Quality of Life and Treatment Decisions

ONE of the most important recent examinations of the subject has been conducted in Canada by the Law Reform Commission. In 1976 the commission established a special study group called the Protection of Life Project. The issues examined in a series of working papers and reports have included abortion, sterilization, criteria for determining death, and consent of medical treatment. The latest study combines recommendations on the law concerning euthanasia, aiding suicide, and cessation of medical treatment. The report has been published after lengthy discussion.

The first two issues of the report were dealt with quickly and without elaborate discussion. The Commissioners recommended that euthanasia — the intentional killing of a person for compassionate motives — remain covered by the criminal code as culpable homicide. Specifically mentioned was the intentional killing of a patient by medical personnel, even when requested by a patient who was terminally ill or in great pain. The commissioners also recommended retaining as a crime an action that would help a patient to commit suicide, such as furnishing a gun, a poison, or a lethal medication that the patient would then self-administer. It was admitted, of course, that prosecutions were rare for helping a suffering patient to commit suicide and that convictions were virtually nonexistent. Nevertheless, it was thought that aiding suicide should not be condoned and that the circumstances of such alleged actions should be investigated, since they could be motivated by improper purposes in some cases.

Most of the report, however, dealt with the third area — decisions to end medical treatment, thus leading to death. First of all, it was recognized that competent patients could refuse treatment, even if the refusal would inevitably lead to death. The Physician's duty in such situations was described as the obligation to inform the patient fully of the options open to the patient and of their consequences. It was asserted that physicians could not treat patients against their wills and that to do so would be an assault under both criminal and civil law in Canada. The commissioners refused, however, to recommend the establishment of a new specific penalty for such medical actions, as had been recommended to the commission by various commentators. Although the commissioners were very strong in their support for patient autonomy, they did not seem to want to single out the physician who treated patients against their will for criminal prosecution (and stronger penalties) and more than any other person in Canada who committed assault and battery.

The commission went on to find that medical treatment of the incompetent patient should be discontinued only for very serious reasons. It was firmly asserted that "in the medical context" the legal presumption in favour of life should always be recognized. However, the commissioners said that this principle was not absolute but applied only when the treatment was "reasonable and useful." The burden was placed on those who would stop treatment, or not initiate life-supporting treatment, to justify a decision resulting in a patient's death.

In an important discussion the commissioners went on to assert that under the federal law, the value of human life should be considered not only from a "quantitative" perspective but also from a "qualitative" viewpoint. It was aptly observed that when the law upheld the patient's freedom to choose to refuse treatment, it was recognizing that the patient's choice was often based on quality-of-life considerations. On the same basis, it should be legally justified to consider quality of life when making "substituted consent" for incompetent, seriously ill patients. The commissioners stressed that they wanted to prevent the possibility that the patient's inability to give or refuse consent because of mental incompetency should impose on the physician a legal duty to provide aggresive treatment under all circumstances. On the contrary, it was found that incompetent patients should be considered within the same context as competent patients. Therapeutically useless treatment should not be begun "to prolong unnecessarily the patient's agony." It was concluded that incompetent should also have the right to die in peace and dignity, assisted by whatever palliative care is needed at the time.

The Law Reform Commission composed of leading Canadian Lawyers placed the primary responsibility on the physician treating the patient. Since the matter involved was found to be primarily medical in nature, physician responsibility was considered the most satifactory solution. However, it was indicated that the medical decision to treat or not to treat should be made "after discussion, explanation and consultation with those close to the patient". These persons would not, however, have veto power over the physician's decision. The commission recommended that there be no criminal liability on physicians for decisions in these situations, including decisions not to treat or to discontinue treatment previously instituted, as long as the decision was valid medically — that is, made on reasonable medical grounds under the circumstances, in the best interest of the incompetent patient and in conformity with other standards set by criminal law. It was also indicated that the commissioners would expect, but not require, that serious medical decisions such as these would involve the treating doctor's seeking an independent second medical consultation supportive of the physician's judgement or the advice of "an interdisciplinary hospital committee."

REFERENCE

Curran W.J. : Quality of Life and Treatment Decisions. The New England Journal of Medicine, 1984;310:297-298.