

Medical Interventions and the Criminal Law: Lawful or Excusable Wounding?

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One difficulty in dealing with the concept of medical treatment in Canadian criminal law is to reconcile some of the dictates of the *Criminal Code*,¹ which have ancient origins, with the reality of modern medicine. Such a situation arises when we ask whether a surgical operation is *prima facie* legal or illegal. This may be considered a rather narrow and esoteric question, but it has and will become increasingly important with the development of modern medical technology. The initial presumption of legality or illegality may determine the final characterization of a given medical intervention as lawful or unlawful. This is particularly important in such areas as non-therapeutic human medical research and live-donor organ transplantation.

This enquiry explores the present situation in Canadian criminal law with respect to the legality of medical interventions and makes some recommendations for change.

I. The theoretical issue

Ask the average man in the street whether he thinks that a surgical operation is *prima facie* legal or *prima facie* a criminal offence. His answer will almost intuitively be that it is legal, because this answer accords with the reality that innumerable surgical interventions take place each day, and it is an extremely rare occurrence to see a physician arraigned in a criminal court. Now, ask a judge the same question. He may reply that medical interventions are *prima facie* illegal when they fall within the provisions of the *Criminal Code*, such as causing bodily harm with intent (section 228), assault (section 244); but that the physician will probably have a defence based on section 45 of the Code.² This section provides:

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¹ *Criminal Code*, R.S.C. 1970, c. C-34, as am.

² For an example of a judge adopting such an approach, see the reasons of Deschênes C.J. in *Cataford v. Moreau* [1978] C.S. 933, 936; (1979) 7 C.C.L.T. 241, 253 [hereinafter cited to C.S.].

Everyone is protected from criminal responsibility for performing a surgical operation upon any person for the benefit of that person if (a) the operation is performed with reasonable care and skill, and (b) it is reasonable to perform the operation, having regard to the state of health of the person at the time the operation is performed and to all the circumstances of the case.

The judge's reasoning is also consistent with the traditional approach taken by the common law. The Canadian *Criminal Code* is based on the common law, which enforced a prohibition against the maiming of oneself or another. Maim was defined as follows in *Stephen's Digest*:

A maim is bodily harm whereby a man is deprived of the use of any member of his body, or of any sense which he can use in fighting, or by the loss of which he is generally and permanently weakened; but a bodily injury is not a maim merely because it is a disfigurement.³

Hence, on the whole, any more than *de minimis* wounding was *prima facie* illegal, but some woundings could be justified.

Such justification could have had the effect of preventing the initial designation of the wounding as illegal, or it could have operated by way of a defence which, at a second and later stage, rebutted the primary characterization of illegality. Stated more specifically in relation to medical interventions, it may be that the effect of a defence, for example under section 45, is to negate the *prima facie* illegality of a surgical intervention, that is, to render such intervention *lawful*.⁴ Alternatively, section 45, or its equivalent at common law, may be a true defence in the sense that the absence of the defence need not be proved by the prosecution in order to establish all the necessary elements of an offence. According to this reasoning, proving the presence of the defence makes any putative offence *excusable*. One consequence of accepting the latter analysis is that all surgical interventions will be illegal until justified. Moreover, the burden of proof of the applicability of a justification, such

³ Stephen, *A Digest of the Criminal Law* (1878) [hereinafter referred to as *Stephen's Digest*], art. 206, p. 145.

⁴ It would seem that Stephen, in Part V of his *Digest, ibid.*, probably adopted this approach: see Chapter XXI, which is entitled "Cases in which Infliction of Bodily Injury is not Criminal". Art. 196 creates exceptions to the rest of Part V, which contains all provisions for offences against the person: "The contents of Part V. are to be taken to be subject to the provisions contained in this chapter". This chapter contains the provisions allowing persons to consent to surgical operations and the provision on which s. 45 was based, which justifies surgery when consent is impossible to obtain.

as that in section 45, will rest with the physician claiming its protection.⁵

One way of avoiding the discussion as to whether surgical interventions are *prima facie* legal or illegal at common law would be to propose that any *prima facie* presumption of illegality has been reversed in Canada by the *Criminal Code*. Such a proposition derives from section 198 of the Code, which provides:

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

If this section is construed in such a way as to qualify the phrase "surgical or medical treatment" by the words "lawful act", that is, that medical or surgical treatment is just one example of lawful acts dangerous to life, the *prima facie* presumption would be one of legality. The difficulty with such an interpretation is that the forerunners of section 198 were, first, *Stephen's Digest*⁶ and then section 212 in the first Canadian *Criminal Code*,⁷ and there is no indication that these provisions were meant to alter the substantive law as it then stood. Rather, in all probability, they merely formulated the standard of care required in order to avoid criminal liability where persons undertook acts requiring special skill or knowledge⁸ which were of "a dangerous character".⁹ Thus, it may be argued that the *prima facie* legality or illegality of any such act was not contemplated by these provisions, and remained to be determined by a separate enquiry.

However, this argument does not quite explain the terms used in section 198. It is arguable that the word "lawful" only refers to "other . . . acts" and not to "surgical or medical treatment", if one proposes that the reason for including the word "lawful" is to preclude any presumption arising that an unlawful act would not be unlawful or criminal if a sufficient standard of care were observed. But this does not indicate the function of the word "other". There are two possible explanations. On one view, the

⁵The Supreme Court of Canada, in *Morgentaler v. The Queen* [1976] 1 S.C.R. 616, clearly regarded s. 45 as a true defence. Although, according to different judges, the defence may or may not be available in the case of abortion, it would, in any event, require the physician relying on it to bring evidence upon which the defence could be left to the jury.

⁶*Supra*, note 3, art. 217.

⁷*The Criminal Code*, 55-56 Vict., c. 29, s. 212.

⁸*Supra*, note 3, art. 217.

⁹*Ibid.*

word has no purpose except to include "surgical or medical treatment" within the description of lawful acts of a dangerous character. The alternative view is that surgical or medical treatment may be lawful or unlawful and that section 198 only refers to the standard of care required in relation to lawful treatment. The word "lawful" is referred back to modify "surgical or medical treatment" by use of the word "other". This qualification of lawfulness is necessary to rebut any presumption that unlawful treatment could be rendered lawful by a sufficient standard of care. Pursuant to such an interpretation, section 198 is silent as to whether treatment is *prima facie* lawful or unlawful; it simply provides that where treatment is, or becomes, otherwise lawful, a certain standard is required to maintain legality.

Thus there is room for argument, both at common law and under Canadian criminal law, as to which analysis of the *prima facie* legality or illegality of surgical interventions is more correct legally and, further, which is more desirable, taking into account the wider ramifications of each approach. The debate is not entirely academic, as apart from legal considerations such as burden of proof and ultimate liability, it certainly makes a psychological difference whether or not one initially regards all surgical interventions as putative criminal offences. Further, this initial designation as to legality, although almost irrelevant when therapy is involved, may be important in the regulation of which non-therapeutic medical interventions will be allowed by the law.

Although it may seem ludicrous today to regard all surgery as *prima facie* criminal, it must be remembered that relatively safe and effective surgery is a very recent phenomenon. The aim of the common law of crimes and of the *Criminal Code* is protection of the person, and at the time these rules were developed, a person may well have been better protected by a prohibition against surgery, unless some justification were shown. Justifications were to be determined according to the concept of public policy, which at common law included a requirement of therapeutic benefit.¹⁰ General provisions of the Canadian *Criminal Code* were similarly interpreted. For example, section 7(3), which retains the common law defence of necessity and hence could be relevant to all medical interventions, and section 45, which may sometimes function as a particular application of the defence of necessity to a surgical

¹⁰ Dworkin, *The Law Relating to Organ Transplantation in England* (1970) 33 M.L.R. 353, 356.

intervention, or in other instances may justify surgery which would not be justifiable under a doctrine of necessity,¹¹ were construed as requiring therapeutic benefit before they became effective defences in medical situations.

In fact, section 45 of the *Criminal Code* has often been treated as codifying this requirement of therapeutic benefit. Moreover, it has generally been treated as setting out the minimum requirements that must be present to justify, and hence legalize, any particular surgical operation. This approach has caused courts some difficulty which, on occasion, has led to innovative interpretations of section 45. One such example is found in the judgement of Chief Justice Deschênes in *Cataford v. Moreau*. The provision in section 45, that it be "reasonable to perform the operation, having regard to the state of health of the person at the time the operation is performed and to all the circumstances of the case", was used to extend the notion of what constitutes a benefit within the meaning of that section. The learned Chief Justice held that

[d]ans le présent cas, compte tenu de l'âge des parties, du nombre de leurs enfants, de leur situation économique et sociale, il fait peu de doute que "toutes les autres circonstances de l'espèce", pour citer le langage de l'article 45 C. cr., conduiraient à la conclusion que l'intervention a été pratiquée "pour le bien" de la demanderesse.¹²

With respect, it is submitted that, both from an historical point of view and as a matter of construction, this is a misinterpretation of section 45. This provision enacts an additional requirement over and above that of therapeutic benefit before a defence under section

¹¹ In *Morgentaler v. The Queen* there are various statements showing that, depending on the circumstances, the defence of necessity may be narrower or wider than the defence codified in s. 45: see *supra*, note 5, 647, 651, 653. S. 45 would have a wider operation than the defence of necessity in circumstances where the latter defence could not apply because there was no emergency. On the other hand, the defence of necessity could have a wider operation than s. 45 would appear to allow, if, as Laskin C.J. suggests, the test for determining whether it applies were a subjective one, based on the honest belief and good faith of the surgeon, whereas the test of reasonableness for performing an operation under s. 45 "raise[s] only an objective question": *ibid.*, 647. This means, for instance, that a surgeon could subjectively believe an operation was urgent when the defence of necessity would apply, and yet a reasonable surgeon would not have thought it reasonable to perform that surgery when s. 45 would not be available. The Chief Justice makes the point that to the extent that this reasoning is based on *R. v. Bourne* [1939] 1 K.B. 687, it may be applicable only to certain cases of abortion. Certainly it must be asked whether such a subjective test would be applied more generally in determining whether the defence of necessity were available.

¹² *Supra*, note 2, 936.

45 is available. Its purpose is to ensure that a person who undergoes an operation is not put at greater risk through having it than not having it. In current medical-law parlance, the provision enacts a risk/benefit criterion which will take all relevant circumstances into account, and which must be positive on the side of overall benefit.

Yet the question remains as to which factors may be taken into account as relevant circumstances. However, even if the scope of the criteria were extended to include wider considerations, such as socio-economic factors, as Deschênes C.J. suggests, this does not obviate the traditional requirement of therapeutic benefit. The very fact that benefit is expressly mentioned in section 45 indicates that this use of the word must have a specific purpose if it is not to be superfluous, and that purpose must be to require an aim of therapeutic benefit: this construction is especially compelling when, under the broad interpretation adopted by the Chief Justice, the Court will already have considered the prospects of general benefit, pursuant to the provision that "all the circumstances of the case... be considered".

It should be noted that Chief Justice Deschênes's interpretation of section 45 has already been adopted in an unreported case, *Re "Eve"*,¹³ which was an application to the Prince Edward Island Family Court for approval of the sterilization of a mentally retarded woman. Mr Justice McQuaid held, on the basis of the *Cataford* case, that

the "benefit" referred to in Section 45 was thereby extended to include not only the health of the patient but as well socio-economic and other considerations with the result that surgery might be employed not only to preserve and protect health, but as well to preserve the quality of life in a broader non-medical sense.¹⁴

Despite the use of this wide criterion, the learned judge refused to authorize the particular sterilization procedure.

An alternative method for a court to reach a decision which it feels to be appropriate, without having to adopt such a strained interpretation of section 45 as that adopted in the two cases just mentioned, would be to treat section 45 as merely one example of a wider range of public policy justifications which are available to authorize medical interventions.¹⁵ More pointedly, we might well

¹³ P.E.I. Family Ct, No. FDS-37, June 14, 1979. See the report of judgement in Ontario Interministerial Committee on Medical Consent, *Options on Medical Consent* (September 1979).

¹⁴ *Ibid.*, 44.

¹⁵ In *Morgentaler v. The Queen*, *supra*, note 5, all members of the Supreme Court of Canada imply that s. 45 is not a complete code of the defences avail-

ask whether it is still the law in 1980 that therapeutic aim is required in order to legalize a surgical intervention. The answer depends on an analysis of both the content of current public policy concerning medical interventions and the operation of section 45.

II. The practical reality

Whether non-therapeutic medical interventions are lawful has become a matter of increasing importance, as such procedures have been more frequently undertaken and are even regarded as commonplace. The question of their legality first arose with the increasing availability and effectiveness of cosmetic surgery. The courts stretched the law a little by asserting that these operations were within the traditional concept of therapeutic benefit because there was psychological benefit present. The problem became even more acute with live-donor organ transplants and, after initial use of the psychological benefit test, most courts faced the reality that in many cases there was no therapeutic benefit to the donors.¹⁶ However, even before the enactment of legislation authorizing such donation,¹⁷ the operation was not in practice considered illegal, at least when performed on a competent consenting adult. Similarly, non-therapeutic sterilization of consenting adults and non-therapeutic medical experimentation are frequent, indeed daily events in our society that do not foment court actions by the mere fact of their performance. With respect to the latter practice, it is worth noting that in *Halushka v. University of Saskatchewan*,¹⁸ one of the earliest modern cases involving non-therapeutic medical research, the question of the illegality of the intervention itself was not raised. How can this *de facto* legalization of non-therapeutic interventions be reconciled with the legal precedents which have been outlined? A solution depends on determining how public policy and section 45 act and interact to legitimize medical interventions.

able to a surgeon. The questions not addressed in this case are whether the defence of necessity could ever apply where there was no therapeutic benefit present, or whether even wider justifications of surgery are possible.

¹⁶ See, e.g., *Strunk v. Strunk* 445 S.W. 2d 145 (Ky Ct App. 1969); *Hart v. Brown* 289 A. 2d 386 (Conn. Super. Ct 1972); for further discussion, see Baron, Botsford & Cole, *Live Organ and Tissue Transplants from Minor Donors in Massachusetts* (1975) 55 Boston U. L. Rev. 159.

¹⁷ E.g., *The Human Tissue Gift Act*, S.O. 1971, c. 83.

¹⁸ (1966) 53 D.L.R. (2d) 436 (Sask. C.A.).

III. Possible reconciliations

A. *Public policy*

It is suggested that certain non-therapeutic interventions are not considered illegal because they are not regarded as contravening public policy. In relation to the use of public policy as a justification of non-therapeutic medical interventions, it is important to remember that the law has always recognized public policy as a doctrine of changing content.¹⁹ In general terms, public policy requires protection of the individual for his own sake and for the benefit of the community. When these individual and community interests came into conflict with respect to a proposed medical intervention, public policy was traditionally to the effect that the individual's interest, as he perceived it, could prevail, but only if the intervention were for his therapeutic benefit. It is this latter requirement that, it is suggested, has changed. A broader range of individual interests may now outweigh the interests of the community, and these community interests have likewise changed in content. Hence, the balance struck in the resolution of any conflict is open to constant modification.

B. *Criminal Code, section 45*

1. Historical approach

If section 45 legislates a requirement of therapeutic benefit in order to legitimize any surgical intervention, then clearly it would not be arguable that certain non-therapeutic interventions are lawful. But, from an historical point of view, section 45 may only need be applied to justify a medical intervention where the person on whom the procedure is to be performed is incapable of giving consent. Section 45 is based on article 205 of *Stephen's Digest* and Stephen's annotations to this section make it clear that this is what he intended.²⁰ A further reason in support of this interpretation

¹⁹ See *Evanturel v. Evanturel* (1874) 1 Q.L.R. 74 (P.C.); Lloyd, *Public Policy: A Comparative Study in English and French Law* (1953), especially at 113 and the cases cited in n. 3 therein.

²⁰ See Starkman, *Preliminary Study on Law and the Control of Life*, an unpublished paper prepared for the Law Reform Commission of Canada, Aug. 23, 1974: after examining various editions of *Stephen's Digest*, the author concludes that "[i]n light of the above [analysis], it would appear that section 45 of the *Criminal Code* was intended to deal with the situation where the patient is not capable of consenting. If the patient is not capable, the person performing the operation is protected from criminal liability

of section 45 is that the section makes no mention of any requirement of consent in order to legalize a surgical operation.

If it is true that section 45 is inapplicable except where the person cannot consent for himself, then the legality of a non-therapeutic intervention on a person capable of consent is determined according to the general provisions of the *Criminal Code* and will ultimately depend on current public policy: but this changes and, consequently, so may be the legality of a particular surgical intervention.²¹ For instance, in a nineteenth century colonialist society, reduction of family size might be regarded as inimical to the community's welfare, but the same would not be true in an overpopulated twentieth century community. Moreover, since the safety of the surgical intervention required for sterilization has increased dramatically during this period, the acceptability of non-therapeutic sterilization could well change. This change can be demonstrated by comparing two cases. *Dicta* handed down in 1954 by Lord Denning in *Bravery v. Bravery*²² reflect the old approach that non-therapeutic sterilization was prohibited by the dictates of public policy. Yet, in 1979, Chief Justice Deschênes clearly stated the contrary in *Cataford v. Moreau*.

To take the example of non-therapeutic sterilization a little further, there may be no perceived threat to other individual or

provided the patient's condition necessitates surgery for the preservation of life or limb. If these conditions are met, the surgeon is protected even if the patient resists treatment. Support for this interpretation of section 45 is obtained from editions of the Digest published after the Draft Code, which state that article 67 of the Draft Code, which is now section 45 of the *Criminal Code*, is based on article 205 of the Digest" (pp. 5-6). For the contrary view, see *Morgentaler v. The Queen*, *supra*, note 5, 643, where Laskin C.J. states that "*Stephen's Digest of the Criminal Law* (5th ed. 1894) at p. 164 shows that s. 67 was deemed by him to apply both to consensual and non-consensual surgery. Certainly, there is no limitation in s. 45 or anywhere else in the *Criminal Code* to suggest that s. 45 is confined to situations where an unconscious or disabled person is the subject of the surgical operation and is unable to give a consent".

Compare Dickson J. in *Morgentaler* (*ibid.*, 676): "Section 45 may be available as an answer to a charge arising out of a surgical operation performed on an *unconscious patient* but it is not, in my view, available as an answer to a charge of procuring an abortion contrary to s. 251" [emphasis added].

²¹ While the Code itself reflects public policy, the manner of its practical application is also a matter of public policy. For instance, even serious injury suffered in sport may not be prosecuted as a criminal assault.

²² [1954] 3 All E.R. 59 (C.A.).

community values when such sterilizations are performed on consenting adults. The situation may be entirely different when incompetent persons unable to consent for themselves are involved. The latter interventions may be contrary to public policy while the former may not be. Thus, even apart from the fact that the requirements of section 45 (including that of therapeutic benefit) would apply to medical interventions on incompetent persons, the doctrine of public policy may also prohibit the performance on them of non-therapeutic procedures.

Yet another, slightly different, analysis to determine which non-therapeutic interventions will be permitted under a doctrine of public policy is possible. In the case of minors able to consent for themselves, this analysis may arrive at a different result from the general approach outlined above. But, as far as competent adults and all incompetent persons are concerned, the conclusion as to whether or not an intervention is allowed by the law will be the same as on the previous analysis. If, as is suggested below, personal consent and benefit are alternative validating criteria of a medical intervention, is the consent of a "mature minor" (one whose consent is recognized by the law as valid) as effective to validate a non-therapeutic intervention on him as it would be if he were a competent adult? One may argue that it is not and justify this stance on the basis of public policy. It is also possible to adopt a more conceptually pleasing approach and arrive at the same conclusion.

The full extent of the dissimilarity between non-therapeutic and therapeutic interventions, as far as the law is concerned, may not always be recognized, because the circumstances surrounding these two types of intervention are factually similar, except for the one aspect of therapeutic aim. Hence, it is usually assumed that any legally significant difference in the way that the law deals with therapeutic and non-therapeutic interventions must depend entirely on this difference in aim. More explicitly, if two similar interventions with different aims are to be treated similarly, the difference must be rationalized or found legally irrelevant. Conversely, if two such interventions are to be treated differently by the law, the difference in aim will be used as the justification of the dissimilar treatment.

It may be, however, that the justification of legally dissimilar treatment of therapeutic and non-therapeutic interventions only depends *partly* on this difference in aim. For instance, it is arguable that the ability to give the necessary consent to a non-therapeutic

intervention is a legal incident of competent adulthood.²³ That is, where a non-therapeutic intervention is otherwise legal, consent to it will be ineffective unless given by a person who is both competent *and adult*. By contrast, the ability to consent to therapeutic interventions at common law or under *le droit commun* may depend on the individual's factual capacity and power of discernment: in the absence of legislation to the contrary, the minor who is capable of discernment may consent to therapeutic interventions. This suggested distinction accommodates the problem of explaining why a minor's consent is ineffective in non-therapeutic circumstances where an adult's is effective, although that minor can consent to therapy to the same extent as a competent adult. Such a distinction and its consequential difference in result may be desirable.

Therefore, therapeutic aim distinguishes a class of procedures to which certain persons may give legally effective consent. Non-therapeutic aim likewise distinguishes a class of procedures to which a narrower group of these same persons may give legally effective consent, provided that these procedures are not otherwise contrary to public policy. Thus, it is not therapeutic aim which directly justifies a procedure; rather, this aim is relevant to identifying the persons who may validly consent to it.

2. "Presumption-alternative" approach

The second possible approach to reconciling the performance of non-therapeutic medical interventions and the provisions of the *Criminal Code* does not require the proposition that section 45 is inapplicable to these procedures. Rather, the argument is that section 45 requires benefit, and benefit is presumed when personal consent is present. The basis for this argument is that it will normally be assumed that individuals act self-protectively and hence, at least in relation to themselves, promote the Code's fundamental purpose of protecting persons. Thus, if valid consent is obtained, one may presume the necessary benefit. Such an approach means that consent and benefit are viewed as alternative, not cumulative,

²³ See Dickens, *Medico-Legal Aspects of Family Law* (1979), 33, who cites the statutory right to consent to "live-organ donation", when this is reserved by law to adults, as an example of such a restriction. The decision that reserves this right of consent to competent adults can only be rationalized on the basis of public policy, apart from express legislation to this effect. Thus, a decision based on public policy cannot be avoided; merely the content of the public policy underlying the decision differs from that previously invoked.

validating criteria of a medical intervention. This is probably what has occurred in practice: for instance, before there was legislation dealing with live-donor organ transplants, authorization of a court was not sought in relation to donation by competent consenting adults, which indicates that their consent was being treated as a sufficient validation.

However, there are limits to the right to consent to the infliction of harm on oneself; and, again, these limits are a matter of public policy. In general, it may be stated that the two most important factors in determining what is allowed are the degree and nature of the harm inflicted, and the purpose of the intervention.²⁴ But to the extent that consent is a validating factor in the absence of therapeutic benefit, and to the extent that the interest promoted by consent has changed from being one of self-protection (or, as has been explained, therapeutic benefit) to one of self-determination or autonomy, some non-therapeutic interventions may be justified in law by consent alone, within the limits set by public policy.

3. Cumulative approach

The other possible approach here is to retain the notion that consent and benefit are cumulative requirements for the lawfulness of a medical intervention, but in doing so to give a very wide definition of benefit.²⁵ There are two problems in such an approach which are avoided under either of the other approaches to section 45 just outlined.

First, it distorts the notion of benefit for all purposes, so that section 45 fails to perform its protective function where it is most needed, that is, when the person is not capable of consent. This occurs because it is apparently inconsistent to argue that it can be beneficial, within the terms of section 45, to carry out non-therapeutic sterilization on a competent consenting adult but not on an incompetent person. The result will be that the presence of sufficient benefit can more readily be found in all cases.²⁶ But for

²⁴ See Somerville, *Consent to Medical Care* (1979), 107-9.

²⁵ See *Cataford v. Moreau*, *supra*, note 2, and the discussion, *supra*, at pp. 86-7. Also see Fortin, Jodoin & Popovici, *Sanctions et réparation des atteintes au corps humain en droit québécois* (1975) 6 R.D.U.S. 150, 180.

²⁶ It should be noted that sufficient benefit will still not necessarily be found in all cases. This can be seen from the fact that, even though the wide definition of "benefit" within s. 45 by Chief Justice Deschênes in *Cataford v. Moreau* was adopted by McQuaid J. in *Re "Eve"*, *supra*, note 13, such that it included "socio-economic and other considerations", sufficient benefit to the mentally incompetent woman to legalize and hence authorize the

the incompetent there is not then the further protection of the requirement of personal consent, with its correlative right of personal refusal of the procedure. As already noted, section 45 does not mention consent, and thus the general law would apply with respect to what is required for consent to medical interventions on an incompetent person. As far as third party or "proxy" consent or authorization²⁷ is concerned, this requires that the intervention be beneficial to the patient before the authorization becomes legally effective. Again, in this context benefit has traditionally been interpreted as therapeutic benefit. But it would seem rather inappropriate to require a potential of therapeutic benefit for a valid consent to the intervention, but not for the application of section 45 to protect the doctor who performs the operation. Hence it is possible that, due to a desire for consistency, the result of broadening the notion of benefit within section 45 will be to widen considerably the notion of what constitutes a sufficient nature or degree of benefit for effective third-party authorization on behalf of those incapable of consent. This could have far-reaching ramifications: for example, there is the controversial issue of whether persons incapable of consent should participate in medical research. One limitation on such participation is the requirement of therapeutic benefit, which can be used to prohibit the involvement of such persons in non-therapeutic research. This control would be severely compromised under an extended notion of benefit.

The second reason why it is suggested that benefit and consent should not be retained as cumulative criteria concerns the doctor-patient relationship and the patient's right to self-determination. Although personal autonomy deserves the highest respect, there are and should be limits to what even a mentally competent person can effectively consent to have inflicted on himself. Such limits

sterilization operation on her was not found to be present in the circumstances of the latter case. In contrast, sufficient benefit to the competent woman who underwent sterilization was held to be present in *Cataford v. Moreau*. In effect, the wider notion of benefit gives competent persons, or a court which is approached in the case of an incompetent person, a wider discretion as to what medical interventions are allowed or, perhaps more accurately, are not prohibited by law. It should be noted that McQuaid J. expressly allows consideration of the "preservation and protection of *quality of life*" (p. 44) [emphasis added] as among the factors to be considered in exercising this discretion, that is, in assessing benefit.

²⁷ It is suggested that the word "consent" be reserved for personal consent, in order to distinguish clearly this situation from the one where authorization is given to intervene on another person, which involves different considerations. See Somerville, *supra*, note 24, 81.

must be determined according to public policy (that is, theoretically, by the community as a whole) and certainly not by just one other person, even a physician. The latter is a possibility, if it be accepted that benefit is a requirement for the legality of a medical intervention and that such benefit is established in law, not simply according to the patient's predilections concerning himself (as long as these do not contravene public policy), but also by the doctor, because section 45 requires that the doctor make an independent judgement²⁸ as to whether the operation is "really for ... the good [of the patient]".²⁹ This judgement may be more restrictive in its assessment of the degree and nature of benefit comprised in undertaking any particular medical procedure than either the patient's or the community's. To this extent, the patient's autonomy is denied and his wish to have the procedure performed frustrated, without the usual justification being present, namely, that to respect his wish would be contrary to public policy.³⁰

Finally, it is to be remembered that section 45 only applies to "surgical operation[s]". Consequently, to the extent that the requirement of therapeutic benefit is restrictive of what interventions are legally valid, it would not apply to purely medical procedures such as the use of drugs or ionizing radiation. It may be incongruous, in terms of the type and degree of harm risked, to require therapeutic benefit in order to justify a surgical intervention, but not these other procedures. The legality of the latter interventions will clearly be governed by public policy, which will include considerations of both consent and therapeutic benefit. But it is submitted that such policy should not and does not state that both consent and therapeutic benefit are always required: either alone may sometimes suffice. Similarly, these criteria should be treated, in the circumstances and within the limits suggested, as alternative validating criteria of surgical interventions.

Conclusion and recommendations

It is necessary for the law to recognize and accommodate three realities in the context of medical interventions. First, medical inter-

²⁸ *R. v. Morgentaler (No. 5)* (1974) 14 C.C.C. (2d) 459, 461 (Q.B., Crown Side) *per* Hugessen A.C.J.

²⁹ *Ibid.*

³⁰ This is to assume that the *only* reason that the physician refused the intervention was his decision that it was not beneficial to the patient. Apart from the fact that a physician is generally not bound to enter a doctor-patient relationship, there are other reasons, such as a physician's own moral

ventions are not regarded in practice as *prima facie* illegal. Second, some non-therapeutic interventions are accepted by our society. Third, those unable to consent for themselves need increased protection. It is proposed that the most satisfactory approach to such an accommodation is to regard therapeutic interventions as *prima facie* legal and to retain the present criteria of *prima facie* illegality with respect to non-therapeutic medical procedures.³¹ Then, at a second stage of the analysis of the legality of any particular medical intervention, therapeutic benefit and personal "informed" consent should be treated as necessary, but not always sufficient, *alternative* validating requirements within the limits set by public policy.

Under such a scheme, the *prima facie* presumption of illegality of any non-therapeutic intervention on those incapable of consent could not be rebutted without statutory authorization of that procedure. In comparison, the personal "informed" consent of at least a competent adult³² would rebut this presumption where to do so was not contrary to public policy. In the therapeutic situation, the use of therapeutic benefit and consent as alternative validating criteria must be subject to the proviso that where the person is capable of consenting, his consent must be obtained if the intervention is not to constitute a criminal offence. That is, the *prima facie* presumption of the legality of therapeutic interventions would be rebutted in such circumstances by the absence of consent.

or ethical beliefs, which would allow him to refuse to perform a particular medical procedure.

³¹ This is the approach which has been recommended by the Law Reform Commission of Canada in *Medical Treatment and Criminal Law* (1980), 61.

³² I leave open for discussion the extent to which the suggested approach should, or arguably does under the present law, apply to minors capable of discernment and hence of giving or refusing consent to medical procedures.