Mammalian Reproductive Cloning” (2006) 2 Stem Cell Rev 265 at 271.

⁵⁴ *Ibid.*

⁵⁵ *Ibid.*; Mary Carrington Coutts, “Fetal Tissue Research” (1993) 3:1 Kennedy Inst Ethics J 81; Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (Ottawa: Government of Canada, December 2010), ch 12, s E.

⁵⁶ Sofia Gkoutela, Anne Lindgren & Amander T Clark, “Pluripotent Stem Cells in Reproductive Medicine: Formation of the Human Germ Line In Vitro” in Appasani & Appasani, *supra* note 8; Marques-Mari et al, *supra* note 29; Zsolt Peter Nagy & Ching-Chien Chang, “Artificial Gametes” (2007) 67:1 Theriogenology 99.

⁵⁷ Karim Nayernia et al, “In Vitro-Differentiated Embryonic Stem Cells Give Rise to Male Gametes that Can Generate Offspring Mice” (2006) 11 Dev Cell 125; H Moore & B Aflatoonian, “From Stem Cells to Spermatozoa and Back” (2007) 65 Soc Reprod Fertil Suppl 19; Jinlian Hua & Kuldip Sidhu, “Recent Advances in the Derivation of Germ Cells From Embryonic Stem Cells” (2008) 17:3 Stem Cells Dev 399.

⁵⁸ See generally Guang-Bin Zhou, Qing-Gang Meng & Ning Li, “In Vitro Derivation of Germ Cells From Embryonic Stem Cells in Mammals” (2010) 77:7 Mol

The risk to women is not the only objection to human therapeutic cloning research. The technique involves the creation and subsequent destruction of the cloned embryo. Some have argued that the product of cloning is not, strictly speaking, an embryo, at least for questions of moral status, although this is unlikely to persuade opponents.⁵⁹ Here too, researchers have suggested an alternative technique to avoid concerns about the destruction of the embryo, namely “altered nuclear transfer.” This technique involves the genetic modification of the donor nucleus prior to its insertion into an enucleated oocyte, so that it can develop pluripotent cells but is incapable of implanting in a uterus and so is developmentally non-viable. This approach is still vulnerable to the charge that it involves the creation and destruction of an embryo—albeit a “severely disabled embryo.”⁶⁰

The second method of reprogramming adult somatic cells to create self-compatible pluripotent stem cells emerged in 2006 with the creation, by Takahashi and Yamanaka, of induced pluripotent stem cells (iPS cells).⁶¹ Their method involved inserting genes that code for a set of proteins (known as transcription factors) into the genome of an adult skin cell. The technique raised great hope as it seems to offer a way to generate self-compatible stem cells from a plentiful and easily accessible source of adult cells without re-

Reprod Dev 586; Emanuele Pelosi, Antonino Forabosco & David Schlessinger, “Germ Cell Formation from Embryonic Stem Cells and the Use of Somatic Cell Nuclei in Oocytes” (2011) 1221 Ann N Y Acad Sci 18; Sarita Panula et al, “Human Germ Cell Differentiation from Fetal- and Adult-Derived Induced Pluripotent Stem Cells” (2011) 20:4 Hum Mol Genet 752; Debra JH Mathews et al, “Pluripotent Stem Cell-Derived Gametes: Truth and (Potential) Consequences” (2009) 5 Cell Stem Cell 11.

⁵⁹ See e.g. JES Hansen, “Embryonic Stem Cell Production through Therapeutic Cloning has Fewer Ethical Problems Than Stem Cell Harvest from Surplus IVF Embryos” (2002) 28 J Med Ethics 86; Insoo Hyun & Kyu Won Jung, “Human Research Cloning, Embryos, and Embryo-Like Artifacts” (2006) 36:5 Hastings Center Report 34; Moreno, *supra* note 4 at 3.

⁶⁰ Green, “Ethically Universal Lines?”, *supra* note 27 at 482; Brevini et al, *supra* note 27 at 129; Hipp & Atala, *supra* note 22 at 6. For discussions of the technique of altered nuclear transfer see William B Hurlbut, “Ethics and Embryonic Stem Cell Research: Altered Nuclear Transfer As a Way Forward” (2007) 21:2 Biodrugs 79; Zachary J Kastenber & Jon S Odorico, “Alternative Sources of Pluripotency: Science, Technics and Stem Cells” (2008) 22 Transplant Rev (Orlando) 215 at 217.

⁶¹ Kazutoshi Takahashi & Shinya Yamanaka, “Induction of Pluripotent Stem Cells from Mouse Embryonic and Adult Fibroblast Cultures by Defined Factors” (2006) 126 Cell 663.

quiring the use of an embryo. However, it also raises some concerns for eventual therapeutic application. The technique poses a risk of cancer, because one of the inserted genes is associated with cancer, and also because the process of inserting genes causes potentially dangerous disruption of the genome.⁶² Researchers have sought ways around this problem, including methods of inducing pluripotency that use other types of molecules, non-integrating methods of gene delivery, or involve only the temporary insertion of the genes.⁶³ The therapeutic use of iPS cells has been demonstrated in a rat model of Parkinson disease, a mouse model for acute myocardial infarction, and mouse models of genetic diseases.⁶⁴ A recent note of caution has been sounded over the potential immunogenicity of iPS cells, and signs that the immune response to them varies according to the method by which iPS cells are produced suggests that there is much more to learn about what happens to these cells during reprogramming.⁶⁵ Nonetheless, these cells might avoid some of the ethical concerns associated with hES cells and cloned stem cells. It is not necessary to use oocytes to create iPS cells, and it is widely thought that iPS cells do not raise concerns about the destruction of the embryo or the instrumentalization of the embryo. However, some have suggested that there may nonetheless be objections to iPS cells similar to those raised against the destruction of the embryo because iPS cells, too, have the potential to form live offspring.⁶⁶

⁶² Nelson et al, *supra* note 12 at 226; Masip et al, *supra* note 14 at 861.

⁶³ See Maureen L Condit & Mahendra Rao, "Alternative Sources of Pluripotent Stem Cells: Ethical and Scientific Issues Revisited" (2010) 19:8 Stem Cells Dev 1121; Masip et al, *supra* note 14 at 861; Reiesha D Robbins et al, "Inducible Pluripotent Stem Cells: Not Quite Ready for Prime Time?" (2010) 15 Curr Opin Organ Transplant 61; Kuldip S Sidhu, "New Approaches for the Generation of Induced Pluripotent Stem Cells" (2011) 11:5 Expert Opin Biol Ther 569.

⁶⁴ Zeng & Zhou, *supra* note 29 at 429, 437 n 21, referring *inter alia* to Jacob Hanna et al, "Treatment of Sickle Cell Anemia Mouse Model with iPS Cells Generated from Autologous Skin" (2007) 318 Science 1920.

⁶⁵ Tongbiao Zhao et al, "Immunogenicity of Induced Pluripotent Stem Cells" (2011) 474:7350 Nature 212; Effie Apostolou & Konrad Hochedlinger, "iPS Cells Under Attack" (2011) 474:7350 Nature 165.

⁶⁶ This requires a technique called tetraploid complementation, which involves the injection of iPS cells into a blastocyst with twice the normal number of chromosomes (tetraploid). The tetraploid cells can form the supporting extra-embryonic tissue, but cannot contribute to the developing embryo. See Hans-Werner Denker, "Induced Pluripotent Stem Cells: How to Deal with the Development Potential" (2009) 19:S1 Reprod Biomed Online 34; Katrien

“Transdifferentiation” or “lineage reprogramming” is also under investigation, and involves the conversion of differentiated cells from one cell type to another without passing through a pluripotent intermediate.⁶⁷ For example, a 2008 study in mice demonstrated the alleviation of diabetes by direct in vivo conversion of pancreatic cells to insulin-secreting cells by infecting the mouse pancreas with a virus bearing genes for specific transcription factors associated with insulin-secreting pancreatic cells.⁶⁸

Finally, another form of “bioengineering” not involving reprogramming of adult cells would be to create a “universal donor” stem cell line. The idea here is that a line of hES cells could be genetically modified to eliminate or suppress the factors that give rise to immune rejection. In theory, this would produce a stem cell line with the pluripotency and proliferative capacities of hES cells without the immunological risks to patients of transplants from exogenous sources.⁶⁹ Increased understanding of the behaviour of the types of stem cells, such as the way that hES cells lose their seemingly immunoprivileged status during differentiation, may also lead to other strategies to modify their immunogenicity.⁷⁰

4. Conclusion

A review of the current state of stem cell science reveals a rapidly-moving field, in which many promising lines of research exist but where there is still very much to learn. We do not yet know which approach will be the best for cell replacement therapies, or for creating cellular models of dis-

Devolder, “To Be or not to Be? Are Induced Pluripotent Stem Cells Potential Babies and Does it Matter?” (2009) 10:12 EMBO Reports 1285; Ronald M Green, “Ethical Considerations” in Atala et al, *supra* note 16, 1117 at 1118.

⁶⁷ Xioajing Huang, James Oh & Sean M Wu, “Regenerative Strategies for Cardiac Disease” in Appasani, *supra* note 8, 579 at 584-85; Masip et al, *supra* note 14; Chris Jopling, Stephanie Boue & Juan Carlos Izpisua Belmonte, “Dedifferentiation, Transdifferentiation and Reprogramming: Three Routes to Regeneration” (2011) 12 Nat Rev Molec Cell Biol 79.

⁶⁸ Qiao Zhou et al, “In Vivo Reprogramming of Adult Pancreatic Exocrine Cells to β -Cells” (2008) 455:7213 Nature 627.

⁶⁹ Nelson et al, *supra* note 12 at 222-223. Zaruhi Karabekian, Nikki Gillum Posnack & Narine Sarvazyan, “Immunological Barriers to Stem-Cell Based Cardiac Repair” (2011) 7:2 Stem Cell Rev 315 at 322.

⁷⁰ English & Wood, *supra* note 15 at 91.

ease and injury in which to study these conditions and to test treatments.⁷¹ Both of these uses are potentially beneficial for sick and injured patients, even though the latter does not involve cellular transplants and so raises fewer patient safety issues.

One important observation from the review is that one of the objections to therapeutic cloning—risk to oocyte donors—may be avoidable through the use of other sources of oocytes or other cloning techniques. This would appear to weaken the claim that all cloning should be banned. On the other hand, other techniques to obtain self-compatible pluripotent cells (such as induced pluripotency) weaken the claim that patients will be harmed if we prohibit therapeutic cloning research. However, we do not know for certain that therapeutic cloning techniques that avoid risk to women will ultimately be satisfactory, nor do we know for certain that alternative forms of stem cells will be adequate. We are not even certain whether we need pluripotent stem cells for cell replacement therapies at all if transdifferentiation works to supply those cell types that are unavailable from multipotent adult stem cells. Should other ways of dealing with the immune rejection problem succeed, we may not need to pursue personalized stem cell lines for clinical applications, although there may still be a need for a method such as cloning or induced pluripotency to create cellular models for studying diseases and their treatment.

In conditions of uncertainty about which lines of biomedical research are likely to generate the best results, a society needs to choose where to invest its scarce resources. We currently do this in a way that depends on multiple constituencies, each facing a slightly different set of incentives. This diversity within our system of channeling research resources leaves open the possibility for work to proceed on unfashionable or seemingly less promising paths while still encouraging most of the time and resources to be invested in the most promising lines of research. In essence, we usually leave it up to scientists (motivated by curiosity, professional recognition, and the pursuit of research funding), public research funders (motivated to demonstrate results valued by taxpayers), and enterprises (motivated to pick commercial winners) to decide where to invest resources.

⁷¹ Masip et al, *supra* note 14 at 862. Certain types of diseased cells cannot easily be obtained from patients for testing treatments or studying disease processes *in vitro*. For example, blood cells can be obtained much more easily than nerve cells. However, some of these relatively inaccessible cell types could potentially be derived through cloning or induced pluripotency techniques.

We do not generally step in to prohibit lines of research considered to be a waste of resources unless there are compelling ethical or harm-based reasons to do so. Indeed, it seems a very risky approach to pick the best lines of research and to ban the others particularly where much is unknown and our predictive abilities are poor. The risks of foreclosing one line of research are not just limited to the loss of the potential therapies that the research might directly have produced. It may also lead to losses more indirectly, given that one line of research might generate insights useful in another area. For example, research on hES cells provided the background knowledge necessary for the discovery of the technique to create iPS cells.⁷² Scientists working with iPS cells argue that we need to continue working with hES cells because they are needed in order to understand the basic mechanisms of pluripotency and self-renewal, and to offer the point of reference against which the characteristics of iPS cells can be judged and understood.⁷³ A recent large review of the scientific literature supports the position that iPS and hES cell research are complementary and interdependent.⁷⁴ Similar arguments are made about the need to continue with therapeutic cloning research—particularly interspecies cloning which does not consume human oocytes—notwithstanding the development of iPS cells.⁷⁵

Of course, where there are compelling reasons to prohibit or restrict lines of research, we may and sometimes should do so notwithstanding that otherwise valuable knowledge may be lost. The widespread consensus on ethical restrictions on human subject research demonstrates the legitimacy of some limitations on unfettered scientific research.

⁷² Insoo Hyun et al, “New Advances in iPS Cell Research Do Not Obviate the Need for Human Embryonic Stem Cells” (2007) 1:4 *Cell Stem Cell* 367; Kristina Hug & Göran Hermerén, “Do We Still Need Human Embryonic Stem Cells for Stem Cell-Based Therapies? Epistemic and Ethical Aspects” (2011) 7:4 *Stem Cell Rev and Rep* 761; Han Lee et al, “Induced Pluripotent Stem Cells in Regenerative Medicine: an Argument for Continued Research on Human Embryonic Stem Cells” (2009) 4:5 *Regenerative Medicine* 759, suggests that research on embryonic cells was essential to identifying culture conditions for maintaining and differentiating stem cells, as well as to identifying the transcription factors needed for reprogramming cells to create iPS cells.

⁷³ Juan Carlos Izpisua-Belmonte et al, “Induced Pluripotent Stem Cells and Reprogramming: Seeing the Science Through the Hype” (2009) 10:12 *Nat Rev Genetics* 878.

⁷⁴ Christopher Thomas Scott et al, “Democracy Derived? New Trajectories in Pluripotent Stem Cell Research” (2011) 145:6 *Cell* 820.

⁷⁵ ISSCR, “Ethics Report”, *supra* note 47.

In the case of therapeutic cloning research, various benefits are envisaged, ranging from an improved basic understanding of cell development, to more applied benefits in the form of a means of creating cellular models of human disease or in the form of self-compatible stem cells for regenerative medicine. Whether we will achieve these benefits and whether these benefits could be achieved in other ways are both unknown at present. As argued above, even if therapeutic cloning research does not appear promising it seems unwise as a matter of policy to ban the research unless there are compelling ethical or harm-based reasons to do so. The reasons put forward against therapeutic cloning research (setting aside opportunity cost arguments for the reasons mentioned above) are that the research

1. destroys embryos, which have moral status;
2. involves the instrumentalization of the nascent human life;
3. puts women at risk by creating a large demand for oocytes; and
4. raises the risk of reproductive cloning by perfecting a technique that may then be used illegally.

Some of these concerns likely motivated the prohibition on all forms of cloning in the Canadian *Assisted Human Reproduction Act*.⁷⁶ Yet, there is considerable variation in the response to therapeutic cloning research even amongst countries with similar cultures and political systems, suggesting a lack of consensus on whether these concerns justify a prohibition on the research. Caulfield et al observe that the UK permits both therapeutic cloning research and inter-species cloning, while Australia permits therapeutic cloning research but prohibits inter-species cloning, and Canada prohibits therapeutic cloning research but may permit inter-species cloning.⁷⁷ The purpose of Part II of this article is to consider the constitutionality of the Canadian prohibition on therapeutic cloning research. In particular, could patients who

⁷⁶ *AHRA*, *supra* note 5.

⁷⁷ Timothy Caulfield et al, "The Stem Cell Research Environment: A Patchwork of Patchworks" (2009) 5:2 *Stem Cell Rev and Rep* 82. Ogbogu & Rugg-Gunn suggest that iSCNT is permitted under the *AHRA*, *supra* note 5, because the process creates a "hybrid" not an "embryo," although they note there is some ambiguity in the *Act*, and it is possible that the hybrid could be considered a cloned embryo, in which case the prohibition on the creation of embryos for research would apply as would the ban on cloning (Ubaka Ogbogu & Peter Rugg-Gunn, "The Legal Status of Novel Stem Cell Technologies in Canada" (2008) 9:5 *J Intl Biotech Law* 186).

might potentially benefit medically from this research claim that their section 7 rights to life and security of the person have been infringed contrary to the principles of fundamental justice and, if so, are those infringements nonetheless justified under section 1 of the *Charter*?

II. Does a Patient have a Right to Unrestricted Medical Research Under Section 7 of the *Charter*? The Case of Therapeutic Cloning Research

1. *The Prohibition on Human Cloning in the Assisted Human Reproduction Act*

The federal *Assisted Human Reproduction Act* (“*AHRA*”) was enacted after a lengthy period of study and debate, and some parts of it have recently been adjudged to be an unconstitutional invasion of the provincial legislative jurisdiction.⁷⁸ However, the criminal prohibitions in section 5, including the provision prohibiting human cloning, survived constitutional challenge.

Several of the provisions of the *AHRA* are relevant to this discussion. Section 5(1)(a) explicitly prohibits human cloning by “any technique.”⁷⁹ A “human clone” is defined as an embryo that “contains a diploid set of chromosomes obtained from a single...human being, foetus or embryo.”⁸⁰ Section 5(1)(b) prohibits the creation of an *in vitro* embryo for non-reproductive purposes.⁸¹ These two provisions independently make therapeutic cloning by somatic cell nuclear transfer illegal, given that the process arguably creates an embryo. Arguments similar to those advanced here against the ban on therapeutic cloning could also be advanced against the ban on the creation of embryos for research purposes.

Some of the alternative techniques described above may actually avoid the cloning prohibition under section 5(1)(a) of the *AHRA*. At the same time, other suggested alternatives may actually be prohibited by different parts of section 5 of the *AHRA*. The objective in raising this point is to show how the constitutional analysis of cutting-edge fields of science may involve both legal uncertainty and scientific uncertainty.

⁷⁸ *Reference re Assisted Human Reproduction Act*, 2010 SCC 61, [2010] 3 SCR 457.

⁷⁹ *AHRA*, *supra* note 5.

⁸⁰ *Ibid* s 3.

⁸¹ *Ibid*.

For example, there is some discussion of whether interspecies cloning is prohibited by the *AHRA*. Section 5(1)(j) prohibits the creation of a hybrid for the purpose of reproduction and also prohibits the transplantation of a hybrid into a human or non-human life form (presumably “transplantation” refers to implantation for gestational purposes, rather than transplantation of stem cells derived from the hybrid).⁸² Several scholars have argued that an interspecies clone is classified as a “hybrid”⁸³ rather than as a “clone” or an “embryo” and so may legally be created and transplanted for non-reproductive purposes.⁸⁴

In another example, section 5(1)(f) prohibits the alteration of the genome of a human cell or *in vitro* embryo “such that the alteration is capable of being transmitted to descendants.”⁸⁵ Since iPS cells are sometimes created through genetic alteration, and iPS cells have been shown to be capable of forming fertile offspring in mice, it would seem that these genetic alterations are capable of being transmitted to descendants.⁸⁶ Ogbogu and Rugg-Gunn argue that iPS cells are not caught by section 5(1)(f) because the genetic alterations become capable of being transmitted to descendants only if the cells are differentiated into germ cells, a process they suggest may therefore be banned by the *AHRA*. However, it is not clear why a genetic alteration becomes “capable of transmission” only at the stage at which an iPS cell is differentiated into a germ cell. Another interpretation is that the alteration becomes “capable of transmission” at an earlier stage or at some later stage of manipulation (such as the creation of an embryo, or the implantation of an embryo in a woman). The point here is not to settle the interpretation of the *AHRA*, but to point out the uncertainty surrounding the legal viability of some of the potential alternatives to therapeutic cloning research.

Note also that if Ogbogu and Rugg-Gunn are correct that the differentiation of germ cells from genetically-modified iPS cells is caught by section

⁸² *Ibid.*

⁸³ A “hybrid” is defined to include the “ovum of a non-human life form into which the nucleus of a human cell has been introduced” (*ibid* s 3(e)).

⁸⁴ Ogbogu & Rugg-Gunn, *supra* note 77 at 187; Roxanne Mykitiuk et al, “The Canadian Assisted Human Reproduction Act; Protecting Women’s Health While Potentially Allowing Human Somatic Cell Nuclear Transfer Into Non-Human Oocytes” (2007) 7:2 *Am J Bioethics* 71.

⁸⁵ *AHRA*, *supra* note 5.

⁸⁶ Xiao-yang Zhao et al, “Viable Fertile Mice Generated From Fully Pluripotent iPS Cells Derived From Adult Somatic Cells” (2010) 6:3 *Stem Cell Rev and Rep* 390.

5(1)(f), this would presumably make it impossible to use artificial oocytes derived from this kind of iPS cell for cloning, even though the enucleation of the artificial oocyte (during the process of somatic cell nuclear transfer) would make it impossible for the modification to be transmitted to offspring. Of course, methods of creating iPS cells that do not involve genetic modification would avoid this problem, as Ogbogu and Rugg-Gunn point out.

2. Does a Patient Have a Right to Unrestricted Medical Research Under Section 7 of the Charter?

a) Introduction

The freedom of scientific research,⁸⁷ and the public interest in and right to the fruits of that research are internationally recognized values.⁸⁸ Of course, the need for and legitimacy of limits on some methods and areas of scientific research are also widely-accepted, particularly to avoid harm to health and safety and to protect fundamental human rights. More controversial though are limits to research where the anticipated harm consists of the erosion of conventional morality or socio-political structures.

The constitutionality of restrictions on scientific research is often addressed as a matter of the freedom of expression of researchers, a freedom that is explicitly recognized in constitutional human rights documents in some jurisdictions.⁸⁹ In Canada, there is no explicit mention of such a freedom in the *Charter of Rights and Freedoms*, although several legal scholars have considered the Canadian ban on human cloning from the perspective of a researcher's constitutional rights.⁹⁰

⁸⁷ See *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 UNTS 3, arts 15, 16 (entered into force 3 January 1976).

⁸⁸ *Universal Declaration of Human Rights*, GA Res 217(III), UN GAOR, 3d Sess, Supp No 13, UN Doc A/810, (1948) art 27, online: <www.un.org/en/documents/udhr>; *Universal Declaration on Bioethics and Human Rights*, UNESCO Gen Conference Res 33/36 (19 October 2005) art 15, online: <unesdoc.unesco.org/images/0014/001461/146180e.pdf>.

⁸⁹ Amedeo Santosuosso, Valentina Sellaroli & Elisabetta Fabio, "What Constitutional Protection For Freedom of Scientific Research?" (2007) 33:6 J Med Ethics 342.

⁹⁰ See e.g. Barbara Billingsley & Timothy Caulfield, "The Regulation of Science and the *Charter* of Rights: Would a Ban on Non-Reproductive Human Cloning Unjustifiably Violate Freedom of Expression?" (2004) 29:2 Queen's LJ 647;

However, researchers are not the only ones with a fundamental interest in scientific research. The question thus arises as to whether those with a particularly deep personal interest in the scientific research, namely those whose lives or health may be improved by that research, have a constitutionally-protected interest in the freedom of the research as well. American legal scholars have explored this question in the context of therapeutic cloning research or embryonic stem cell research, reaching varying conclusions about whether the argument is likely to succeed under existing US precedents.⁹¹

The constitutional analysis in Canada is likely to differ from that in the US for various reasons, including the different analytical methods used in the two jurisdictions to determine the scope of constitutionally protected rights and to identify qualifications on those rights.⁹² We must thus embark on a Canadian-focused analysis under the *Charter*, using the prohibition on human cloning as the focus for the exploration.

The specific question to be explored is whether the prohibition on all human cloning in section 5 of the *AHRA* violates the section 7 rights of patients who may one day benefit from treatments or medical knowledge derived through therapeutic cloning and, if so, is the infringement nonetheless justified under section 1 of the *Charter*?

Downie, Llewellyn & Baylis, *supra* note 4. In the US context, see Lori B Andrews, "Is There a Right To Clone? Constitutional Challenges to Bans on Human Cloning" (1998) 11:3 Harv JL & Tech 643.

⁹¹ See e.g. Russell Korobkin, "Stem Cell Research and the Cloning Wars" (2007) 18 Stan L & Pol'y Rev 161; Cass R Sunstein, "Is There A Constitutional Right to Clone?" (2002) 53 Hastings LJ 987; John A Robertson, "Embryo Culture and the 'Culture of Life': Constitutional Issues In the Embryonic Stem Cell Debate" (2006) U Chicago Legal F 1; Joshua W Sussman, "Freedom, Fate, and the Fear Of Frankenstein: Due Process Protection For Embryonic Stem Cell Research" (2009) 11:4 U Pa J Const L 1077; Kristin M Hicks, "Embryonic Stem Cell Research and the Theory Of Medical Self-Defense" (2008) 21:2 Harv JL & Tech 547. See also the overview of potential constitutional issues provided from a Canadian perspective by SA Muscati, "Therapeutic Cloning and the Constitution: A Canadian Perspective" (2001) 22:1 Health Law Can 7.

⁹² See e.g. Peter W Hogg, *Constitutional Law of Canada*, 5th ed (Markham: Carswell, 2007) at 789: "[T]he American Bill of Rights contains no limitation clause, and many of the guaranteed rights are expressed in unqualified terms...American courts have had to imply qualifications on the rights in order to accommodate legitimate restraints...In Canada, the courts can point to s. 1 as authorizing the development of limits on the guaranteed rights."

The constitutional analysis will proceed in three main steps. First we must consider whether there is a deprivation of the right to life, liberty, or security of the person. Here, we need to address several complexities in the analysis. Can the loss of a chance at a therapy deprive a patient of his or her section 7 rights? I will argue that the loss of an uncertain medical benefit can and should be understood as a deprivation of section 7 rights, although in the case of the prohibition on human cloning the claim may be weak. Another question is whether a restriction on the actions of a third party researcher constitute a deprivation of the patient's section 7 rights? I will argue that it is well-established on the precedents that it can be.

Second, we must consider whether the deprivation is in accordance with the principles of fundamental justice or not. This is a challenging step in section 7 jurisprudence, as it is not always clear what the principles of fundamental justice are, or how they relate to the later analysis under section 1. One principle that has been recognized in the jurisprudence as a principle of fundamental justice is that laws should not unnecessarily infringe *Charter* rights, and so laws that are overbroad will not accord with the principles of fundamental justice. The primary (and, in my view, most clearly legitimate) objective of the ban on therapeutic cloning research is to protect women from the demand for oocytes for research. I will argue that the law is overbroad because it needlessly forecloses lines of human cloning research that do not endanger women. An alternative approach would be to ban the use of oocytes sourced from women and girls (except for immature oocytes from tissue removed for therapeutic purposes) in cloning research. Some may think that there are even less restrictive approaches to protecting women (such as banning compensation for oocytes), but a government can reasonably (and, thus, constitutionally) take the position that this would be insufficient.

Third, having established a violation of section 7, we must determine whether the infringement is justified under section 1 of the *Charter*. I will address the various objectives that might underlie the ban on therapeutic cloning research, concluding that the most clearly valid objective is to protect women. The overbreadth of the legislation, discussed also in the context of the principles of fundamental justice, is relevant here. A law that is overbroad cannot be said to impair a *Charter* right as little as reasonably possible, a requirement to establish justification under section 1.

- b) Does the Ban on Therapeutic Cloning Research Constitute a Deprivation of a Patient's Section 7 Interests in Life or Security of the Person?

Section 7 of the *Charter* states that “[e]veryone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.”⁹³ It is clear from the existing case law that a right to access existing medical treatments is included in one or more of the rights to life, liberty, and security of the person protected by section 7 of the *Charter*.⁹⁴ The underlying subject matter—an interest in one's health, and medical treatment to preserve it—is thus covered by section 7, and is at issue in the case of prohibitions on medical research. However, there are a number of key differences between the existing precedents and the argument being advanced here. The analysis will be organized around three key points. First, it is unclear whether therapeutic cloning research will produce useful therapies and so the patient's claim is based on the loss of a speculative benefit. The effect of this speculativeness on the viability of the constitutional claim must therefore be considered.

Second, the analysis addresses the question of whether a patient can advance a claim based on a restriction of the freedom of a third-party researcher. This is ultimately not particularly different from the existing precedents dealing with section 7 rights in the medical context, which often involve challenges to laws prohibiting third parties from providing those treatments.

Third, American courts have rejected a constitutional claim of access to experimental drugs for terminal patients, and it may seem that the lack of a constitutional right to an experimental drug ought to entail the lack of a constitutionally protected interest in other steps of the research and development process for novel therapies. As argued below, this does not follow, particularly under a Canadian constitutional analytical approach, which allows for the articulation of a fairly general concept of a right, with the necessary limitations to be dealt with under the separate limiting provision of section 1 on a case by case basis. Since one can imagine cases in which a government might try to foreclose medical research for illegitimate reasons (as with the

⁹³ *Charter*, supra note 1 s 7.

⁹⁴ *R v Parker* (2000), 146 CCC (3d) 193, 188 DLR (4th) 385 (ONCA) [*Parker* cited to DLR] (medical marijuana use); *Rodriguez v British Columbia (AG)*, [1993] 3 SCR 519, 107 DLR (4th) 342 [*Rodriguez* cited to SCR] (physician assisted suicide); *R v Morgentaler*, [1988] 1 SCR 30, 63 OR (2d) 281 [*Morgentaler*] (abortion); *Chaoulli*, supra note 6 (private health insurance).

hypothetical case of a ban on testing an improved new abortifacient drug, discussed below), it seems unwise to declare out of hand that there can never be a constitutional challenge to a restriction on medical research.

The effect of speculativeness

In the context of bans on medical research, we are dealing with potential medical treatments rather than existing medical treatments. The underlying subject matter—medical treatment—is of deep importance to patients and to their interests in life and security of the person. This is particularly the case for patients who lack effective treatments or cures for their conditions. However, does the ban on “upstream” research engage their section 7 interests? The problem here lies in the uncertainty about whether the research would have succeeded in producing a useful treatment as well as in whether other lines of permissible research might lead to the same or maybe superior treatments. From the perspective of the patient, what is being lost is a chance at a beneficial therapy—albeit a chance whose precise value is difficult to establish.

Medical research exists along a spectrum of increasing likelihood that it will benefit patients medically. At one end we can put scientific inquiry in which knowledge is pursued for its own sake, and at the other we can put advanced clinical testing of a specific therapeutic application. As we move from the first to the last point on this spectrum, the possible therapeutic benefits become more concrete and eventually are demonstrated convincingly enough to receive regulatory approval or to enter standard medical practice. Between these poles lie many potential types of scientific inquiry, increasingly targeted at specific therapeutic applications. The following is a list of possible classes of scientific research, in order of increasing likelihood of generating a beneficial therapeutic application:

1. pursuit of knowledge for its own sake in the area of human biology and disease;
2. exploration of aspects of human biology and disease with a particular therapeutic application in mind;
3. generation of evidence of the potential effectiveness of a particular therapeutic application (e.g. testing in experimental models); and
4. generation of evidence of the safety and effectiveness of a particular therapeutic application in humans (e.g. clinical trials in humans).

At some point, the speculativeness of the benefit should be sufficiently reduced to allow a patient to claim that a government ban on the research encroaches on their section 7 interests. Furthermore, it seems to be good policy to recognize the availability of such a claim. It would otherwise be possible for a government to stave off the development of a treatment that it could not constitutionally withhold from patients later. The following hypothetical illustrates this point. Imagine that a government, seeking to prevent an increase in abortion, decided to prohibit the clinical testing of a new abortifacient drug that looked very likely to be a considerable improvement over existing methods in terms of safety and cost-effectiveness. There is some (albeit little) speculativeness in this hypothetical about whether the clinical testing will culminate in a safer form of abortion. If potential patients were unable to establish a claim because of the speculativeness of the benefit, then governments could try to restrict abortion by preventing the upstream research that might improve access to abortion.

If this intuition is correct, it demonstrates that one may have a section 7 interest in a potential medical treatment and the unimpeded medical research that may bring it to fruition, at least where the chance of success is reasonably high. The issue then is not whether the claim has to do with an established treatment or research aimed at developing a treatment, but instead how likely it is that the research will give rise to a treatment.

It is worth noting that the constitutional law contemplates the protection of other “upstream” actions that, individually, seem to be of only speculative worth—and sometimes seem likely to be worthless. One such context is the right to freedom of expression, which is justified not just as of inherent value to the individual, but also for its beneficial social consequences. Courts often refer to consequentialist justifications for freedom of speech, including the pursuit of the “truth” through the “marketplace of ideas.”⁹⁵ The marketplace of ideas theory expressly contemplates that some speech may seem clearly useless or offensive, yet it is still often protected on the theory that the competition of clashing views is the best route to the “truth.”⁹⁶ In other words, we do not know which expression is valuable, therefore we protect all of it because of the possibility that even the most offensive and seemingly useless speech may be valuable. A parallel contention can be made with respect to medical research. We do not know which lines of research will turn out to be useful, and it may be that the cross-fertilization of different lines of research

⁹⁵ See *Grant v Torstar Corp*, 2009 SCC 61 at paras 47-50, [2009] 3 SCR 640.

⁹⁶ *R v Sharpe*, 2001 SCC 2 at para 21, [2001] 1 SCR 45.

will, like a marketplace of ideas, produce the best outcomes. Of course, as with expression, there may be good harm-based reasons to infringe a constitutional interest in medical research, but that is a separate question from whether the speculativeness of the benefit bars the recognition of a constitutional interest in the first place.

Notwithstanding these arguments, one Canadian precedent that seems to run against the idea that one can claim a section 7 right to a speculative benefit is *Operation Dismantle v Canada*.⁹⁷ In that case, the plaintiffs argued that the Canadian government's decision to permit US cruise missile testing in Canada violated their section 7 rights because it heightened the risk of nuclear war. Their claim was struck out as disclosing no reasonable cause of action. The Supreme Court rejected the appeal, declaring that the claim that the government's decision would increase the risk of nuclear war was too hypothetical and speculative to ever be capable of proof at trial, even with the assistance of expert opinion. In essence, it depended upon the reactions of other countries to Canada's decision, and this was "not capable of prediction, on the basis of evidence, to any degree of certainty approaching probability."⁹⁸ The Supreme Court explained that remedial action to forestall future harm may be appropriate and available in some cases, but not "where the link between the action and the future harm alleged is not capable of proof."⁹⁹

This case stands as a fairly clear statement that where benefits or harms of a law are so speculative as to amount to guesswork, it will be impossible for a court to find that a deprivation of a section 7 interest is likely to follow from the impugned law. It does not stand for the proposition that speculativeness will always bar a section 7 claim. Indeed, the reference to "certainty approaching probability" suggests that something less than full certainty is needed.

Turning to the prohibition of human cloning research, there is considerable uncertainty over whether therapeutic cloning research will generate a useful cell replacement therapy. There is perhaps more confidence that knowledge gained during the research might contribute more indirectly to the development of stem cell therapies—for example, by shedding light on the processes of nuclear reprogramming that lead to refinements of induced plu-

⁹⁷ *Operation Dismantle v The Queen*, [1985] 1 SCR 44, 18 DLR (4th) 481 [*Operation Dismantle* cited to SCR].

⁹⁸ *Ibid* at para 18.

⁹⁹ *Ibid* at para 30.

ripotency techniques. If experts in stem cell science are able to show that the ban on therapeutic cloning research is more likely than not to delay or prevent the discovery of safe and effective stem cell therapies, this may offer enough evidence of harm to meet the “probability” threshold identified in *Operation Dismantle*.

As the research proceeds in the stem cell field, more information is likely to be gained on the potential utility of therapeutic cloning research (e.g. by extrapolation from developments in therapeutic cloning research in non-human animals, or by observing the results of research from countries where therapeutic cloning research is permitted) as well as on the adequacy or inadequacy of alternatives to therapeutic cloning research. This may reduce the uncertainty about whether the prohibition on therapeutic cloning research can be said to endanger a patient’s life or health, depriving the patient of his or her section 7 interests.

A review of the literature suggests that, at present, few researchers would be willing to guess at whether or not therapeutic cloning is likely to become a therapeutically viable treatment. More might accept that the ban on therapeutic cloning research (and perhaps any ban on research in the stem cell field) is more likely than not to delay or hinder the discovery of the optimal form of stem cell therapy.

The problem of indirect interests in the freedom of others

A patient who complains that restrictions on research have violated his constitutional rights is really complaining about restrictions on the freedom of third parties (researchers). There may be a few exceptions where researchers are pursuing a treatment or cure for their personal use. However, most cases will likely involve a claim that one’s rights are infringed by restrictions imposed on another person.

Human interdependency is such that this is not an unusual or necessarily problematic obstacle. Many people are unable by themselves to take a whole range of actions on their own behalf, and they often rely on the assistance of others. This is nearly always the case in the medical context. Courts recognize this and have accepted without much comment that a patient has a potential constitutional claim where it is the freedom of a willing third party to provide medical treatment that is being curtailed. This makes sense. If a state could constitutionally prohibit others from assisting someone unable to vindicate their own constitutionally-protected interests, this would be a way to achieve indirectly what would be constitutionally invalid if done directly. In-

deed, this interdependency, giving rise to constitutional interests in the freedom of others, is implicitly recognized in a range of non-medical contexts as well.¹⁰⁰

A couple of examples will illustrate that a prohibition on providing assistance to a person may violate that person's constitutional rights notwithstanding that it is the liberty of a third party that is directly curtailed. In *Rodriguez v British Columbia (AG)*,¹⁰¹ the Supreme Court of Canada considered the constitutionality of the *Criminal Code* provision prohibiting third parties from assisting someone to commit suicide.¹⁰² The plaintiff's challenge was ultimately unsuccessful, but not because she was challenging a restriction on the freedom of third parties. The challenge failed because the Supreme Court found that the deprivation of her section 7 interests was not contrary to a principle of fundamental justice. The fact that her section 7 interest in security of the person was engaged by the restriction of third party assistance was recognized and accepted.¹⁰³

In *R v Morgentaler*,¹⁰⁴ the Supreme Court of Canada considered the constitutionality of the *Criminal Code* provisions dealing with abortion. In that case, three physicians challenged the legislative scheme that criminalized the actions of both the physician and the woman undergoing an abortion. The scheme contemplated an exemption where abortion was needed to protect a pregnant woman's life or health, but the Supreme Court found it unworkable. The provisions were struck down, on the basis that they all violated a pregnant woman's section 7 interest in security of the person. The constitutional

¹⁰⁰ The Supreme Court has repeatedly interpreted the right to freedom of expression as including a listener's right to receive information (see e.g. *Little Sisters Book & Art Emporium v Canada*, 2000 SCC 69 at para 41, [2000] 2 SCR 1120). The US Supreme Court similarly finds a right to receive information, and has allowed potential recipients standing to challenge restrictions on other speakers (see e.g. *Virginia State Board of Pharmacy v Virginia Citizen's Consumer Council*, 425 US 748 (1976)). In *Benner v Canada*, [1997] 1 SCR 358, 143 DLR (4th) 577, the Supreme Court allowed the male applicant for citizenship to claim that his rights were violated by a law that discriminated against women by applying different citizenship rules to those born of Canadian fathers versus Canadian mothers. The necessary relationship to his mother meant that the son was affected by discrimination against her.

¹⁰¹ *Supra* note 94.

¹⁰² *Criminal Code*, RSC 1985, c C-46, s 241(b).

¹⁰³ *Rodriguez*, *supra* note 94 at para 137.

¹⁰⁴ *Morgentaler*, *supra* note 94.

right invoked here was clearly that of the patient, not the physician, and it was used to strike down a criminal prohibition applicable to the physician (as well as a criminal prohibition applicable to the patient).

In *Hitzig v Canada*, dealing with access to medical marijuana, the Ontario Court of Appeal stated,

“...a criminal sanction applied to another who would assist an individual in a fundamental choice affecting his or her personal autonomy can constitute an interference with that individual’s security of the person.”¹⁰⁵

The parallel between these cases and the prohibition on medical research is that patients will generally rely on third parties to conduct the research that is of interest to them. As is the case with medical treatment, the fact that the interests of patients are inextricably bound up in the freedom of willing third parties to conduct research provides the foundation for the potentially constitutionally-protected interest in that freedom.

In sum, a potential patient is not foreclosed from challenging a prohibition on medical research under section 7 by reason only that the prohibition applies directly to a third party, and only indirectly affects their interests.

If there is a right to medical research, is there a right of access to the resulting treatment?

A right to unimpeded medical research does not necessarily mean that there will be a right of access to an experimental drug prior to government approval. Nor does it necessarily mean there will be a right of unimpeded access to the resulting treatment. Differing governmental objectives may come into play once there is an actual treatment available, such as the protection of vulnerable patients from exploitation or dangerous treatments.

In the American case, *Abigail Alliance*, the plaintiff claimed a right of access to an experimental drug prior to the completion of its clinical testing and government approval.¹⁰⁶ The claim was framed as a right of access by terminally ill patients to experimental drugs that had passed limited safety (Phase I) trials but had not yet been proven safe and effective in subsequent broader testing. The Court of Appeals rejected the claim, saying there is no such constitutional right, although it expressly refrained from commenting

¹⁰⁵ *Hitzig v Canada* (2003), 231 DLR (4th) 104 at para 95, 177 CCC (3d) 449.

¹⁰⁶ *Abigail Alliance*, *supra* note 2.

on the “broader question of whether access to medicine might ever implicate fundamental rights.” The Court of Appeals emphasized the fact that the drug in this case had not been shown to be safe or effective, and that it might in fact be harmful.

This case might seem to suggest that there is no right to only potentially beneficial treatments. By extension, this might seem to suggest that there can be no right to unimpeded upstream research, the benefits of which are even more speculative. However, this is a false analogy. The plaintiff in *Abigail Alliance* was seeking to consume an experimental drug that might potentially be beneficial or harmful, she was not seeking to overturn a ban on clinical testing of the experimental drug. Different policy justifications exist for prohibiting access to an experimental drug and prohibiting research that may generate a new drug. Research will not harm the potential patient, although consuming a drug may do so. Concerns about the exploitation of desperate patients or the integrity of the clinical trials system¹⁰⁷ do not arise until there is an experimental treatment that can be tested in humans. The type of claim being explored in this article (an interest in the continuation of research that may generate a medical therapy) may have other problems but they are different from those raised in *Abigail Alliance*.

Evidently, this case is not binding authority in Canada. However, even if a similar case were brought in Canada, it would be unwise to decide it in a manner that forecloses the possibility of a patient’s constitutional challenge to restrictions on potential medical benefits, whether this consists of a challenge to a research ban or a ban on access to an experimental treatment. As I have argued earlier, there are good reasons to leave open this possibility, and to address the appropriate limitations on that right under section 1 in the varying circumstances of each case.

The principles of fundamental justice

According to the judicial interpretation of section 7 of the *Charter*, a deprivation of the right to life, liberty, or security of the person will be unconsti-

¹⁰⁷ One of the reasons put forward to justify restricting patient access to drugs that have not yet gone through full testing is that if many patients were able to insist on getting the untested but promising drug they would likely do so rather than take part in a drug trial where they run the risk of falling into a placebo group. This would make the process of clinical drug trials more difficult. See Eugene Volokh, “Medical Self-Defense” (2007) 120:7 Harv L Rev 1813 at 1830.

tutional only if it fails to accord with the “principles of fundamental justice.” The content of the principles of fundamental justice is a source of some uncertainty in *Charter* jurisprudence, and the considerations at this stage sometimes overlap with analysis under section 1 of the *Charter*.

In essence, the Supreme Court has said that the principles of fundamental justice are legal principles that are “to be found in the basic tenets of our legal system.”¹⁰⁸ In addition, they must be generally accepted as “vital or fundamental to our societal notion of justice,”¹⁰⁹ and “capable of being identified with some precision and applied to situations in a manner that yields an understandable result.”¹¹⁰

One candidate for a relevant principle of fundamental justice in the context of restrictions on potentially life-saving or health improving medical research is a putative fundamental right of self-defense or self-preservation. Volokh advances this argument in the US context invoking the long legal tradition of recognizing a right to protect one’s life from attack, the constitutional right to bear arms, and the judicial recognition of a constitutional right to abortion after the point at which a fetus is viable when a woman’s life is in danger (“medical self-defense”).¹¹¹ This line of reasoning ultimately failed to help the plaintiff in *Abigail Alliance* where the Court of Appeals said that access to experimental drugs was not the same as access to life-saving medical treatment because the experimental drugs are only potentially helpful and in fact may be harmful. This ruling does not directly settle the point for a claim to unimpeded medical research for reasons discussed above.

Whether a similar argument about self-defense as a principle of fundamental justice could be made in Canada is uncertain. Certainly, the appeal to self-defense based on a right to bear arms is unlikely to succeed. Canadian courts have rejected arguments that restrictions on the possession or ownership of firearms violate section 7.¹¹² On the other hand, the Supreme Court

¹⁰⁸ *Reference re s 94(2) of the Motor Vehicle Act (British Columbia)*, [1985] 2 SCR 486 at paras 31, 24 DLR (4th) 536.

¹⁰⁹ *Rodriguez*, *supra* note 94 at para 141.

¹¹⁰ *Ibid.*

¹¹¹ Volokh, *supra* note 107. See also Mary Briody Mahowald, “Self-Preservation: An Argument for Therapeutic Cloning, and a Strategy for Fostering Respect for Moral Integrity” (2004) 4:2 Am J Bioethics 56.

¹¹² *R v Montague*, 2010 ONCA 141, 206 CRR (2d) 146; *Hudson v Canada (AG)*, 2007 SKQB 455, [2008] 6 WWR 572 (Sask CA).

has implicitly recognized a fundamental interest in self-preservation in the context of the criminal defense of duress. In *R v Ruzic*, the Supreme Court determined that it was a principle of fundamental justice that morally involuntary conduct (including actions taken under threat of death or serious bodily harm) should not be criminalized. As the Court put it, “[d]epriving a person of liberty and branding her with the stigma of criminal liability would infringe the principles of fundamental justice if the accused did not have any realistic choice.”¹¹³

It seems unlikely that unimpeded access to necessary medical treatment itself constitutes a principle of fundamental justice given the Supreme Court’s failure to mention it in its various rulings on section 7 impediments to medical treatment. In its ruling on access to medical marijuana in *R v Parker*, the Ontario Court of Appeal made various statements suggesting that unimpeded access to drugs needed to protect life and health is a requirement of fundamental justice,¹¹⁴ it ultimately relied on other principles of fundamental justice that had already been established in other cases—including the requirement that legislation not be arbitrary and that defences not be illusory. As a result, this case does not provide a particularly solid foundation for unimpeded access to necessary medical treatment as principle of fundamental justice.

The courts have tended to be very cautious in recognizing new principles of fundamental justice, instead often invoking one of a set of well-established principles that focus on defects in the legislative scheme such as arbitrariness, vagueness, or overbreadth. In the present case study, the prohibition on therapeutic cloning in the *AHRA*, the “overbreadth” principle may prove applicable. Overbreadth refers to a situation in which the state uses means which are broader than is needed to achieve a legitimate objective, thereby needlessly infringing a protected *Charter* right.¹¹⁵

For reasons that will be discussed in more detail within the next section (dealing with section 1), the only justification for the prohibition that is clearly valid from the legal perspective is the protection of women from harm. If this is correct, then the prohibition on cloning is likely overbroad because of

¹¹³ *R v Ruzic*, 2001 SCC 24 at para 47, [2001] 1 SCR 687.

¹¹⁴ *R v Parker*, *supra* note 94 at paras 136-137, 139.

¹¹⁵ See *R v Heywood*, [1994] 3 SCR 761 at 792-93, 120 DLR (4th) 348; RJ Sharpe & K Roach, *The Charter of Rights and Freedoms* (Toronto: Irwin Law, 2009) at 237-38.

the various potential avenues of therapeutic cloning research that could be pursued without risking the health of oocyte donors. Alternatives to the use of oocytes procured at risk to women donors include: cell fusion, “stem-brids,” inter-species cloning, the use of failed IVF oocytes, the use of immature oocytes, or the use of oocytes created from pluripotent stem cells. Rather than prohibiting cloning outright, the law could instead prohibit therapeutic cloning research using oocytes taken from women and girls (with the possible exception of oocytes from ovarian tissue excised solely for therapeutic reasons). Such an approach would provide equivalent protection for women from the health risks of supplying oocytes for research while leaving open the possibility of therapeutic cloning research.

c) Is the Ban on Therapeutic Cloning Research Justified Under Section 1 of the Charter?

If the foregoing discussion has been correct, and patients may make a claim that the Canadian ban on therapeutic cloning research violates their section 7 interests in a manner contrary to the principles of fundamental justice, the next question is whether the violation is nonetheless justified under section 1 of the Canadian Charter of Rights and Freedoms.

Section 1 states that the guaranteed rights and freedoms are subject to “such reasonable limits prescribed by law as can be demonstrably justifiable in a free and democratic society.”¹¹⁶ Whether or not the limit is so justified is determined using the Oakes test,¹¹⁷ which involves two main steps. First, the objective of the law must be sufficiently important to warrant overriding a constitutionally protected right or freedom. Second, the means chosen must be a proportionate response given the objective of the legislation. This proportionality is assessed by considering whether the law is rationally connected to the objective, whether it impairs the Charter right as little as is reasonably possible, and whether the harmful effects on the rights holder are proportionate to the benefits sought by the law.

The objective of the law

It is not always easy to identify the Parliamentary objectives in enacting legislation. In the case of the *Assisted Human Reproduction Act*, the Act it-

¹¹⁶ *Charter*, *supra* note 1 at s 1.

¹¹⁷ *R v Oakes*, [1986] 1 SCR 103, 26 DLR (4th) 200.

self contains a declaration of principles that sheds some light on its underlying objectives.¹¹⁸ Those that are relevant to cloning demonstrate a legislative concern with the health of children born through assisted reproduction, the health of women, the need to protect human individuality and diversity and the integrity of the genome, and the need to secure the benefits of assisted human reproductive technologies and associated research by taking “appropriate measures for the protection and promotion of human health, safety, dignity and rights in the use of these technologies and in related research.”

Canadian legal academics are split on the proper characterization of the legislative objections behind the ban on cloning.¹¹⁹ Rather than trying to offer a persuasive interpretation of Parliament’s actual legislative objectives in banning human cloning, I will take a different approach. I will consider the main concerns about therapeutic cloning research that one may find in the literature and will consider the extent to which these concerns furnish constitutionally valid objectives. These concerns have to do with (1) the risk of harm to women from the demand for oocytes, (2) the ascription of moral status to the embryo and resulting concern about the destruction of the embryo, (3) the instrumentalization of nascent human life that might be implicit in the deliberate creation and use of embryos for research, and (4) the risk that if therapeutic cloning is permitted, the risk of reproductive cloning increases (the “slippery slope” argument). It is possible that in enacting the *AHRA*, some of these issues were not among the motivating concerns of the Canadian Parliament. However, it seems likely that the actual objectives of the legislation respond to one or more of these concerns.

Concern #1: Harm to women

The first and, in my view, most compelling concern is that cloning research is likely to consume a large number of oocytes. These oocytes must be obtained at some risk to women due to hormonal manipulation and surgical removal. These risks, which are also faced by women undergoing *in vitro* fertilization treatment, include the possibility of ovarian hyperstimulation syndrome (which can range from mild to severe and life-threatening), as well as the risks of infection and injury during the surgical removal of the eggs. In addition, there is uncertainty about whether the hormones pose an

¹¹⁸ *AHRA*, *supra* note 5 s 2.

¹¹⁹ See Billingsley & Caulfield, *supra* note 90; Downie, Llewellyn & Baylis, *supra* note 4.

elevated long-term risk of some cancers.¹²⁰ The demand for oocytes will only increase if therapeutic cloning turns out to be clinically useful and commercially promising.¹²¹ Most authors agree that this is a risk, and opponents of cloning bans quickly shift to arguments about less restrictive ways of ensuring protection of women such as through research ethics board oversight (i.e. to watch for undue inducement, and to ensure proper disclosure of risks), or through a ban on payment. These arguments will be discussed further in the context of the proportionality analysis of section 1 below. For the moment, we can safely conclude that the protection of women from harm to their health through oocyte donation is a legitimate legislative objective. Whether the means chosen is proportionate will be addressed below.

Concern #2: Moral status of the embryo

The second common justification for prohibiting therapeutic cloning research is based on the conviction that the embryo has a moral status equivalent or similar to a human being, and it is thus unethical deliberately to destroy an embryo or to use it solely as a means to benefit others.¹²² Therapeutic cloning research usually involves the destruction of the cloned embryo in order to derive cloned embryonic stem cells. Alternatives such as blastomere biopsy (which would take one cell) would not destroy the embryo, but may also be viewed as unethical if one attributes moral status to the embryo since it creates a risk of harm without corresponding benefit to the cloned embryo.

The difficulty with the protection of the embryo as a legislative objective is that it rests on a contested moral judgment about the moral status of the very early embryo and reasonable people differ about whether the embryo has a status equivalent to a person, a status equivalent to a collection of somatic cells like skin cells, or something in between.¹²³ It is thus a shaky basis for a law in a pluralistic society. Furthermore, the attribution of moral status to the embryo is inconsistent with Canadian jurisprudence, which does not

¹²⁰ For a recent discussion of these risks, see B Ellison & J Walker, "Assessing the Risk of Ovarian Hyperstimulation Syndrome in Egg Donation: Implications for Human Embryonic Stem Cell Research" (2011) 11:9 Am J Bioethics 22. See also F Baylis & C McLeod, "The Stem Cell Debate Continues: The Buying and Selling of Eggs for Research" (2007) 33 J Med Ethics 726.

¹²¹ Beeson & Lippman, *supra* note 4.

¹²² The President's Council on Bioethics, *Human Cloning and Human Dignity: An Ethical Inquiry* (Washington, DC: Public Affairs, 2002) at 173-82.

¹²³ *Ibid* at 152-53.

attribute personhood to the embryo.¹²⁴ Finally, the fact that the *AHRA* allows supernumerary embryos created during IVF to be used in research establishes that the protection of the embryo due to its moral status is not a likely objective of the Canadian legislature in enacting the ban on therapeutic cloning research.¹²⁵

Concern #3: Instrumentalization of nascent human life

The third common objection to therapeutic cloning research relates to the position that the deliberate creation and use of embryos for research represents the unethical instrumentalization of nascent human life. This is a different objection to the one based on the moral status of the embryo, and one may still object to this instrumentalization even if one does not accept that an embryo has full moral status.

The exact nature of the concern with the instrumentalization of nascent human life is difficult to articulate, but seems to be that (1) it is inherently disrespectful and undignified to treat nascent forms of human life as tools and/or that (2) the instrumental outlook on nascent human life is likely to lead to other harmful social or psychological consequences (such as a tendency to view all human or other life in instrumental terms).

With respect to the first point, there is some debate over whether the use of embryos in medical research is disrespectful or undignified. Some argue that far from undermining human dignity, using early embryos to discover treatments to cure disease and alleviate suffering would promote human dignity. Others accept that the embryo ought to be treated with respect, but that this is achieved by using it only for weighty rather than trivial or contemptuous purposes.¹²⁶

On the second point, Heidegger raised a similar concern in his discussion of technology, suggesting that by taking a relentlessly instrumental perspective, in which everything is to be mastered and bent to our human purposes, we are at risk of coming to see ourselves in similar instrumental ways, losing

¹²⁴ *Tremblay v Daigle*, [1989] 2 SCR 530, 62 DLR (4th) 634. This case interprets the Quebec Civil Law and the *Charter of human rights and freedoms*, RSQ, c C-12, but it also comments on the Anglo-Canadian tradition.

¹²⁵ *AHRA*, *supra* note 5 s 10(2).

¹²⁶ Bonnie Steinbock, "The Science, Policy and Ethics of Stem Cell Research" (2007) 14:S1 *Reprod BioMed Online* 130; MJ Sandel, "Embryo Ethics: The Moral Logic of Stem-Cell Research" (2004) 351:3 *N Engl J Med* 207.

our humanity and missing the real essence and value of the natural world.¹²⁷ In the end, it is not uncommon for people to react to scientific advances with unease, particularly advances that blur settled and comfortable boundaries (e.g. between artificial and natural, animal and human, or man and woman)¹²⁸ or that upset familiar ways of doing things (e.g. assisted reproductive technologies).¹²⁹ With time, many practices originally rejected as unnatural or immoral have come to be widely accepted and welcomed, and others, formerly accepted, have come to be rejected. It is difficult to know therefore when this kind of unease ought to be a constitutionally legitimate basis for prohibiting a particular practice.

The Supreme Court of Canada has struggled with when legislation may be justified by reference to collective moral norms rather than by demonstrated harm. In *R v Malmo-Levine*; *R v Caine*, the Supreme Court explicitly rejected the idea that the only constitutionally acceptable ground upon which the majority may limit the liberty of the individual is on the basis of harm (i.e., the “harm principle” familiar from John Stuart Mill’s *On Liberty*).¹³⁰ However, despite denying that the harm principle is the touchstone for identifying constitutionally valid criminal law, the Court routinely looks for and invokes forms of harm to justify restrictions on liberties.¹³¹ The challenge, of course, is in determining what counts as harm that legitimizes the use of state

¹²⁷ Martin Heidegger, “The Question Concerning Technology” in *The Question Concerning Technology and Other Essays*, translated by William Lovitt (New York: Harper & Row, 1977) 3.

¹²⁸ Martijntje Smits, “Taming Monsters: The Cultural Domestication of New Technology” (2006) 28 *Technol Soc* 489 at 495.

¹²⁹ Korobkin, *supra* note 91 at 173 observes that IVF was criticized as “immoral interference with the natural process of procreation” at the outset, despite now being largely uncontroversial.

¹³⁰ *R v Malmo-Levine*; *R v Caine*, 2003 SCC 74 at para 129, [2003] 3 SCR 571 [*Malmo-Levine*].

¹³¹ See e.g. *R v Butler*, [1992] 1 SCR 452, 89 DLR (4th) 449 [*Butler*]. The Court, after discussing whether moral disapprobation was an acceptable basis for the obscenity law, concluded that the basis of the law was not moral disapprobation anyway but the avoidance of harm from the reinforcement of the inequality of women (*ibid* at para 82). Similarly, the ruling in *Malmo-Levine* was based on harm, despite the rejection of the harm principle in that case (*supra* note 130 at para 136). *R v Labaye*, 2005 SCC 80, [2005] 3 SCR 728 [*Labaye*] also supports the idea that some form of harm must be shown to justify a criminal prohibition, despite the objections of the dissenting judges, who thought the majority position was inconsistent with the rejection of the harm principle in *Malmo-Levine*.

coercion.¹³² In cases such as *R v Butler* (dealing with “obscenity”) and *R v Labaye* (dealing with “common bawdy houses”) the Court has stated that criminalization is justified to prevent behaviours that normalize socially harmful attitudes or that induce harmful attitudinal shifts.¹³³ Not every shift in attitude or values will be harmful, however. In order to ensure that the criminal law is not used as an illiberal instrument to enforce majoritarian customs and preferences, the Court accepts only claims about harmful attitudinal shifts that are viewed as harmful on the basis of fundamental moral values, such as those embodied in the *Charter*.¹³⁴

The prohibition on cloning in the *AHRA* may reflect a concern with the instrumentalization of nascent human life. After all, the *Act* prohibits the creation of embryos for purposes other than reproduction and restricts embryo research to the use of supernumerary embryos created for IVF purposes. This might reflect a greater unease with the deliberate creation of embryos for research, while the instrumental use of embryos that were not created for that purpose and that will be discarded is viewed as a “lesser degree” of instrumentalization. Another interpretation is that the legislative prohibition on the creation of embryos for research purposes is really aimed at protecting women from the demand for oocytes, rather than a condemnation of the instrumentalization of very early human life.

Ultimately, I suspect that the objection to cloning based on the undesirability of encouraging an instrumental view of nascent human life is insufficient to offer a constitutionally robust “pressing and substantial objective” for the prohibition of therapeutic cloning research. Even if there were a clear majority moral position on this matter (which, I suspect, there is not),¹³⁵ *But-*

¹³² Bradley W Miller, “Morals Laws in an Age of Rights: Hart and Devlin at the Supreme Court of Canada” (2010) 55 Am J Juris 79; *Malmo-Levine*, *supra* note 130 at para 127.

¹³³ *Labaye*, *supra* note 131 at para 46; *Butler*, *supra* note 131.

¹³⁴ *Butler*, *ibid* at paras 80-81.

¹³⁵ As noted earlier, both the UK and Australia (countries with similar cultures and political systems to Canada) permit therapeutic cloning (Caulfield et al, *supra* note 77). Notably, UN members were unable to agree on a treaty to ban therapeutic cloning research despite agreement that reproductive cloning should be prohibited. See Helen Pearson, “UN Ditches Cloning Ban: Delegates Opt for Compromise Statement” *Nature* (22 November 2004) online: <www.nature.com/news/2004/041122/full/news041122-2.html>. The General Assembly adopted Declaration 59/280 on March 8, 2005, which was ambiguous as to whether therapeutic cloning research ought to be banned (see *United Nations Declaration*

ler makes it clear that majoritarian moral judgments about which attitudinal shifts are harmful cannot constitutionally be imposed unless they are based on fundamental values like those embodied in the *Charter*. It is clear that the instrumental use of human beings would be contrary to fundamental *Charter* values, which include “respect for the inherent dignity of the human person,”¹³⁶ but it is not clear that this extends to very early stage embryos, which are not legally recognized as “human persons.”

Concern #4: Slippery slope to reproductive cloning

A fourth justification for the ban on therapeutic cloning research in humans is that researchers will be able to learn about and perfect the process of human cloning, thereby raising the risk that an unscrupulous person will illegally engage in reproductive cloning.¹³⁷ There is currently strong and widespread consensus that human reproductive cloning should be opposed on safety grounds, although some question the strength of other arguments against the practice.¹³⁸ The concerns expressed in section 2 of the *AHRA* regarding human individuality and diversity, as well as the health and well-being of children born through assisted reproductive technologies, explain the ban on reproductive cloning. It is conceivable that the ban on therapeutic cloning is also intended to promote the same values by reducing the risk that someone might attempt reproductive cloning.

The objectives of protecting human individuality, diversity, and the health and well-being of children are indeed “pressing and substantial objectives.” The ban on therapeutic cloning research is put forward as a second line of defence to buttress the direct criminalization of reproductive cloning. The prohibition against therapeutic cloning in order to protect women is also a second and indirect line of defence added to the direct prohibition against paying for gametes. The simultaneous pursuit of multiple strategies to con-

on *Human Cloning*, GA Res 59/280, UNGAOR, 59th Sess, UN Doc A/Res/59/280 (2005)). The diversity of international views is revealed in the delegates’ statements after the vote (see UNGAOR, 59th Sess, 82d Plen Mtg, UN Doc A/59/PV.82 (2005)).

¹³⁶ See *Oakes*, *supra* note 117 at para 64.

¹³⁷ The President’s Council on Bioethics, *supra* note 122 at 164, 189; Capron, *supra* note 4 at 1061-62.

¹³⁸ S Camporesi & L Bortolotti, “Reproductive Cloning in Humans and Therapeutic Cloning in Primates: Is the Ethical Debate Catching Up With the Recent Scientific Advances?” (2008) 34:9 J Med Ethics e15.

trol a proscribed behaviour is a legitimate governmental approach where it is deemed necessary and each strategy is, itself, constitutional.

Nevertheless, the slippery slope justification in this case is weakened by the fact that a ban on therapeutic cloning is unlikely to have much effect, if any, on the risk that someone will illegally attempt reproductive cloning. After all, human therapeutic cloning research is permitted and is proceeding in multiple jurisdictions outside Canada. Non-human reproductive cloning research is permitted in Canada and elsewhere and has succeeded in producing cloned mammals of many species. Cloning techniques are thus being slowly refined despite the *AHRA*. Against this backdrop, the ban on therapeutic cloning research does not seem to add much, if anything, to the criminalization of reproductive cloning as a means to prevent reproductive cloning. Laws that violate *Charter* rights and yet do little or nothing to advance even admittedly important legislative objectives are unlikely to satisfy the last step of the section 1 proportionality analysis, which demands that the beneficial effects of the legislation be proportionate to the harm of infringing *Charter* rights. Recent case law suggests that the Supreme Court will consider the actual benefits or effectiveness of legislation (rather than merely the importance of the objective) in determining whether the infringement of a *Charter* right is justified.¹³⁹

Alternatives, opportunity costs, and the realism of the end goal of personalized medicine.

In the literature, one may also find other arguments against therapeutic cloning research, namely, that (1) there are better alternative lines of research,¹⁴⁰ (2) the dream of widely available personalized cloned stem cell therapies is financially impossible, and (3) the personalized cloned stem cell therapies will only be available to the wealthy.¹⁴¹ These concerns are fundamentally about two things: the waste of resources and the exacerbation of social inequality. For the reasons that follow, they have not been included as possible legislative objectives that motivate the *AHRA*. As a result, they are not considered further in this article in the discussion of the balancing exercise under section 1 of the *Charter*, which weighs the benefits of the law in achieving “pressing and substantial” legislative objectives against the harms

¹³⁹ Sharpe & Roach, *supra* note 115 at 76-77.

¹⁴⁰ Katrien Devolder & Julian Savulescu, “The Moral Imperative to Conduct Embryonic Stem Cell and Cloning Research” (2006) 15 Cambridge Q Healthcare Ethics 7; Baylis & McLeod, *supra* note 120 at 727.

¹⁴¹ Devolder & Savulescu, *ibid* at 16.

of limiting *Charter*-protected rights. However, a short discussion is included below in order to provide a comprehensive view of the objections to therapeutic cloning research that are contained in the literature.

With respect to the first objection—that therapeutic cloning research is a waste of resources—it is extremely difficult to be sure which of the available lines of research is preferable, and it may be that simultaneous research along synergistic lines would ultimately be best. Unless there are independent reasons to prohibit human cloning, the existence of alternatives does not explain why a criminal prohibition is needed. As discussed earlier, we normally rely upon researchers, funders, and the market to channel resources among various alternative lines of medical research rather than to criminalize those expected to be a waste of resources.

It is true that, ultimately, we may decide that personalized stem cells are too expensive and impractical, preferring strategies related to stem cell banks,¹⁴² although there are concerns that such an approach might disadvantage members of minority ethnicities.¹⁴³ A parallel strategy, with personalized stem cells for minority or rare haplotypes and banked cells for everyone else might ultimately be best. It is also important to recall that therapeutic cloning research may contribute to treatments in other ways that do not pose the kinds of impracticalities that personalized stem cell therapies might. For example, therapeutic cloning research and iPS cell research could help researchers to create cellular models of particular diseases in order to understand them or to test treatments.¹⁴⁴ Again, the usual mechanisms for determining whether a particular line of research is likely to be useless ought to apply here unless there are independent reasons to criminalize therapeutic cloning research.

The concerns, based on social justice, that medical research is stacked too much toward the ailments of the wealthy or that the fruits of the research are accessible only to the wealthy are widespread and well-founded concerns. A thorough treatment of this topic is beyond the scope of this article, but it is worth noting that the argument applies much more broadly and could

¹⁴² See Izpisua-Belmonte, *supra* note 73 at 880.

¹⁴³ See e.g. Hilary Bok, Kathryn E Schill & Ruth R Faden, “Justice, Ethnicity, and Stem-cell Banks” (2004) 364:9429 *Lancet* 118 at 119.

¹⁴⁴ Devolder & Savulescu, *supra* note 140 at 18; The President’s Council on Bioethics, *supra* note 122 at 146; J Savulescu & L Skene, “The Kingdom of Genes: Why Genes from Animals and Plants will Make Better Humans” (2008) 8:12 *Am J Bioethics* 35 at 35.

equally condemn many other lines of modern biomedical research (as well as other ways that affluent societies spend their resources other than on biomedical research). Again, we do not normally address this problem through the criminalization of medical research likely to generate expensive therapies. Unless there are reasons specific to therapeutic cloning research itself, the fact that it is predicted not to generate the most socially useful results could be addressed with a shift in public funding away from it, and other lines of research deemed unlikely to be socially useful, toward research considered more socially desirable. There is some danger in this approach given that we may be wrong about what turns out to be most useful, although it is a decision that a society could legitimately and perhaps should take given the scarcity of resources. Nonetheless, the ultimate distributive impact of particular medical research and its therapeutic applications is also hard to predict, and depends in part on health care funding models.

In sum, it seems unlikely that these considerations are among the legislative objectives of Parliament in enacting the *AHRA*. In addition, it would be very unusual and would likely be unwise to prohibit a particular line of medical research on these grounds alone.

Summary on the extent to which the potential objectives are “pressing and substantial”

The objective of protecting women from exploitation is sufficiently important to constitute a “pressing and substantial” objective under section 1 of the *Charter*. The moral status of the embryo, or the prevention of the instrumentalization of very early human life seem less likely to meet this requirement.

While the prevention of reproductive cloning does constitute a “pressing and substantial” objective (in order to protect children born from assisted reproductive technologies, and to protect human individuality and diversity), the criminalization of therapeutic cloning research does not seem to add much, if anything, to the objective of preventing reproductive cloning that is not already achieved through the direct criminalization of reproductive cloning. I draw this conclusion based on the fact that the necessary cloning techniques are being developed elsewhere, so a ban designed to prevent the perfection of the techniques in Canada will have little or no effect on the likelihood of an illegal attempt at reproductive cloning. A law that does not achieve its objective with complete success is not for that reason unconstitutional, but a law that infringes a *Charter* right while contributing little or nothing is less likely to be justified. Although I will not pursue the analysis of this objective further, it is possible that a court might find that even a small contribution to delaying the de-

velopment of techniques that could be used illegally in reproductive cloning would justify the ban on therapeutic cloning research.

Accordingly, in the following section 1 proportionality analysis, I focus on the most compelling objective underlying the prohibition on therapeutic cloning—that of protecting women from exploitation.

Is the prohibition on therapeutic cloning research a proportionate legislative response to the risk posed by that research to women?

The second stage in the section 1 analysis is to consider whether the state infringement of a *Charter* right is a proportionate response given the legislative objectives. This is assessed by considering whether the law is rationally connected to the objective, whether it impairs the *Charter* right as little as is reasonably possible, and whether the harmful effects on the holder of the right are proportionate to the benefits achieved by the law.

There seems little doubt that the objective of protecting women from the risks associated with a growing demand for oocytes to fuel cloning research is rationally connected to a prohibition on therapeutic cloning research. It is less clear that the prohibition does so in a manner that impairs *Charter* rights as little as reasonably possible.

One response to the concern about the risk that women will be exploited or offered undue inducements to risk their health by donating oocytes is that it is enough to ban compensation for oocytes (as the *AHRA* already does). Others reject even a prohibition on compensation, arguing that research ethics oversight is enough to avoid undue inducement.¹⁴⁵ Some doubt that this is sufficient, pointing to the difficulties of doing so as well as to the fact that this approach places great faith in the oversight abilities of ethics review boards.¹⁴⁶ The topic is a controversial one, even within the International Society for Stem Cell Research, whose task force was sharply divided during attempts to create guidelines for how to treat oocyte donors.¹⁴⁷ The guidelines now list various requirements intended to protect female donors (including guarding against undue inducement and monitoring for the dispro-

¹⁴⁵ See R Klitzman & MV Sauer, “Payment of Egg Donors in Stem Cell Research in the USA” (2009) 18:5 *Reprod Biomed Online* 603; SL Crockin, “A Legal Defense for Compensating Research Egg Donors” (2010) 6 *Cell Stem Cell* 99; Insoo Hyun, “Fair Payment or Undue Inducement?” (2006) 442:7103 *Nature* 629-630.

¹⁴⁶ Editorial, “Safeguards for Donors” (2006) 442:7103 *Nature* 601.

¹⁴⁷ Erika Check, “Ethicists and Biologists Ponder the Price of Eggs” (2006) 442:7103 *Nature* 606-07.

portionate recruitment of poorer donors).¹⁴⁸ Ultimately, the practice of paying people to undergo invasive and potentially risky removal of bodily tissue that they would not otherwise undergo for their own therapeutic benefit raises reasonable concerns, and a prohibition on compensation for oocyte donation falls well within the range of measures that a government could reasonably take.

In addition, a government could reasonably decide that it wants to offer more protection to potential donors than it thinks will be provided by a ban on compensation. For example, a government could point to several reasons to question the adequacy of a ban on compensation. First, women remain exposed to non-financial pressures and inducements, as was demonstrated by serious ethical concerns about the sourcing of oocytes from junior members of Woo-Suk Hwang's laboratory.¹⁴⁹ Second, the demand for oocytes might fuel either an illicit market in Canada or contribute to licit or illicit markets abroad. Finally, where it is permissible to take and use tissue donated altruistically, we can expect increased pressure to permit payment for valuable resources that are not donated in sufficient quantities altruistically.¹⁵⁰ Some may question whether these are justifiable reasons to prohibit therapeutic cloning research, suggesting that the practices in the Hwang lab were an aberration or pointing out that in the context of organ transplants we ban organ sales but not transplantation. This may be true, but a government may be more willing to tolerate these risks in the context of organ transplantation (where a relatively small number of patients exists) than in the context of therapeutic cloning research. Many of the concerns associated with fuelling a demand for oocytes and the potential inadequacy of a ban on compensation are borne out in the organ donation context including in relation to non-financial pressures and inducements (e.g. family pressure to donate to a sick family member), illicit markets, and pressure to legalize compensation. Again it seems to fall within the range of reasonableness for a government to

¹⁴⁸ International Society for Stem Cell Research, "Guidelines for the Conduct of Human Embryonic Stem Cell Research", online: ISSCR <www.isscr.org>.

¹⁴⁹ Seoul National University, *supra* note 36. According to this report, Dr. Hwang claimed not to have known that his laboratory members had donated eggs, although he accompanied one graduate student who donated eggs to the hospital for the collection of her eggs. See also Françoise Baylis, "For Love or Money? The Saga of Korean Women Who Provided Eggs for Embryonic Stem Cell Research" (2009) 30:5 *Theor Med Bioeth* 385.

¹⁵⁰ See e.g. Crockin, *supra* note 145, who writes that (in the US context) reproductive egg donors can be compensated, as can other human research subjects, and argues that research egg donors should be treated no differently.

conclude that a ban on compensation would not be adequate in the circumstances.

Another response to concerns about endangering women is that financial incentives be permitted only for women undergoing IVF who already face the risks of oocyte retrieval. This might take the form of reduced fees for IVF in exchange for “egg-sharing.”¹⁵¹ This too raises concerns, particularly as it is likely that women who are less well-off are most likely to participate, it reduces a woman’s own chances to produce frozen embryos for later implantation should initial attempts fail, and it may increase the pressure for aggressive ovarian stimulation to ensure a large number of eggs.¹⁵² The significance of the financial factor in overcoming a fertility patient’s reluctance to share eggs is suggested by the fact that when Belgium began to reimburse the full costs of IVF in 2003, the number of those choosing to share eggs with other IVF patients dropped by about 70%.¹⁵³

As a result, a government could reasonably reject the foregoing options (which are less restrictive on research than a complete ban on therapeutic cloning) as inadequate to meet its objectives. However, there is an alternative approach that would provide equivalent protection to women while not foreclosing therapeutic cloning research in Canada. Methods of cloning that do not use oocytes at all (e.g. cell fusion or stembrids), that use artificial oocytes (created from iPS cells or hES cells), that use non-human oocytes or that use immature oocytes taken from human ovarian tissue removed solely for therapeutic reasons would not threaten women. It is true that these options are experimental, but they may turn out to be effective alternatives. A more narrowly tailored prohibition would thus prohibit therapeutic cloning research using oocytes or precursor cells taken from girls and women but would permit cloning research where it made use of one of the alternatives mentioned above. As a result, the Canadian prohibition on therapeutic cloning research arguably fails the second branch of the section 1 proportionality test—it does not infringe the section 7 rights of potential beneficiaries of the research as little as reasonably possible.

¹⁵¹ Celia Roberts & Karen Throsby, “Paid to Share: IVF Patients, Eggs and Stem Cell Research” (2008) 66:1 Soc Sci & Med 159.

¹⁵² *Ibid* at 164. But see MY Thum et al, “Does Egg-Sharing Compromise the Chance of Donors or Recipients Achieving a Live Birth?” (2003) 18:11 Hum Reprod 2363, which examines 276 instances of egg-sharing and finds success rates to be the same for egg-sharers and non-egg-sharers.

¹⁵³ See Guido Pennings & Paul Devroey, “Subsidized In-Vitro Fertilization Treatment and the Number of Egg Sharers” (2006) 13:1 Reprod Biomed Online 8 at 8.

Conclusion

Freedom of scientific research, within appropriate and justified limits, is an important value that is recognized in international human rights instruments. While this value is often understood as an interest of researchers, the importance to the broader public of this research (particularly the right to share in the fruits of the research) is also recognized internationally.

So far, constitutional arguments regarding the freedom of scientific research have tended to focus on the freedom of speech of researchers, with much less attention to the potential constitutional arguments that could be made on behalf of potential patients. In my view, this latter argument is available, particularly where the benefits from research are shown to be reasonably probable rather than highly uncertain.

As for prohibitions on earlier stages of research, the argument becomes more challenging because the benefits of the research are often highly speculative. This makes it difficult to demonstrate that any weighty harm has been done to the patient in foreclosing a potentially useful line of research. Nonetheless, in some cases, it may be possible to predict with reasonable certainty (greater than the balance of probabilities, for example) that the research will contribute to the development of another therapy even if it is unclear that the particular therapy envisaged by the research will ultimately be successful. It is possible, for example, that human therapeutic cloning research would produce information regarding human cell reprogramming that would enable more rapid refinement of iPS cells for therapeutic purposes.

The possibility of a patient's *Charter* right to unimpeded medical research has been explored here by focusing on the Canadian ban on therapeutic cloning research in humans. While several potential legislative objectives may underpin the legislation, the one that seems most likely to be constitutionally valid is that of protecting women from the risks associated with donating the oocytes one assumes would be needed for the research and subsequent treatment of actual patients. Assuming it is possible to overcome the hurdle of speculativeness in establishing that this prohibition does infringe the section 7 rights of potential patients, the infringement in this case appears to be overbroad (and thus contrary to the principles of fundamental justice) since methods of cloning research that do not endanger women as oocyte donors are available. A prohibition on cloning research using oocytes sourced from women and girls (with the possible exception of immature oocytes taken from ovarian tissue excised for therapeutic purposes) would provide equivalent protection for women while permitting the research to proceed. In

addition, other methods of achieving therapeutic cloning without oocytes (such as cell fusion) are available without putting oocyte donors at risk, and methods of creating artificial oocytes (such as from iPS cells or hES cells) would similarly permit therapeutic cloning using oocytes but without the risk to donors. This overbreadth is also relevant at the stage of the section 1 analysis, and suggests that the law does not infringe the section 7 rights of potential patients as little as is reasonably possible.

Stem cell science is moving extremely rapidly, making it challenging to analyze the constitutionality of specific restrictions on aspects of stem cell research. However, there remains a real risk that restrictions on the research may impede the discovery of useful therapies. Where prohibitions are found to be necessary they should be crafted as narrowly and precisely as possible. Finally, as advances in biomedical science generate further novel therapies, the constitutional resolution of any ensuing clashes in interests and values will be incomplete if it considers only the freedom of researchers. The interests of patients who might potentially benefit from new treatments should also be represented and given due consideration in the balance.

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WHY WITHDRAWING LIFE-SUSTAINING TREATMENT SHOULD NOT REQUIRE “*RASOULI* CONSENT”

*Hilary Young**

Technology allows us to keep patients alive despite very poor prognoses and quality of life. We must therefore confront questions of when medical intervention should cease, and who should be allowed to make that decision.

Until recently it was unclear whether doctors or patients have the ultimate say in whether to withhold or withdraw life-sustaining treatment. In *Rasouli v Sunnybrook Health Sciences Centre*, the Ontario Court of Appeal held that doctors may only withdraw certain life-sustaining treatment with the consent of patients or their substitute decision makers. It reasoned that withdrawing certain treatment is “treatment” for which consent is required under Ontario’s *Health Care Consent Act*. This effectively gives the patient an entitlement to continued life support.

I argue that the law of informed consent should not dictate who may decide whether treatment is withheld. When consent is applied to create *de facto* entitlements to medical treatment, as “*Rasouli* Consent” does, interests other than those of the patient become relevant, such as physicians’ interest in not having to provide non-beneficial treatment and the public interest in not having to fund treatment of little or no medical value. Yet the law of informed consent is exclusively patient-centered and does not allow these factors to be considered; neither the Consent and Capacity Board nor the courts may give weight to competing interests.

La technologie nous permet maintenant de maintenir certains patients en vie malgré de mauvais pronostics et une pauvre qualité de vie. Il est donc important de se questionner sur le moment auquel ces interventions médicales devraient cesser ainsi que sur les personnes autorisées à prendre ces décisions.

Jusqu’à récemment, il était encore incertain à qui, des médecins ou des patients, il revenait de décider si les traitements permettant le maintien en vie devraient être suspendus. Dans l’affaire *Rasouli v Sunnybrook Health Sciences Centre*, la Cour d’appel de l’Ontario a jugé que les médecins ne peuvent suspendre certains traitements vitaux qu’avec l’accord des patients ou de ceux légalement autorisés à décider pour eux. La Cour a conclu que la suspension d’un traitement constitue en soi comme une intervention nécessitant un consentement en vertu de la *Loi sur le consentement aux soins de santé* de l’Ontario. Ceci donne en pratique aux patients un droit au maintien de traitements.

Je soutiens ici que le droit portant sur le consentement éclairé ne devrait pas déterminer qui a le pouvoir de suspendre des traitements. En effet, lorsque la notion de consentement est utilisée afin de créer un droit *de facto* aux traitements médicaux, comme c’est le cas avec le « Consentement *Rasouli* », des intérêts autres que ceux des patients entrent en jeu, par exemple ceux des médecins à ne pas fournir des traitements devraient posséder le droit d’unilatéralement suspendre des traitements vitaux. Il s’agirait en effet de

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This is not to say that physicians should have the right unilaterally to withhold life-sustaining treatment. However, any entitlement to treatment should flow from laws other than the law of informed consent, such as the *Charter*, or ideally a new law that explicitly addresses the issue.

traitements sans bénéfices réels ou celui du public à ne pas financer d'interventions peu ou pas utiles d'un point de vue médical. Or, le droit sur le consentement éclairé se concentre exclusivement sur les patients, sans prendre ces autres facteurs en considération.

Cela ne signifie pas, par contre, que les médecins ne pas faire découler le droit aux traitements du droit portant sur le consentement éclairé mais plutôt de lois comme la *Charte* ou, idéalement, d'une loi spécifique abordant la question de front.

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[C]onsent by itself creates no obligation to treat.

*It is merely a key which unlocks a door...*¹

Introduction

Hassan Rasouli is at the centre of a legal debate over who may decide whether to withdraw a patient's life support: the patient's substitute decision maker ("SDM"), or the treating physician. Since 2010 Mr. Rasouli has been at Sunnybrook Health Sciences Centre in Toronto, where he receives food and water through a tube inserted into his stomach, and requires a mechanical ventilator to breathe. Mr. Rasouli's doctors initially diagnosed him as being in a persistent vegetative state ("PVS") and wanted to withdraw his life-sustaining treatment.² They consider it contrary to their professional duties to continue treating a patient when there is no realistic hope that treatment will improve his condition.³ Although they later changed their diagnosis, concluding that Mr. Rasouli is now in a "minimally conscious state,"⁴ the doctors still believe that their patient's life support should be withdrawn. Mr. Rasouli's wife, Parichehr Salasel, insists that treatment continue. As a physician herself, she disputes the doctors' bleak diagnosis and holds out hope for her husband's recovery.

Decisions about whether to continue treating seriously ill patients must be made every day in hospitals, where Canadians increasingly spend their last days.⁵ Yet it has long been unclear who is legally entitled to make the

¹ *In Re R (A Minor) (Wardship: Consent to Treatment)*, [1992] Fam 11, 1 FLR 190 at 196 (Lord Donaldson of Lynton MR) (CA) [*In Re R*].

² I use the term life-sustaining treatment broadly to include any treatment necessary to prevent the patient from dying. This would therefore include life support, such as mechanical ventilation, and measures such as cardiopulmonary resuscitation ("CPR").

³ *Cuthbertson v Rasouli (Litigation Guardian of)*, SCC Docket No 34362 (10 February 2012) (Factum of the Appellant at para 61 [*Cuthbertson v Rasouli* FOA]).

⁴ Lisa Priest, "Vegetative Patient Now Able to Give 'Thumbs Up', Fuelling Debate over Life Support" *The Globe and Mail* (24 April 2012) online: *Globe and Mail* <www.theglobeandmail.com/life/health/end-of-life/vegetative-patient-now-able-to-give-thumbs-up-fuelling-debate-over-life-support/article2413296/>.

⁵ Close to 60% of Canadians now die in hospital. See Canadian Cancer Society et al, "Canadian Cancer Statistics 2010; Special Topic: End of Life Care" at 72-73 online: The Canadian Cancer Society <www.cancer.ca/Canada-wide/About%20

decision whether to withhold or withdraw life-sustaining treatment. The question was answered in part in *Rasouli v Sunnybrook Health Sciences Centre*.⁶ In that case, the Ontario Court of Appeal held that if palliative care drugs are required following withdrawal of life-sustaining treatment, that treatment may not be withdrawn without the consent of the patient or patient's SDM. It considered withdrawing life-sustaining treatment to be part of a treatment package for which consent is required according to the *Health Care Consent Act* ("HCCA").⁷ Although the court's decision is restricted to situations where withdrawing treatment leads both to palliative care and death, its effect is to create a kind of entitlement to life-sustaining treatment, even where physicians consider such treatment to be of no medical benefit.

Regardless of whether a legal entitlement to life-sustaining treatment is desirable as a matter of policy, neither the HCCA, nor the common law of consent to medical treatment, is best interpreted as creating an entitlement to treatment that doctors do not want to provide. The duty of physicians not to treat without first obtaining informed consent only applies where the physician is willing to provide treatment. In other words, the law of informed consent itself creates no entitlements to treatment.

That said, the law of consent has evolved considerably over the last few decades. The courts or legislatures could continue to expand its scope to encompass situations in which doctors do not wish to provide treatment, as the Ontario Superior Court and Court of Appeal have so far done in *Rasouli*. Given the significant implications of such expansion, however, the courts should leave any such change to the legislatures. The law of consent is one-sided and absolute, allowing competent patients to refuse treatment for almost any reason, in almost any circumstances, and requiring SDMs to decide based only on the patient's wishes or best interests. This is appropriate in the context of the ability to refuse treatment, but different interests arise where patients may demand treatment, such that an absolute and one-sided approach requires justification. If applied to create entitlements to life support, the law of consent would require doctors sometimes to treat patients in a manner contrary to the standards of the medical profession. In addition, there are resource implications of consent-based entitlements to life-sustaining

cancer/Cancer%20statistics/~media/CCS/Canada%20wide/Files%20List/English%20files%20heading/pdf%20not%20in%20publications%20section/Canadian%20Cancer%20Statistics%202010%20-%20English.ashx>.

⁶ 2011 ONCA 482, 107 OR (3d) 9 [*Rasouli CA*].

⁷ *Health Care Consent Act*, SO 1996, c 2 Schedule A [*HCCA*].

treatment: given *Rasouli*, a patient would effectively be entitled to treatment regardless of cost or scarcity of resources. Also unclear is the justification for limiting consent-based entitlements to life-sustaining treatment, rather than to other treatments that implicate patients' fundamental interests in autonomy and bodily integrity. As a result, *Rasouli*'s consent-based approach could ultimately result in entitlements to treatment other than life-sustaining treatment.

The Supreme Court of Canada has granted leave to appeal the Court of Appeal's decision. It should interpret "treatment" in the *HCCA* to exclude withholding and withdrawing treatment, such that a patient's or SDM's consent would not be required to withhold or withdraw treatment. As a result, a patient could not effectively demand treatment by refusing consent to that treatment being withheld. The Supreme Court should also clarify that the common law of consent, like the *HCCA*, creates no entitlements to treatment.

Rejecting a consent-based entitlement to life-sustaining treatment does not mean that patients do not have or should not have legal entitlements to such treatment, nor does it mean that physicians are permitted or should be permitted unilaterally to withdraw life-sustaining treatment. Rather, any entitlement to care that physicians do not want to provide must find its basis in laws other than the *HCCA* or the common law of consent to treatment, such as the *Charter* or the law of negligence. Given that there are limitations to the protections offered by existing laws, new more flexible laws or guidelines should be implemented. Although this article reviews some possible mechanisms for better protecting patients regarding access to life-sustaining treatment, its aim is not to argue for a particular approach.

I. Withholding and Withdrawing Life-Sustaining Treatment in Practice

Deciding whether to withhold or withdraw life-sustaining treatment from a patient is an extremely important and difficult decision. It is literally a matter of life and death. No one wants to deny care to a patient who could materially benefit from it, but advances in technology allow health practitioners to keep people alive even when there is no realistic prospect of improvement to their underlying condition.⁸ As a result, life-sustaining treatment *can* be pro-

⁸ This is the starting point for the debate about medical futility. See e.g. John J Paris, "Pipes, Colanders, and Leaky Buckets: Reflections on the Futility Debate" (1993) 2:2 *Camb Q Healthc Ethics* 147; M Gordon, "Cardiopulmonary Resuscitation in the Elderly Long-Term Care Population: Time to Reconsider" (1994) 27:2 *Ann R Coll Physicians Surg Can* 81.

vided, but as potential returns diminish and costs (including to the patient, in terms of invasiveness and suffering, as well as to the public purse) increase, it is not obvious that such treatment *should* be provided.⁹ Also unclear is who should decide whether and when life-sustaining treatment is provided. Patients' interest in autonomy and dignity suggests that they or their SDMs should have a say.¹⁰ However, doctors also have legal and ethical obligations to treat patients according to certain standards, regardless of what patients want. In addition, when we grant entitlements to treatment, issues of resource allocation arise, such that the government may wish to limit available treatment.

In Canadian hospitals, policies and practices vary regarding how a decision whether to continue life-sustaining treatment is made and who ultimately decides.¹¹ To the extent there is a norm, however, it would seem to require the patient's physician to confer with the patient or SDM.¹² The physician's

⁹ *Ibid.* Also consider that "at some point, when dealing with questions of serious medical treatment, a truly thoughtful society must ask itself not merely whether it can, but, also whether it should provide advanced medical treatment." (Paul A Gomez, "Promises and Pitfalls: An Analysis of the Shifting Constitutional Interests Involved in the Context of Demanding a Right to Treatment in Health Care" (2000-2001) 64 Alb L Rev 361 at 361).

¹⁰ See Jocelyn Downie, "Unilateral Withholding and Withdrawal of Potentially Life-Sustaining Treatment: a Violation of Dignity Under the Law in Canada" (2004) 20:3 Journal of Palliative Care 143.

¹¹ *Ibid* at 148.

¹² I arrive at this conclusion based on various articles and professional guidelines. For example, "[t]he physician must identify the person(s) with whom he/she must communicate about withholding or withdrawing life-sustaining treatment and communicate with that person as early as possible and, where possible before life-sustaining treatment is withheld or withdrawn" (The College of Physicians and Surgeons of Manitoba, "Withholding and Withdrawing Life-Sustaining Treatment", Statement No 1602 (First Print 2007) at 15-S7, online: The College of Physicians and Surgeons of Manitoba <cpsm.mb.ca/about-the-college/by-laws-code-of-conduct-statements-and-guidelines/statements/590-2> [Manitoba Guidelines]). A proposed practice for Ontario is discussed in Laura Hawryluck, Redouane Bouali & Nathalie Danjoux Meth, "Multi-professional Recommendations for Access and Utilization of Critical Care Services: Towards Consistency in Practice and Ethical Decision-Making Processes" (2011) 39:2 JL Med & Ethics 254; *Cuthbertson v Rasouli* FOA, *supra* note 3 at paras 48-57, 104-108. For the US context, see Nicholas Smedira et al, "Withholding and Withdrawal of Life Support from the Critically Ill" (1990) 322:5 New Eng J Med 309.

hope is that if he or she does not believe further treatment is medically warranted, the patient or SDM will agree that life-sustaining treatment may be withheld or withdrawn.¹³ If the patient or SDM still insists on treatment, it seems that most physicians accede to this wish even where they consider the treatment futile.¹⁴ Some, however, refuse to treat. Legal action may then follow, as was the case in *Rasouli*.

II. The Law of Consent to Withholding and Withdrawing Life-Sustaining Treatment

Although consensus is often possible, there are inevitably situations in which physicians and SDMs cannot agree on whether treatment should continue. A judicial resolution becomes necessary. Yet until recently it was unclear who has the legal right to decide whether to withhold or withdraw life-sustaining treatment. The issue is not addressed by statute, at least not explicitly.¹⁵ As for any decision making authority at common law, some courts have indicated that the case law is unresolved,¹⁶ while some courts and

¹³ *Ibid* at 312, discuss the family's role in decision making and note that most families agreed with the doctor's recommendation to withdraw life support from the outset. Of those who initially disagreed, eight out of ten were convinced to agree within a few days.

¹⁴ Smedira et al's study of California ICUs revealed that in the few cases in which the family could not be convinced to agree to withdraw life support, treatment continued (*ibid*). A dearth of legal cases in Canada suggests a similar practice here.

¹⁵ Glen Rutland states that "the question of who has the final authority when a demand for life-sustaining treatment is made has not been answered by statute" ("Futile or Fruitful: The *Charter* and the Decision to Withhold or Withdraw Life-Sustaining Treatment" (2009) 17 Health LJ 81 at 82). However, the courts in *Rasouli v Sunnybrook Health Sciences Centre and Cuthbertson*, 2011 ONSC 1500, 105 OR (3d) 761, 231 CRR (2d) 26 [*Rasouli* SC], and *Rasouli* CA, *supra* note 6, treated the *HCCA* and specifically its requirement for consent to treatment, as governing the issue.

¹⁶ According to the application judge in *Rasouli*, "the common law position on whether consent is needed to withdraw or withhold treatment in Canada is not firmly decided" (*Rasouli* SC, *supra* note 15 at para 83). See also Joan Gilmour, "Death, Dying and Decision-Making About End of Life Care" in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds, *Canadian Health Law and Policy* 4th ed (Markham: LexisNexis, 2011) 385 at 410.

commentators think case law indicates that doctors may make the final decision.¹⁷

Logically, doctors have no legal obligation to treat, including continuing treatment that has already begun,¹⁸ unless the law imposes such an obligation. Although this article argues that no such legal obligation is created by the *HCCA* or the common law of consent, it recognizes the existence of legal obligations to provide certain life-sustaining treatment on the basis of other laws. In this section I discuss the law of consent to medical treatment and why it does not ground an entitlement to life-sustaining treatment. I begin with the common law of consent, then examine consent under the *HCCA*. Although the courts resolved *Rasouli* on the basis of the *HCCA* alone, the common law of consent to medical treatment informs the interpretation of the *HCCA*. Finally, I consider the possibility that the law of informed consent has developed so as to now require consent to withholding and withdrawing life-sustaining treatment. In Section 5 I examine other laws that could ground an entitlement to life-sustaining treatment.

1. The Common Law of Consent

Before 1980, the legal role of consent to medical treatment was essentially that of a defence to the tort of battery.¹⁹ Non-trivial touching without permission is battery,²⁰ and that is also true of touching in the medical context. Thus, the requirement of consent to medical treatment "is designed to protect a person's bodily integrity from interference."²¹ As a defence to battery, consent is only relevant where medical treatment involves physical interference

¹⁷ See Rutland, *supra* note 15 at 82. See also *Child and Family Services of Central Manitoba v Lavallee et al*, 154 DLR (4th) 409, 123 Man R (2d) 135 (CA) [Lavallee].

¹⁸ Withdrawing and withholding treatment are treated identically in the common law and in the *HCCA*. Thus, consent is no more required to withdraw treatment than it is to withhold it.

¹⁹ It was also a defence to the crime of assault, but since neither the *HCCA*, nor the Ontario common law of informed consent affects the criminal law of Canada, I do not mention criminal assault again.

²⁰ *Non-Marine Underwriters, Lloyd's of London v Scalera*, 2000 SCC 24 at para 16, [2000] 1 SCR 551, 185 DLR (4th) 1 [Scalera].

²¹ Lorne Rozovsky, *The Canadian Law of Consent to Treatment*, 3d ed (Markham: LexisNexis Canada, 2003) at 5; *Scalera*, *supra* note 20 at para 10 (battery protects individual autonomy).

with the patient, since physical contact is an element of the tort. Because unwanted touching is a serious violation of personal autonomy, the tort provides broad protection against even relatively innocuous unwanted touching, and is actionable without proof of loss.²²

The protection is broad in the sense that a competent patient may refuse consent to treatment under almost any circumstances, including when refusal would lead to death,²³ and for any reason. The few exceptions relate to emergencies²⁴ and to public health threats.²⁵ It is no defence to argue that defendants had a good reason to touch plaintiffs or were acting in their best interests.²⁶

The law of consent as a defence to battery clearly cannot ground an entitlement to treatment a physician does not want to provide. Although the requirement of consent provides broad protection against unwanted touching, its scope is limited to situations where a physician intentionally touches a patient,²⁷ where a physician chooses to act in a manner objectionable to the patient, and where physical interference is involved. It cannot, by itself, ground an entitlement to be touched or otherwise treated.

²² Barney Sneiderman, John Irvine & Philip Osborne, *Canadian Medical Law*, 2d ed (Toronto: Carswell Thompson, 2003) at 20.

²³ *Malette v Shulman* (1990), 72 OR (2d) 417 at para 19, 67 DLR (4th) 321 (CA) [*Malette*].

²⁴ Emergencies are an exception in that health practitioners may treat without a basis to infer the patient's consent to treatment. That said, if there is good reason to believe the patient would have refused consent (as when a Jehovah's Witness carries a card indicating a refusal to receive blood transfusions), the health practitioner may not treat even in an emergency (*ibid* at paras 20-25).

²⁵ *Health Protection and Promotion Act*, RSO 1990, c H7, s 22.

²⁶ There is no "best interests" defence. The law is clear that informed consent is required: "It may be that in the operating room the parties hereto were of the opinion that they were acting in the best interests of Mrs. Yule in extracting the teeth, but that is not the point. That would have been very important in their consultation with and their advising of Mrs. Yule, but it does not justify their proceeding without her consent. As was said by Garrison J., 'No amount of professional skill can justify the substitution of the will of the surgeon for that of his patient.' " (*Parmley v Parmley*, [1945] SCR 635 at 646, 4 DLR 81). See also *HCCA*, *supra* note 7 s 10.

²⁷ Battery is an intentional tort (*Reibl v Hughes*, [1980] 2 SCR 880 at 890, 114 DLR (3d) 1).

Over the past thirty or forty years there has been a significant shift in the law of consent to medical treatment. Not only is it no longer exclusively an issue of battery, it is no longer even primarily an issue of battery. Rather, the law of consent has come to be understood primarily as an issue of negligence law.²⁸ Reasonable medical practice requires physicians to provide patients with relevant information about treatment, including its risks, likely outcomes, and alternatives to treatment. This enables patients to make an informed decision whether or not to be treated. Since the seminal cases *Hopp v Lepp*²⁹ and *Reibl v Hughes*,³⁰ failure to properly inform patients before treating them amounts to a breach of the standard of care in negligence.³¹

Furthermore, the duty to obtain informed consent does not depend on whether non-consensual treatment would amount to battery—that is, whether it involves physical touching. For example, the standard of care requires obtaining informed consent to treatment that does not involve touching, such as psychotherapy³² or prescribing medication.³³ This reflects the rationale for requiring consent to treatment: to ensure patients are able to make informed and autonomous decisions about their medical treatment, rather than having treatment paternalistically imposed on them.³⁴

Just as consent as a defence to battery cannot ground an entitlement to medical treatment, neither can the duty to obtain informed consent in the negligence context. The latter is fundamentally a duty to inform, or a duty not to treat without first informing, not a duty to treat. Its scope is limited to providing information about material risks, benefits, and alternatives to treatment.³⁵ The duty is part of a broader duty in negligence to treat according to the standard of a reasonable physician. A physician may have a duty under negligence law to provide life-sustaining treatment in certain circumstances, as discussed in Section 5(b). However, that duty does not arise spe-

²⁸ Patricia Peppin, "Informed Consent" in Jocelyn Downie et al, *Canadian Health Law And Policy*, 4th ed (Markham: LexisNexis Canada, 2011) at 154; Rozovsky, *supra* note 21 at 5.

²⁹ [1980] 2 SCR 192, 112 DLR (3d) 67.

³⁰ *Supra* note 27.

³¹ Peppin, *supra* note 28 at 153; Rozovsky, *supra* note 21 at 5.

³² Downie, *supra* note 10 at 145.

³³ Rozovsky, *supra* note 21 at 5.

³⁴ Peppin, *supra* note 28 at 153.

³⁵ See *HCCA*, *supra* note 7 at s 11, especially s 11(3). The *HCCA* largely reflects the common law in this respect.

cifically from the duty to obtain informed consent: it arises from the broader duty to provide care that a reasonable physician would provide.

Courts have generally rejected the proposition that the common law of informed consent—either as a defence to battery or as part of the duty of care in negligence owed to patients—creates entitlements to treatment. As stated in the English case of *Re R*, “consent by itself creates no obligation to treat. It is merely a key which unlocks a door...”³⁶ The Manitoba Court of Appeal similarly stated in *Lavallee*:

It follows, in my opinion, that the word “treatment” when used in s. 25(3) [of the *Child and Family Services Act*] is used only in a positive sense. There is no need for consent from anyone for a doctor to refrain from intervening.³⁷

The issue in *Lavallee* was whether doctors could place a “do not resuscitate” (“DNR”) order on a patient’s chart against the wishes of the patient’s SDM. The Manitoba Court of Appeal held that doctors had no obligation to provide treatment against their clinical judgment. In particular, it held that individuals or their SDMs had no right to consent to treatment being withheld because “treatment” for which consent is required means positive treatment and does not include refraining from intervening.³⁸ The court concluded that

neither consent nor a court order in lieu is required for a medical doctor to issue a non-resuscitation direction where, in his or her judgment, the patient is in an irreversible vegetative state. Whether or not such a direction should be issued is a judgment call for the doctor to make having regard to the patient’s history and condition and the doctor’s evaluation of the hopelessness of the case. The wishes of the patient’s family or guardians should

³⁶ *In Re R*, *supra* note 1 at 187.

³⁷ *Lavallee*, *supra* note 17 at para 13.

³⁸ *Ibid* at para 13. This aspect of the court’s reasoning has been criticized for its reliance on an untenable distinction between acts and omissions (consent, according to *Lavallee*, is only required for treatment that amounts to an act, not an omission). Joan Gilmour argues that because consent to CPR is presumed, consent is required in order *not to provide* CPR, even though not providing it is an omission (*supra* note 16 at 411). See also Barney Sneiderman, “A Do Not Resuscitate Order for an Infant Against Parental Wishes: A Comment on the Case of *Child and Family Services of Central Manitoba v. R.L. and S.L.H.*” (1999), 7 Health LJ 205.

be taken into account, but neither their consent nor the approval of the court is required.³⁹

Sawatzky v Riverview Health Centre Inc.,⁴⁰ also involved a DNR order. In that case, the court was asked to grant an injunction preventing a physician from imposing a DNR order against the wishes of the patient’s SDM. The Manitoba Court of Queen’s Bench concluded based on the pre-*Charter* case law that “a decision not to provide treatment is exclusively within the purview of the doctor...the courts would not interfere with a medical decision not to provide treatment.”⁴¹ The court noted, however, that there was very little case law to rely on.⁴² The injunction was granted due largely to uncertainty as to whether the *Charter* or a human rights code might prevent a physician from unilaterally imposing a DNR. The implication of the Court’s decision is that the law of consent to medical treatment does not create entitlements to treatment a physician does not want to provide. Otherwise there would have been no need to rely on *Charter*-related uncertainty.

However, one Canadian case casts doubt on the proposition that the law of consent to medical treatment creates no entitlement to treatment—at least regarding life-sustaining treatment. In *Golubchuk v Salvation Army Grace General Hospital*,⁴³ the Manitoba Court of Appeal held that consent is not required for treatment that does not involve touching, but that removing life support would require some touching, including administering drugs for pain. Consent would therefore be required.⁴⁴ This reasoning relies on the law of consent as a defence to battery and the proposition that withdrawing life support necessarily involves touching. Note, however, that the court is not saying that turning off a ventilator or stopping artificial hydration or nutrition requires touching the patient. It is saying that the relevant touching may simply be administering drugs after life support is withdrawn.

This is presumably the origin of the “treatment package” reasoning used by the Ontario Court of Appeal in *Rasouli*. By conceptualizing two treatments (one that requires touching the patient, such as administering palliative

³⁹ *Ibid* at para 17.

⁴⁰ [1998] MJ No 506, 167 DLR (4th) 359 [*Sawatzky*].

⁴¹ *Ibid* at para 26.

⁴² *Ibid*.

⁴³ 2008 MBQB 49, [2008] MJ No 54 [*Golubchuk*].

⁴⁴ *Ibid* at para 23; *Sweiss v Alberta Health Services*, 2009 ABQB 691, [2009] AJ No 1303.

care drugs, and one that may not, such as turning off a ventilator) as a single treatment, the court concludes that consent is required. The treatment package reasoning will be considered in greater detail below, but for now it is sufficient to note that this argument creates an entitlement to life-sustaining treatment, but only where palliative care drugs will be administered. It would presumably not, for example, allow a patient or SDM to resist a physician placing a DNR order on a patient's chart, as in *Lavallee* or *Sawatzky*.

Other than *Golubchuk*, I am aware of no cases that recognize an entitlement to medical treatment on the basis of the common law of informed consent.⁴⁵ Rather, consent as a defence to battery or as part of the physician's duty to inform before treating is generally considered an issue of permission for physicians to do what they are willing to do. Physicians may not treat until they have both provided material information to patients and obtained their permission to proceed.

A review of the common law of consent to medical treatment gives little reason to think it creates entitlements to treatment. That said, the fundamental rights that the law of informed consent protects, such as self-determination, could arguably justify interpreting the law more broadly. This will be addressed following the discussion below of informed consent under the *HCCA*.

2. *The Health Care Consent Act*

The Ontario Court of Appeal applied the *HCCA* rather than the common law to Mr. Rasouli's case. It is therefore possible that the law of consent as set out in the *HCCA* creates an entitlement to life-sustaining treatment, even if the common law does not. For the following reasons, I conclude that it does not.

The *HCCA* was not intended to override the common law regarding when consent is required, but rather primarily to allow for orderly and principled substitute decision making where the patient lacks capacity.⁴⁶ It sets

⁴⁵ *Rasouli* relies on the same reasoning, but in relation to the *HCCA* rather than the common law.

⁴⁶ *HCCA*, *supra* note 7 s 1, entitled "Purposes", lists "to facilitate treatment...for persons lacking the capacity to make decisions about such matters," and "to ensure a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment..." among others.

out rules for deciding who may make substitute medical decisions and on what basis.⁴⁷ Other provinces also have legislation that provides for substitute decision making, usually on similar bases as the *HCCA*, although some laws only apply where the patient, while competent, has designated an attorney for personal care.⁴⁸

The *HCCA* largely modifies rather than displaces the common law of consent to medical treatment. Despite acknowledging the necessity of consent in order for medical treatment to be lawful, the *HCCA* creates no new causes of action or remedies in relation to a failure to obtain consent. Therefore, the common law torts of battery and negligence continue to apply to non-consensual treatment.⁴⁹ In addition, courts and commentators have stated that the *HCCA* codifies and modifies the common law.⁵⁰

Rasouli has so far been resolved on the basis of the *HCCA*. Specifically, the issue has been whether the *HCCA*'s definition of “treatment”, for which

⁴⁷ *Ibid* ss 20, 21.

⁴⁸ Alberta: *Adult Guardianship and Trusteeship Act*, SA 2008, c A-4.2, ss 89, 92, 93; *Personal Directives Act*, RSA 2000, c P-6, s 14. British Columbia: *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181, ss 4, 16, 19. Manitoba: *Health Care Directives Act*, CCSM c H27, s 13. New Brunswick: *Infirm Persons Act*, RSNB 1973, c I-8, ss 40-44. Newfoundland: *Advance Health Care Directives Act*, SNL 1995, c A-4.1, ss 10, 12. North West Territories: *Personal Directives Act*, SNWT 2005, c 16, s 15. Nova Scotia: *Personal Directives Act*, SNS 2008, ss 14 and 15. Prince Edward Island: *Consent to Treatment and Health Care Directives Act*, RSPEI 1988, c C-17.2, ss 4, 11, 13. Quebec: *Civil Code of Québec*, LRQ, c C-1991, arts 10-12. Saskatchewan: *Health Care Directives and Substitute Health Care Decision Makers Act*, SS 1997, c H-0.001, s 16. Yukon: *Care Consent Act*, SY 2003, c 21, Schedule B, ss 3, 12, 20.

⁴⁹ Courts continue to apply the law of battery and negligence under the *HCCA*. See e.g. *Remtulla v Zeldin*, 2005 CanLII 28428 (available on CanLII) (ONSC); *Thompson v Zeldin*, 2008 CanLII 46703 (available on CanLII); *Bafaro v Dowd*, 2008 CanLII 45000 (available on CanLII). In fact, “courts have largely ignored the legislation in their analysis of tort claims” (Robert Solomon et al, *Cases and Materials on the Law of Torts* 8th ed (Toronto: Carswell, 2011) at 198).

⁵⁰ See Justice Ellen I Picard & Gerald B Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4th ed (Toronto: Carswell, 2007) at 56. The applications judge in *Rasouli* SC, *supra* note 15 at para 53 cites Dr Hy Bloom & Michael Bay, *A Practical Guide to Mental Health, Capacity, and Consent Law of Ontario* (Scarborough: Thomson Canada, 1996) at 17: “[t]he common law continues to apply to any matters that fall outside the purview of the [*HCCA*] and the [*Substitute Decisions Act*].”

consent is required, includes treatment a physician does not want to provide. The *HCCA* is silent on this matter, so it does not change the common law.

The legislative history of the *HCCA* provides no evidence that the Ontario government intended the *HCCA* to require consent for a procedure that a physician is not willing to provide, and thereby to create an entitlement to that procedure. Like the *HCCA* itself, the legislative history is silent on this issue. Legislators were primarily concerned with protecting patients' ability to designate an SDM and to have their own wishes respected; codifying who would be the SDM if no one was appointed by the patient; and codifying principles for substitute decision making.⁵¹

The only discussion found in the legislative history relating to what counts as treatment for the purposes of the *HCCA* relates to the exclusion of minor or trivial acts from the definition of treatment. For example, no consent is required under the *HCCA* for taking a medical history, because taking a medical history is explicitly excluded from the definition of treatment.⁵² At least one member of provincial parliament expressed concern that this gives doctors too much power to treat without consent.⁵³ However, the exclusion from the definition of treatment of certain routine and low-risk acts, such as communicating a diagnosis, was legislated. If anything, this suggests a legislative intent to narrow rather than expand the common law definition of treatment. There is certainly no indication that the common law or earlier legislation was being altered to include procedures not offered by a physician in the definition of "treatment." One would expect clear language, as well as debate in the legislature, if the legislature were intending to create de facto entitlements to treatment through the *HCCA*. The reasonable conclusion is that the *HCCA* does not alter the common law of consent by creating an entitlement to treatment.

We therefore return to the common law position, which is that consent creates no entitlements to treatment, subject to the *Golubchuk* treatment package reasoning, to which I shall return. There may be legal entitlements to certain treatment, including life-sustaining treatment, but these must de-

⁵¹ See Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, 36th Parl 1st Sess, No 28, (22 Nov 1995) at 1710, 1730.

⁵² The *HCCA*, *supra* note 7. See definition of "treatment" at s 2(1).

⁵³ Ontario, Legislative Assembly, *Official Reports of Debates (Hansard)*, 36th Parl 1st Sess, No 30, (27 Nov 1995) at 1700 (Rosario Marchese).

rive from other laws, such as the *Charter*, the broader law of negligence, and the law of professional responsibility.

3. *Incremental Change to the Law of Consent?*

One further possibility is that the law of informed consent, although not originally capable of grounding entitlements to treatment, should now be understood as doing just that. After all, the law has been evolving: what began as a defence to battery is now much broader. The law of informed consent applies in an expanding range of contexts in order to "protect a patient's right to control his or her medical treatment."⁵⁴ Whether or not a treatment is offered to patients certainly implicates their ability to control their medical treatment and implicates the underlying principles of autonomy and bodily integrity. It may therefore be appropriate to extend the law of consent.

This is essentially what Jocelyn Downie suggests. She reasons that requiring informed consent to medical treatment protects self-determination, and that self-determination is implicated in a fundamental way when patients are precluded from making decisions about life-sustaining treatment. Thus, the law of consent also protects patients' ability to make decisions about whether treatment will be given, even if a doctor does not want to provide it.⁵⁵

In Downie's opinion, the law of informed consent does not grant an absolute entitlement to life-sustaining treatment. Rather, it grants the presumption of an entitlement, which may be rebutted by relevant countervailing considerations.⁵⁶ To Downie, the most compelling such consideration relates to scarce resources.⁵⁷ She may also consider the nature of the medical treatment to be a relevant consideration in whether the law of informed consent creates entitlements. I infer this from the fact that she only argues that life-sustaining treatment should require consent in the demand context; she does not state that the law of informed consent creates a presumption of entitlement to antibiotics or a hip replacement. There may be good reasons for this, in that decisions about life-support implicate self-determination and dignity in ways that other treatment decisions may not, or it may be that she believes

⁵⁴ *Malette*, *supra* note 23 at para 18.

⁵⁵ Downie, *supra* note 10 at 146.

⁵⁶ *Ibid* at 146.

⁵⁷ *Ibid* at 147.

the law of informed consent grounds entitlements to all medical treatment, subject to resource limitations.

As for physicians' interests in not treating against their clinical judgment, Downie is less convinced that this could justify withholding life-sustaining treatment. The situation could usually be avoided, she suggests, by arranging for another physician to take over a patient's care. Where they cannot, a physician should be required to treat.⁵⁸

The above reasoning has some appeal, and would continue the trend of expanding the law of informed consent in order to protect individual autonomy and bodily integrity. My concern, however, is that such an expansion could undermine fundamental characteristics of the law of informed consent—specifically that where consent is required, a competent refusal of consent must always be respected,⁵⁹ and that the need for consent does not depend on the kind of treatment in question. Downie's proposal would mean that consent to withdrawing life support must only be respected if no countervailing considerations (lack of resources, for example) override the patient's wishes. In other words, if wanting ongoing life support is construed as refusing consent to have life support withdrawn, then that refusal of consent must sometimes yield to other interests such as the cost or availability of life support.

Another way to conceive of the same concern is that expanding the law of consent in this way would require creating one or more new exceptions to the requirement of consent to treatment. Assuming that considerations of cost and perhaps the standard of care could justify withdrawing life support even where a patient's SDM refuses consent, we would have to add such circumstances to the list of exceptions to the requirement for informed consent. Thus, in addition to public health threats, the fact that treatment is unreasonably expensive might justify not respecting a refusal to consent to treatment.

The second fundamental characteristic of the law of informed consent, that the need for consent does not depend on the type of treatment,⁶⁰ would be called into question if consent to withholding or withdrawing treatment

⁵⁸ Ibid.

⁵⁹ There is currently only one exception to this proposition, relating to public health threats. See the *Health Protection and Promotion Act*, *supra* note 25.

⁶⁰ The fact that this characteristic is fundamental does not mean it is absolute. For example, as discussed above, the *HCCA* excludes certain extremely low-risk treatment from the requirement of informed consent.

were only required for withholding or withdrawing life support, as opposed to other treatments. This is exactly what *Rasouli* dictates.

One way around these potential problems is simply to accept that the law of informed consent applies differently when a physician is offering to provide treatment (which I will call the refusal context)⁶¹ than where a physician is not offering to provide treatment (the demand context). In the refusal context, the law of consent would be inflexible, whereas in the demand context, the law of consent would create only a presumption of patient choice. In the refusal context, consent would be required for all types of treatment. In the demand context, it would only be required in relation to withholding or withdrawing life-sustaining treatment.

The danger in this approach is that by referring to both as the law of informed consent, the current understanding of the law as inflexible, broadly applicable, and exclusively patient-centered could give way to a more flexible, less certain approach to informed consent generally. After all, there may be allocation issues associated with a refusal to accept treatment,⁶² and there may be good reasons to extend a *Rasouli* approach to withdrawing treatment other than life-sustaining treatment. Thus, the expansion of the law of informed consent to the demand context could affect its interpretation in the refusal context. Even if patients' right to refuse treatment almost always prevailed over competing interests, the law would have lost some of its certainty and predictability.

Instead of expanding the law of informed consent to include the demand context, I therefore suggest that the law of informed consent be interpreted so as not to apply in the demand context. In deciding whether a patient is legally entitled to life-sustaining treatment, other laws should dictate the outcome.

III. The *Rasouli* Decisions

This was the state of the law of consent to medical treatment when Hassan Rasouli's wife sought an injunction to prevent his doctors from withdrawing life support. Recall that Mr. Rasouli's doctors initially diagnosed him as being in a persistent vegetative state due to complications from an op-

⁶¹ The refusal context does not mean that consent is denied, only that the patient has the option of accepting or rejecting offered treatment, as opposed to being able to demand or not demand it.

⁶² For example, if patients refuse surgery, it may ultimately cost more to treat their condition.

eration to remove a brain tumour. His physician wife disagreed that her husband was permanently unconscious and subsequent events have largely vindicated Dr. Salasel in this respect.⁶³ The doctors wanted to withdraw mechanical ventilation, but Mr. Rasouli's wife and SDM under the *HCCA*, wanted treatment to continue. The primary issue for the courts was who has the final say in whether life-sustaining treatment is withdrawn: treating physicians or patients (or their SDMs). Both the application judge and the Ontario Court of Appeal addressed the issue in terms of whether withdrawing treatment is "treatment" for which consent is required according to the *HCCA*. Both courts concluded that life-sustaining treatment is "treatment" and therefore cannot be withdrawn, at least in certain circumstances, without the patient's or SDM's consent.

The application judge, Justice Himel, arrived at this conclusion on the basis that the *HCCA* requires consent for "treatment", and by interpreting the word "treatment" in the *HCCA* to include withdrawing treatment. "Treatment" is a defined term and includes a "plan of treatment." Since a "plan of treatment" may provide for withdrawing treatment, Justice Himel held that withdrawing treatment is "treatment" for which consent is required. Justice Himel also noted that "treatment," as defined in the *HCCA*, relates to things done for a "therapeutic" or "preventive" purpose.⁶⁴ Because withholding or withdrawing treatment could be therapeutic or preventive (based on definitions of those terms in medical dictionaries), she held that withdrawing or withholding treatment could count as "treatment" under the *HCCA*.

⁶³ Nothing in my analysis turns on whether Mr. Rasouli is in a PVS or a minimally conscious state. However, the fact that doctors made a mistake here (if not in the original PVS diagnosis then in their conclusion that Mr. Rasouli would never regain any degree of consciousness) illustrates that decisions about what treatment is appropriate, reasonable, beneficial, or indicated may be extremely difficult and controversial. Knowledge of possible and likely outcomes is imperfect, and in any event must often be considered in light of non-medical factors such as the patient's wishes and values. Recent research demonstrates that a significant percentage of people diagnosed as being in a persistent vegetative state are, in fact, conscious but unable to communicate in any way. See Damian Cruise et al, "Bedside Detection of Awareness in the Vegetative State: A Cohort Study" (2011) 378 *Lancet* 2088. I do not pretend to resolve the issue of what amounts to reasonable, appropriate, or futile treatment in this article. Rather, I simply proceed on the assumption that circumstances exist in which providing requested treatment would be unreasonable because the treatment would be harmful, ineffective, or inefficient.

⁶⁴ *Rasouli CA*, *supra* note 6 at para 29.

The Court of Appeal took a different approach, but arrived at the same conclusion, that a patient's or SDM's consent is required to withdraw life-sustaining treatment, albeit in narrower circumstances. It reasoned that palliative care is treatment for which no reasonable decision maker would refuse to grant consent once life-sustaining treatment is withdrawn. Because consent to palliative care is the necessary result of withdrawing life-sustaining treatment, it must also be required for withdrawing life support. The court referred to the two as a "treatment package," such that consent for one cannot be separated from consent for the other.⁶⁵ The treatment package reasoning only applies in circumstances where death will follow imminently and inevitably from withdrawing treatment.⁶⁶

The Ontario Court of Appeal's treatment package reasoning mirrors that in *Golubchuk*, where the Manitoba Court of Queen's Bench stated that removing life support without consent amounted to imposing non-consensual treatment on the patient: "it involves the providing of narcotics over the plaintiff's objection in the sense that, if the ventilator is not disconnected, it will not be necessary to give [narcotics]."⁶⁷ In other words, although the patient would presumably consent to having narcotics administered under the circumstances, the court considers giving narcotics to be non-consensual treatment if the need for drugs resulted from the non-consensual withdrawal of life support.

The court was willing to assume that the *HCCA* does not require physicians to obtain consent for medically ineffective or inappropriate treatment generally,⁶⁸ but held that the consent of Mr. Rasouli's SDM was nevertheless required in order for treatment to be withdrawn. It acknowledged that where a patient had requested, before becoming incompetent, that all possible life-support interventions be used, doctors would be unable to challenge that decision,⁶⁹ presumably no matter how harmful or pointless ongoing treatment would be.

⁶⁵ *Ibid* at para 52.

⁶⁶ *Ibid* at para 53.

⁶⁷ *Golubchuk*, *supra* note 43 at para 23.

⁶⁸ "For present purposes, we are prepared to accept that the *HCCA* does not require doctors to obtain consent from a patient or [SDM] to withhold or withdraw 'treatment' that they view as medically ineffective or inappropriate" (*Rasouli CA*, *supra* note 6 at para 46).

⁶⁹ *Ibid* at para 59.

The Ontario Court of Appeal indicated that its ruling is limited to contexts in which death would follow inevitably and almost immediately from a treatment decision such that palliative care is, for all intents and purposes, immediately required. In other words, it apparently relates only to withdrawing life-sustaining treatment where death is the imminent and necessary result of such withdrawal. The narrowness of the treatment package reasoning avoids the slippery slope argument raised by the appellant doctors that requiring consent would create an unaffordable entitlement for patients to demand many types of treatment, but it also leaves unanswered who may make decisions whether to withhold or withdraw treatment in other circumstances.

There are two significant problems with the Ontario Court of Appeal's analysis. First, its basis in the law of consent to medical treatment is tenuous. Second, the absolute and one-sided nature of the law of informed consent has significant implications for the demand context that do not arise in the refusal context. These implications are not explored or justified in *Rasouli*. This section examines the Ontario Court of Appeal's reasoning, and the problems that arise from treating the issue as one of consent.

The Ontario Court of Appeal created a new kind of consent, which I call "*Rasouli* Consent." Whereas the law of consent has long protected patients against unwanted touching and requires health professionals to provide information about the material risks of and alternatives to treatment, *Rasouli* Consent creates an entitlement to a particular kind of treatment regardless of physicians' willingness to provide it. As a result, *Rasouli* Consent amounts to a significant and problematic departure from the law of consent to medical treatment.

Even if there were not such a long and clear history of the law of consent to medical treatment providing for informed permission or refusal, rather than creating entitlements to treatment, the Ontario Court of Appeal's interpretation of the *HCCA* would still be unconvincing. The court reasoned that since no one would reasonably refuse consent to palliative care after life-sustaining treatment is withdrawn, that decision, for which consent is required, cannot be separated from the decision to withdraw treatment. This is the treatment package theory. The argument appears to be that granting the ability to insist on continued life support is the only way to avoid non-consensual touching in the form of palliative care, since once life-sustaining treatment has been withdrawn, no reasonable person would refuse to consent to palliative care.

There are three problems with the treatment package reasoning. First, it is not true that consent to palliative care is inevitable when life-sustaining treatment is withdrawn. Second, even if it were true, it is not clear why this would create an entitlement to life-sustaining treatment. Third, it is not clear that death does, in fact, follow immediately and inevitably from withdrawing life support in a way that would meaningfully distinguish life-sustaining treatment from other treatment.

Although in most circumstances patients or their SDMs will consent to palliative care when life support is withdrawn, patients are entitled to reject palliative care just as they are entitled to reject any other type of treatment.⁷⁰ So long as patients are competent (or were competent when they decided), their decision need not be reasonable.⁷¹ Where substitute consent is required, SDMs must make decisions based first on what a patient wanted: only if that is not known does the SDM decide based on the patient's best interests. Since the best interests test incorporates patients' values and wishes, even on a best interests standard it is not obvious that SDMs must always affirmatively consent to palliative care when life support is withdrawn, although it is admittedly inconceivable that a doctor or SDM would suggest that receiving palliative pain medication is not in a patient's best interests.

Consent to palliative care could conceivably be refused—perhaps because it involves drugs patients do not want to take (e.g. former addicts to pain killers who want to die “clean”), or because patients want to be left alone. It is also possible that patients might want life-sustaining treatment withdrawn even if no palliative care resources were available. The connection between affirmative consent to palliative care and withdrawing life support is statistical, in that the vast majority of people would presumably want the comfort that palliative care brings and there are few reasons to reject drugs that minimize pain and distress at the end of life. Withdrawing mechanical ventilation without palliative drugs could lead to “air hunger and distress,” which would not only be traumatic for the patient, but extremely difficult for family and staff present.⁷² However, the connection between withdrawing life sup-

⁷⁰ People may generally refuse consent to any treatment regardless of whether doctors agree with the decision and even if refusal to consent would lead to death (*Malette*, *supra* note 23 at para 19).

⁷¹ *Ibid*; *Nancy B v Hotel Dieu de Quebec* (1992), 86 DLR (4th) 385 [*Nancy B*].

⁷² Smedira et al, *supra* note 12. In personal communication, a critical care physician described the prospect of a patient being withdrawn from mechanical ventilation without accompanying palliative drugs as “horrible.”

port and palliative care is not inevitable. There is no barrier to refusing palliative care following withdrawal of life support. In fact, any attempt to create such a barrier would presumably be considered a violation of patients' almost absolute right to refuse unwanted treatment.⁷³

Further, some patients on mechanical ventilators will already be receiving palliative care. For these patients, consent to palliative care has already been given and so consent to palliative care cannot be integrally linked to consent to withdrawing life support.⁷⁴

The fact that affirmative consent to palliative care is not inevitable upon withdrawing life support means that the treatment package reasoning fails. A high correlation between withdrawing life support and consenting to palliative care is insufficient to create a treatment package because the whole point of the treatment package reasoning is that the decisions cannot be separated. Consent must be obtained for the "entire treatment package."⁷⁵ This suggests the impossibility of consenting to withdrawing treatment but refusing palliative care, whereas in reality these are separate decisions that may be based on different motivations. In addition, consent to palliative care may precede a decision to withdraw life support.

Two treatments may be related in the sense that rejecting one leads to the need for another treatment that patients would most likely consent to or that doctors must provide to meet the standard of care. This does not mean that if consent is required for the latter it must be required for the former. Consider what would follow if this were so. Imagine that Robert has kidney disease and requires a transplant. A doctor denies Robert a transplant because the only available kidney must be given to a different patient in accordance with organ allocation protocols. Refusing to provide the transplant would inevitably lead to the need for Robert to continue dialysis in order to prevent death. Consent is required for dialysis. That hardly means that Robert can demand (i.e. must consent to the withholding of) a kidney transplant on the basis that refusing a kidney transplant inevitably leads to more dialysis, for which consent is required. This would mean that a doctor who refuses to provide a re-

⁷³ *Malette*, *supra* note 23; *Nancy B*, *supra* note 71.

⁷⁴ *Cuthbertson v Rasouli* FOA, *supra* note 3 at para 79.

⁷⁵ *Rasouli CA*, *supra* note 6 at para 58.

quested kidney transplant violates the duty to obtain informed consent.⁷⁶ Similarly, if a doctor performs emergency surgery on an unconscious patient, there will inevitably be invasive follow-up for which consent will be required once the emergency has passed. This does not mean that consent is necessarily required for the emergency surgery.⁷⁷

The Ontario Court of Appeal distinguished this kind of example on the basis that death does not follow immediately from the refusal to provide a kidney transplant. The court makes clear that two preconditions are required before consent is required for withdrawing treatment: not only must there be a need for palliative care as a result of withdrawing treatment, but death must also follow imminently. Thus, with regard to a decision to end medically futile chemotherapy, the court states that "[e]nding chemotherapy does not spell the patient's imminent death – and it does not trigger a requirement for a particular form of palliative care."⁷⁸

Given the law of consent to medical treatment discussed above, however, either at common law or under the *HCCA*, it is unclear why the imminence of death or the need for "a particular form of palliative care" should determine whether consent is required. The need for consent has only ever been triggered where a doctor is willing to provide treatment. Then the doctor must provide information and obtain consent before treating to avoid potential legal problems. Whether informed consent is required has never been a function of whether withholding treatment would lead to death or to the need for other procedures for which consent is required. The reasoning seems to

⁷⁶ I acknowledge that the allocation issues are different in this hypothetical than those regarding mechanical ventilation, for example. This difference, however, should not affect the critique of the treatment package reasoning.

⁷⁷ Emergencies are a clear exception to the consent requirement both at common law and according to the *HCCA*, *supra* note 7. Section 25(2) of the *HCCA* states that despite the general rule that a health practitioner must not treat without consent, "a treatment may be administered without consent to a person who is incapable with respect to the treatment, if, in the opinion of the health practitioner proposing the treatment, (a) there is an emergency; and (b) the delay required to obtain a consent or refusal on the person's behalf will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm." It must not be possible for the doctor to obtain consent, and—to satisfy *Malette*, *supra* note 23—it must also be true that there is no reason to believe the patient would have refused consent.

⁷⁸ *Rasouli CA*, *supra* note 6 at para 53.

be an arbitrary mechanism to limit, for policy reasons, the ability to use the law of consent to demand treatment.

It is also worth noting that withdrawing life-sustaining treatment does not necessarily lead immediately and inevitably to death. A study published in the *New England Journal of Medicine* revealed that of 166 patients who had mechanical ventilation withdrawn in anticipation of the patient's death (as opposed to for purposes of weaning a patient off ventilation), only 87.3% died in the intensive care unit ("ICU"). More than 12% survived at least long enough to be transferred out of the ICU. In fact, 3.6% (6 patients) were ultimately discharged from hospital.⁷⁹ This study suggests that withdrawing mechanical ventilation, which is the most common form of life-sustaining treatment in the ICU,⁸⁰ need not inevitably lead to death, and even if it does, death is not necessarily imminent. The Tony Bland case in the UK involved the permissibility of discontinuing life support in the form of artificial feeding.⁸¹ Death would then follow within one to two weeks. This illustrates that, depending on the particular life-sustaining treatment to be withdrawn and the individual patient's condition, removing life support may result in almost immediate death, result in death after two weeks, or not result in death at all.

This is problematic for the Ontario Court of Appeal's reasoning in *Rasouli* because it makes it unclear which treatments may only be withheld or withdrawn with the patient's or SDM's consent. If withdrawing life support does not necessarily lead immediately or inevitably to death, it is less distinguishable from withdrawing other treatments, such as chemotherapy. If the time frame is days or even weeks instead of minutes, it becomes more plausible to say that withholding kidney transplants or withdrawing chemotherapy leads to death in the same way as withdrawing artificial nutrition or mechanical ventilation. As a result, the Ontario Court of Appeal's criteria of imminent and inevitable death create considerable uncertainty. Arguably, on the court's reasoning, consent would be required to withdraw Mr. Rasouli's mechanical ventilation, but not to withdraw his artificial nutrition and hydration.

It is also unclear whether consent would be required where a physician wishes to place a DNR on a patient's chart, as in *Lavallee* and *Sawatzky*.

⁷⁹ Cook et al, "Withdrawal of Mechanical Ventilation in Anticipation of Death in the Intensive Care Unit" (2003) 349:12 *New Eng J Med* 1123 at 1126.

⁸⁰ *Ibid* at 1124.

⁸¹ *Airedale NHS Trust v Bland*, [1993] 1 All ER 821, [1993] AC 789 HL (Eng).

Although death would presumably follow imminently from a refusal to provide CPR, it is not clear whether the relevant treatment decision is the imposition of a DNR order on the patient's chart, which could happen weeks before any need for CPR (in which case there is no imminence), or whether it is the refusal to provide CPR at the time it is needed.⁸² It is also unclear whether the palliative care requirement of the Court of Appeal's test in *Rasouli* would be met.

Even if the uncertainty could be resolved, the Court of Appeal's reasoning is arbitrary, in the sense of being unrelated to the principles underlying the law of consent to medical treatment. There is no obvious reason to make the determination of whether consent is required depend on how quickly death results, whether or not death is the inevitable result of withdrawing treatment, or whether narcotics will be administered. For these reasons, the court's treatment package reasoning is seriously flawed. It relies on incorrect assumptions, creates uncertainty, and in any event does not support the court's conclusions.

IV. Implications of *Rasouli* Consent

Regardless of whether the Court of Appeal's reasoning in *Rasouli* is persuasive, creating an entitlement to life support through the law of informed consent has significant implications that require justification and policy debate. Most of the implications arise from the one-sided and essentially absolute nature of the law of consent, which is more easily justified in the refusal context than the demand context. They include requiring doctors to treat even when treatment would not be beneficial, tying doctors' hands regarding resource allocation, and leaving decisions to the Consent and Capacity Board, a body created by the *HCCA* whose primary role is to resolve disputes about capacity and to decide whether substitute consent decisions are made in accordance with the *HCCA*.⁸³ An additional implication, discussed first, relates to confusion regarding remedies for a breach of *Rasouli* Consent.

⁸² At least some have suggested that the act of placing a DNR order on a patient's chart, regardless of whether CPR is subsequently required, amounts to treatment. Gilmour argues that imposing a DNR is treatment, and notes that the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research rejected the claim that DNR orders are not treatment (*supra* note 16 at 411).

⁸³ See *HCCA*, *supra* note 7 ss 32, 37, 70-81.

1. *Uncertain Remedies*

Imagine that in post-*Rasouli* Ontario, a physician withdraws life-sustaining treatment from a patient without consent because she considers continued treatment to be contrary to the standard of care. The patient dies. What remedy might be granted given the breach of the requirement to obtain *Rasouli* Consent?

Recall that informed consent is a defence to the tort of battery and a component of non-negligent medical treatment. Since the *HCCA* does not create new causes of action or remedies, it modifies, but does not replace, common law causes of action related to a failure to obtain informed consent, namely negligence and battery.

At common law, treatment without any consent (as opposed to treatment with insufficiently informed consent) may be battery, and the Ontario Court of Appeal held that withdrawing life support is “treatment” according to the *HCCA*. Thus, at first blush, failing to obtain *Rasouli* Consent (that is, failing to obtain permission *not* to treat) could constitute battery. Yet battery has for centuries required physical contact.⁸⁴ It is therefore necessary to know whether life support can be removed without touching the patient. If we ignore the sleight of hand that necessarily makes withdrawing life-support touching by inextricably linking it with providing palliative care drugs, it is at least possible sometimes to remove life support without touching the pa-

⁸⁴ “The common law over the centuries has always protected individuals from unwanted intentional contacts with their person... . The common law action of battery developed out of the law’s recognition of an individual’s interest in personal autonomy and bodily integrity—that is, the right of a person to participate in and make decisions about his own body” (*People v Medina* 705 P 2d 961 at 968 (Colo Sup Ct 1985)).

tient.⁸⁵ In those circumstances, you would have a failure to obtain *Rasouli* Consent but no battery.⁸⁶

More realistically, failing to obtain *Rasouli* Consent could constitute negligence. However, negligence requires a breach of the standard of care. The standard of care is "that degree of care and skill which could reasonably be expected of a normal, prudent practitioner."⁸⁷ Therefore, negligence requires an unreasonable act or omission. We must therefore examine whether a failure to obtain *Rasouli* Consent would breach the standard of care.

The standard of care does not require doctors always to provide treatment requested by patients. For example, doctors presumably do not breach the standard of care by refusing to prescribe requested antibiotics to patients with viral conditions. They may, in fact, breach the standard of care by doing precisely what a patient asks them to do:⁸⁸ "[w]hat is demanded may not be indicated, effective or beneficial."⁸⁹

Of course, the reason a doctor withholds treatment will be highly relevant to whether the standard of care is breached. One legitimate reason for

⁸⁵ Withdrawing life-sustaining treatment can be done in a number of ways, some of which may involve touching the patient. Mechanical ventilation is the most common means of life support in the ICU (Cook et al, *supra* note 79 at 1123). It may require touching the patient (*Golubchuk, supra* note 43 at para 23), although it would seem equally possible to turn off the machines without touching the patient. Ceasing to provide artificial nutrition or hydration, or ceasing to provide life-sustaining drugs, could logically be accomplished without touching the patient.

⁸⁶ This is in no way to suggest that the ability to demand continued life support should depend on whether life support could be withdrawn without touching the patient. See Downie, *supra* note 10 at 145.

⁸⁷ *Crits v Sylvester* [1956] OR 132 at 143, 1 DLR (2d) 502 (CA), affirmed [1956] SCR 991, 5 DLR (2d) 601.

⁸⁸ "In general medical practice, it is well recognized that physicians have an ethical and professional obligation not to provide medically inappropriate or unethical treatment no matter how insistent the patient may be" (Manitoba Law Reform Commission, *Withholding or Withdrawing Life-Sustaining Medical Treatment, Report #109* (Winnipeg: Manitoba Law Reform Commission, 2003) at 4 [Manitoba LRC].

⁸⁹ Edmund Pellegrino, "Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship" (1994) 10 J Contemp Health L & Pol'y 47 at 59.

withholding treatment is that it would not be effective. “General agreement exists that if the desired intervention were truly futile, there would be no duty on the part of the health care team to provide the intervention.”⁹⁰ Arguing against a patient’s right always to demand treatment, Pellegrino notes that physicians have a “moral obligation...to avoid medically useless or futile treatments.”⁹¹ Controversy regarding this matter relates less to whether physicians may properly refuse to provide futile treatment, and more to how one decides which treatments are futile.⁹²

That the standard of care does not always require even life-sustaining treatment to be provided, if it is not beneficial, is evident from the binding guidelines of Manitoba’s College of Physicians and Surgeons and the Ontario College of Physicians and Surgeon’s policy statement on the issue. These guidelines allow physicians to withhold or withdraw life-sustaining treatment against the wishes of a patient or SDM under certain circumstances. In Manitoba, clinical assessment must be based on a minimum goal of life-sustaining treatment, which means the goal should be

maintenance of or recovery to a level of cerebral function that enables the patient to:

achieve awareness of self; and

achieve awareness of environment; and

experience his/her own existence.⁹³

Whether or not this minimum goal is achievable affects the physician’s clinical assessment. If it is potentially achievable, the patient’s values are to

⁹⁰ Amir Halevy, “Medical Futility, Patient Autonomy, and Professional Integrity: Finding the Appropriate Balance” (2008) 18:2 Health Matrix 261 at 271. This source discusses US law, but Canadian law similarly imposes no duty of care to provide futile treatment (Manitoba LRC, *supra* note 88 at 4). See also Picard, *supra* note 50 at 346 (“there is no legal duty to perform treatment the doctor reasonably believes to be medically futile, that is, treatment which offers no prospect of therapeutic benefit for the patient”).

⁹¹ Pellegrino, *supra* note 89 at 59.

⁹² See e.g. Robert Truog, Allan Brett & Joel Frader, “The Problem With Futility” (1992) 326:23 New Eng J Med 1560; Charles Weijer & Carl Elliott, “Pulling the Plug on Futility: Futility is not the Ethical Trump Card Some Would Like it to Be” (1995) 310:6981 Brit Med J 683; Steven Leuthner, “Futility: Interpretation and Usefulness in Clinical Practice” (2008) 18:2 Health Matrix 245.

⁹³ Manitoba Guidelines, *supra* note 12 at 15-S6.

be considered in light of any benefits and negative effects on the patient that will result from providing life-sustaining treatment. If it is not realistically achievable, the physician may conclude that life-sustaining treatment should be withheld or withdrawn and, so long as certain procedures are followed, may withhold or withdraw life-sustaining treatment without the patient's or SDM's consent.⁹⁴

The Ontario policy statement similarly provides that no consent is needed to withhold or withdraw life-sustaining treatment from a patient who will almost certainly not benefit from it, although the question of benefit must take into account patient values.⁹⁵

The fact that these guidelines were set by the Manitoba and Ontario Colleges of Physicians and Surgeons is excellent evidence that they represent the standard of care in those provinces, since members of the medical profession determine the standard of care.⁹⁶ In addition, some critical care practitioners in Ontario have suggested more specific guidelines for critical care practice. The proposed guidelines make clear that

if these reasonable medical goals [improving the patient's well-being, and taking the patient's best interests into account] cannot be achieved as outlined, the use of potentially life-sustaining treatment *would fall outside the standard of care* and any patient or SDM wishes to initiate/continue on life support would not prevail.

...

⁹⁴ *Ibid.*

⁹⁵ College of Physicians and Surgeons of Ontario, "Decision-Making for End of Life" 2002 (updated 2006) at 4-5, online <www.cpsso.on.ca/policies/default.aspx?ID=1582>. See also Canadian Medical Association, Canadian Nurses Association, Canadian Healthcare Association and the Catholic Healthcare Association of Canada, "Joint Statement on Resuscitative Interventions" (1995) 153 CMAJ 1652A-C.

⁹⁶ *Crits v Sylvester*, *supra* note 87 at 143. It is possible for a customary medical practice to be negligent if it is unreasonable, since the standard of care is reasonableness. However, a profession's customary practices will only breach the standard of care if their unreasonableness is "fraught with obvious risks". See *Ter Neuzen v Korn* [1995] 3 SCR 674 at para 41, 127 DLR (4th) 577.

Participants recommended that critical care services should NOT be used (since would not be of benefit) if any of the following apply:

1. there is no reversible cause for the need for the ICU admission;
2. the patient would not be expected to survive an ICU admission:
 - a. due to very poor baseline quality of life ...;
 - c. if the patient is in very end-stage of life due to illness;
3. the patient's quality of life is expected to be extremely poor should the patient survive the ICU...⁹⁷

Significantly, the guidelines state that if basic medical goals cannot be achieved, not only does it fall within the standard of care to withhold treatment, but it would actually breach the standard of care to provide it.

These guidelines have not been adopted by the Ontario College of Physicians and Surgeons, and it is not clear to what extent they represent the standard of care in Ontario. However, an Ontario survey indicated that 92% of responding critical care practitioners considered the guidelines reasonable.⁹⁸ Given the general rule that doctors have no duty to their patients to provide non-beneficial treatment, the guidelines of the Manitoba and Ontario Colleges of Physicians and Surgeons' guidelines, and attempts in Ontario to promote specific critical care guidelines, the standard of care in Ontario at the very least sometimes permits physicians to withhold life-sustaining treatment, regardless of the patient's or SDM's wishes, and may sometimes actually *prohibit* doctors from providing such treatment. Withholding treatment under certain circumstances would therefore not be negligent, regardless of the patient's or SDM's wishes.

One way to avoid the conclusion that withholding life-sustaining treatment may not breach the standard of care in negligence is to conclude that failing to respect *Rasouli* Consent is *necessarily* unreasonable, and a breach

⁹⁷ Hawryluck, Bouali & Meth, *supra* note 12 at 257 [emphasis added].

⁹⁸ Four hundred and three Ontario "critical care leaders," including critical care leaders, ICU directors, and nurse managers, responded to the survey (*ibid* at 258). Since not all respondents were physicians, they would not all be qualified to opine on the standard of care. In addition, respondents were commenting on the reasonableness of the set of guidelines as a whole.

of the standard of care, given the Ontario Court of Appeal's decision in *Rasouli*. In other words, the court will have dictated a new standard of care. If this is so, it may not be a legitimate exercise of the court's power. On the one hand, lawmakers, including common law courts, are entitled to limit physicians' ability to regulate their own practice. For example, the criminal prohibition on assisted suicide conflicts with what many physicians would consider the humane practice of medicine. On the other hand, given the judiciary's role and expertise, it is often reluctant to dictate appropriate medical practice,⁹⁹ believing that: "[t]he less the courts try to tell doctors how to practice medicine the better."¹⁰⁰ In *Rotaru v Vancouver General Hospital Intensive Care Unit*, Justice Burnyeat agreed with the position that it would be "an abuse of [the court's] power to require a medical practitioner to act contrary to the fundamental duty which that practitioner owed to his or her patient."¹⁰¹ That duty, as seen above, sometimes requires a doctor not to treat. It is also worth noting that if the Ontario Court of Appeal has changed the standard of care in negligence, it has done so implicitly without providing reasons.

Thus, where withdrawing life-sustaining treatment is reasonable (because treatment cannot benefit the patient, for example),¹⁰² physicians do not breach the standard of care by doing so, even without *Rasouli* Consent, unless the Ontario Court of Appeal dictated a new standard of care in *Rasouli*. If there is no breach of the standard of care, there is no liability in negligence. If the court changed the standard of care, we should be dissatisfied by its unexplained intrusion into what is normally the domain of the medical profession.

⁹⁹ Sneiderman, Irvine & Osborne, *supra* note 22 at 94.

¹⁰⁰ *McLean v Weir*, [1977] 5 WWR 609, 3 CCLT 87 at para 40 (BCSC), *aff'd* (1980), 18 BCLR 325 (BCCA), 4 WWR 330.

¹⁰¹ *Rotaru v Vancouver General Hospital Intensive Care Unit*, 2008 BCSC 318 at para 16, 165 AC/WS (3d) 746.

¹⁰² One potential complication relates to the difference between what is reasonable in the sense of the standard of care and what the profession considers reasonable. The profession may decide what is reasonable based primarily on medical facts, whereas the reasonableness analysis for the purposes of the standard of care may be broader, giving greater weight to patient's wishes. The law establishes that custom need not be reasonable in the latter sense, but for such custom to breach the standard of care, it must be "within the ordinary common sense of juries" that the custom is unreasonable (*Ter Neuzen v Korn*, [1995] 3 SCR 674 at para 44, 127 DLR (4th) 577). Whether doctors must provide futile but desired life-sustaining treatment is not a matter that could be resolved on the basis of ordinary common sense.

Section 5 discusses the possibility of remedies for withdrawing life support without consent under laws other than battery and negligence. There could be professional sanctions or a criminal charge, for example. However, most other legal mechanisms are, like negligence, based on the standards of the profession. Thus, for the reasons that I claim there would be no breach of the standard of care, there may be no basis for professional sanctions or for criminal charges. Finally, since there is no tort of breach of statute in Canada, breach of the *HCCA* itself would not be sufficient to create a private cause of action. Rather, regular negligence principles would apply.¹⁰³ Since the *HCCA* imposes no public law sanctions, it is not clear that any remedy would lie for a reasonable withdrawal of life-support, notwithstanding a failure to respect *Rasouli* Consent.

As a practical matter, the issue of remedies for a failure to respect *Rasouli* Consent will rarely arise. Physicians who wish to avoid legal problems will abide by the Court of Appeal's clear pronouncements and take any disputes about the validity of a refusal to consent to the Consent and Capacity Board. They are presumably unlikely to expose themselves to tort liability and other legal sanctions by withdrawing treatment from a patient if the Board determines that treatment should continue.

Nevertheless, the existence of *Rasouli* Consent is premised on the court's interpretation of the statutory duty on health practitioners to obtain informed consent. A breach of that duty must have consequences. That reasonably withdrawing life-sustaining treatment without obtaining *Rasouli* Consent may amount neither to battery nor to a breach of the standard of care in negligence¹⁰⁴ suggests that *Rasouli* Consent is a significant departure from the law of consent to medical treatment under the *HCCA*.

2. Requiring Physicians to Provide Non-Beneficial Treatment

Despite the potential absence of legal sanctions, the Ontario Court of Appeal has clearly held that the *HCCA* imposes a duty on doctors to obtain *Rasouli* Consent before withholding life-sustaining treatment, regardless of whether that treatment is medically beneficial. It stated in *obiter* that physi-

¹⁰³ *R v Saskatchewan Wheat Pool*, [1983] 1 SCR 205 (*sub nom Canada v Saskatchewan Wheat Pool*), 143 DLR (3d) 9.

¹⁰⁴ Contrast this with treating despite consent having been refused. That will *always* amount to a breach of the standard of care in negligence unless an emergency or public health exception applies.

cians should not have to provide treatment they consider non-beneficial, "[f]or present purposes, we are prepared to accept that the [HCCA] does not require doctors to obtain consent from a patient or [SDM] to withhold or withdraw 'treatment' that they view as medically ineffective or inappropriate."¹⁰⁵ Yet this is the inevitable result of an entitlement to life-sustaining treatment grounded in the law of consent to medical treatment, since the requirement of informed consent arises regardless of the physician's clinical judgment or even the reasonableness of the treatment. The court acknowledges as much when it says that if an SDM's decision to continue treatment respects a wish expressed by the patient, "the [Consent and Capacity] Board's hands are tied and this effectively ends the matter."¹⁰⁶

Ultimately, everything turns on the test set out in section 21 of the *HCCA*. If the patient's wishes are to continue treatment, the court's consent-based reasoning dictates that a doctor may not withhold or withdraw treatment against the patient's wishes regardless of how hopeless or even harmful continued treatment would be. If the incompetent patient's wishes are not known, the best interests test prevails per subsection 21(2) of the *HCCA*. The best interest test balances medical considerations against the patient's wishes and values. Specifically, one must balance a) the patient's values and beliefs; b) any wishes the patient expressed while incompetent; and c) a range of medical factors, including the prospect for improving the patient's condition, preventing deterioration, the risk of harm, and the existence of alternative treatments.¹⁰⁷

It is clear that a doctor cannot impose unwanted treatment on a capable patient, and this is because the patient has a nearly absolute right to be free from unwanted medical treatment. That right flows from the patient's interest in self-determination. Yet just because self-determination is also implicated where the patient does want medical treatment, it does not follow that a doctor must provide all treatment that a patient requests, even if resource allocation is not at issue. If this were true, what patients want would always deter-

¹⁰⁵ *Rasouli CA*, *supra* note 6 at para 46.

¹⁰⁶ *Ibid* at para 59.

¹⁰⁷ *HCCA*, *supra* note 7 s 21(2).

mine what they are entitled to receive from a doctor. Clearly this is not the case.¹⁰⁸

Whether and to what extent patients should be allowed to demand life-sustaining treatment of questionable medical benefit is debatable. Patients have an interest in self-determination that justifies their playing a significant role in deciding what treatment they will receive. On this basis, Jocelyn Downie argues that doctors are, or should be, required to provide life-sustaining treatment patients want, regardless of whether doctors consider it beneficial. At the very least, they must find another doctor who will take over the patient's care before they may decline to treat.¹⁰⁹

Physicians have an interest in practicing medicine according to their own clinical judgment.¹¹⁰ For many years Canadian society has considered this interest insufficient to justify imposing unwanted treatment on patients. The physician-patient relationship is a fiduciary one, and doctors must therefore place their patients' interests above their own.¹¹¹ The patient's interests prevail, and a patient is the best judge of her own interests.

However, when the issue is not simply preventing physicians from treating how they would like, but rather forcing them to treat contrary to ethical and legal duties owed to patients and the profession, the balancing of interests changes. This is in part because requiring doctors to act is generally a greater interference with their liberty than preventing them from acting.¹¹² Even then, however, doctors must place patients first when deciding whether

¹⁰⁸ See the discussion of the standard of care above. See also the discussion below of what is required by *Regulated Health Professions Act, 1991*, SO 1991, c 18 [RHPA].

¹⁰⁹ Downie, *supra* note 10 at 147.

¹¹⁰ "The physician as a human being has the same claim to respect for his or her capacity to make personal choices, to follow his or her conscience about what is good medicine and what is morally acceptable as a person... [T]he patient's moral right of autonomy must be balanced with respect for the physician's autonomy" (Pellegrino, *supra* note 89 at 51).

¹¹¹ Picard, *supra* note 50 at 4-7.

¹¹² Consider that the law is much more reluctant to proscribe omissions than acts. It is considered a greater interference with liberty to require someone to act in a particular way than to prevent them from acting in a particular way. See Gomez, *supra* note 9 at 391. That said, I acknowledge that the difference between an act and an omission is not always clear, and that scholars dispute the moral significance of requiring someone to act versus prohibiting them from acting.

to treat. Physicians are therefore sometimes morally and legally required to treat patients, perhaps even when doing so poses a risk to themselves.¹¹³ However, physicians sometimes refuse to practice at all rather than provide what they see as harmful treatment.¹¹⁴

There is, however, at least one limitation on physicians' affirmative legal duty to treat. They may refuse to provide treatment that would not be beneficial to a patient, at least under some circumstances.¹¹⁵ The reasons for this are somewhat unclear but likely relate to physicians' interest in practicing medicine according to the standards of the profession. And while the profession recognizes patients' interest in autonomy, it also recognizes principles of beneficence and non-maleficence, such that doctors should not provide treatment they consider to be harmful or non-beneficial.¹¹⁶

Sometimes the patient's interest in self-determination will conflict with the physician's interest in not providing useless or harmful medical treatment. Whether a doctor should be required to provide life-sustaining treatment requested by a patient when the doctor considers the treatment harmful or non-beneficial is debatable. This article does not set out to answer this question. Rather, it suggests that resolving the issue requires policy debate by

¹¹³ The regulations to the *Medicine Act, 1991*, SO 1991, c 30, require doctors not to withhold medically necessary treatment (*Professional Misconduct*, O Reg 856/93, s 1(1)(7) [*Professional Misconduct Regulation*]). In addition, some have argued that doctors' fiduciary obligation to patients requires them to treat AIDS patients and SARS patients despite a risk to themselves. See Edwin C Hui, "Doctors as Fiduciaries: Do Medical Professionals Have the Right Not to Treat?" (2005) 3 *Poiesis Prax* 256.

¹¹⁴ Three doctors resigned from their ICU practice rather than treat Samuel Golubchuk following a court order requiring treatment to continue. One considered such treatment "tantamount to torture" (CBC News, "2 More Winnipeg Doctors Resign in Dispute Over Elderly Man's Treatment" *CBC News Manitoba* (16 June 2008) online CBC News Manitoba <www.cbc.ca/news/canada/manitoba/story/2008/06/16/golubchuk.html>).

¹¹⁵ The pronouncement of the Court of Appeal in *Rasouli* that doctors may generally withhold non-beneficial treatment without consent suggests as much. In the US context, see Pellegrino, *supra* note 89 at 59.

¹¹⁶ See James Drane & John Coulehan, "The Concept of Futility: Patients Do Not Have a Right to Demand Medically Useless Treatment" (1993) 74:10 *Health Progress* 28. See also Gilmour, *supra* note 16 at 407-08 ("health care providers raise legitimate concerns about the morality of being required to provide what they consider ineffective and sometimes damaging therapy to a patient contrary to their own beliefs and those of the medical profession generally").

the legislatures or principled analysis by the courts. It is insufficient to base a significant change to the law (namely that doctors must provide life-sustaining treatment regardless of whether they believe it to be medically indicated) on an analysis that simply treats the law of informed consent the same way in the demand context as in the refusal context, when the contexts clearly suggest that a different balancing of interests is warranted.

Rasouli places physicians in the unenviable situation of having to decide between providing treatment they consider inappropriate or breaking the law. It may be good policy to sometimes require physicians to provide requested treatment of questionable medical value, but the Ontario Court of Appeal's analysis in *Rasouli* does not justify this outcome on policy grounds. Rather, the conclusion follows from a mechanical application of the law of informed consent to the demand context.

3. *Precluding Efficient Resource Allocation*

Although few like to admit it, health care is a limited resource that must be rationed.¹¹⁷ Canadian provinces cannot realistically provide all the medical care that their citizens would like. And with the cost of health care increasing much faster than the rate of inflation,¹¹⁸ rationing will become an increasingly necessary exercise.

Both health practitioners and governments have a role in allocation decisions. Governments decide, for example, which pharmaceuticals will be covered by provincial insurance plans and which will not.¹¹⁹ Health practitioners

¹¹⁷ In his recent report on the future of Canadian healthcare, Don Drummond states: "economic realities mean that provincial governments will soon be compelled to rein in healthcare cost increases" ("Therapy or Surgery? A Prescription for Canada's Health System" (CD Howe Institute Benefactors Lecture, delivered in Toronto, 17 November 2011) at 1, online: CD Howe Institute <www.cdhowe.org/pdf/Benefactors_Lecture_2011.pdf>). He later states: "The primary method to control costs in a large public health system is by rationing services" (*ibid* at 7). See also David Naylor, "Allocation of Health Care Resources: a Challenge for the Medical Profession" (1986) 134:4 Can Med Assoc J 333.

¹¹⁸ Don Newman, "Cut Health-care Costs by Getting Back to Basics", 22 April 2010, online: CBC News <www.cbc.ca/news/canada/story/2010/04/22/f-vp-newman.html>.

¹¹⁹ "Because no federal guidelines or laws currently cover outpatient drug reimbursement policies, provinces establish and fund their own plans" (Virginie

also make many allocation decisions: they decide who gets a bed, what tests to order, which patients get priority, etc.¹²⁰ Doctors' clinical decisions are at least sometimes legitimately influenced by cost considerations. John Irvine notes that it would be unreasonable for physicians to pursue any gain in health at any cost. "Physicians, then, *do* on a daily basis...weigh economic considerations against purely clinical or therapeutic ones when assessing therapies."¹²¹ The extent to which physicians may legitimately be influenced by resource allocation considerations is controversial,¹²² but in the absence of more detailed legislative or other guidance, I suggest that it is both necessary and desirable for physicians to play at least *some* role in allocating health care resources.

The Ontario Court of Appeal did not consider rationing arguments because such arguments were not before it: the defendant doctors in *Rasouli* did not argue that they have insufficient resources to provide all the life-sustaining treatment their patients desired. Strategically, this was probably the right approach. However, the court's decision has implications for physicians' ability to allocate health care resources.

Although *Rasouli* does not require the government or hospitals to provide sufficient resources to fund life-sustaining treatment,¹²³ it limits doctors' ability to allocate health resources among their patients. Whether to consent is a decision left entirely to patients or SDMs, and does not permit an inquiry into the decision's reasonableness,¹²⁴ or the competing interests of those other than the patient. It therefore follows from *Rasouli* that doctors cannot

Demers et al, "Comparison of Provincial Prescription Drug Plans and the Impact on Patients' Annual Drug Expenditures" (2008) 178:4 Can Med Assoc J 405 at 405).

¹²⁰ Naylor notes: "[D]octors are expected to serve both as suppliers of services and as purchasing agents on their patients' behalf for services such as hospital days, drugs, diagnostic tests and consultations with other physicians" (*supra* note 117 at 334).

¹²¹ John Irvine, "The Physician's Duty in the Age of Cost Containment" (1994) 22:3 Man LJ 345 at 346.

¹²² See Downie, *supra* note 10 at 147.

¹²³ This follows from the fact that the duty to obtain informed consent is a duty imposed on health practitioners. A breach subjects only health practitioners to legal sanctions. The law of informed consent creates no cause of action against governments or hospitals.

¹²⁴ Except as relevant to a patient's best interests in the context of substitute decision making.

withhold or withdraw ineffective life-sustaining treatment in order to free up a bed for someone with a better prognosis unless the competent patient agrees that treatment should be stopped, the incompetent patient's prior capable wishes were to stop treatment, or withdrawing treatment is in the incompetent patient's best interests.

Rationing decisions are, of course, extremely difficult. Much has been written about the basis on which such decisions should be made. The literature on Quality Adjusted Life Years alone fills volumes.¹²⁵ It is beyond the scope of this article to discuss how rationing should be accomplished. Suffice it to say that health care rationing, in the sense of not providing all the health care that individuals want, is necessary and desirable.

This is not to suggest that doctors should be permitted unilaterally to pull the plug on patients to save resources. Jocelyn Downie argues that allocation decisions are for society to make,¹²⁶ and I agree (unless she means that physicians have *no* legitimate role in allocation decisions). But changing the status quo by preventing physicians from giving *any* weight to cost and scarcity of resources is another seemingly unintended consequence of treating the question of a right to life support as an issue of informed consent.

As a practical matter, health practitioners are unlikely to withdraw life-sustaining treatment for reasons of resource allocation. When it comes to life and death, most will go to great lengths to ensure that all medically appropriate treatment is provided.¹²⁷ However, due to the Ontario Court of Appeal's

¹²⁵ See Michael Nichol et al, "Evaluating Quality-Adjusted Life Years: Estimation of the Health Utility Index (HUI2) from the SF-36" (2001) 21:2 Medical Decision Making 2; John LaPuma & Edward Lawler, "Quality-Adjusted Life-Years: Ethical Implications for Physicians and Policymakers" (1990) 263:21 Journal of the American Medical Association 2917; Yolanda Verel & Mark Sculpher, "Quality-Adjusted Life Years" (2008) 8 Practical Neurology 175.

¹²⁶ Downie, *supra* note 10 at 147.

¹²⁷ This follows from the nature of the medical profession and physicians' duties to patients. For example, the College of Physicians and Surgeons of Ontario states: "Service is not only competence; it is also putting the patient first. A physician has professional responsibility to their patients, individually and collectively; their patients' families; their own practice; and the health care system. However, at any given time a physician's primary responsibility is to the individual patient before them" ("The Practice Guide: Professionalism and College Policies", 2008, at 8, online: CPSO <www.cpso.on.ca/policies/guide/default.aspx?id=1696>). Anecdotally, one physician and ethicist refused to remove an infant, Baby X, from

conclusion that consent is required to withdraw life-sustaining treatment, doctors apparently no longer even have the possibility of freeing up a needed bed or machine for someone who could benefit from it more. The result may be justifiable, but it has not yet been justified.

4. *The Consent and Capacity Board's Limited Mandate*

Those who believe patient consent should be required to withhold or withdraw treatment, or who otherwise have concerns about physicians' power to make life and death decisions, often cite the fact that the *HCCA* provides for a dispute resolution mechanism by way of the Consent and Capacity Board ("Board").¹²⁸ The Ontario Court of Appeal agreed that "if the physician is not content with the refusal of [an SDM] to provide consent to the withdrawal of life support, the physician's recourse is to refer the matter to the Board for disposition."¹²⁹ The Board's mandate, however, does not permit it to consider the range of relevant issues that arise regarding decisions whether or not to continue treatment, including the physician's interest in not having to provide medically non-beneficial treatment, and resource allocation issues. In addition, board members do not necessarily have any medical expertise that would permit them to determine whether continued treatment is *medically* appropriate.¹³⁰ Because of the Board's mandate and composi-

a life-sustaining machine even though from a resource allocation standpoint, it made sense to do so. The number of machines available was limited and Baby X's chances of survival were less than 5% even with continued treatment. Baby Y had a 95% chance of survival if given access to a machine but only about a 50% chance of survival without it. Because Baby X was already on the machine, the doctor refused to withdraw treatment from Baby X in order to allow Baby Y to have access to the machine (personal communication with Dr. Robert Truog, 2011).

¹²⁸ Mr. Rasouli's lawyers made this argument and it was raised by some who emailed me in response to an op-ed I published in the *Toronto Star*, Hilary Young, "When Family and Doctors Disagree on When to End Life", *The Toronto Star* (20 September 2011) online: *Toronto Star* <www.thestar.com/opinion/editorialopinion/article/1057057--when-family-and-doctors-disagree-on-when-to-end-life>. See e.g. Alex Schadenberg's blog: "Article Concerning the Rasouli Case is Based on False Assumptions" (27 September 2011), online: <alexschadenberg.blogspot.com/2011/09/article-concerning-rasouli-case-is.html>.

¹²⁹ *Rasouli CA*, *supra* note 6 at para 45.

¹³⁰ As noted by the Appellants, the Board is currently composed primarily of lawyers, psychologists, and laypersons (*Cuthbertson v Rasouli FOA*, *supra* note 3 at para

tion, it is not suited to resolving disputes about whether to withhold or withdraw life support.

The Board's statutory mandate includes advising SDMs how best to make a consent decision that complies with the *HCCA*,¹³¹ and resolving disputes where a health practitioner believes a consent decision has been made inappropriately.¹³² In addressing these consent decisions, the Board must decide based first on the desires expressed by the patient while competent. If no such desires were expressed before incapacity, the decision must be based on the patient's best interests.¹³³ Relying on wishes and best interests, originally common law considerations now codified in the *HCCA*, aims to promote respect for the patient's autonomy and bodily integrity. It reflects the fact that a patient has an almost absolute right to refuse treatment while acknowledging the reality that a person may not be competent to make treatment decisions.

Thus, according to *Rasouli*, if a physician wishes to withdraw life-sustaining treatment because it is no longer helping a patient, and the competent patient wants treatment to continue, the Board *must* side with the patient: her wishes prevail according to the *HCCA*. If the patient's wishes are not known but the SDM wants treatment to continue, the Board may only consider whether continued treatment is in the patient's best interests, an analysis that combines medical criteria and the patient's values. The Board may not consider that the physician does not want to treat, except insofar as that is relevant to the medical criteria under the best interests test. The Board may also not give *any* weight to the cost or availability of health care resources. There may be reasons, such as respect for religious freedom, to provide expensive treatment that is not likely to be beneficial. However, the Board is not statutorily permitted to engage in such debates.

This demonstrates again that while it is appropriate to rely exclusively on the patient's wishes and best interests to resolve disputes about whether a patient or SDM should accept or refuse offered treatment, it may be inappropriate to rely solely on those factors to resolve disputes over whether a patient may *demand* treatment. Competing interests come into play in a demand context that do not in a permission context. Specifically, whether the doctor

100). The choice of psychologists rather than other health professionals reflects the Board's mandate in determining patients' capacity.

¹³¹ *HCCA*, *supra* note 7 s 35.

¹³² *Ibid* s 37.

¹³³ *Ibid* s 21.

is willing to provide non-beneficial treatment and whether the doctor thinks scarce resources would be more effective if expended elsewhere are relevant in a demand context in a way that they are not in a refusal context.

V. Alternatives to Consent

I have argued that the law of informed consent to medical treatment, as it relates to battery and negligence, does not and should not ground entitlements to treatment, including entitlements to life-sustaining treatment. I have also been careful to note, however, that this does not mean doctors do have or should have free reign in deciding whether or not to offer certain treatments. Existing laws other than the law of informed consent (as it relates to negligence and battery) prevent physicians from withholding or withdrawing life-sustaining treatment in certain circumstances. I discuss how the *Charter*, criminal law, and the law of professional responsibility protect patients.¹³⁴ However, because the protection offered by existing law is limited, additional, more specific guidelines or laws are desirable. I briefly examine two proposals that address the question of whether life support may be withheld or withdrawn. The first suggests that the decision is entirely up to physicians if a certain threshold of benefit to the patient cannot be attained. The second suggests that the decision should always be up to the patient unless others' rights are affected.

1. The Charter

The *Canadian Charter of Rights and Freedoms*¹³⁵ may protect against a doctor withholding or withdrawing life-sustaining treatment against a patient's or SDM's wishes. Specifically, section 7 of the *Charter* (life, liberty and security of the person), section 2(a) (freedom of religion) or section 15 (equality) could support entitlements to care, at least under certain circumstances. That said, no court has yet recognized a *Charter* right to life-sustaining medical treatment.

The first barrier to a *Charter* right not to have life-sustaining treatment withheld or withdrawn is uncertainty regarding whether the *Charter* applies to doctors' treatment decisions at all. *Stoffman v Vancouver General Hospi-*

¹³⁴ Having discussed the role of the standard of care in negligence in Section 4a, I do not do so again here.

¹³⁵ *Canadian Charter of Rights and Freedoms*, Part 1 of the *Constitution Act, 1982*, being Schedule B to the *Canada Act, 1982* (UK), 1982, c 11 [*Charter*].

tal held that it does not.¹³⁶ Other cases and commentators cast doubt on that proposition,¹³⁷ but the trial judge in *Rasouli* held that the plaintiff had failed to prove that the *Charter* applied to doctors' decisions. Mr. Rasouli's *Charter* argument was therefore not addressed on its merits.¹³⁸ The Ontario Court of Appeal declined to comment on Justice Himel's holding on the applicability of the *Charter*.¹³⁹

If a court were to find the *Charter* applies to doctors' decisions not to provide treatment,¹⁴⁰ it might well conclude that the *Charter* confers a right to some degree of life-sustaining treatment—even if the treating physician did not want to provide it. The Supreme Court of Canada has stated that there is no general constitutional right to health care,¹⁴¹ but in certain cases a specific right has been held to exist. For example, in *Eldridge v British Columbia (AG)*, the Supreme Court held it unconstitutional for British Columbia not to provide sign language interpreters to deaf people seeking medical treatment.¹⁴² In other words, it created an entitlement to sign language interpreters. It reasoned that not to provide such interpreters was discriminatory, contrary to section 15 of the *Charter*.

It is beyond the scope of this article to examine whether a denial of life-sustaining treatment would be unconstitutional, and under what circumstances. Suffice it to say that in the context of *Rasouli*, where the refusal to provide treatment is grounded in clinical judgment that such treatment is not beneficial to the patient, it is arguable whether the *Charter*, if it applied, would protect an entitlement to treatment. On the one hand, the *Charter* may not require offering treatment that physicians reasonably consider medically ineffective. On the other hand, patients may have a constitutional right to

¹³⁶ *Stoffman v Vancouver General Hospital*, [1990] 3 SCR 483, 76 DLR (4th) 700, 1990 CarswellBC 277 (WL Can) at para 106.

¹³⁷ See the discussion in *Rasouli* SC, *supra* note 15 at paras 84-93.

¹³⁸ *Ibid* at para 93.

¹³⁹ *Rasouli* CA, *supra* note 6 at para 36.

¹⁴⁰ Alternately, if a government were to make a legislative or operational decision that limited people's access to life-sustaining treatment, the application question would presumably not arise.

¹⁴¹ See *Chaoulli v Quebec (AG)*, 2005 SCC 35 at para 104, [2005] 1 SCR 791.

¹⁴² [1997] 3 SCR 624, 151 DLR (4th) 577.

life-sustaining treatment where denying that treatment would implicate patients' fundamental values and beliefs about a good life and a good death.¹⁴³

If the refusal to offer treatment were based in part on resource allocation decisions, it is perhaps more likely that a *Charter* right would be found, since "budgetary considerations cannot be used to justify a [*Charter*] violation."¹⁴⁴ Even then, however, courts are often reluctant to interfere with allocation decisions made for policy reasons.¹⁴⁵ For example, a couple that was denied fertility treatments by the Nova Scotia government challenged the constitutionality of that decision. The Nova Scotia Court of Appeal held that the government's allocation decision was discriminatory, but that it was saved by section 1 of the *Charter*, since the government's means for achieving the important goal of funding medically necessary health care with limited resources were reasonable.¹⁴⁶

2. Criminal Law

Criminal law provides some protection against a doctor refusing to treat. Criminal negligence,¹⁴⁷ like the tort of negligence, is based on the concept of reasonableness, although unlike negligence in tort, the criminal offence requires a marked departure from the reasonableness standard as well as a "wanton or reckless disregard for the lives or safety of other persons."¹⁴⁸ Thus, in egregious cases of unreasonably withholding or withdrawing life-sustaining treatment, a physician could be found guilty of a criminal act. As

¹⁴³ See Downie, *supra* note 10 for a discussion of how dignity and self-determination are implicated even where treatment offers little or no medical benefit.

¹⁴⁴ *Schachter v Canada*, [1992] 2 SCR 679 at 709, 93 DLR (4th) 1.

¹⁴⁵ The likelihood of success of allocation arguments in *Charter* cases depends in part on the section of the *Charter* being invoked. Courts hesitate to use section 7 to second-guess decisions of pure policy, whereas they may be more likely to invalidate allocation decisions that are discriminatory and contrary to section 15. See Louise R Sweetman & Diane Woollard, "Resource Allocation Decisions in Canada's Health Care System: Can These Decisions Be Challenged in a Court of Law?" (2002) 62:3 Health Policy 275 at 284.

¹⁴⁶ See *Cameron v Nova Scotia (AG)* (1999), 204 NSR (2d) 1, 177 DLR (4th) 611 (CA), leave to appeal to SCC refused, 531 (November 9, 1999).

¹⁴⁷ See *Criminal Code*, RSC 1985, c C-46, ss 219-221.

¹⁴⁸ *Ibid*, s 219. See also *R v Rogers*, [1968] 4 CCC 278, 65 WWR 193 (BCCA). For an example of criminal negligence involving a medical practitioner, see *R v Manjanatha*, [1995] 8 WWR 101, 131 Sask R 316 (CA).

with tortious negligence, however, this is unlikely to be the case where a decision not to provide life-sustaining treatment is based on reasonable clinical judgment. It will therefore rarely apply to protect patients in *Rasouli*-type situations.

3. *The Regulated Health Professions Act*¹⁴⁹

Medicine is a self-regulating profession and the *Regulated Health Professions Act* (RHPA) seeks to ensure that “practitioners meet agreed standards of practice and competence.”¹⁵⁰ The RHPA allows the profession to impose sanctions on physicians who commit misconduct or who are incompetent. Misconduct includes failing to meet the standards of the profession¹⁵¹ and discontinuing professional services that are needed.¹⁵² Thus, failure to provide needed or appropriate medical treatment, whether life-sustaining or otherwise, could expose physicians to professional discipline, including a fine or suspension or loss of their license to practice medicine.¹⁵³ As a result, professional regulation of the medical profession helps protect against unreasonable or improper withholding of medical treatment.

Professional self-regulation, however, suffers from the same limitations as tortious and criminal negligence in that the reasonable exercise of clinical judgment is unlikely to run afoul of professional standards of conduct. The RHPA proscribes improper or unreasonable medical practice. It is not concerned with broader moral questions, such as whether and when people should be entitled to life-sustaining treatment of questionable medical benefit. Nor should it be, since the medical profession has no legitimate claim to making moral decisions for patients.

The three legal mechanisms above are not necessarily the only ways in which the law may protect against a doctor withholding life-sustaining treatment against a patient’s will. Other laws, such as human rights legislation, may protect against denials of life-sustaining treatment. Together, these

¹⁴⁹ RHPA, *supra* note 108.

¹⁵⁰ Ontario, Health Professions Regulatory Advisory Council, *Regulation of Health Professions in Ontario: New Directions* (Toronto: HPRAC, 2006) at 7, online: <www.health.gov.on.ca/english/public/pub/ministry_reports/new_directions/new_directions.pdf>.

¹⁵¹ *Professional Misconduct Regulation*, *supra* note 113 s 1(1)(2).

¹⁵² *Ibid* s 1(1)(7).

¹⁵³ RHPA, *supra* note 108, Schedule 2, s 51(2).

mechanisms demonstrate that it is not necessary to rely on the law of informed consent in order to protect a patient's interest in not having life-sustaining treatment withheld or withdrawn. That said, as tools to protect patients against a doctor withholding life-sustaining treatment, the laws discussed above all have limitations. The *Charter* may not apply at all. Criminal prohibitions and professional self-regulation, like the law of negligence, target breaches of the standards of the medical profession. But since existing medical standards may be uncertain or may not sufficiently protect patients, some commentators have suggested new protocols—in the form of professional guidelines or legislation—that would help ensure a more nuanced and appropriate approach to whether certain life-sustaining treatment will be offered. As examples, I briefly describe certain Ontario critical care workers' suggestions for guidelines, and Jocelyn Downie's informed consent-based proposal.

4. *The Hawryluck Proposal*

In Section 4a, I noted that certain Ontario critical care practitioners proposed a set of guidelines that would help them make principled and transparent decisions about whether to treat or continue treating critical care patients.¹⁵⁴ Although many people were involved in developing the guidelines, I refer to them as the "Hawryluck proposal" for the sake of simplicity. These guidelines are said to represent a "proposed new standard of care,"¹⁵⁵ although in some respects the proposal likely codifies the existing standard of care for life-sustaining treatment in a critical care setting.¹⁵⁶

The Hawryluck proposal makes clear that the goal should be shared decision making. Practitioners should provide all relevant information; make efforts to determine how various options fit with the patient's wishes, values, and goals; answer all a patient's or an SDM's questions; make recommendations; and document the process.¹⁵⁷ It recommends second opinions where patients want them, and promotes continued assessment of the patient's condition.

¹⁵⁴ Hawryluck, Bouali & Meth, *supra* note 12.

¹⁵⁵ *Ibid* at 256.

¹⁵⁶ I suggested in Section 4a that the Hawryluck proposal reflects the standard of care—at least to the extent of permitting treatment sometimes to be withheld despite the objections of the patient or SDM. That said, since practice varies, it is unclear what exactly the standard of care requires.

¹⁵⁷ Hawryluck, Bouali & Meth, *supra* note 12 at 256.

Whether treatment is offered should depend on whether treatment is beneficial. Benefit to the patient takes into account the patient's informed wishes and factors related to a patient's best interests, as set out in the *HCCA*.¹⁵⁸ However, it also takes into account medical reasonableness. Treatment is only reasonable where it can achieve certain minimum medical goals, taking into account a patient's wishes or values. If it is not reasonable in this sense, it should not be offered. Thus, certain treatment would not have to be provided regardless of a patient's wishes or values:

Participants recommended that critical care services should NOT be used (since would not be of benefit) if any of the following apply:

1. there is no reversible cause for the need for the ICU admission;
2. the patient would not be expected to survive an ICU admission:
 - a. due to very poor baseline quality of life ...;
 - c. if the patient is in very end-stage of life due to illness;
3. the patient's quality of life is expected to be extremely poor should the patient survive the ICU...¹⁵⁹

The Hawryluck proposal has strengths and weaknesses. It provides guidance regarding how to decide whether life-sustaining treatment should be provided—at least in the critical care setting—and takes into account the patient's wishes and best interests. It aims to resolve conflicts between patients or SDMs and doctors regarding whether life-sustaining treatment should be continued, and to that end requires a number of procedures aimed at achieving consensus. It neither gives doctors free reign to decide based only on medical considerations, nor does it always allow patients' wishes to be determinative.

However, the Hawryluck proposal may give insufficient weight to the wishes and values of patients. It is unclear whether doctors should ever have the authority unilaterally to deny life-sustaining treatment, even under the limited circumstances described above. In addition, the proposal leaves many questions unanswered. Assuming the minimum medical goals *can* be achieved, it is unclear how competing factors (e.g. the extent of the medical

¹⁵⁸ *Ibid.*

¹⁵⁹ *Ibid* at 257.

benefit, and the patient's wishes and values) should be balanced in deciding whether treatment should be provided. The Hawryluck proposal implies that doctors may still be entitled to refuse life-sustaining treatment if treatment is on the whole unreasonable, taking into account a patient's wishes and best interests. This is so even where the minimum goals of treatment can be met. The implication is that the decision whether to treat would still ultimately be up to physicians, so long as they consider the relevant factors. The proposal accepts the premise that physicians do not have to provide non-beneficial treatment. It may therefore be that the Hawryluck proposal would still give too much discretion to physicians.

5. *The Downie Proposal*

Jocelyn Downie's proposal for resolving disputes about whether life-sustaining treatment may be withheld or withdrawn is much less deferential to physicians' judgment. I discussed her proposal in Section 2c above, in the context of whether the law of informed consent applies to create entitlements to life-sustaining treatment. I concluded that the law of informed consent should not be interpreted as creating such entitlements, but Professor Downie's proposed solution could nevertheless form the basis of policy that need not flow from the law of informed consent.

Recall that Downie proposes a presumption in favour of patients deciding whether or not life-sustaining treatment is provided. The primary and perhaps sole factor Downie considers relevant in rebutting the presumption is resource allocation. Further, resource allocation decisions are only legitimate, she implies, where made by policymakers.¹⁶⁰ She largely dismisses physicians' interest in not treating against their clinical judgment, although that interest would seem to at least justify physicians removing themselves from a patient's care if another physician were willing to take over.¹⁶¹

Professor Downie's proposal has the benefit of being more simple and predictable than the Hawryluck proposal. The decision whether to withdraw life-sustaining treatment would be entirely up to patients unless resource allocation was at issue. Even then, she implies that life-sustaining treatment could not be withheld in the absence of a legislative or other policy decision to limit such treatment. That legislative decision would be based on balancing the public interest against the patient's interest, but no ad hoc balancing

¹⁶⁰ Downie, *supra* note 10 at 147.

¹⁶¹ *Ibid.*

by doctors would be permitted. It would ultimately be for legislators or hospitals to decide how these decisions should be made.¹⁶²

The problem with simplicity and predictability, as is often the case, is that it comes at the cost of flexibility. According to Professor Downie's proposal, in the absence of an explicit policy, resource scarcity must be ignored. As with the status quo since *Rasouli*, patients may essentially demand life-sustaining treatment regardless of the medical benefit that treatment would provide, or the cost of that treatment to the taxpayer. That said, Downie's proposal would apply more broadly than *Rasouli* since it would not be limited to situations in which palliative care drugs are administered when life-sustaining treatment is withdrawn.

In fact, Professor Downie's proposal might apply much more broadly. There is no apparent reason to limit her approach to life-sustaining treatment at all. Downie's proposal is based on the right to self-determination. Other types of medical treatment implicate self-determination to a similar degree as life-sustaining treatment. It is unclear whether Downie would advocate for presumed entitlements to all treatment that significantly implicates bodily integrity, subject only to explicit policies limiting access to such treatment for reasons of resource allocation. That should perhaps be the law, but I believe it would amount to a significant change to the status quo—one that requires debate and consultation with stakeholders such as taxpayers, hospitals and patients.

VI. What Should the Supreme Court Do?

Given all this, what should the Supreme Court of Canada do when it ultimately hears the *Rasouli* case? Its options are limited, in that it cannot simply legislate a better solution to the issue of entitlements to life-sustaining treatment. While a legislative response is desirable, realistically it is the Supreme Court that will set the law on this subject.

There are a number of ways in which the Court could resolve *Rasouli*. The first is to simply uphold the Court of Appeal's decision without altering its reasoning. It should be clear why I reject this approach. Similarly, I reject any other consent-based mechanism for creating entitlements to treatment, such as Justice Himel's approach. Rather, the Court should hold that the law of informed consent, under the common law and the *HCCA*, creates no entitlements to medical treatment.

¹⁶² *Ibid.*

If this were the result, the Court would presumably send the matter back for a new trial in which Mr. Rasouli could seek an injunction on the basis that withdrawing treatment would breach the standard of care in negligence, for example. I think this is the most reasonable outcome on the existing law. However, I acknowledge the limitations, discussed above, of negligence law as a mechanism for deciding whether life-sustaining treatment should be provided. In particular, since it is based on the standards that doctors set for themselves, negligence law may insufficiently reflect non-medical factors.

The Court could conceivably resolve Mr. Rasouli's case on constitutional grounds. However, since Mr. Rasouli's physicians did not appeal the trial judge's holding that the *Charter* does not apply to doctors' decisions, either to the Ontario Court of Appeal or to the Supreme Court, this seems unlikely.

There are undoubtedly other ways of resolving the legal issues *Rasouli* raises, and I hope the Court will arrive at a solution that is consistent with the law of informed consent, which creates no entitlements to treatment—either at common law or in the *HCCA*. That outcome may not be ideal from a policy perspective, but it is not for the Court to set policy on the fundamental question of whether people should be entitled to life-sustaining treatment of questionable medical value.

Conclusion

For more than a year, Hassan Rasouli has been lying in a hospital bed at Sunnybrook Health Sciences Centre. Without modern technology, he would long ago have died. The increasing availability of such life-sustaining technology creates a need for decisions that raise complex issues regarding quality of life, autonomous decision making, health care rationing, and the proper role of physicians. Few decisions are more fraught than deciding that there is no longer hope, or that someone's life is no longer worth living. Yet these decisions must be made. It is not simply a matter of erring on the side of providing life-sustaining treatment. This too is a decision, and a costly one—both in terms of health care resources and in terms of the toll it takes on families and health practitioners. Do we want to provide an unlimited right to life-sustaining treatment at any cost because of the way we value life? If not, how do we decide when enough is enough, given that medical knowledge is incomplete and that people have different values when it comes to a good death? More importantly for the purpose of this article, who should decide?

There are, of course, no easy answers. I have argued that the *Rasouli* approach to this last question does not follow from existing law and is seriously

flawed. By treating the entitlement to demand treatment the same way as the entitlement to refuse it, *Rasouli* ignores relevant differences between the two contexts. It makes the decision whether to provide life-sustaining treatment one based solely on the patient's desires and interests, whereas the interests of physicians and the public interest in the appropriate use of health care resources are also relevant in the demand context. That is not to say that physicians should unilaterally decide whether treatment is offered, but nor should the decision necessarily belong solely to the patient. *Rasouli* Consent is therefore an inappropriate mechanism for resolving disputes about whether life-sustaining treatment should be withdrawn or withheld. The issue is a policy matter for the legislatures. In the meantime, the Supreme Court of Canada should interpret the law of informed consent as creating no entitlements to treatment.

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A RESPONSE TO “WHY WITHDRAWING LIFE- SUSTAINING TREATMENT SHOULD NOT REQUIRE ‘RASOULI CONSENT’”

*Laura Hawryluck**

I read Professor Young’s article with great interest.¹ In this reply, I aim to clarify key issues surrounding the “Hawryluck proposal.”² From my perspective as a practicing intensivist and bioethicist, I would also like to highlight key challenges of end of life care for frontline clinicians. To begin, Professor Young slightly misconstrues the Hawryluck proposal. She states that even if “minimal criteria” (terminology that does not exist in the actual proposal) were met, physicians would still have unilateral discretion to withdraw life-sustaining treatments.³ Far from promoting unilateral withdrawal, the Hawryluck proposal calls for effective communication; transparent decision making; disclosure of rationale for recommendations; second opinions; and procedures for conflict resolution, with ultimate adjudication through the courts.⁴

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¹ Hilary Young, “Why Withdrawing Life-Sustaining Treatment Should Not Require ‘*Rasouli* Consent’” (2012) 6:2 MJLH 54.

² Laura Hawryluck, Redouane Bouali & Nathalie Danjoux Meth, “Multi-professional Recommendations for Access and Utilization of Critical Care Services: Towards Consistency in Practice and Ethical Decision-Making Processes” (2011) 39:2 JL Med & Ethics 254.

³ Young, *supra* note 1 at 101.

⁴ *Supra* note 2 at 258.

The Hawryluck proposal does draw a distinguishing line to determine if life-sustaining treatments are treatment options at all. Only viable treatment options should be presented to patients or their substitute decision makers for consideration. This distinction is based on standard of care considerations, which in turn are founded on a clear concept of patient benefit.

Critical care medicine is very aggressive and invasive. It has to be to respond to the very nature, severity, and aggressiveness of the illnesses it seeks to stabilize. The potential harms are greater than those seen elsewhere in medicine, and the risk of harm does not decrease over time. For these reasons, life-sustaining treatments must be able to benefit any given patient. The Hawryluck proposal states that if life-sustaining treatments will not be of benefit, they should not be offered or continued, as they would fall outside of the standard of care.⁵ This approach is consistent with statements and policies of critical care societies nationally and internationally.⁶

The Hawryluck proposal seeks however to further clarify the concept of benefit within the field of critical care medicine. Life-sustaining treatments are defined as being of benefit when they constitute part of a treatment plan that (a) could result in a cure; (b) improves or stabilizes progression of illness, symptoms, and well-being; or (c) slows the rate or extent of deterioration of health and well-being.⁷ Physicians must consider whether potential benefits outweigh risks, and how to minimize invasiveness to achieve these results before recommending one treatment plan over another. The following criteria were provided to define when life-sustaining treatments will not be of benefit:

1. there is no reversible cause for the need for the ICU admission;
2. the patient would not be expected to survive an ICU admission:
 - a. due to very poor baseline quality of life [*the concept of poor quality of life as used here reflects the patient's per-*

⁵ *Ibid* at 257.

⁶ College of Physicians and Surgeons of Ontario, "Policy Statement #1-06: Decision-making for the End of Life", online: CPSO <www.cpsso.on.ca> [CPSO "Policy Statement"]; Graeme Rocker & Scott Dunbar, "Withholding or Withdrawal of Life Support: The Canadian Critical Care Society Position Paper" (2000) 16 *Supple J Palliat Care* S53; Robert D Truog et al, "Recommendations for End of Life Care in the Intensive Care Unit: A Consensus Statement by the American College [corrected] of Critical Care Medicine" (2008) 36:3 *Crit Care Med* 953.

⁷ Hawryluck, Bouali & Meth, *supra* note 2 at 256-57.

- ception/opinion and not the biases of the healthcare provider*];
- b. if the patient was or will be in a permanently unconscious state; or
 - c. if the patient is in very end-stage of life due to illness;
3. the patient's quality of life is expected to be extremely poor should the patient survive the ICU, such that the patient would:
- a. be in a state of severe irreversible dependency in all activities of daily living;
 - b. have severe irreversible functional limitations *that the patient would not want to endure* (as expressed in previous wishes or based on the SDM's interpretation of the incapable patient's wishes, values and beliefs).⁸

Such considerations of benefit are crucial to determine if offering, continuing, withholding, or withdrawing life-sustaining treatments are options to be presented to the patient or substitute decision maker. It should also be noted that this definition of non-benefit also clearly incorporates patient values and wishes.⁹

If life-sustaining treatments are among the treatment options for a given patient, the physician would then be expected to fulfill their ethical and legal obligations to make a recommendation regarding their use in the context of the patient's state of health and values.¹⁰ At this stage, patient values and wishes prevail as they would in any other situation.¹¹ In cases of uncertainty, the value of a trial of life-sustaining treatments and the re-evaluation of the response to treatments is emphasized. This approach errs on the side of caution, by placing patients on, or continuing, such treatments until lack of benefit is certain.¹² This approach was elaborated precisely to enhance flexibility in the outcomes of decision making. High quality, patient-centered care is ensured by mandating that each patient be seen as a person, whose particular situation is considered.¹³ In the event life-sustaining treatments would not be

⁸ *Ibid* at 257 [emphasis as in original paper].

⁹ *Ibid* at 256-57.

¹⁰ CPSO "Policy Statement", *supra* note 6.

¹¹ Hawryluck, Bouali & Meth, *supra* note 2 at 256-61.

¹² *Ibid* at 256-57, 260-61.

¹³ This is different than the outcomes in the Downie proposal that Professor Young (*supra* note 1 at 101) suggests would be more simple and predictable. I am unclear that "simple and predictable" are values we should target as the loss of

of benefit, the proposal mandates this be fully disclosed in order to facilitate open discussion of the rationale and to allow a second opinion to be obtained where desired. Patient self-determination and wishes are still important factors determining the standard of care. Ultimately, our proposal sought to achieve an explicit balance between benefit and patient values, and also to make these criteria for decision-making publicly available so as to ensure fairness and transparency reflective of the plurality of values within a just, multicultural society.

The purpose of medicine has never been to prolong life indefinitely, but to prevent, diagnose, and treat illnesses to the fullest extent possible that is desired by patients. The College of Physicians and Surgeons of Manitoba describes medical criteria of benefit and the achievement of “minimal goals,” as “the maintenance of or recovery to a level of cerebral function that enables the patient to: achieve awareness of self; achieve awareness of existence; and experience his/her own environment.”¹⁴ Downie argues that these determinations of benefit are moral judgments, not medical ones.¹⁵ It follows according to her reasoning that decisions to withdraw life-sustaining treatments are not to be made by physicians, because they do not have the “specialized knowledge to make moral assessments” to determine whether life-sustaining treatments are worthwhile.¹⁶

What Downie fails to recognize is that physicians are not making moral judgments in these circumstances. The test they are applying seeks to assess the ability of life-sustaining treatments to help a patient. Such a test is simply and transparently based on the same considerations of potential benefits, and the same process of treatment trials and evaluation of response to treatment I described above. Furthermore, they are usually made in consultation with other healthcare teams and, within the ICU itself, in consultation with a multi-professional team. These considerations are used in decision making re-

individuality, and the loss of recognition of personhood is not one we have embraced within our society; rather we have sought to promote individuality within limits of its infringement on others.

¹⁴ Jocelyn Downie & Karen McEwen, “The Manitoba College of Physicians and Surgeons Position Statement on Withholding and Withdrawal of Life Sustaining Treatment (2008): Three Problems and a Solution” (2009) 17:1 Health LJ 115 at 116.

¹⁵ *Ibid.*

¹⁶ Jocelyn Downie, “Unilateral Withholding and Withdrawal of Potentially Life-Sustaining Treatment: a Violation of Dignity Under the Law in Canada” (2004) 20:3 J Palliat Care 143 at 147.

garding all medical treatments across all fields of medicine. Why are physicians suddenly making moral judgments simply because decisions about life-sustaining treatments are perceived to be decisions about life versus death?¹⁷ Death is and always will be an integral part of life and the reality is that medicine can only do so much. Moreover, such decisions are not truly "unilateral": physicians must consider principles of benefit defined by legislation,¹⁸ and given weight in common law. These definitions reflect society's values and expectations of its healthcare providers.

When life-sustaining treatments are without or can no longer provide benefit and hence no longer a treatment option subject to patient or substitute decision maker choice, this does not mean that patients are abandoned and ignored. A patient's dignity must be respected at all times. Dignity in the medical setting means caring for a patient as a person, no matter their illness impairment or vulnerability. If a patient's illness were to progress to the point of needing life-sustaining treatments in the future, it may very well be that under his or her particular circumstances, such treatments would be of no benefit. Conceivably before the illness reaches this point, however, there may remain any number of other treatment options that can be potentially pursued according to the patient's values and wishes. The difference is in the ability of life sustaining treatments to always cause harm, the magnitude of such harms, and the continued ability of such treatments to harm even when they cannot benefit. If critical illness ultimately ensues, treatments would focus exclusively on pain and symptom control so as to improve the quality of life in the time remaining.

I agree that physicians should have a voice in resource allocation in the healthcare system, for the reasons argued effectively by Professor Young. In the Downie proposal, however, the only real constraints on a patient's right to self-determination are those concerning resource limitations.¹⁹ This would create even greater variability in the standard of care than the use of the concept of benefit. Decisions under the Downie proposal would not be "predict-

¹⁷ In circumstances where initiating or continuing life-sustaining treatments are deemed outside of the standard of care, it is a fallacy to view these decisions as life versus death. A more appropriate way of looking at these situations in the clinical context is that death is the only possible outcome and the question is more how will the patient die, i.e. how much pain and suffering will the patient be asked to undergo? How prolonged will the dying process be?

¹⁸ See e.g. *Health Care Consent Act*, SO 1996, c 2, Schedule A, s 21.

¹⁹ *Supra* note 14 at 134.

able and simple,”²⁰ as Professor Young suggests. On the contrary, they would be subject to considerable regional variability in resources. This would, if anything, promote more inconsistencies in ensuring the fundamental value of our healthcare system – that of fair access to those in need – is achieved. While overarching values and policies may be helpful in macro-resource allocation decisions within the healthcare system, their application in practice when caring for an individual patient is far less clear. Resources can vary day to day within a given hospital, between hospitals, and between regions across Canada. Why should patients trust hospital resource allocation policies²¹ more than the physicians who have a fiduciary obligation to seek and advocate for the best possible healthcare for their patients? Such a proposal would make access to life-sustaining treatment dependent on the vicissitudes of an individual hospital’s financial situation and expenditure decisions. Are patients now supposed to investigate each hospital’s use of funding to know where to go to seek care? The Downie proposal requires a *prima facie* shift in values. The fundamental question becomes how hard physicians should try to find resources for a given patient, not whether medicine can help a vulnerable person in a time of need. Is this truly the core value we wish to emphasize in the Canadian healthcare system? Such a shift would undermine the trust central to the physician-patient relationship.

In clinical practice, when conflicts arise when treatments are deemed no longer of benefit, the transfer of care to another physician, as suggested by the Downie proposal, is not a credible solution.²² Physicians rarely accept such patients in transfer. They do not want to willingly engage to provide care that offers no benefit, but retains its ability to cause significant harm.²³ Such care is a violation of the fundamental oath of medicine to “first do no harm.” This implausible, yet blithely suggested solution, points to a significant lack of appreciation for the reality of medical practice: the standard of care and the concept of benefit are far less variable and nebulous than critics would suggest. Instead, the variability seen in clinical practice is rooted in how patients’ and substitute decision makers’ insistence and demands for non-beneficial treatments are handled.

²⁰ Young, *supra* note 1 at 101.

²¹ Downie & McEwen, *supra* note 14 at 134.

²² *Ibid.*

²³ Judith E Nelson et al, “Chronic Critical Illness” (2010) 182:4 *Am J Respir Crit Care Med* 446; Kathleen A Puntillo et al, “Symptoms Experienced By Intensive Care Unit Patients at High Risk of Dying” (2010) 38:11 *Crit Care Med* 2155.

Resolution of such cases with negligence considerations would require physicians to meet a robust standard of care that incorporates whether (1) the proposed treatment plans are justified under clear criteria of potential benefit; (2) the option of trials of treatment are proposed in cases of uncertainty; and (3) patients' wishes and best interests prevail in cases of potential benefit when life-sustaining treatments are among the treatment options offered. Physicians are not the sole arbitrators of the standard of care. While it must reflect and recognize medical knowledge, research, and skill, the standard of care is also critically shaped by legislation and case law, which reflect societal values and bring out the best practices within medicine. We need to guard against their ability to bring out the worst.

PROSECUTORIAL DISCRETION IN ASSISTED DYING IN CANADA: A PROPOSAL FOR CHARGING GUIDELINES

*Jocelyn Downie & Ben White**

An Expert Panel of the Royal Society of Canada and a Select Committee of the Québec National Assembly both recently recommended the issuance of permissive guidelines for the exercise of prosecutorial discretion on voluntary euthanasia and assisted suicide and “medical aid in dying” respectively. It seems timely, therefore, to propose a set of offence-specific guidelines for how prosecutorial discretion should be exercised in cases of voluntary euthanasia and assisted suicide in Canadian provinces and territories. We take as our starting point the only existing guidelines of this sort currently in force in the world (i.e. the British Columbia Guidelines, and the England and Wales Guidelines). In light of certain concerns we have with these guidelines, we outline an approach to constructing guidelines for Canadian jurisdictions that begins with identifying three guiding principles we argue are appropriate for this purpose (respect for autonomy, the need for high-quality prosecutorial decision making, and the importance of public confidence in that decision making), and ends with a concrete and detailed set of proposed guidelines. The paper is consistent with, but also extends, the work of the Royal Society of

Un panel d’expert de la Société Royale du Canada et une Commission spéciale de l’Assemblée nationale du Québec ont tous les deux récemment recommandé que soit émises des directives permettant l’exercice d’un pouvoir de poursuite discrétionnaire concernant l’euthanasie et le suicide assisté et « l’assistance médicale pour mourir », respectivement. Il semble donc à propos de proposer une série de directives spécifiques aux offenses sur la façon dont le pouvoir de poursuite discrétionnaire dans les territoires et provinces canadiennes serait appliqué dans les cas d’euthanasie et de suicide assisté. Nous avons pris comme point de départ les seules directives de la sorte existant déjà (c’est-à-dire celle de la Colombie-Britannique et de l’Angleterre et du Pays de Galles). Par contre, compte tenu de certaines de nos réserves concernant ces directives, nous avons ensuite établi les grandes lignes d’une approche permettant de mettre sur pied des directives pour les juridictions canadiennes, qui débute par l’identification de trois principes de base qui sont selon nous appropriées à cette fin (respect de l’autonomie, besoin pour une grande qualité de prise de décision de poursuite et la confiance

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Canada Expert Panel on End of Life Decision Making.

du public envers cette prise de décision) pour se terminer par une série de directives concrètes et détaillées. Le présent document est compatible avec le travail de la Société royale du Canada tout en en augmentant la portée.

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Introduction

In Canada, it is illegal to counsel, aid, or abet a person to commit suicide.¹ Voluntary euthanasia is also illegal, as it contravenes the *Criminal Code* prohibition on murder.² While clear, the legal status of these forms of assisted death has been the subject of seemingly intractable debate for a number of years. However, during the past year, there have been three major developments in the arena of assisted death law and policy. First, the Royal Society of Canada appointed an Expert Panel on End-of-Life Decision Making tasked with contribution to the public policy debate on end of life law and policy in Canada (“RSC Panel”).³ Second, the Québec National Assembly appointed a Select Committee on the Right to Die with Dignity to study the issues (“Québec Committee”).⁴ Third, a constitutional challenge of the *Criminal Code* prohibitions on voluntary euthanasia and assisted suicide was launched in British Columbia.⁵ Within a seven-month period, the RSC Panel, the Québec Committee, and the BC Supreme Court released their respective reports and decision. All three, each in their own way, concluded that the current laws on assisted suicide and voluntary euthanasia must change. In this paper, we explore one of the recommended avenues of reform arising from the RSC Panel and the Québec Committee: guidelines for the exercise of prosecutorial discretion.⁶

The RSC Panel report included the following recommendation:

The Panel recommends that, unless or until the *Criminal Code* is reformed as recommended above [“that the prohibitions on assisted suicide and voluntary euthanasia in the *Criminal Code* be

¹ *Criminal Code*, RSC 1985, c C-46, s 241(b).

² *Ibid*, s 229(a)(i).

³ The Royal Society of Canada Expert Panel, *End-of-Life Decision Making* (Ottawa: RSC, 2011), online: <http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf> [RSC Panel Report].

⁴ National Assembly of Québec Select Committee, *Dying With Dignity* (Québec City: National Assembly of Québec, 2010) at 37, online: <www.assnat.qc.ca/en/actualites-salle-presse/nouvelle/Actualite-25939.html> [Québec Committee Report].

⁵ *Carter v Canada (AG)*, 2012 BCSC 886 (available on CanLII) [Carter].

⁶ Both the RSC Panel and the Québec Committee made recommendations beyond prosecutorial guidelines (e.g. changes to the *Criminal Code* and changes to provincial legislation respectively). However, these are not the subject of this paper.

modified such that, in carefully circumscribed and monitored circumstances, they are legally permissible” (at 96)], those with authority over prosecutorial policies in all provinces and territories introduce such policies to provide guidance with respect to the exercise of prosecutorial discretion and to make clear the circumstances within which a prosecution for assisted suicide or voluntary euthanasia would not be in order.⁷

The Québec Committee report included the following recommendation:

The Committee recommends that the Attorney General of Québec issue directives (in the form of “guidelines and measures”) to the Director of Criminal and Penal Prosecutions to ensure that a physician who provides medical aid in dying in accordance with the criteria provided by law cannot be prosecuted.⁸

In light of these recommendations, a challenge has clearly been set: to develop offence-specific guidelines for the exercise of prosecutorial discretion in cases of voluntary euthanasia and assisted suicide.⁹

In this paper we seek to meet this challenge. We propose specific guidelines to supplement the existing general guidelines. First, we outline the way in which charging guidelines operate in Canadian provinces in relation to the prosecution of offences generally. Second, we consider the offence-specific guidelines promulgated in British Columbia (“Crown Counsel Policy Manual: Euthanasia and Assisted Suicide”)¹⁰, and England and Wales (“Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide”)¹¹. We

⁷ RSC Panel Report, *supra* note 4.

⁸ Québec, Select Committee on Dying with Dignity, *Report* (Québec City: National Assembly of Québec, 2012) at 90, online: <www.assnat.qc.ca/en/actualites-salle-presse/nouvelle/Actualite-25939.html> [Québec Committee Recommendations].

⁹ Both the RSC Panel and the Québec Committee called for prosecutorial charging guidelines and indicated some content for them by way of “criteria” (Québec) or “core elements” (RSC Panel) for a permissive regime. However, neither one developed actual guidelines.

¹⁰ Office of the Attorney General, by the Criminal Justice Branch (Victoria: AG, 2004), online: <www.ag.gov.bc.ca/prosecution-service/policy-man/pdf/EUT1-EuthanasiaAndAssistedSuicide-15Mar2004.pdf> [BC Guidelines].

¹¹ England and Wales, Director of Public Prosecutions, “Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide” by the Crown Prosecution Service (London: DPP, 2010), online: <www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.pdf> [England and Wales Guidelines]. These guidelines

look first at the BC Guidelines, as they are the only existing assisted death offence-specific guidelines from a Canadian jurisdiction. We then focus on the England and Wales Guidelines, the only existing detailed assisted suicide prosecutorial charging guidelines in the world.¹²

However, while these two sets of guidelines provide a useful starting point, we argue that they are deficient in a number of respects. We therefore advance an approach to constructing alternative guidelines that begins by identifying three guiding principles that we argue are appropriate for this purpose: respect for autonomy; the need for high-quality prosecutorial decision making; and the importance of public confidence in that decision making. Using those principles, we then construct our own detailed guidelines for the exercise of prosecutorial discretion in those cases of voluntary euthanasia and assisted suicide that the RSC Panel concluded should be permitted in Canada.

For ease of reference, as each element is discussed in detail, the relevant portion of our proposed guidelines is set out in a text box. The proposed guidelines are set out in full in Appendix I.¹³ Before proceeding, we must

do not apply in Scotland. See James Chalmers, “Assisted Suicide: Jurisdiction and Discretion” (2010) 14:2 Ed L Rev 295; Sheila AM McLean, Clare Connelly & J Kenyon Mason, “Purdy in Scotland: We Hear, But Should We Listen?” (2009) 4 Jurid Rev 265 at 265.

¹² In drafting our proposed guidelines, we were influenced by the experience of the Netherlands with charging guidelines between 1994 and 2002. However, the Dutch guidelines grew out of the defence of necessity, which has not been accepted by Canadian courts as the foundation for a permissive regime with respect to voluntary euthanasia and assisted suicide. See e.g. *R v Latimer*, 2001 SCC 1, [2001] 1 SCR 3, 193 DLR (4th) 577. Furthermore, the Dutch guidelines were superseded by the Dutch *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* (entered into force April 2002), online: <www.nvve.nl/assets/nvve/english/EuthanasiaLaw.pdf>. Therefore, we will not review them here.

¹³ For those who are persuaded by the limits on access to assisted suicide or voluntary euthanasia recommended by Madam Justice Smith in *Carter* or the Québec Committee, we offer elements that could be added to our proposed guidelines to make them consistent with Madam Justice Smith’s limits (Appendix II) or the Québec Committee’s limits (Appendix III). It must be emphasized that Madam Justice Smith’s decision does not contemplate prosecutorial charging guidelines but rather compels changes to the *Criminal Code*. It is not anticipated that the draft guidelines provided in Appendix II would be implemented, should the government fail in its attempts to have her decision overturned at the BC Court of Appeal and

address three preliminary issues. First, we offer the following definitions of our key terms (taken from the RSC Panel Report):

“Assisted suicide” is the act of intentionally killing oneself with the assistance of another. An example is a woman with advanced ALS [amyotrophic lateral sclerosis, also known as Lou Gehrig’s Disease] who gets a prescription from her physician for barbiturates and uses the drugs to kill herself.

“Voluntary euthanasia” is an act undertaken by one person to kill another person whose life is no longer worth living to them in accordance with the wishes of that person. An example is a man bedridden with many of the consequences of a massive stroke whose physician, at his request, gives him a lethal injection of barbiturates and muscle relaxants.¹⁴

the Supreme Court of Canada. In such a case, the *Criminal Code* would be revised to reflect the framework set out in her decision. Similarly, the Québec Committee did not recommend prosecutorial charging guidelines alone but, rather, in addition to changes to provincial legislation. It is not anticipated that the draft guidelines provided in Appendix III would be implemented as is, should the Québec National Assembly pass legislation with respect to medical aid in dying. If it did, there would be provincial legislation to set out a statutory framework within which prosecutors would be required to act. The charging guidelines would be drafted against that statutory backdrop. Rather, these additional draft guidelines are offered to show what our proposed prosecutorial charging guidelines would look like if the concerns regarding protection of the vulnerable, expressed in Madam Justice Smith’s decision and in the Québec Committee Report, but rejected by the RSC Panel, were reflected in them, through additional factors tending to favour prosecution. If the government is successful on appeal against Madam Smith’s decision, then a provincial or territorial Attorney General wishing to provide guidance re: prosecutions of assisted suicide and voluntary euthanasia and persuaded by her proposed limits on access, could use the draft guidelines presented in Appendix II. If there is no legislation passed in Québec but the Attorney General nonetheless wishes to follow the recommendations of the Québec Committee with respect to charging guidelines, then he or she could use the draft guidelines presented in Appendix III.

¹⁴ These definitions were taken from the definitions provided in the RSC Panel Report, *supra* note 4 at 7. In turn, the Panel’s definitions were drawn (and sometimes modified) from Jocelyn Downie, *Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada* (Toronto: University of Toronto Press, 2004) at 6-7; Canada, Special Senate Committee on Euthanasia and Assisted Suicide, *Of Life and Death: Final Report* (Ottawa: Special Senate

Second, we explain our use of the Royal Society of Canada Panel Report (rather than the Québec Committee Report or the *Carter* decision) as the foundation for our guidelines. Like the RSC Panel and unlike the Québec Committee, we do not seek to limit access to voluntary euthanasia or assisted suicide to those who are “suffering from a serious, incurable disease”, “in an advanced state of weakening capacities, with no chance of improvement”, or having “constant and unbearable physical or psychological suffering that cannot be eased under conditions he or she deems tolerable.”¹⁵ We were persuaded by the arguments on limits to access presented in the RSC Panel Report and the literature grounding it, and so in this paper we are attempting to demonstrate the implications of that report for practice by rolling it out into concrete guidelines.

Third, we anticipate a possible argument that our proposed guidelines could be subject to an administrative law challenge. Section 14 of the *Criminal Code* states: “No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.”¹⁶ The administrative law challenge could be made because our guidelines are based on an autonomous choice by the deceased for his or her life to end – this is inconsistent with the prohibition on consenting to one’s own death. We consider, however, that our proposed guidelines would withstand such a challenge because they do not infringe on the criteria delineating when criminal responsibility is established as a matter of law. Instead, the proposed voluntary euthanasia and assisted suicide guidelines are relevant only to the exercise of discretion in determining whether it is in the public interest for that conduct to be prosecuted. We also note that the public interest factor of autonomous choice in the proposed guidelines would not be the sole criterion for the exercise of prosecutorial discretion, since prosecutors would also have to apply the other public interest considerations, as set out in the general prosecution guidelines.

I. Prosecutorial Guidelines in Canada

The criminal offences that principally arise in the context of voluntary euthanasia and assisted suicide are murder; manslaughter; administering a

Committee on Euthanasia and Assisted Suicide, June 1995), online: <www.parl.gc.ca/Content/SEN/Committee/351/euth/rep/lad-e.htm>.

¹⁵ Québec Committee Recommendations, *supra* note 9 at 5.

¹⁶ *Supra* note 2.

noxious thing; and aiding, abetting, or counselling suicide.¹⁷ It is no defence that an accused's conduct was motivated by compassion,¹⁸ nor is a person excused from criminal responsibility because a victim consented to his or her own death.¹⁹ However, the commission of one of the above offences is not in and of itself sufficient to lead to prosecution. Prosecutors have discretion with respect to the prosecution and withdrawal of charges under the *Criminal Code*. Individual prosecutors are assisted in the exercise of this discretion through their upward reporting relationships and by instructions, guidelines, or directives (hereafter "guidelines") issued under the authority of the Director of Public Prosecutions ("DPP") or the Attorney General.²⁰ These guide-

¹⁷ *Ibid* ss 229, 234, 245, 241.

¹⁸ Motive is not relevant to determining *criminal responsibility* in these cases. Justice Dickson, as he then was, stated the general rule with respect to motive and the criminal law in *R v Lewis*, [1979] 2 SCR 821 at 831, 98 DLR (3d) 111: "In ordinary parlance, the words 'intent' and 'motive' are frequently used interchangeably, but in the criminal law they are distinct. In most criminal trials, the mental element, the *mens rea* with which the Court is concerned, relates to 'intent,' i.e., the exercise of a free will to use particular means to produce a particular result, rather than with 'motive,' i.e., that which precedes and induces the exercise of the will. The mental element of a crime ordinarily involves no reference to motive." That said, motive may be relevant to *sentencing* an individual. It should also be noted here that, as somewhat of an exception to the general approach taken to motive in respect of criminal responsibility, the motives of health care professionals have been taken into account in certain instances. See Joan Gilmour, "Death, Dying and Decision-Making about End of Life Care" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, *Canadian Health Law and Policy*, 4th ed (Toronto: LexisNexis, 2011) at 431. However, these 'instances' are explicitly distinguished from euthanasia and assisted suicide by those who embrace the exception (rather, they relate to pain management and withholding or withdrawal of potentially life-sustaining treatment).

¹⁹ *Criminal Code*, *supra* note 2 s 14.

²⁰ In some jurisdictions, there is both a statutorily independent Director of Public Prosecution and an Attorney General (i.e., Nova Scotia, Québec, and at the federal level) while in others, there is no DPP or the DPP is not independent of the Attorney General. For examples of charging guidelines in various jurisdictions, see British Columbia, Prosecution Services, "Crown Counsel Policy Manual" (British Columbia: PS, 18 November 2005), online: <www.ag.gov.bc.ca/prosecution-service/policy-man/index.htm> [BC General Guidelines]; Nova Scotia, Public Prosecution Service, "Crown Attorney Manual" (Halifax: PPS, 2004), online: <www.gov.ns.ca/pps/ca_manual.htm> [NS Guidelines]; Newfoundland and Labrador, Office of the Director of Public Prosecutions, "Guidebook of Policies and Procedures for the Conduct of Criminal Prosecutions in Newfoundland and Labrador", (St. John's: ODPP, October 2007), online:

lines set out the test that the Crown will apply in considering whether to prosecute the accused. Generally, there are two considerations:

1. Whether there is sufficient evidence such that there is a reasonable prospect of securing a conviction
2. If so, whether it is in the public interest that a prosecution occur

Of significance for this article is the second consideration. The various Canadian prosecution guidelines identify a range of factors that may be relevant to determining whether a prosecution is in the public interest: the seriousness of the alleged offence; any mitigating or aggravating circumstances; the characteristics of the accused, the victim and any witnesses (such as age, physical or mental health, or disability); the degree of the accused's culpability in relation to the offence; antecedents and background of the accused; the prevalence of this type of offence and the need for deterrence; the level of public concern about the offence; the attitude of the victim with regards to prosecution; the level of co-operation from the accused; the need to maintain confidence in Parliament, the courts, and the law; public order and morale; the likely sentence if the accused is convicted; and the likely length and cost of trial.²¹

Although some of these factors may have particular applicability to cases involving voluntary euthanasia and assisted suicide, only the Province of British Columbia has developed guidelines that explicitly address such cases. However, the bulk (>90% of the text) of the BC Guidelines is directed at providing guidance under the heading of "substantial likelihood of conviction"²² with respect to the characterization of "the conduct of the person involved in a death"²³; in particular, the Guidelines clearly delineate the following categories of conduct: euthanasia, assisted suicide, palliative care,

<www.justice.gov.nl.ca/just/prosecutions/pp_guide_book.pdf> [NL Guidelines]; Alberta, Justice and Solicitor General, "Crown Prosecutors' Policy Manual" (Edmonton: JSG, 15 January 2009), online: <justice.alberta.ca/programs_services/criminal_pros/Publications%20Library%20%20Criminal%20Prosecutions/CrownProsecutors%27PolicyManual.aspx/DispForm.aspx?ID=3> [AB Guidelines]; Ontario, Ministry of the Attorney General, "Crown Policy Manual" (Toronto: MAG, 2005), online: <www.attorneygeneral.jus.gov.on.ca/english/crim/cpm/default.asp> [ON Guidelines].

²¹ *Ibid.*

²² BC Guidelines, *supra* note 11 at 1.

²³ *Ibid.*

and withholding or withdrawing treatment. The characterization of the conduct is critical because the guidelines clearly state that euthanasia and assisted suicide are offences under the *Criminal Code*, while each of palliative care and the withholding or withdrawal of treatment, “when provided or administered according to accepted ethical medical standards,” are “not subject to criminal prosecution.”²⁴ Euthanasia and assisted suicide are clearly, under these guidelines, subject to criminal prosecution in BC. In the remaining <10% of the text of the guidelines, under the heading “Public interest”²⁵, three factors are set out to provide guidance with respect to when the public interest requires prosecution: “1) the importance of supporting proper professional and ethical standards within the health care professions; 2) society’s interest in the protection of vulnerable persons; and 3) society’s interest in protecting the sanctity of human life, recognizing this does not require life to be preserved at all costs.”²⁶ Of note is the fact that these three factors are expressed in terms that are usually relied upon by those arguing against permitting voluntary euthanasia and assisted suicide. This suggests that, to the extent these public interest factors are relevant to a particular case, their application would tend in favour of prosecution. In sum, the BC Guidelines clarify what is already permitted and what is not, rather than expanding what is permitted.

In light of this, the BC Guidelines should not be taken as sufficient to meet the recommendations made by the Québec Committee or the RSC Panel. They do not carve out at least some cases of medical aid in dying or voluntary euthanasia and assisted suicide as not being appropriately subject to prosecution. The BC guidelines do not establish circumstances within which voluntary euthanasia and assisted suicide would not be prosecuted, but rather distinguish conduct that would not be prosecuted (palliative care and withholding or withdrawal of treatment) from conduct that would (all cases of euthanasia and assisted suicide, and those cases of palliative care and withholding or withdrawal that were not provided or administered according to accepted ethical medical standards).

²⁴ *Ibid* at 2.

²⁵ *Ibid* at 4.

²⁶ *Ibid*.

II. Prosecutorial Guidelines in England and Wales

England and Wales recently produced prosecutorial guidelines dealing with assisted suicide (the guidelines do not cover voluntary euthanasia).²⁷ This occurred after the final judicial decision of the House of Lords in July 2009: *R. (on the application of Purdy) v Director of Public Prosecutions*.²⁸ Ms. Purdy suffered from primary progressive multiple sclerosis and wished to obtain assistance from her husband to travel to a jurisdiction where assisted suicide was lawful so that she might die. She was, however, concerned that her husband might be prosecuted and so she requested information from the DPP as to the factors he would consider when deciding whether to consent to the initiation of a prosecution for assisted suicide. This consent is specifically required by section 2(4) of the *Suicide Act 1961* (UK). The DPP declined to provide that information, and Ms. Purdy challenged that decision. The House of Lords concluded that Ms. Purdy was entitled to know what factors the DPP would consider when deciding whether or not to prosecute, and directed him to promulgate an offence-specific policy to this effect.

In reaching this conclusion, the House of Lords considered that Ms. Purdy's right to respect for her private life under article 8(1) of the *European Convention for the Protection of Human Rights and Fundamental Freedoms*²⁹ was engaged. A failure to provide an offence-specific policy setting out the factors that will be used to determine whether a prosecution is in the public interest interfered with that right in a manner that was not "in accordance with law" as required by article 8(2). Of significance for the House of

²⁷ England and Wales Guidelines, *supra* note 12.

²⁸ *R (on the application of Purdy) v Director of Public Prosecutions*, [2009] UKHL 45, [2010] 1 AC 345 [*Purdy*]. The case of *R (on the application of Pretty) v Director of Public Prosecutions*, [2001] UKHL 61, [2002] 1 AC 800 [*Pretty*] also dealt with the issue of prosecutorial discretion in the context of assisted suicide. We do not discuss this case here, as it is *Purdy* that ultimately triggered the England and Wales Guidelines, and it is these Guidelines that we considered, drew upon, and distinguished from ours.

²⁹ *Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 4 November 1950, 213 UNTS 221 (entered into force 3 September 1953), as amended by *Protocol No 14 to the Convention for the Protection of Human Rights and Fundamental Freedoms, Amending the Control System of the Convention*, art 8(1), opened for signature 13 May 2004, CETS No 194 (entered into force 1 June 2010).

Lords was that the general “Code for Crown Prosecutors”³⁰ provided inadequate guidance as to when cases of this type would be prosecuted. The court also noted the disparity between the prohibition on assisted suicide and the general practice in terms of prosecutions actually brought. These factors meant that Ms. Purdy, and those who might assist her, such as her husband, were not able to make decisions about how to conduct themselves in accordance with the criminal law. Further offence-specific guidance was therefore needed from the DPP.

In September 2009, the DPP produced an interim policy setting out proposed factors for and against the prosecution of cases of assisted suicide.³¹ That policy was then the subject of a wide public consultation process which included the participation of over 4,700 individuals and organisations.³² In February 2010, after considering the results of that consultation exercise, the DPP published its final *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide*.³³ In determining whether a prosecution is in the public interest, the guidelines set out 16 factors that favour prosecution and six factors that tend against it.

The public interest factors tending in favour of prosecution are:³⁴

1. the victim was under 18 years of age;

³⁰ England and Wales, Crown Prosecution Service, “The Code for Crown Prosecutors” (London: CPS, February 2010), online: <www.cps.gov.uk/publications/docs/code2010english.pdf>.

³¹ See England and Wales, Director of Public Prosecutions, “Interim Policy for Prosecutors in Respect of Cases of Assisted Suicide”, by the Crown Prosecutions Service (London: DPP, September 2009), online: <www.cps.gov.uk/consultations/as_policy.pdf> [England and Wales Interim Policy Consultation].

³² See England and Wales, Director of Public Prosecutions, *Public Consultation Exercise on the Interim Policy for Prosecutors in respect of Cases of Assisted Suicide: Summary of Responses*, by the Crown Prosecution Service (London: DPP, February 2010), online: <www.cps.gov.uk/consultations/as_responses.pdf> [England and Wales Interim Policy Summary]. See also England and Wales Interim Policy Consultation, *supra* note 32.

³³ England and Wales Guidelines, *supra* note 12. Note also that the Isle of Man has recently followed suit and issued guidelines in similar terms, see “Suicide policy same as UK”, *Isle of Man News* (28 September 2011), online: Isle of Man Today <www.iomtoday.co.im/news/isle-of-man-news/suicide_policy_same_as_uk_1_3814031>.

³⁴ England and Wales Guidelines, *supra* note 12 at para 43.

2. the victim did not have the capacity (as defined by the *Mental Capacity Act 2005*) to reach an informed decision to commit suicide;
3. the victim had not reached a voluntary, clear, settled and informed decision to commit suicide;
4. the victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect;
5. the victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative;
6. the suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim;³⁵
7. the suspect pressured the victim to commit suicide;
8. the suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide;
9. the suspect had a history of violence or abuse against the victim;
10. the victim was physically able to undertake the act that constituted the assistance him or herself;
11. the suspect was unknown to the victim and encouraged or assisted the victim to commit or attempt to commit suicide by providing specific information via, for example, a website or publication;
12. the suspect gave encouragement or assistance to more than one victim who were not known to each other;

³⁵ The guidelines later clarify that a common sense approach should be taken in relation to this factor. Some benefit may accrue to the suspect from the victim's death but the critical element is the suspect's motive: England and Wales Guidelines, *ibid* at para 44.

13. the suspect was paid by the victim or those close to the victim for his or her encouragement or assistance;
14. the suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer [whether for payment or not], or as a person in authority, such as a prison officer, and the victim was in his or her care;
15. the suspect was aware that the victim intended to commit suicide in a public place where it was reasonable to think that members of the public may be present;
16. the suspect was acting in his or her capacity as a person involved in the management or as an employee (whether for payment or not) of an organisation or group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.

The public interest factors tending against prosecution are:³⁶

1. the victim had reached a voluntary, clear, settled and informed decision to commit suicide;
2. the suspect was wholly motivated by compassion;
3. the actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance;
4. the suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide;
5. the actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide;
6. the suspect reported the victim's suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.

³⁶ England and Wales Guidelines, *supra* note 12 at para 45.

There is a growing body of academic work that examines the England and Wales Guidelines.³⁷ There is not space in this paper to rehearse that literature, nor is it our goal to undertake a detailed critique of the guidelines themselves. To contextualise our recommendations, however, we do make four brief observations that inform our alternative approach, and lead to points of disagreement and thereafter divergence between our guidelines and those in England and Wales.

The first observation is that the guidelines do not appear to be founded on a set of coherent guiding principles. This seemed to be confirmed by evidence given by the DPP responsible for developing the guidelines, Keir Starmer, to the privately established Commission on Assisted Dying.³⁸ In response to a question about what the “underlying principle” was for the guidelines, he noted that a “schematic approach” had been avoided on the basis

³⁷ See for example, Penney Lewis, “Informal Legal Change on Assisted Suicide: The Policy for Prosecutors” (2011) 31 LS 119; JJ Shaw, “Fifty Years On: Against Stigmatising Myths, Taboos and Traditions Embedded Within the Suicide Act 1961 (UK)” (2011) 18 J Law Med 798; Glenys Williams, “Assisting Suicide, the Code for Crown Prosecutors and the DPP’s Discretion” (2010) 39:2 C L World Rev 181; John Finnis, “Invoking the Principle of Legality Against the Rule of Law” (2010) Part IV NZL Rev 601; Carol C Cleary, “From ‘Personal Autonomy’ to ‘Death-on-Demand’: Will *Purdy v DPP* Legalize Assisted Suicide in the United Kingdom?” (2010) 33 BC Int’l & Comp L Rev 289; Rob Heywood, “The DPP’s Prosecutorial Policy on Assisted Suicide” (2010) 21 King’s Law Journal 425; John Coggon, “Prosecutorial Policy on Encouraging and Assisting Suicide – How Much Clearer Could It Be?” (2010) 36 J Med Ethics 381; Jonathan Rogers, “Prosecutorial Policies, Prosecutorial Systems, and the *Purdy* Litigation” (2010) Issue 7 Crim L Rev 543; Roger Daw & Alex Solomon, “Assisted Suicide and Identifying the Public Interest in the Decision to Prosecute” (2010) Issue 10 Crim L Rev 737; Alexandra Mullock, “Overlooking the Criminally Compassionate: What Are the Implications of Prosecutorial Policy on Encouraging or Assisting Suicide” (2010) 18 Med L Rev 442; Suzanne Ost, “The De-Medicalisation of Assisted Dying: Is a Less Medicalised Model the Way Forward?” (2010) 18 Med L Rev 497; Clive Seale, “Do It Properly or Not at All” (2010) 340 BMJ 775; John Coggon, “Doctors and Assisted Suicide” (2010) 340 BMJ 547. Although not in the academic context, see also the detailed examination of the England and Wales Guidelines in The Commission on Assisted Dying, “The Current Legal Status Of Assisted Dying Is Inadequate and Incoherent...”, online: Demos see especially pp 89-105 <www.demos.co.uk/files/476_CoAD_FinalReport_158x240_I_web_single-NEW_.pdf?1328113363>.

³⁸ More information about the Commission on Assisted Dying is available online: <www.commissiononassisteddying.co.uk/about-the-commission-for-assisted-dying>.

that such an approach would risk, “unless it’s very carefully constructed, undermining Parliament’s intention that this should be an offence.”³⁹ The role of the DPP was instead, he explained, to exercise discretion on a case-by-case basis. The risk of this approach, however, is that the guidelines may not be conceptually sound and may lead to undesirable outcomes in practice. Consider, for example, the factor in favour of prosecution that the suspect was aware that the deceased intended to commit suicide in a public place where people may be present. It is clear that this factor is different in character to the others in the guidelines and seems to be aimed at different considerations. We ultimately omitted this factor from our guidelines because it did not flow from the guiding principles we established as relevant for our approach. We were also concerned that it may inadvertently capture places where we would argue it could be appropriate for voluntary euthanasia or assisted suicide to occur, such as a hospital room which, at least sometimes, is a “public place.”⁴⁰ Nevertheless, depending on the starting point of the analysis, such a factor could be regarded as appropriate. However, without a clear articulation of relevant guiding principles, it is unclear whether this is so, and what purpose this factor is serving.⁴¹

The second observation is linked to the first: the authors of the guidelines failed to articulate the significance of, and the relationship between, the various factors in the guidelines.⁴² For example, as we outline below when con-

³⁹ Commission on Assisted Dying, *Transcript of Evidence from Keir Starmer QC, Director of Public Prosecutions* (14 December 2010) at 17, online: Commission on Assisted Dying <commissiononassisteddying.co.uk/wp-content/uploads/2010/12/Keir-Starmer-Transcript-Final1.pdf> [Keir Starmer Transcript].

⁴⁰ We also note that there are public order offences that are capable of addressing this concern in a more nuanced fashion.

⁴¹ It could reflect an attempt to prevent harm to third parties who witness the assisted suicide or voluntary euthanasia. The language is both so under-inclusive and over-inclusive that it would not achieve this objective. It could capture individuals in a public place, such as a hospital room, where no innocent third parties will be harmed, and it could also fail to capture individuals in a private place, where third parties will be harmed by discovering the body. Location seems to be a poor proxy for some consequences one might legitimately seek to prevent.

⁴² A similar critique is made in relation to the various elements of the “public interest” test of the “Code for Crown Prosecutors” (*supra*, note 31) in Jonathan Rogers, “Restructuring the Exercise Of Prosecutorial Discretion in England” (2006) 26 Oxford J Legal Stud 775 at 793-94. The interim policy did suggest some factors be given greater weighting than others but this was ultimately removed, to make

structuring our approach, some factors are considerations in their own right. An illustration from the England and Wales Guidelines is that “the victim had not reached a voluntary, clear, settled and informed decision to commit suicide.”⁴³ By contrast, other factors might best be described as “evidential,” that is, they are evidence as to whether or not other factors in the guidelines will be substantiated. A relevant England and Wales example is whether or not “the suspect pressured the victim to commit suicide,”⁴⁴ as this in turn becomes evidence that is directly related to another factor: the voluntary nature of the decision. This distinction matters, since consistent and considered decision making requires an understanding of the role and significance of the relevant factors in a process of deliberation. We acknowledge that the guidelines note that assessing the public interest is not a numerical exercise and that prosecutors “must decide the importance of each public interest factor in the circumstances of each case and go on to make an overall assessment.”⁴⁵ However, we consider this sort of guidance to still fall short of articulating, in a meaningful way, how the factors are to be used in a decision making process.

The third observation is that the England and Wales Guidelines apply only to assisted suicide and do not deal with voluntary euthanasia. Although this is the case because the guidelines were produced in response to the *Purdy* decision (which focused exclusively on assisted suicide), we consider that differentiating between voluntary euthanasia and assisted suicide is not justifiable for four reasons.⁴⁶ Firstly, to differentiate discriminates on the ba-

the policy “clearer and more accessible” (England and Wales Interim Policy Summary, *supra* note 33 at 18, 20, 32, 34).

⁴³ England and Wales Guidelines, *supra* note 12 at para 43.

⁴⁴ *Ibid* at para 43.

⁴⁵ *Ibid* at para 39.

⁴⁶ While we can only provide a very brief justification for our position here, we note that the RSC Panel (*supra* note 4 at 100) and Smith J in *Carter* (*supra* note 6 at para 1393) included both voluntary euthanasia and assisted suicide in their permissive regimes. The Québec Committee Report seems to draw a distinction and include only euthanasia within “medical aid in dying”: “assisted suicide, considered an individual act in time and space, does not reflect the values of medical support and safety that are inseparable from the medical aid in dying option, as we propose it. Moreover, assisted suicide certainly cannot be considered a form of care and therefore runs counter to one of the main principles that guided our thinking and our recommendations, namely that any openness in this regard should be situated in the context of a continuum of care.” (*supra* note 5 at 79) To this statement we would simply respond that it is not the suicide that needs to fit

sis of disability. If the guidelines do not include voluntary euthanasia, a person whose disability or illness means that he or she is not capable of ending life on his or her own (and so requires another to do the final act that ends his or her life), may be deprived of that assistance because of concerns about prosecution.⁴⁷ Second, given that we argue for guidelines grounded in respect for autonomy, both assisted suicide and voluntary euthanasia are justified (even though the final agent of death is different). Third, a false assumption that sometimes underpins treating assisted suicide differently from voluntary euthanasia is that the former is *always* less serious than the latter. Including both in the guidelines allows prosecutors to assess whether a prosecution is appropriate in the circumstances of each case. Furthermore, as noted below, this assessment would occur not only having regard to the offence-specific guidelines, but also the general prosecutorial charging guidelines which take into account factors such as the level of culpability of the accused. Finally, we accept that some people may say that they would experience an emotional difference between assisting another person to commit suicide and participating in voluntary euthanasia.⁴⁸ However, different emotional reactions do not provide a foundation for a claim of there being a morally significant distinction – particularly a distinction to be used as the basis for public policy. Otherwise, of course, the fact that some people experience withholding treatment and withdrawing treatment differently could justify permitting one and not the other. In the context of public policy grounded in respect for autonomy, in most circumstances, the emotional difference could justify a person, such as a medical or other health professional, not being forced to provide both assisted suicide and voluntary euthanasia (autonomy is often constrained where its exercise would result in harm to others). It could not, however, justify a difference in public policy with respect to the permissibility of one and not the other.⁴⁹

The final observation is concerned with the emphasis the England and Wales Guidelines place on the conduct of the suspect being characterized as

within the “continuum of care” but rather the provision of assistance and the provision of a prescription for a lethal medication, arguably, fits as well within the continuum of care as does provision of a lethal injection.

⁴⁷ Margaret Otłowski, *Voluntary Euthanasia and the Common Law* (Oxford: Clarendon Press, 1997) at 194-95.

⁴⁸ Ilinka Haverkate et al, “The Emotional Impact on Physicians of Hastening the Death of a Patient” (2001) 175 Med J Aust 519.

⁴⁹ Otłowski, *supra* note 48. See also, for example, Dan Brock, “Voluntary Active Euthanasia” (1992) 22:2 The Hastings Center Report 10.

non-professional, “compassionately-motivated one-off assistance.”⁵⁰ Related to this, the guidelines specifically discourage the involvement of medical and other health professionals as well as individuals belonging to organizations that facilitate assisted suicide. Such an approach gives rise to concerns that, without the relevant expertise and experience, incorrect assessments of the deceased’s competence might be made.⁵¹ Also of concern is the fact that attempts by the unqualified to assist the deceased may lead to the latter dying in pain or discomfort, or experiencing the indignity in death that he or she was seeking to avoid.⁵² Further, precluding the involvement of medical and other health professionals may also reduce the deceased’s opportunity to make a decision about whether to die in light of complete and accurate information about his or her prognosis and treatment options.⁵³ For these reasons, our proposed guidelines do not treat acting in a professional capacity in and of itself as a factor in favour of prosecution.⁵⁴ We note finally that this aspect of the England and Wales Guidelines is the subject of legal challenge by a man who wishes to end his life but whose family would not assist him. “Martin” is challenging the guidelines seeking that they be “clarified” so that he could be helped by “a member of the public ... , a health professional or a solicitor.”⁵⁵

⁵⁰ England and Wales Interim Policy Consultation, *supra* note 32. See also comments in Keir Starmer Transcript, *supra* note 40 at 7-8, 10. See also Williams, *supra* note 38 at 192-93 and Mullock, who notes the significant weight given to this consideration (*supra* note 38).

⁵¹ Lewis, *supra* note 38 at 129. Although there are aspects of assessing whether decision making is competent and voluntary that do not require medical expertise (for example, the impact of family dynamics), medical involvement in capacity assessments is likely to reduce error (Ost, *supra* note 38 at 534-37).

⁵² Lewis, *supra* note 38 at 129-30; Seale, *supra* note 32; Ost, *supra* note 38 at 534-37; Mullock, *supra* note 38 at 452-53; Commission on Assisted Dying, *supra* note 32 at 98-99.

⁵³ Ost, *supra* note 38 at 537.

⁵⁴ This is consistent with the RSC Panel, which recommended “health care professionals be permitted to provide assistance with suicide or voluntary euthanasia” (RSC Panel Report, *supra* note 4 at 101). The Québec Committee Report (*supra* note 5 at 82) and Madam Justice Smith (*Carter*, *supra* note 6 at para 1393) both limit permissible assistance to physicians.

⁵⁵ Clare Dyer, “Nicklinson’s Widow is Refused Right to Appeal to Higher Court” (2012) 345 Brit Med J e6690. “Martin” received leave to appeal against the English High Court’s conclusion in *R (on the application of Nicklinson) v Ministry of Justice*; *R (on the application of AM) v Director of Public Prosecutions* [2012]

III. Proposed Voluntary Euthanasia and Assisted Suicide Guidelines

1. *Introduction*

We turn now to setting out our proposed guidelines for when prosecutions should or should not occur in relation to voluntary euthanasia and assisted suicide. In this effort, we are informed by our above critiques, the academic literature and case law on prosecutorial discretion in general and charging guidelines in particular, and the arguments presented in the RSC Panel Report. Although we were not able to undertake a detailed review of the British Columbia or the England and Wales Guidelines in this paper, we consider that there are sufficient concerns about those models to warrant starting anew and designing a set of guidelines for the Canadian context, albeit informed by the experience in BC and England and Wales. As part of that process, we start from first principles and identify three guiding principles for constructing these guidelines: respecting autonomous choice, promoting high-quality decision making by prosecutors, and ensuring public confidence in the decisions of prosecutors. Each of these principles is discussed in more detail below.

Having identified those principles, we are then in a position to determine the content of the guidelines, which we have organized into six components. The first component states that a public interest factor that tends in favour of, or against, prosecution is whether the deceased's death occurred as a result of an autonomous choice made by the deceased for his or her life to end.⁵⁶ The second and third components of the guidelines deal with how the nature of the deceased's choice (if any) is to be established: what are the elements of an autonomous choice in the context of voluntary euthanasia and assisted suicide, and what is the evidence that may be directly relevant to determining whether those elements are present or not. For example, one element of an autonomous choice is that it was made voluntarily, and direct evidence of whether that is the case or not might include whether the suggestion to consider voluntary euthanasia or assisted suicide came from the deceased or

EWHC 2381 that the DPP was not required to clarify his policy as requested. Martin's case was heard along with the related case of Tony Nicklinson (who challenged the law rather than the DPP policy). Nicklinson was unsuccessful before the High Court and his widow (Nicklinson had subsequently died) was denied leave to appeal: Dyer above.

⁵⁶ We use the language of "tends in favour, or against" because some discretion is needed (otherwise the guidelines shift to favour ceasing to apply the law with obvious consequences for the rule of law).

from the suspect. The fourth component is comprised of factors that do not constitute direct evidence of whether the elements of an autonomous choice are present or not, but that nevertheless give confidence or raise doubts as to the nature of the choice. An example of this is where the suspect has a financial interest in the death of the deceased. While in such cases it is still possible to show that, as a matter of fact, an autonomous choice has been made, the mere presence of this factor creates a real risk that this may not be the case. Recognition of such “confidence factors” in the guidelines is important in individual cases but also in the longer term for ensuring that the public has confidence in these decisions and that these guidelines do not foster situations where non-autonomous choices are acted upon.

These four components comprise the decision making content of the offence-specific guidelines, and explain how a prosecutor should use each component in his or her decision making. Although this is explained further below when each component is considered in more detail, we have briefly indicated here the role played by each of the components and how they relate to each other. This is important in light of the objection expressed earlier asserting that the England and Wales Guidelines fail to articulate the significance of, and the relationship between, the various factors in those guidelines. We anticipate the suggestion that in practice, such decision making may not be as nuanced and orderly as our approach. Nevertheless, deficits in practice do not detract from the importance of conceptual clarity in decision making and there is merit in attempting to articulate how decisions should be made in a principled way.

The final two components relate more to process issues of decision making than to the content of those decisions. The fifth component requires that decisions regarding whether or not to prosecute under the guidelines be made with the consent of the relevant Attorney General himself or herself. The sixth component establishes a reporting structure for decisions whether or not to prosecute. Reporting should occur in relation to individual decisions but systematic data should also be kept and published to ensure the system is, and is seen to be, working.

It should be noted that our guidelines contemplate roles for both prosecutors and the Attorney General. The first four components will, in the first instance, be investigated and assessed by prosecutors. The fifth and sixth components are the responsibility of the Attorney General. However, in undertaking these latter roles, the Attorney General must also engage with the first four components. To illustrate, engaging with whether or not the deceased’s life ended as a result of an autonomous choice is essential when deciding

whether or not to prosecute and why. In doing so, the Attorney General would have regard to the advice of prosecutors who have conducted investigations and formed views as to these matters although the ultimate decision as to whether a prosecution occurs remains with the Attorney General. For ease of reference, the discussion that follows of “prosecutors” in relation to the first four components will, except where the context indicates otherwise, include both prosecutors (as they have responsibility for these matters in the first instance), and the Attorney General (as the person charged with ultimate prosecutorial decision making responsibility).

Turning finally to the scope and operation of the proposed guidelines: they are intended not to exclude, but to supplement the operation of the general prosecutorial guidelines. Prosecutors would be required to apply the broader public interest considerations in the general guidelines as well as the additional public interest factor identified as significant for these specific offences set out below.⁵⁷ Our guidelines also apply only where the deceased was capable of making an autonomous choice for his or her life to end (that is, competent adults and mature minors alike, as discussed below).⁵⁸ Given the centrality of autonomy in these guidelines, it is not appropriate that they govern adults or children who are incompetent. Finally, for the reasons outlined above,⁵⁹ the guidelines apply to both voluntary euthanasia and assisted suicide. We note though that the operation of the general prosecutorial guidelines may be significant in terms of how these two situations are treated. As noted above,⁶⁰ some of the factors in the general guidelines to be considered in assessing whether prosecution is in the public interest include the seriousness of the alleged offence and the degree of culpability of the accused. It may be that in particular cases of voluntary euthanasia the greater level of participation by the accused in the deceased’s death points more towards prosecution than if he or she had only assisted the deceased’s suicide. That will not always be the case, however, and allowing the guidelines to deal with both situations allows this discretion to be exercised in light of the facts of each case.

⁵⁷ This is also the approach taken in England and Wales Guidelines, *supra* note 12 at para 38.

⁵⁸ See below at “Capacity”.

⁵⁹ See above at “Prosecutorial Guidelines in England and Wales”.

⁶⁰ See above at “Prosecutorial Guidelines in Canada”.

2. *Three Guiding Principles*

In drafting the proposed prosecutorial guidelines, we were guided by three principles:

1. the critical factor that tends against prosecution is if the deceased's death occurred as a result of an autonomous choice made by the deceased for his or her life to end;
2. the decision making pursuant to the prosecutorial discretion in this area needs to be of high-quality; and
3. the decision making pursuant to that discretion needs to attract public confidence.

We consider each in turn.

Guiding Principle One: An Autonomous Choice

One can find support in law for the consideration of autonomy as an appropriate value underpinning these guidelines.⁶¹ The principle of autonomy in the medical treatment context is of fundamental importance in Canadian common law and is enshrined in the *Charter of Rights and Freedoms*.⁶² As Robins, JA noted for the Ontario Court of Appeal in the well-known case of *Fleming v Reid*:

⁶¹ Of course, support for this idea can also be found in ethics. We do not, however, rely upon an ethical argument for respect for autonomy here. This is in part because we believe that the argument can be made without introducing the complexity and controversy associated with competing ethical theories about autonomy (contrast, for example, the conceptions of autonomy articulated in Immanuel Kant, *Fundamental Principles of the Metaphysics of Morals* (1785); John Stuart Mill, *On Liberty* (1859), online: Bartleby <www.bartleby.com/25/2>; and Susan Sherwin, "Relational Autonomy and Global Threats" in Jocelyn Downie & Jennifer Llewellyn, eds, *Being Relational: Reflections on Relational Theory and Health Law* (Victoria: University of British Columbia Press, 2011). We believe that it is necessary and sufficient to ground the guidelines proposed in this article in the conventional understanding of autonomy that underpins the law more generally. The guidelines can and should evolve insofar as the law evolves in relation to changing conceptions of autonomy within moral philosophy. We do not see the project in this article as contributing to or driving such change.

⁶² *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

The common law right to bodily integrity and personal autonomy is so entrenched in the traditions of our law to be ranked as fundamental and deserving of the highest order of protection. This right forms an essential part of an individual's security of the person and must be included in the liberty interests protected by s. 7 [of the Canadian *Charter of Rights and Freedoms*]. Indeed, in my view, the common law right to determine what shall be done with one's own body and the constitutional right to security of the person, both of which are founded on the belief in the dignity and autonomy of each individual, can be treated as co-extensive.⁶³

In light of its recognition by Canadian law, we consider that respect for autonomy is an appropriate guiding principle to inform our approach to drafting guidelines that outline when prosecution may or may not be in the public interest. Therefore, as argued below, we consider that the critical factor that tends against prosecution in such cases is if the deceased's death occurred as a result of an autonomous choice made by the deceased for his or her life to end.⁶⁴

Guiding Principle Two: High-quality Decision Making

A decision regarding whether or not to prosecute cases potentially involving voluntary euthanasia and assisted suicide is significant. Most obviously, whether a prosecution occurs in relation to a death is significant for the deceased. For example, a choice not to prosecute on public interest grounds means the taking of the deceased's life does not, in all of the circumstances, warrant criminal sanctions. While in some instances such an outcome would be as the deceased had hoped, in other circumstances such a decision could be regarded as a failure to acknowledge the wrongful nature of the death. The decision is also significant for the suspect (who may also be a member of the deceased's family or a friend). A decision to prosecute imposes the "harms of prosecution"⁶⁵ on the suspect, and he or she also faces the prospect of conviction for a serious criminal offence, potentially murder, which carries a mandatory life sentence in Canada. Finally, it is significant for society as a whole: the ending of another person's life matters for the

⁶³ [1991] OJ No 1083, 4 OR (3d) 74 (Ont CA) at paras 30-36.

⁶⁴ This argument is made in greater depth and at greater length in the RSC Panel Report, *supra* note 4. We rely on that text (particularly chapter three) as further explanation and justification for the foundation of our proposed guidelines.

⁶⁵ Rogers, *supra* note 43 at 787-91.

community,⁶⁶ and so determining the appropriate criminal law response is important. It is therefore critical that decisions regarding whether or not to prosecute in such cases be of high-quality. For the purposes of this article, we consider high-quality decision making to require a process that is rigorous, transparent, and accountable, and that results in outcomes that accurately reflect conceptually sound criteria (which here we put forward in our proposed guidelines). This is particularly so given that such decisions are not susceptible to judicial review in Canada, except to prevent an abuse of process.⁶⁷

The production of clear guidelines dealing with the exercise of prosecutorial discretion in relation to cases of voluntary euthanasia and assisted suicide is one way to promote high-quality decision making. As discussed above in *Purdy*, clear guidelines provide a basis for ensuring whether decisions to prosecute are made predictably and consistently.⁶⁸ This is a function of prosecution guidelines generally,⁶⁹ and this claim can also be made in relation to those designed for specific offences. Making the guidelines publicly available also helps promote high-quality decision making as prosecutorial decisions (even in the absence of reasons for those decisions as discussed below) can attract a certain level of scrutiny that can be referenced against those criteria.⁷⁰

⁶⁶ The purposes and principles of sentencing outlined at section 718 of the *Criminal Code* explicitly recognize that criminal conduct harms both the victim and the community at large. With respect to homicide in particular, Kilpatrick J noted in *R v VanEindhoven*, 2007 NUCJ 2 at para 64, [2007] NuJ no 2 (QL): “As a family, as a community, as a people we are all diminished when a life is taken from us prematurely.”

⁶⁷ *R v Power*, [1994] 1 SCR 601, [1994] SCJ no 29 (QL).

⁶⁸ *Purdy*, *supra* note 29 at 395 (Lord Hope of Craighead).

⁶⁹ See e.g. ON Guidelines, *supra* note 21; Alberta, Justice and Solicitor General, “Decision to Prosecute, The Criteria Governing the Decision to Commence or Continue Prosecution” in “Alberta Crown Prosecutors’ Policy Manual” (Edmonton: JSG, 20 May 2008), online: <justice.alberta.ca/programs_services/criminal_pros/crown_prosecutor/Pages/decision_to_prosecute.aspx>.

⁷⁰ Andrew Ashworth, “The ‘Public Interest’ Element in Prosecutions” (1987) Issue 9 Crim L Rev 595 at 605-06; Keir Starmer Transcript, *supra* note 40 at 4; Marc Rosenberg, “The Attorney General in the 21st Century: A Tribute to Ian Scott: The Attorney General and the Administration of Criminal Justice” (2009) 34 Queen’s LJ 813.

The terms of the guidelines themselves can also establish ways in which high-quality decision making in this area can be promoted. One is by ensuring there is rigour in the decision making process, and the requirement to produce reasons for decisions can help to achieve that.⁷¹ Another is by advocating an open approach to the exercise of the prosecutorial discretion and making those reasons for decisions publicly available so that decision making is transparent and accountable to the community.⁷² Developing monitoring systems of longer term trends to ensure the efficacy of the guidelines and decision making pursuant to them can also ensure that the discretion is being exercised to a high standard.⁷³ The terms of the guidelines can also support high-quality decision making by requiring that the Attorney General consent to a prosecution whether a prosecution occurs or not.⁷⁴

Guiding Principle Three: Public Confidence in Exercise of Prosecutorial Discretion

The third guiding principle that informs our proposed guidelines is that they, and the decisions made pursuant to them by prosecutors, need to retain public confidence. As noted above, these are significant decisions in a complex and contested area and so it is important that the public has confidence in how they are made.⁷⁵ While this guiding principle is related to the previ-

⁷¹ David Phillip Jones & Anne S de Villars, *Principles of Administrative Law*, 5th ed (Toronto: Carswell, 2009) at 372-73; Sara Blake, *Administrative Law in Canada*, 5th ed (Markham: LexisNexis Canada, 2011) at 92.

⁷² Ashworth, *supra* note 71 at 605-06. This is why the current England and Wales DPP, Keir Starmer QC, states that he makes publicly available reasons for decisions not to prosecute in cases that are already in the public domain (Keir Starmer Transcript, *supra* note 40 at 4).

⁷³ While not gathered in relation to prosecutorial guidelines of the sort advocated for in this article, the systemic data collected in the Netherlands have, for example, highlighted issues of concern that have then been able to be demonstrably addressed through changes to law and practice. See e.g. the discussion of changing reporting requirements and rates in Judith AC Rietjens et al, "Two Decades of Research on Euthanasia from the Netherlands. What Have We Learnt and What Questions Remain?" (2009) 6:3 J Bioeth Inq 271 at 279.

⁷⁴ See below "Component Five: Decision Consented to by the Attorney General".

⁷⁵ Daw & Solomon, *supra* note 38 at 742, 750-51; Jeremy Rapke, "R (Purdy) v DPP – Its Implications for Prosecuting Authorities" (Paper delivered at the Conference of Australian and Pacific Prosecutors, October 2009). Some of the provincial prosecutorial guidelines explicitly recognize that wrongly exercising prosecutorial discretion undermines public confidence in the criminal justice system. See for

ous one, in that high-quality decision making can attract public confidence, these principles are distinct and so warrant separate consideration. Public confidence could be had in decision making that is not of a high standard, and high-quality decision making will not always attract public confidence.

One way to earn public confidence in prosecutorial decision making is through openness. As noted above, the public availability of the guidelines can make decision making more transparent, which can engender public confidence in the exercise of prosecutorial discretion.⁷⁶ There is also scope for the guidelines to impose requirements designed to promote public confidence. Requiring decisions to be made publicly available enables the public to scrutinize the exercise of the discretion and discretion – if exercised appropriately – will attract public confidence.⁷⁷ A similar argument applies to making publicly available systemic data about how the guidelines are being used.⁷⁸ Requiring the Attorney General to consent to the decision as to

example, Nova Scotia, Public Prosecution Service, “The Decision to Prosecute (Charge Screening)” (Halifax: PPS, 1 February 2011) at 2, online: <www.gov.ns.ca/pps/publications/ca_manual/ProsecutionPolicies/DecisionToProsecute.pdf>; Newfoundland and Labrador, Office of the Director of Public Prosecutions, “Communications with the Media” in “Guidebook of Policies and Procedures for the Conduct of Criminal Prosecutions in Newfoundland and Labrador” (St. John’s, ODPP, October 2007) at 10-1, online: <www.justice.gov.nl.ca/just/prosecutions/pp_guide_book.pdf>; Justice and Public Safety, “Guide Book of Policies and Procedures for the Conduct of Criminal Prosecutions in Prince Edward Island” by the Crown Attorney’s Office (Charlottetown: JPS, November 2009) at 9-18, online: <www.gov.pe.ca/photos/original/jps_crownconduc.pdf>. The RSC Panel also noted the importance of the maintenance of public trust in the system (albeit in the context of its discussion of a national oversight commission), *supra* note 4 at 102.

⁷⁶ Ashworth, *supra* note 71 at 605-06; Keir Starmer Transcript, *supra* note 40 at 4.

⁷⁷ Louis Blom-Cooper, “Reasons For Not Prosecuting” (2000) PL 560; Ashworth, *supra* note 71 at 605-06; Keir Starmer Transcript, *supra* note 40 at 4.

⁷⁸ For example, the public availability of data about the Netherlands, Belgium, Oregon and Washington State as to the practice of voluntary euthanasia and/or assisted suicide has made it possible for the public to see that claims about slippery slopes and risks to vulnerable groups (such as the poor, the elderly, people from ethnic backgrounds and people with disabilities) are demonstrably false. See e.g. Rietjens et al, *supra* note 74; Kenneth Chambaere et al, “Trends in Medical End-of-Life Decision Making in Flanders, Belgium 1998-2001-2007” (2011) 31:3 Med Decis Mak 500. See also data available on the websites of the Oregon Health Authority, online: <public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx> and the Washington State Department of

whether or not to prosecute in these cases can also promote public confidence in the guidelines.

Of course, one could argue that all decisions should be made well and should attract public confidence, and that the guiding principles of high-quality decision making – and public confidence in the exercise of this discretion – should apply not only in relation to the offences being discussed in this article, but to all offences. Indeed, many of the factors identified above could be applied or adapted to other offences, particularly those of a serious nature. However, because of the nature of the conduct at issue and the novelty of the approach (effectively allowing that some instances of assisted suicide and voluntary euthanasia do not warrant prosecution), decisions as to whether or not prosecuting a case involving voluntary euthanasia or assisted

Health, online: <www.doh.wa.gov/dwda/>. Of course there are authors who argue that there is empirical evidence of slippery slopes and risks to vulnerable groups. Evidence from these authors was introduced into court in *Carter*, *supra* note 6 listed at para 160. See e.g. John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalization* (New York: Cambridge University Press, 2002); Kennedy Institute of Ethics, “Care Not Killing: Considering Physician-Assisted Suicide: An Evaluation of Lord Joffe’s Assisted Dying for the Terminally Ill Bill” (Georgetown University, 2006), online: <kenedyinstitute.georgetown.edu/files/Keown_report.pdf>; Emily Jackson & John Keown, *Debating Euthanasia* (Oxford: Hart Publishing, 2011); Herbert Hendin & Kathleen Foley, “Physician-Assisted Suicide in Oregon: A Medical Perspective” (2008) 106 Mich L Rev 1613; Jose Pereira, “Legalizing Euthanasia or Assisted Suicide: The Illusion Of Safeguards and Controls” (2011) 18:2 Current Oncology 38. However, following cross-examination by the plaintiff’s counsel, Madam Justice Smith concluded that: “An absolute prohibition might be called for if the evidence from permissive jurisdictions showed abuse of patients, or carelessness or callousness on the part of physicians, or evidence of the reality of a practical slippery slope.

However, that is not what the evidence shows. I have found that the evidence supports the conclusion that a system with properly designed and administered safeguards could, with a very high degree of certainty, prevent vulnerable persons from being induced to commit suicide while permitting exceptions for competent, fully-informed persons acting voluntarily to receive physician-assisted death” (*Carter*, *supra* note 6 at 1365-66). Furthermore, a rebuttal of Jose Pereira’s paper was recently published in Current Oncology (the same journal that published his paper), and the journal contemporaneously acknowledged that his paper was an “opinion” rather than a peer-reviewed paper and issued a correction: Jocelyn Downie et al, “Pereira’s Attack On Legalizing Euthanasia Or Assisted Suicide: Smoke and Mirrors” (2012) 19:3 Current Oncology 133 and Jose Pereira, “Erratum: Legalizing Euthanasia Or Assisted Suicide: The Illusion Of Safeguards and Controls” (2012) 19:3 Current Oncology e227.

suicide is in the public interest can give rise to a particularly high level of community interest, and sometimes concern.⁷⁹ We therefore believe it to be especially important to explicitly articulate these guiding principles here.

3. *Six Components*

Component One: An Additional Public Interest Factor - Autonomous Choice

As outlined above, respect for autonomy is one of the guiding principles we used when constructing the proposed prosecutorial guidelines, and whereas high-quality decision making and public confidence are directed at least in part to procedural matters, respect for autonomy makes a greater contribution to determining the content of the guidelines. Accordingly, we place autonomy at the centre of our approach and identify whether the deceased's death occurred as a result of his or her autonomous choice as the sole additional public interest factor. As noted above, this does not preclude consideration of the broader public interest factors contained in the general prosecutorial guidelines. Rather, these proposed guidelines add a factor for prosecutors to consider that is specifically tailored for this context.

Guidelines text

Autonomous Choice: an Additional Public Interest Factor Specific to These Offences

An additional public interest factor that tends against prosecution is that the deceased's death occurred as a result of an autonomous choice made by the deceased for his or her life to end.

An additional public interest factor that tends in favour of prosecution is that the deceased's death did not occur as a result of an autonomous choice made by the deceased for his or her life to end.

Components Two and Three: Elements and Direct Evidence of an Autonomous Choice

In this section, we develop the second and third components of the proposed guidelines. The second component identifies how the nature of the deceased's choice is to be established (through the satisfaction of three elements) and the third component sets out an inclusive list of the direct evi-

⁷⁹ For evidence of this high level of community interest and concern in the England and Wales, see England and Wales Interim Policy Summary, *supra* note 33.

dence that may be relevant in assessing whether or not those three elements have been satisfied or not.

The three elements that need to be satisfied for the deceased's death to have occurred as a result of his or her autonomous choice are:

1. the deceased was capable of making the decision to end his or her life;
2. the decision was made voluntarily by the deceased; and
3. the deceased was offered sufficient information in relation to the decision to end his or her life.

These elements are derived from the law applying to the refusal of medical treatment. Although not entirely apposite to cases of voluntary euthanasia and assisted suicide, the law with respect to refusals provides a useful departure point (one, we note, that was taken by the England and Wales Guidelines).⁸⁰

Capacity

The common law presumes that every adult is capable of making medical treatment decisions.⁸¹ However, this presumption may be rebutted by evidence to the contrary. The test for capacity is decision specific; an individual may have the capacity to consent to a routine procedure such as a blood test but lack the necessary capacity to consent to deep brain stimulation. Capacity may also fluctuate over time.⁸² An individual will be judged to have decisional capacity if that person has the ability to understand the information that is relevant to making the decision in question and the foreseeable risks and consequences of undergoing, or refusing to undergo, the proposed treatment.⁸³ The common law presumption of capacity does not extend to minors.

⁸⁰ England and Wales Guidelines, *supra* note 12 at para 43(2).

⁸¹ *C (JS) v Wren* (1986), [1987] 76 AR 118, (*sub nom C v Wren*) 35 DLR (4th) 419 (CA); *Starson v Swayze*, 2003 SCC 32 at para 7, [2003] 1 SCR 722.

⁸² *Ibid* at para 118.

⁸³ In some provinces and territories, this test has been codified in legislation. See e.g. *Personal Directives Act*, RSA 2000, c P-6, s 1(b); *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181, s 7 [HCCACFAA]; *The Health Care Directives Act*, SM 1992, c 33, CCSM c H27, s 2; *Personal Directives Act*, SNWT 2005, c 16, s1; *Hospitals Act*, RSNS 1989, c 208, s 52(2A); *Health Care*

Instead, children and adolescents are entitled to a degree of decisional autonomy commensurate with their level of maturity.⁸⁴

Evidence that is relevant to determining whether a deceased had capacity or not includes whether he or she had a recent capacity assessment undertaken by an appropriately qualified medical or other health professional. Also relevant is whether the deceased was in need of assistance to make decisions about other aspects of his or her life. Although capacity is specific to the particular decision to be made, findings of incapacity in other realms can sometimes shed light on whether the deceased had capacity to choose for his or her life to end.

Voluntariness

Once again building upon the law that governs refusal of medical treatment, a decision to commit suicide must also be free of undue influence.⁸⁵ It is worth noting though that not all influence will be undue provided the decision remains that of the person; it is legitimate for others – such as family, friends, and doctors – to provide advice and even seek to dissuade the person.⁸⁶ Evidence relevant to the voluntary nature of the decision includes

Consent Act, SO 1996, c 2, s 4(1); *Consent to Treatment and Health Care Directives Act*, RSPEI 1988, c C-17.2, s 7(1) [CTHCDA]; *Health Care Directives and Substitute Health Care Decision Makers Act*, SS 1997, c H-0.001, s 2(1)(b); *Care Consent Act*, SY 2003, c 21, s 6(2).

⁸⁴ In the recent case of *AC v Manitoba (Director of Child and Family Services)*, 2009 SCC 30 at para 87, [2009] 2 SCR 181, Abella J, for the majority, held that even in cases of a refusal of life-saving treatment, “a minor may be of sufficient maturity that [the distinction between] the principles of welfare and autonomy will collapse altogether and the child’s wishes will become the controlling factor.”

⁸⁵ *Norberg v Wynrib*, [1992] 2 SCR 226 at 28, 74 BCLR (2d) 2. A number of provinces and territories have codified the elements of consent, including voluntariness, in legislation. See e.g. *HCCACFAA*, *supra* note 84 at s 6; *Health Care Consent Act*, *supra* note 84 at s 11(1); *CTHCDA*, *supra* note 84 at s 6(1); *Care Consent Act*, *supra* note 84 at s 5.

⁸⁶ Barney Sneiderman, John C Irvine & Philip H Osborne, *Canadian Medical Law*, 3d ed (Toronto: Thomson Carswell, 2003) at 31. See also *Re T (Adult: Refusal of Treatment)* (1992), [1993] Fam 95 at 121, [1992] 4 All ER 649 (CA), where the Court of Appeal found that a woman’s refusal of treatment was not binding on the treating team; Staughton LJ considered that influence will be undue only if there is “such a degree of external influence as to persuade the patient to depart from her own wishes.” This case is referenced in Canadian secondary sources such as Ellen

whether there was any pressure placed on the deceased in his or her decision making: whether the suggestion for taking such steps originally came from the deceased, and whether there was a clear and unequivocal request from the deceased for assisted suicide or voluntary euthanasia.

Deceased Offered Sufficient Information

Our proposed guidelines require that the deceased be offered sufficient information about the decision to end his or her life including, where appropriate, information from qualified medical or other health professionals. Since *Hopp v Lepp*⁸⁷ and *Reibl v Hughes*⁸⁸, Canadian law has recognized that medical and other health professionals have a duty to offer all information that a reasonable person in the position of the patient would want to know about the recommended treatment, alternatives to this treatment, and the consequences of not undergoing any treatment. The Supreme Court of Canada's reasoning in both decisions was based on autonomy: a person can only make a meaningful choice to undertake or refuse treatment with relevant information about what that treatment involves, including its potential risks. Recognition of the need for an autonomous decision requires that the deceased was offered such information.

Evidence as to whether sufficient information has been offered to the deceased will include evidence about the nature of the information offered to the deceased, such as whether it included relevant information about the diagnosis, prognosis, and treatment options for a person's illness or disability (if any), other care options including palliative care, the nature of possible methods of voluntary euthanasia or assisted suicide and associated risks, and the consequences of alternative courses of action. Further evidence that is relevant to the sufficiency of information offered to the deceased is whether any of that information was misleading or inaccurate, whether the deceased had already gathered some or all of the relevant information on his or her own, and whether the information offered was in a form that the deceased could understand.

Picard & Gerald Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4th ed (Toronto: Thomson Carswell, 2007).

⁸⁷ [1980] 2 SCR 192, 4 WWR 645.

⁸⁸ [1980] 2 SCR 880, 114 DLR (3d) 1.

Guidelines text**Elements of an Autonomous Choice**

The elements of an autonomous choice by the deceased for his or her life to end are:

1. The deceased was capable of making the decision to end his or her life;
2. The decision was made voluntarily by the deceased; and
3. The deceased was offered sufficient information in relation to the decision to end his or her life.

Direct Evidence in Relation to the Elements of an Autonomous Choice

Factors that may be relevant to determining whether the deceased's death occurred as a result of an autonomous choice by him or her include:

- Whether the deceased had been assessed recently as having capacity to make the decision to end his or her life by an appropriately qualified medical or other health professional (capacity);
- Whether the deceased needed assistance to make decisions about other aspects of his or her life (capacity);
- Whether there was a clear and unequivocal request from the deceased for voluntary euthanasia or assisted suicide (voluntary);
- Whether the suggestion to consider voluntary euthanasia or assisted suicide came from the deceased or from the suspect or others (voluntary);
- Whether the suspect or others took steps to ensure that the deceased's decision was not brought about by pressure or coercion (voluntary); and
- Whether the suspect or others took steps to ensure that the deceased was offered sufficient information about the decision including, where appropriate, by qualified medical or other health professionals (information).

Component Four: Confidence Whether Death Occurred as a Result of Autonomous Choice

The proposed guidelines also include factors that are relevant to a prosecutor's confidence about whether the death that occurred was the result of an autonomous choice by the deceased ("confidence factors"). The role of these factors is different from those mentioned in the previous section, where the goal was to identify matters that could be used as direct evidence in relation to whether the three elements of an autonomous choice discussed above were

satisfied. The factors in this section do not have that same direct probative value and so cannot be used in that way.

Two examples of confidence factors are where the suspect has an interest that conflicts with the interest of the deceased in making an autonomous choice about death (conflict of interest), and where there is a history of violence or abuse towards the deceased by the suspect. These factors are not direct evidence of an absence of autonomy, as it is possible that decisions that occur in the presence of such factors can still be autonomous and therefore not give rise to prosecution. For example, a DPP who was firmly satisfied that a deceased had made an autonomous choice to die, in spite of the existence of potentially negative confidence factors, would be justified under our guidelines in not prosecuting. Nevertheless, the presence of these circumstances can give rise to real doubts that such a choice has been made. This risk is sufficient to justify addressing them in the guidelines.

One of the guiding principles for constructing these guidelines is the importance of public confidence in prosecutorial decision making. If circumstances raising doubt that there was an autonomous choice are specifically addressed, the public can have confidence that prosecutorial discretion is only being exercised to decline to prosecute in clear cases of autonomous decision making.

Also included in this section are confidence factors that are indirectly about autonomy. An example is whether a suspect reported the deceased's death to the police or coroner, and co-operated with the investigation into the death. Such action is not directly about whether the death occurred as a result of an autonomous choice. However, reporting and co-operation by a suspect might suggest that his or her behaviour is more likely to be consistent with the non-prosecution factors in the guidelines than if the suspect concealed his or her involvement. Given that the non-prosecution factors are based on the deceased making an autonomous choice, these factors can still, albeit indirectly, give rise to confidence or doubts as to the nature of any choice made by the deceased.

These confidence factors have two functions in the guidelines. The first is that factors which give rise to doubts about whether the deceased made an autonomous choice for his or her life to end act as triggers for further investigation or scrutiny of the circumstances in which the death occurred. The presence of these confidence factors is a warning that should prompt a prosecutor to review even more closely the direct evidence in relation to the elements of an autonomous choice in the case at hand. We note that confidence

factors can also provide reassurance that the deceased chose to die, but we are not proposing a reduced level of scrutiny in such cases. The second function of confidence factors is that they must be used by prosecutors in their deliberations when weighing the direct evidence of the elements of an autonomous choice set out above. To illustrate, the existence of a troubling conflict of interest is an important part of the context in which prosecutors would assess the available direct evidence about whether the deceased was capable of making a voluntary decision. We now consider the four confidence factors we include in our proposed guidelines.

History of Violence or Abuse

A history of violence or abuse by the suspect towards the deceased gives rise to real concerns about whether the deceased made an autonomous choice for his or her life to end. Such abuse need not be physical in nature and can include emotional or psychological abuse. While it is possible for a decision to end one's life to be made autonomously despite that history, the existence of this type of relationship between the suspect and the deceased casts doubt over this and poses a risk as to whether or not the decision was autonomous.⁸⁹ Accordingly, the guidelines identify this factor as one that should trigger very close scrutiny of the circumstances in which the death occurred. A prosecutor should weigh any available evidence as to whether the deceased made an autonomous choice in light of this history. Part of this may include accessing information or advice about the dynamics of such relationships and the impact that any violence or abuse may have had on the deceased's capacity to make his or her own choices.

Settled Decision

A confidence factor which may point the other way is that the deceased's decision appeared to be a settled one (that is, that the deceased is not ambivalent about his or her death). One way this could be demonstrated is through repeated requests by the deceased for his or her life to end. We note that the settled nature of a decision is not an element of an autonomous choice: it is

⁸⁹ For a discussion of some of the evidence as to the impact that a history of violence and/or coercion can have on autonomy, albeit in the case of domestic violence, see Tamara Kuennen, "Analysing the Impact of Coercion on Domestic Violence Victims: How Much is Too Much?" (2007) 22 *Berkeley Journal of Gender, Law & Justice* 1. See also Cheryl Hanna, "The Paradox of Progress: Translating Evan Stark's Coercive Control into Legal Doctrine for Abused Women" (2009) 15 *Violence Against Women* 1458.

not part of the law that governs the refusal of medical treatment discussed above. Nevertheless, if a decision appears to be a settled one, then a prosecutor, and indeed the public, could have greater confidence that the choice was autonomous. However, as noted above, we are not suggesting this should lead to a lower level of scrutiny than that which generally occurs in these cases.

Conflict of Interest

One factor tending to undermine confidence that the deceased's death occurred as a result of an autonomous choice by him or her is that there is an interest on the part of the suspect that conflicts with the interest of the deceased in making that choice. Sometimes the nature of the conflict is such that it tempts the suspect to coerce the deceased or otherwise undermine free choice. Other times the conflict might not be in direct opposition to a deceased's autonomy, but might instead indicate that the suspect was careless or disinterested in ensuring that death was genuinely the deceased's choice. In both instances, however, the existence of a conflict creates the risk that the deceased is not making an autonomous choice: this is what warrants inclusion of conflict of interest as a confidence factor in the guidelines.

There is a range of interests that can give rise to this conflict. One is where a suspect has a financial interest in the deceased's death. The obvious example is where the suspect or a person close to him or her will benefit financially through an inheritance. A financial conflict of interest can also arise not because of the deceased's death, but because a suspect is financially remunerated for providing assistance of some kind. This could arise in relation to an organization that facilitates voluntary euthanasia or assisted suicide for a fee. Another such example is where a medical or other health professional participates in the deceased's death and is remunerated for that. Other conflicts of interest may be non-financial: e.g., a suspect may have reputational interests which may be in conflict with the deceased's autonomous choice. A suspect may also wish to be relieved of the burden of caring for the deceased.

Under our proposed guidelines, the presence of a conflict of interest will trigger a prosecutor to closely scrutinize the circumstances of the deceased's death and to weigh the evidence in relation to the nature of any choice made by the deceased in light of that conflict. The level of this additional scrutiny and deliberation will depend, however, on the nature of the conflict and the

extent to which the suspect's own interests were significant in the decision to end the deceased's life or provide assistance to do so.⁹⁰

The nature of the conflict will determine the extent of additional scrutiny and deliberation required. The issue here is whether the potential for the suspect to benefit is either, firstly, so remote so that it is of no consequence for the suspect, or secondly, if it is not too remote, whether it is insufficient to be a relevant factor in the decision to end, or to assist with ending, the deceased's life. It is this second issue that will be most significant in this context. It is ultimately a matter for the prosecutor to determine, on the facts of the case, how concerned he or she should be by the conflict of interest. To illustrate, an inheritance for a suspect will automatically trigger additional scrutiny and deliberation, but a prosecutor will need to determine the extent to which it could be regarded as a relevant factor in the suspect's decision making process. We consider that very close scrutiny would be called for where the suspect's financial circumstances had recently changed for the worse and this seemed to prompt a renewed interest in assisting the deceased. By contrast, a medical or other health professional who received payment for providing a medical or other health service as part of their usual care for a patient is unlikely to have considered that remuneration a relevant factor in their decision to be involved in the death. More scrutiny will be required, however, if that professional had established a practice devoted exclusively or primarily with assisting people to die, and consequently depended on voluntary euthanasia or assisted suicide for his or her livelihood.⁹¹

Reporting the Death

The guidelines include as a confidence factor whether or not the suspect reported the death to the police or coroner and co-operated fully with its in-

⁹⁰ This approach has similarities to the "common sense" one outlined in the England and Wales guidelines where a suspect may obtain a benefit from the deceased's death but that this need not be a factor in favour of prosecution if "compassion was the only driving force" for his or her actions. See England and Wales Guidelines, *supra* note 12 at para 44.

⁹¹ We note that earlier in this paper we argued against treating "acting in a professional capacity in and of itself" as a factor tending in favour of prosecution, see England and Wales Guidelines, *supra* note 12. This is not an inconsistency. The fact that a medical or other health professional is involved in voluntary euthanasia or assisted suicide in a professional capacity does not of itself point towards prosecution. However, if that involvement gives rise to a conflict of interest then that must be considered by a prosecutor as a confidence factor.

vestigation. How a suspect behaves in this regard can inform a prosecutor's confidence as to whether a person's death occurred in conformity with the non-prosecution factors in the guidelines which, as noted above, goes indirectly to the confidence a prosecutor can have in relation to whether there was an autonomous choice by the deceased. While there can be other motivations, one reason why a suspect may feel able to report the death to police or coroner is that they will not be prosecuted based on the criteria in the guidelines. By contrast, it could be argued that a suspect whose involvement in a death points towards the factors in favour of prosecution would be more likely to conceal the death or his or her involvement in it, or refuse to participate in a police or coroner's investigation, for fear of the adverse consequences.⁹²

Assuming that these arguments are correct, then reporting and co-operation is an appropriate confidence factor for the guidelines. As with other confidence factors, a troubling response warrants additional scrutiny and deliberation whereas a comforting response does not reduce the rigour of a prosecutor's approach, but is relevant to deliberations as to how any evidence in relation to an autonomous choice is weighed.

We also note that including this particular factor has additional systemic benefits for how the guidelines operate above and beyond deliberations in particular cases. Incentivizing disclosure of cases involving voluntary euthanasia and assisted suicide so they may be investigated adds to the public confidence that potential suspects are acting, and will in the future act, in accordance with the guidelines. It also bolsters the public reporting of cases involving the guidelines (proposed below), which again promotes public confidence that the guidelines are functioning appropriately.

Guidelines text

Confidence Whether Death Occurred as a Result of Autonomous Choice

The presence of factors that *give confidence* that the deceased's death occurred as a result of an autonomous choice by him or her does not reduce the scrutiny that the circumstances of the death receive. Such factors can, howev-

⁹² Of course, there could also be other motivations for not reporting the death to police or coroner and co-operating with its investigation. For example, a person whose conduct is otherwise unlikely to attract prosecution may not be aware of the guidelines and so conceal his or her involvement in the death for fear of prosecution.

er, be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

- The deceased's decision for his or her life to end appeared to be a settled one; and
- The suspect reported the death to the police or coroner within a reasonable time and co-operated fully with the investigation.

The presence of factors that *raise doubts* that the deceased's death occurred as a result of an autonomous choice by him or her triggers additional scrutiny of the circumstances of the death. Such factors can also be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

- There is a history of violence or abuse by the suspect towards the deceased;
- There is an interest on the part of the suspect that conflicts with the interest of the deceased in making an autonomous choice about death. In determining the level of additional scrutiny and deliberation that is required, regard must be given to the likelihood of the conflict arising and whether the interest is such as to be a relevant factor in the suspect's decision making; and
- The suspect did not report the death to the police or coroner within a reasonable time or did not co-operate fully with the investigation.

Component Five: Decision Consented To By the Attorney General

It was noted above that two of the principles that inform how the guidelines are constructed are:

1. the decision making pursuant to the prosecutorial discretion in this area needs to be of high-quality; and
2. the decision making pursuant to that discretion needs to attract public confidence.

One way in which these goals can be promoted is by requiring that decisions whether or not to prosecute under the guidelines be consented to by the Attorney General. We note that this is consistent with Canadian jurisdictions already having provisions dealing with when the Attorney General's consent is

specifically required either to bring or to discontinue a prosecution.⁹³ Such an approach is also largely consistent with the position in England and Wales, although the DPP's role in that jurisdiction is given legislative force – section 2(4) of the *Suicide Act, 1961* (UK)⁹⁴ provides that proceedings under that Act may be instituted only with the consent of the DPP. However, there are some important differences between the position there and what is being proposed in these guidelines. First, our proposed guidelines rest the consent requirement with the Attorney General rather than, as is done in England and Wales, with the DPP. We would argue that it is better to have the consent rest at the highest point of public accountability in all jurisdictions (which is the Attorney General even in those few jurisdictions with a statutorily independent DPP).⁹⁵ Also, it seems unwise to have the consent on a matter such as this rest at different levels of political superintendence and public accountability in different jurisdictions (and given the different approaches taken in different provinces and territories, it would have to rest with the DPP in some jurisdictions and with the Attorney General or Assistant Attorney General in others). Second, our proposed guidelines are broader than the position in England and Wales in that the DPP's consent is only required if a prosecution is instituted. The DPP is not required by the Act to make decisions where it is proposed that a person not be prosecuted; his or her role is only mandated where there is a decision to prosecute. We understand, however, that the approach taken to date is for the DPP to be involved in all decisions (including those not to prosecute),⁹⁶ which is consistent with our proposed approach.

Another key difference relates to the wider function of the consent provision in England and Wales. The House of Lords in *Purdy* identified that the “basic reason” for the relevant subsection is to prevent the risk of prosecutions in “inappropriate circumstances.”⁹⁷ A significant motivation for imposing a legislative requirement for DPP consent to prosecutions is to avoid

⁹³ For example, *Criminal Code*, *supra* note 2 s 477.2(1) (offences committed in or on territorial sea of Canada) and s 4.1 (offence in relation to sexual offences against children committed outside Canada) require the consent of the Attorney General of Canada. See e.g. Ontario, Ministry of Attorney General, “Attorney General’s Consents” in “Crown Policy Manual” (Toronto: MAG, 21 March 2005), online: <www.attorneygeneral.jus.gov.on.ca/english/crim/cpm/2005/AGConsents.pdf>.

⁹⁴ England and Wales Guidelines, *supra* note 12; *Suicide Act, 1961* (UK), c 60, s 2(1).

⁹⁵ Nova Scotia, Québec, and federal.

⁹⁶ Keir Starmer Transcript, *supra* note 40.

⁹⁷ *Purdy*, *supra* note 29 at 392 (Lord Hope of Craighead).

vexatious or inappropriate private prosecutions.⁹⁸ Our proposed guidelines do not directly address this concern as they only purport to guide the exercise of prosecutorial discretion by the State and cannot in and of themselves, unlike a legislative requirement for consent, prevent inappropriate private prosecutions.

Nevertheless, despite these differences, some of the rationales for section 2(4) of the *Suicide Act 1961* (UK) are relevant to the proposed fifth component of our guidelines. In particular, we note that the House of Lords in *Purdy* pointed to reasons underpinning the consent requirement as including “to secure consistency of practice, ... to enable account to be taken of mitigating factors and to provide some central control of the use of the criminal law where it has to intrude into areas which are particularly sensitive or controversial.”⁹⁹ We agree and consider that requiring the Attorney General to consent to all decisions whether to prosecute or not under these guidelines will provide central control and lead to greater consistency and predictability in decision making. These factors would also promote public confidence in decisions made pursuant to the guidelines.

Guidelines text

Decision Consented to by the Attorney General

All decisions whether or not to prosecute cases involving voluntary euthanasia and assisted suicide pursuant to these guidelines must be consented to by the Attorney General.

Component Six: Public Reporting of Decision Making

Another way in which high-quality decision making that attracts public confidence can be promoted is through giving reasons for decisions and making them publicly available. We propose this be done where possible in relation to individual decisions not to prosecute, but also through the collection and publication of information about how the guidelines are operating at a systemic level.

⁹⁸ For a wider discussion of the importance of the right to bring a private prosecution, and the corresponding justifications advanced for requiring DPP or other consents to prosecution, see UK, Law Commission, *Consents to Prosecution* (Law Com No 255) (London: Her Majesty’s Stationery Office, 1998) at paras 2-3. See also *Purdy*, *supra* note 29 at 392 (Lord Hope of Craighead).

⁹⁹ *Purdy*, *supra* note 29 at 392 (Lord Hope of Craighead); Williams, *supra* note 38 at 184-85.

Reasons for Decisions

Subject to any contrary legal obligations prohibiting such a course, prosecutors are able to give reasons for their prosecutorial decisions and make them publicly available.¹⁰⁰ In British Columbia, a commission of inquiry made the following recommendation, which has been adopted by the Crown:

Where a decision not to prosecute has been made, and the public, a victim or other significantly interested person is aware of the police investigation, it is in the public interest that the public, victim or other significantly interested person be given adequate reasons for the non-prosecution, by either the police or Crown Counsel.¹⁰¹

In Prince Edward Island, prosecutors are advised to keep a record of the reasons for a decision not to prosecute, and to be conscious of the need in appropriate cases to explain the reasons for the decision to affected parties.¹⁰²

¹⁰⁰ Indeed in Canada, the common law imposes a duty on administrative decision makers to provide reasons in certain circumstances “where the decision has important significance for the individual, when there is a statutory right of appeal, or in other circumstances” (*Baker v Canada (Minister of Citizenship and Immigration)*, [1999] 2 SCR 817 at para 48, 174 DLR (4th)).

¹⁰¹ British Columbia, *Discretion to Prosecute Inquiry: Commissioner’s Report* (“The Owen Inquiry”) (Victoria: Discretion to Prosecute Inquiry, 1990) at 110, 118, Recommendation 8(2). Section 15(4) of the *Freedom of Information and Protection of Privacy Act*, RSBC 1996, c 165 facilitates compliance with this recommendation:

15(4) The head of a public body must not refuse, after a police investigation is completed, to disclose under this section the reasons for a decision not to prosecute

(a) to a person who knew of and was significantly interested in the investigation, including a victim or a relative or friend of a victim, or
(b) to any other member of the public, if the fact of the investigation was made public.

See also British Columbia, Ministry of Attorney General, “Disclosure of Information to Parties other than the Accused” in “Crown Counsel Policy Manual” by the Criminal Justice Branch (Victoria: MAG, 18 November 2005), online: <www.ag.gov.bc.ca/prosecution-service/policy-man/pdf/DIS1.1-DisclosureOfInformationToParties-18Nov2005.pdf>.

¹⁰² Justice and Public Safety, “Guide Book of Policies and Procedures for the Conduct of Criminal Prosecutions in Prince Edward Island” by the Crown Attorneys’

According to the guidelines: “this approach will encourage reasoned decision making.”¹⁰³ The Newfoundland guidelines explicitly recognize that public confidence in the administration of justice may require the giving of reasons where appropriate.¹⁰⁴ Several other provinces have guidelines dealing with media interaction that acknowledge that public confidence is enhanced by the timely provision of accurate information to the public.¹⁰⁵ In Alberta, however, prosecutors are instructed to refuse the release of information on any file where a decision has been made not to prosecute.¹⁰⁶

To advance the guiding principles of high-quality decision making and public confidence, the guidelines should require that where possible, reasons for decisions be given in these cases and made publicly available. We note, however, that this aspect of the guidelines applies only to decisions *not* to prosecute, and *not* to decisions favouring a prosecution. Aside from concerns about prejudicing either the Crown’s ability to prosecute or the accused’s right to a fair trial, a decision to prosecute means the Crown’s case is sub-

Office (Charlottetown: JPS, November 2009) at 5-7, online: <www.gov.pe.ca/photos/original/jps_crownconduc.pdf>.

¹⁰³ *Ibid.*

¹⁰⁴ Office of the Director of Public Prosecutions, “Communications with the Media” in “Guidebook of Policies and Procedures for the Conduct of Criminal Prosecutions in Newfoundland and Labrador” (St. John’s: ODPP, October 2007) at 10-1, online: <www.justice.gov.nl.ca/just/prosecutions/pp_guide_book.pdf>.

¹⁰⁵ See e.g. Nova Scotia, Public Prosecution Service, “Media Inquiries and Public Statements” in “Crown Attorney Manual” (Halifax: PPS, 4 July 2011), online: <www.gov.ns.ca/pps/publications/ca_manual/AdministrativePolicies/MediaRelations.pdf>; Ontario, Ministry of Attorney General, “Media Contact by Crown Counsel by the Criminal in “Crown Policy Manual” by the Law Policy Branch (Toronto, MAG, 21 March 2005), online: <www.attorneygeneral.jus.gov.on.ca/english/crim/cpm/2005/MediaContactByCrown.pdf>; Manitoba, Department of Justice, “Communication with the News Media” in “Prosecution Policies” by the Manitoba Prosecution Service (Winnipeg, DOJ, November 2008), online: <www.gov.mb.ca/justice/prosecutions/policy/index.html>.

¹⁰⁶ Section 20(6) of the *Freedom of Information and Protection of Privacy Act*, RSA 2000, c F-25 provides that the head of a public body may disclose reasons for a decision not to prosecute to the public. However, the Minister of Justice and Attorney General instructs prosecutors to rely on s 20(1)(g), which permits the head of a public body to refuse to disclose information that could reasonably be expected to reveal any information relating to or used in the exercise of prosecutorial discretion. Although this exemption is found in the legislation of several provinces, only prosecutors in Alberta have been explicitly advised to consistently rely on it to deny information regarding decisions not to prosecute.

jected to the public rigour of the criminal justice system, and this is sufficient to address the guiding principles of high-quality decision making and public confidence identified above.

There are a number of benefits in publishing reasons for decisions. One is that the discipline of producing written reasons assists a decision maker in his or her deliberations and ensures the reasoning is subjected to the rigour of justification, thereby promoting high-quality decision making.¹⁰⁷ Requiring justification of a conclusion to the public also ensures accountability and transparency in decision making, which in turn supports public confidence.¹⁰⁸ A third benefit is that awareness of how these decisions are made promotes predictability and consistency in decision making, and certainty in the law.¹⁰⁹ This is of advantage for prosecutors and the Attorneys General, as this body of knowledge would enhance their deliberations in relation to these decisions. It also assists members of the public who will not only know the general criteria for prosecution decisions, but also how those criteria are being applied in practice. This will enable people to regulate their own conduct so as to ensure, if possible, that it is not in the public interest for them to be prosecuted.

While these benefits are applicable generally to the exercise of prosecutorial discretion, we consider the case for published reasons for decisions is particularly compelling in relation to voluntary euthanasia and assisted suicide. As the experience in England and Wales has demonstrated, prosecutorial discretion in this area can give rise to a high level of public interest and concern about how it may be exercised.¹¹⁰ It is therefore appropriate that the public be able to scrutinize these decisions, and be reassured they are being made in accordance with the guidelines. These concerns have prompted the DPP in England and Wales to make publicly available the reasons for his decisions in relation to the assisted suicide guidelines where the information about the case is already in the public domain.¹¹¹ Accordingly, although the majority of guidelines already address in a generic way the issue of reasons

¹⁰⁷ Jones & de Villars, *supra* note 72 at 372-73; Blake, *supra* note 72 at 92.

¹⁰⁸ Jones & de Villars, *supra* note 72; Blake, *supra* note 72.

¹⁰⁹ Jones & de Villars, *supra* note 72; Blake, *supra* note 72.

¹¹⁰ See England and Wales Interim Policy Summary, *supra* note 33.

¹¹¹ Keir Starmer Transcript, *supra* note 40 at 4. See e.g. The Crown Prosecution Service, "The Suicide of Mr Raymond Cutkelvin: Decision on Prosecution" (25 June 2010), online: CPS <www.cps.gov.uk/news/articles/the_suicide_of_mr_raymond_cutkelvin_decision_on_prosecution/>.

for decisions, we consider it should be specifically dealt with in these guidelines, and that reasons for decisions should be provided and made public wherever possible.

We do recognize, however, that the context of prosecutorial decision making means that there are constraints that may limit or preclude giving full reasons or making reasons publicly available. Attorneys General are subject to various legislative privacy obligations which, absent a relevant exception, prohibit publication of certain information.¹¹² Some or all of these obligations may not apply, however, in relation to information that is already in the public domain (for example, where information is discussed in open court at a committal hearing and the prosecution is later discontinued). Another relevant consideration is whether the production and publication of reasons would prejudice the prosecution of a co-offender or an ongoing investigation. Other public interest considerations which may weigh against giving reasons are if doing so would significantly prejudice the administration of justice or cause serious harm to witnesses or the suspect. Accordingly, it will not always be possible to produce and publish reasons for decisions. Nevertheless, we consider the publication of reasons should be the presumed norm and where publication of reasons is not possible, consideration should also be given to whether it is possible to publish reasons of some kind that do not prejudice those other obligations. For example, it might be possible to make reasons for a decision available in a de-identified form, or for the reasons not to refer to particular information that should not be disclosed.

Systemic Data Reporting in Annual Report

Another way in which high-quality decision making that attracts public confidence can be promoted is to monitor how the guidelines are working at a systemic level. This permits a level of scrutiny of global trends to ensure that the guidelines are leading to appropriate outcomes. Such an approach is generally a feature of voluntary euthanasia and assisted suicide laws which establish or empower a Commission or other body to oversee the administra-

¹¹² See e.g. *Privacy Act*, RSC, 1985, c P-21; *Freedom of Information and Protection of Privacy Act*, SNS 1993, c 5; *Freedom of Information and Protection of Privacy Act*, SM 1997, c 50, CCSM c F175; *Freedom of Information and Protection of Privacy Act*, RSO 1990, c F-31; *Youth Criminal Justice Act*, SC 2002, c 1.

tion of the legislation.¹¹³ Again, this information should be made available for public scrutiny.

The reporting of systemic data (which can be done in a de-identified form)¹¹⁴ will be valuable for determining whether the terms of the guidelines themselves are appropriate or not. It will also permit scrutiny of how the guidelines are being applied in practice over a period of time. This sort of scrutiny ensures that decision making is of a high-quality and enables problems to be identified and addressed.¹¹⁵ It also can provide a measure of public confidence in that the community knows how the guidelines are being used and what the outcomes are. This data can include decisions to prosecute as concerns about prejudicing the prosecution identified in relation to reasons for decisions need not arise at this systemic de-identified level of reporting, or if they do, the data can be included at a later stage once all proceedings have been concluded.

The nature of the systemic data we consider should be captured includes:

- demographic data for the deceased such as gender, age, ethnic background, health status, disabilities (if any), income level and educational level;
- the deceased's underlying illness (if any);

¹¹³ See the summary description of the various oversight mechanisms in the Netherlands, Belgium, Luxembourg, Oregon and Washington State in RSC Panel, *supra* note 4. The need for the collection and reporting of data was also recognized by the RSC Panel, *ibid* at 102. The collection and publication of data to improve the administration of criminal law processes has also been suggested in relation to 'death penalty' cases in the United States. See James Liebman, "The Overproduction of Death" (2000) 100 Colum L Rev 2030.

¹¹⁴ Although there will likely be few cases, other jurisdictions with smaller or similar populations to a number of Canadian provinces (e.g. Oregon is very close to or smaller than Québec, Ontario, BC, and Alberta) have been able to publish systemic data without revealing identifiable information. That said, reporting without risking identification may be difficult in the smaller jurisdictions. This point could support the pooling of information and reporting at a regional or national level (Canada's population is substantially larger than Oregon and the Netherlands).

¹¹⁵ See for example experiences with respect to "life ending acts without explicit request of the patient" and reporting rates in the Netherlands and Belgium as discussed in Rietjens et al, *supra* note 74 and Chambaere et al, *supra* note 79.

- whether the deceased had access to palliative care;
- whether the deceased had private health insurance;
- the relationship between the suspect and the deceased;
- whether the case involved voluntary euthanasia or assisted suicide;
- the number of decisions reached to prosecute or not prosecute; and
- the number of convictions that occurred in those cases where the decision was to prosecute.

To achieve an understanding of the trends that might be emerging from the use of the guidelines, the data collected with respect to the first six elements in this list needs to be correlated with that collected with respect to the final two.

Guidelines text

Public Reporting of Decision Making

Subject to any contrary legal obligation, the Attorney General will produce and publish reasons for a decision to not prosecute a case involving voluntary euthanasia and assisted suicide. Before concluding that the production and publication of reasons for a decision is not possible, consideration will be given to whether the reasons could be published in a more limited form.

The Attorney General will publish in an Annual Report systemic data about what decisions are being made and how they are being made in accordance with these guidelines.

Conclusion

The purpose of this article was to construct offence-specific guidelines for how prosecutorial discretion should be exercised in cases of voluntary euthanasia and assisted suicide. The guidelines are meant to be consistent with the arguments made and conclusions drawn in the RSC Panel Report and to translate into practice the Panel's recommendation with respect to prosecutorial charging guidelines. In undertaking this task, we were guided by the well-established principles of respect for autonomy, the need for high-quality

prosecutorial decision making, and the importance of public confidence in that decision making. From these principles, we derived six components of a set of guidelines: an additional public interest factor (autonomy); elements of an autonomous choice; direct evidence of an autonomous choice; confidence whether death occurred as a result of autonomous choice; decision consented to by the Attorney General; and public reporting of decision making. It is our hope that the preceding discussion and proposed guidelines can make a useful contribution to Canadian provinces and territories as they wrestle with the issue of how to respond to calls for the development of permissive regimes with respect to voluntary euthanasia and assisted suicide through the adoption of guidelines for the exercise of prosecutorial discretion.

Appendix I: Proposed Prosecutorial Guidelines for Voluntary Euthanasia and Assisted Suicide (Consistent with RSC Panel Approach)**Autonomous Choice: An Additional Public Interest Factor Specific to these Offences**

An additional public interest factor that tends against prosecution is that the deceased's death occurred as a result of an autonomous choice made by the deceased for his or her life to end.

An additional public interest factor that tends in favour of prosecution is that the deceased's death did not occur as a result of an autonomous choice made by the deceased for his or her life to end.

Elements of an Autonomous Choice

The elements of an autonomous choice by the deceased for his or her life to end are:

1. The deceased was capable of making the decision to end his or her life;
2. The decision was made voluntarily by the deceased; and
3. The deceased was offered sufficient information in relation to the decision to end his or her life.

Direct Evidence in Relation to the Elements of an Autonomous Choice

Factors that may be relevant to determining whether the deceased's death occurred as a result of an autonomous choice by him or her include:

- Whether the deceased had been assessed recently as having capacity to make the decision to end his or her life by an appropriately qualified medical or other health professional (capacity);
- Whether the deceased needed assistance to make decisions about other aspects of his or her life (capacity);
- Whether there was a clear and unequivocal request from the deceased for voluntary euthanasia or assisted suicide (voluntary);

- Whether the suggestion to consider voluntary euthanasia or assisted suicide came from the deceased or from the suspect or others (voluntary);
- Whether the suspect or others took steps to ensure that the deceased's decision was not brought about by pressure or coercion (voluntary); and
- Whether the suspect or others took steps to ensure that the deceased was offered sufficient and accurate information about the decision including, where appropriate, by qualified medical or other health professionals (information).

Confidence Whether Death Occurred as a Result of Autonomous Choice

The presence of factors that *give confidence* that the deceased's death occurred as a result of an autonomous choice by him or her does not reduce the scrutiny that the circumstances of the death receive. Such factors can, however, be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

- The deceased's decision for his or her life to end appeared to be a settled one; and
- The suspect reported the death to the police or coroner within a reasonable time and co-operated fully with the investigation.

The presence of factors that *raise doubts* that the deceased's death occurred as a result of an autonomous choice by him or her triggers additional scrutiny of the circumstances of the death. Such factors can also be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

- There is a history of violence or abuse by the suspect towards the deceased;
- There is an interest on the part of the suspect that conflicts with the interest of the deceased in making an autonomous choice about death. In determining the level of additional scrutiny and deliberation that is required, regard must be had to the likelihood of the conflict arising and whether the interest is such as to be a relevant factor in the suspect's decision making; and

- The suspect did not report the death to the police or coroner within a reasonable time or did not co-operate fully with the investigation.

Decision Consented to by the Attorney General

All decisions whether or not to prosecute cases involving voluntary euthanasia and assisted suicide pursuant to these guidelines must be consented to by the Attorney General.

Public Reporting of Decision Making

Subject to any contrary legal obligation, the Attorney General will produce and publish reasons for a decision to not prosecute a case involving voluntary euthanasia and assisted suicide. Before concluding that the production and publication of reasons for a decision is not possible, consideration will be given to whether the reasons could be published in a more limited form.

The Attorney General will publish in an Annual Report systemic data about what decisions are being made and how they are being made in accordance with these guidelines.

Appendix II: Alternative Prosecutorial Guidelines for Voluntary Euthanasia and Assisted Suicide (Our Proposed Guidelines with the Addition of Protection of the Vulnerable Public Interest Factors Consistent with the Carter Approach)**Autonomous Choice: An Additional Public Interest Factor Specific to These Offences**

An additional public interest factor that tends against prosecution is that the deceased's death occurred as a result of an autonomous choice made by the deceased for his or her life to end.

An additional public interest factor that tends in favour of prosecution is that the deceased's death did not occur as a result of an autonomous choice made by the deceased for his or her life to end.

Elements of an Autonomous Choice

The elements of an autonomous choice by the deceased for his or her life to end are:

1. The deceased was capable of making the decision to end his or her life;
2. The decision was made voluntarily by the deceased; and
3. The deceased was offered sufficient information in relation to the decision to end his or her life.

Direct Evidence In Relation to the Elements of an Autonomous Choice

Factors that may be relevant to determining whether the deceased's death occurred as a result of an autonomous choice by him or her include:

- Whether the deceased had been assessed recently as having capacity to make the decision to end his or her life by an appropriately qualified medical or other health professional (capacity);
- Whether the deceased needed assistance to make decisions about other aspects of his or her life (capacity);
- Whether there was a clear and unequivocal request from the deceased for voluntary euthanasia or assisted suicide (voluntary);

- Whether the suggestion to consider voluntary euthanasia or assisted suicide came from the deceased or from the suspect or others (voluntary);
- Whether the suspect or others took steps to ensure that the deceased's decision was not brought about by pressure or coercion (voluntary); and
- Whether the suspect or others took steps to ensure that the deceased was offered sufficient and accurate information about the decision including, where appropriate, by qualified medical or other health professionals (information).

Confidence Whether Death Occurred as a Result of Autonomous Choice

The presence of factors that *give confidence* that the deceased's death occurred as a result of an autonomous choice by him or her does not reduce the scrutiny that the circumstances of the death receive. Such factors can, however, be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

- The deceased's decision for his or her life to end appeared to be a settled one; and
- The suspect reported the death to the police or coroner within a reasonable time and co-operated fully with the investigation.

The presence of factors that *raise doubts* that the deceased's death occurred as a result of an autonomous choice by him or her triggers additional scrutiny of the circumstances of the death. Such factors can also be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

- There is a history of violence or abuse by the suspect towards the deceased;
- There is an interest on the part of the suspect that conflicts with the interest of the deceased in making an autonomous choice about death. In determining the level of additional scrutiny and deliberation that is required, regard must be had to the likelihood of the conflict arising and whether the interest is such as to be a relevant factor in the suspect's decision making; and

- The suspect did not report the death to the police or coroner within a reasonable time or did not co-operate fully with the investigation.

Protection of the Vulnerable: A Further Additional Public Interest Factor Specific to These Offences

Factors that tend in favour of prosecution include:

- the assistance was not provided by a medical practitioner in the context of a physician-patient relationship; and
- the assistance was provided to the deceased who:
 - was not materially physically disabled or soon to become so;
 - had not been diagnosed by a medical practitioner as having a serious illness, disease or disability (including disability arising from traumatic injury);
 - was not in a state of advanced weakening capacities with no chance of improvement;
 - did not have an illness that was without remedy as determined by reference to treatment options acceptable to him or her; or
 - did not have an illness causing enduring physical or psychological suffering that was intolerable to him or her and could not be alleviated by any medical treatment acceptable to him or her.

Decision Consented To by the Attorney General

All decisions whether or not to prosecute cases involving voluntary euthanasia and assisted suicide pursuant to these guidelines must be consented to by the Attorney General.

Public Reporting of Decision Making

Subject to any contrary legal obligation, the Attorney General will produce and publish reasons for a decision to not prosecute a case involving voluntary euthanasia and assisted suicide. Before concluding that the production and publication of reasons for a decision is not possible, consideration will be given to whether the reasons could be published in a more limited form.

The Attorney General will publish in an Annual Report systemic data about what decisions are being made and how they are being made in accordance with these guidelines.

Appendix III: Alternative Prosecutorial Guidelines for Voluntary Euthanasia and Assisted Suicide (Our Proposed Guidelines with the Addition of Allowing for Advance Directives as Well as Protection of the Vulnerable Public Interest Factors Consistent With the Québec Committee Approach)**Autonomous Choice: An Additional Public Interest Factor Specific to These Offences**

An additional public interest factor that tends against prosecution is that the deceased's death occurred as a result of an autonomous choice made by the deceased for his or her life to end.

An additional public interest factor that tends in favour of prosecution is that the deceased's death did not occur as a result of an autonomous choice made by the deceased for his or her life to end.

Elements of an Autonomous Choice

The elements of an autonomous choice by the deceased for his or her life to end are:

1. The deceased was capable of making the decision to end his or her life;
2. The decision was made voluntarily by the deceased; and
3. The deceased was offered sufficient information in relation to the decision to end his or her life.

Direct Evidence In Relation to the Elements of an Autonomous Choice

Factors that may be relevant to determining whether the deceased's death occurred as a result of an autonomous choice by him or her include:

- Whether the deceased had been assessed recently as having capacity to make the decision to end his or her life by an appropriately qualified medical or other health professional (capacity);
- Whether the deceased needed assistance to make decisions about other aspects of his or her life (capacity);

- Whether there was a clear and unequivocal request from the deceased for voluntary euthanasia or assisted suicide (voluntary);
- Whether the suggestion to consider voluntary euthanasia or assisted suicide came from the deceased or from the suspect or others (voluntary);
- Whether the suspect or others took steps to ensure that the deceased's decision was not brought about by pressure or coercion (voluntary); and
- Whether the suspect or others took steps to ensure that the deceased was offered sufficient and accurate information about the decision including, where appropriate, by qualified medical or other health professionals (information).

Confidence Whether Death Occurred as a Result of Autonomous Choice

The presence of factors that *give confidence* that the deceased's death occurred as a result of an autonomous choice by him or her does not reduce the scrutiny that the circumstances of the death receive. Such factors can, however, be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

- The deceased's decision for his or her life to end appeared to be a settled one; and
- The suspect reported the death to the police or coroner within a reasonable time and co-operated fully with the investigation.

The presence of factors that *raise doubts* that the deceased's death occurred as a result of an autonomous choice by him or her triggers additional scrutiny of the circumstances of the death. Such factors can also be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

- There is a history of violence or abuse by the suspect towards the deceased;
- There is an interest on the part of the suspect that conflicts with the interest of the deceased in making an autonomous choice about death. In determining the level of additional scrutiny and

deliberation that is required, regard must be had to the likelihood of the conflict arising and whether the interest is such as to be a relevant factor in the suspect's decision making; and

- The suspect did not report the death to the police or coroner within a reasonable time or did not co-operate fully with the investigation.

Advance Directives

Despite the foregoing, the element of an autonomous choice is not violated in the context of an advance directive for medical aid in dying where:

- the deceased was irreversibly unconscious, based on scientific knowledge;
- the advance directive:
 - was given in a free and informed manner;
 - was legally binding; and
 - took the form of a notarized act or an instrument signed by two witnesses, including a commissioner of oaths; and
- the assisting physician:
 - consulted another physician to confirm the irreversible nature of the unconsciousness; and
 - the physician consulted was independent of the deceased and the assisting physician.

Protection of the Vulnerable: A Further Additional Public Interest Factor Specific to These Offences

Factors that tend in favour of prosecution include:

- the assistance was not provided by a medical practitioner;

- the medical practitioner providing assistance did not consult with another physician on whether the request met the protection of the vulnerable public interest factor;
- the physician consulted was not independent of the deceased and the assisting physician;
- the assisting physician did not complete a formal declaration of medical aid in dying;
- the assistance was provided to an individual who:
 - was not a resident of Québec;
 - was not suffering from a serious, incurable disease;
 - was not in an advanced state of weakening capacities, with no chance of improvement; or
 - did not have constant and unbearable physical or psychological suffering that could not be eased under conditions he or she deemed tolerable;
- the deceased's request was not:
 - made in writing by way of a signed form; or
 - repeated within a reasonable period of time, depending on the type of disease.

Decision Consented to by the Attorney General

All decisions whether or not to prosecute cases involving voluntary euthanasia and assisted suicide pursuant to these guidelines must be consented to by the Attorney General.

Public Reporting of Decision Making

Subject to any contrary legal obligation, the Attorney General will produce and publish reasons for a decision to not prosecute a case involving voluntary euthanasia and assisted suicide. Before concluding that the production and publication of reasons for a decision is not possible, consideration

will be given to whether the reasons could be published in a more limited form.

The Attorney General will publish in an Annual Report systemic data about what decisions are being made and how they are being made in accordance with these guidelines.

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