

AGAINST DOCTOR'S ORDERS: THE FORCE AND LIMITS OF PERSONAL AUTONOMY IN THE HEALTH CARE SETTING

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A. Introduction

Our aim in this paper is to consider two related questions, which go to the heart of the larger concern of conflict between a patient's choice and a medical professional's judgment about the proper course of treatment and care. First, how should a medical professional respond to a patient's refusal to conform to medically necessary dietary advice? Second, having been confronted with such a refusal, how should that medical professional then respond to the patient's request of an alternative but potentially harmful dietary choice?¹ We will examine these questions – of refusal and then of contra-indicated demands – by reviewing and analyzing pertinent Canadian authorities, giving particular consideration to the applicable standard of care that is required of a medical professional in the circumstances just described.

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The authors are grateful to Tracey Bailey, Timothy Caulfield, Ted DeCoste, Moin Yahya and an anonymous peer reviewer for their helpful comments on an earlier draft of this paper.

1 Ubaka Ogbogu, "Respecting the Patient's Freedom to Disagree: Risk Management Standards in Medical Care" (Paper presented to the Alberta Gerontological Nurses Association, Edmonton, Alberta, 13 March 2007) The paradigm has been described to one of us by members of the Alberta Gerontological Nurses Association as the instance of an elderly patient with swallowing difficulties who refuses a prescribed pureed diet and instead demands contra-indicated solid food. See also S. Keszthelyi & B. Blasszauer, "Challenging non-compliance" (2003) 29 *Journal of Medical Ethics* 257; Jauhar Sandeep, "A Patient's Demands Versus a Doctor's Convictions" *New York Times* (3 April 2007) online: The New York Times <<http://www.nytimes.com/2007/04/03/health/03essa.html>>.

Our focus, then, will be a principally legal one. We do not, for example, purport to consider associated professional questions or “ethical” (in the sense of formalized professional ethics) concerns that arise.² That said, our analysis will in a sense implicate moral considerations inasmuch as we also seek to construct a justificatory framework in order to explain what we see as the legal duties that are (or are not) owed to the patient. In that sense, questions of autonomy, the limits on autonomy imposed by social norms, and the normative validity of those limits will be interwoven within our legal analysis. In concluding, we will situate those questions in a broader context by suggesting that our framework might usefully inform analyses of any refusal of a patient’s request for care, such as (*inter alia*) where the care specifically requested is considered by the medical professional to be futile.

For our purposes, we shall assume that the patient is legally competent to make decisions, and that the patient has refused all other recommended alternatives to the potentially harmful dietary choice (such as tube feeding). We shall also assume the patient’s total dependence upon the medical professional’s indulgence. That is, the patient is confined to his or her hospital bed or other residential care facility, such as a nursing home or other senior care facility,³ and lacks the physical ability to resist the recommended dietary

2 The literature on the practical difficulties for patient care posed by non-compliance with the health care provider’s recommendations is canvassed in Fred Rosner, “Patient Noncompliance: Causes and Solutions” (2006) 73:2 Mount Sinai Journal of Medicine 553. See also Karen Paddison, “Complying with pelvic floor exercises: a literature review” (2002) 16:39 Nursing Standard 33. Beyond purely instrumental concerns, contra-indicated demands for medical care have also generated a great deal of ethical and legal debate. See e.g. John M. Luce, “Physicians do not have a responsibility to provide futile or unreasonable care if a patient or family insists” (1995) 23:4 Critical Care Medicine 760; Charles Weijer *et al.*, “Bioethics for clinicians: 16. Dealing with demands for inappropriate treatment” (1998) 159 Canadian Medical Association Journal 817; Jerry Menikoff, “Demanded Medical Care” (1998) 30 Ariz. St. L.J. 1091; Ellen I. Picard & Gerald B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4th ed. (Toronto: Thomson Carswell, 2007) at 345-47.

3 For our purpose, the specific care setting is not significant, so long as it contemplates dietary advice being given by a medical professional as an aspect of treatment or caregiving. Canadian health care statutes typically define “medical treatment” and/or “health care” widely to include “anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose.” *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 2(1). See also

regimen and to procure his or her dietary choice through other sources. Our analysis also presupposes that the alternative dietary choice is truly unacceptable – that is, that its provision would fall outside an appropriate standard of medical care.

B. Refusal of Medical Care

The 1980 decisions of the Supreme Court of Canada in *Hopp v. Lepp*⁴ and *Reibl v. Hughes*⁵ largely settled the question of the general necessity and the specific scope of informed consent in Canadian law and health care practice. Both decisions confirmed the normative status of informed consent under Canadian law by reiterating the obligation placed on medical professionals to disclose all material information⁶ to patients prior to obtaining their consent to medical treatment or intervention. In so doing, they rejected the previous practice of medical disclosure based upon what a reasonable medical professional would tell his or her patient in favour of a new standard of disclosure, based upon what a reasonable person in the patient's position would want to know before making a decision about medical treatment.⁷

Health Care (Consent) and Care Facility (Admission) Act, R.S.B.C. 1996, c. 181, s. 1; *Health Care Directives Act*, C.C.S.M. c. H27, s. 1; *Consent to Treatment and Health Care Directives Act*, R.S.P.E.I. 1988, c. C-17.2, s. 1(p). Similarly, the *Canada Health Act*, R.S.C. 1985, c. C-6, s. 2 defines "hospital services" as "services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability" including "accommodation and meals at the standard or public ward level and preferred accommodation if medically required."

4 [1980] 2 S.C.R. 192, 112 D.L.R. (3d) 67.

5 [1980] 2 S.C.R. 880, 114 D.L.R. (3d) 1 [*Reibl* cited to S.C.R.].

6 Material information includes answers to "specific questions posed by the patient as to the risks involved [in the treatment procedure, and disclosure of]... the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation." *Supra* note 4 at 210. Also, "if a certain risk is a mere possibility which ordinarily need not be disclosed, yet if its occurrence carries serious consequences, as for example, paralysis or even death, it should be regarded as a material risk requiring disclosure." *Reibl, ibid.* at 884-85.

7 See Erin Nelson & Timothy Caulfield, "You Can't Get There From Here: A Case Comment on *Arndt v. Smith*" (1998) 32 U.B.C. L. Rev. 353 [Nelson & Caulfield];

These cases also settled a number of other key considerations relevant to informed consent, including the specific kinds of information to be disclosed to the patient, and the applicable threshold for determining causation where there has been a failure to disclose.⁸

The law of battery is also implicated here. In *Malette v. Shulman*,⁹ the Ontario Court of Appeal affirmed that “no medical procedure may be undertaken without the patient’s consent obtained after the patient has been provided with sufficient information to evaluate the risks and benefits of the proposed treatment and other available options.”¹⁰ To act otherwise constitutes unlawful battery, notwithstanding that “the procedure was performed with a high degree of skill and actually benefited the patient.”¹¹ The rationale, the Court explained, is grounded in the patient’s “right of self-determination” by which it is the patient, not the medical professional, who has the final decision on whether to undergo treatment. As such, the patient can decide to refrain from recommended treatment such as an operation, therapy or (on the facts of *Malette*) a blood transfusion.

The key point for our purposes here is the law’s identification of the interest at stake. Specifically, the need for informed consent was said to flow in part from the patient’s autonomy interest. By “autonomy”, in this context, we refer to the patient’s liberty to “make his or her own decisions as to which medical interventions to accept and which to refuse.”¹² Concern for autonomy therefore directs those providing medical treatment or intervention to seek the patient’s consent before proceeding, and to respect *whatever* decision the patient makes – whether it is to accept or abstain from medically necessary treatment. Canadian courts have consistently endorsed this understanding of the privileged role of autonomy in medical decision-making. For example, in *Ciarlariello v. Schacter*,¹³ Cory J. stated:

Myron Gochnauer & Donald J. Fleming, “Tort Law – Informed Consent – New Directions for Medical Disclosure – Hopp v. Lepp and Reibl v. Hughes” (1981) 15 U.B.C. L. Rev. 475.

8 See Nelson & Caulfield, *ibid.*

9 (1990), 72 O.R. (2d) 417, 67 D.L.R. (4th) 321 (C.A.), [*Malette* cited to D.L.R.].

10 *Ibid.* at 327.

11 *Ibid.* at 328.

12 Nelson & Caulfield, *supra* note 7 at 355.

13 [1993] 2 S.C.R. 119, 100 D.L.R. (4th) 609 [*Schacter* cited to S.C.R.].

It should not be forgotten that every patient has a right to bodily integrity. This encompasses the right to determine what medical procedures will be accepted and the extent to which they will be accepted. Everyone has the right to decide what is to be done to one's own body. This includes the right to be free from medical treatment to which the individual does not consent. This concept of individual autonomy is fundamental to the common law and is the basis for the requirement that disclosure be made to a patient. If, during the course of a medical procedure a patient withdraws the consent to that procedure, then the doctors must halt the process. This duty to stop does no more than recognize every individual's basic right to make decisions concerning his or her own body.¹⁴

Legal protection of this interest is, moreover, and as Robins J.A. stated in *Fleming v. Reid*,¹⁵ fundamental both to law in a generalized, abstract sense, and to the physician-patient relationship specifically:

The right to determine what shall, or shall not, be done with one's own body, and to be free from non-consensual medical treatment, is a right deeply rooted in our common law. This right underlies the doctrine of informed consent.... The fact that serious risks or consequences may result from a refusal of medical treatment does not vitiate the right of medical self-determination.... It is the patient, not the doctor, who ultimately must decide if treatment – any treatment – is to be administered.¹⁶

Note that both Cory J. and Robins J.A. conceive of autonomy in a bifurcated sense. It justifies both the granting *and the withholding* of consent. The autonomy interest, then, is implicated no less by refusal (whether informed or uninformed) than by consent. And, as is also the case with informed consent, the patient's power to refuse is affirmed by the operation of the legal principle of disclosure. Patients are free to consent to *or refuse* medical treatment or intervention for *any reason whatsoever*, even after being presented with all material information relating to the treatment or intervention (and, as Cory J. tells us in *Schacter*, at any time before or after the medical proce-

14 *Ibid.* at 135.

15 (1991), 4 O.R. (3d) 74, 82 D.L.R. (4th) 298 (C.A.) [*Fleming* cited to D.L.R.].

16 *Ibid.* at 309-10.

dures commences).¹⁷ Put succinctly, the patient's refusal absolutely requires the medical professional to take no further action with respect to the course of treatment. He or she cannot provide treatment or intervention that a patient refuses, even where there is no alternative treatment or where the patient also refuses alternative treatment(s).

Although our definition and discussion of autonomy has so far been specific to the health care setting, Robins J.A.'s statement in *Fleming* suggests that its significance transcends that confined scope. In all aspects of life, autonomy encapsulates the idea that persons can assert their self-governing agency by regarding their own judgment on matters pertaining to themselves as authoritative. Because autonomy represents such a general and privileged reference point,¹⁸ it is tempting when challenged to account for its normative force to fall into tautology by rationalizing it with reference to itself (why do we privilege autonomy? Because we wish to be autonomous). In so doing, however – that is, in treating “autonomy” as representing an *a priori*, transcendent idea about the principles that ought to govern relations between human beings – we evade the hard justificatory question of why autonomy matters. More to the point, we avoid the task of reconciling the conflicting moral imperatives underlying a patient's autonomy and a medical professional's obligation to assist. It therefore remains necessary and – because we are dealing with a specific problem derived from actual facts and experience – *possible* for us to justify autonomy as a governing norm in answering the two questions we have posed, and to elucidate its implications for the larger health care context.

Autonomy's normative force, both generally and in the health care setting we have described, is most clearly understood by considering what Isa-

17 *Supra* note 13. See also *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 at 588, 107 D.L.R. (4th) 342, Sopinka J. [*Rodriguez* cited to S.C.R.]. “That there is a right to choose how one's body will be dealt with, even in the context of beneficial medical treatment, has long been recognized by the common law. To impose medical treatment on one who refuses it constitutes battery, and our common law has recognized the right to demand that medical treatment which would extend life be withheld or withdrawn.”

18 Autonomy has, on one basis or another, been privileged by philosophers as diverse as Wolff, Crucius, Voltaire, de la Mettrie, Diderot, Rousseau and Kant. See J.B. Schneewind, *The Invention of Autonomy: A History of Modern Moral Philosophy* (Cambridge: Cambridge University Press, 1998).

iah Berlin conceptualized as “negative liberty.”¹⁹ Whereas “positive liberty” represents the triumph of one’s so-called authentic, or “higher”²⁰ self over passions and selfish interests that encumber our inferior self, negative liberty is “the possibility of fulfilling our projects without coercion.”²¹ Positive liberty, then, speaks to giving persons the capacity to be what others judge they *can* be, while negative liberty speaks to permitting persons the power to be what they *wish themselves* to be. While the idea has been expressed in different ways, the fundamental point is that negative liberty reflects the autonomous ideal. It privileges a certain realm of personal freedom which can suffer no violation and within which one “should be able to make as many effective decisions without fear or favor about as many aspects of [one’s] life as is compatible with the like freedom of every other adult.”²²

In this respect, health care represents an aspect of life where autonomy is uniquely – and paradoxically – implicated. “Uniquely,” because in most Western countries, health care (among all modern human endeavours) stands out for its exclusive provision by the state through a publicly funded system.²³ “Paradoxically,” because it is at least arguable that Berlin specifically intended that health care be understood as a goal that, “at times,” justifies coercion.²⁴ In most quotidian and mundane instances, however, the coercion

19 Isaiah Berlin, “Two Concepts of Liberty” in Henry Hardy, ed., *Isaiah Berlin Liberty: Incorporating “Four Essays on Liberty”* (Oxford: Oxford University Press, 2002) 168 [Berlin, “Two Concepts”].

20 *Ibid.* at 179.

21 Judith N. Shklar, “Positive Liberty, Negative Liberty in the United States” trans. by Stanley Hoffman in Judith N. Shklar, *Redeeming American Political Thought*, ed. by Stanley Hoffmann & Dennis F. Thompson (Chicago: University of Chicago Press, 1998) 111 [Shklar, “Positive Liberty, Negative Liberty”].

22 Judith N. Shklar, “The Liberalism of Fear” in Nancy L. Rosenblum, ed., *Liberalism and the Moral Life* (Cambridge, Mass.: Harvard University Press, 1989) 21 at 21. Or, as has been stated in the health care context specifically, “[e]xercising control, no matter at how visceral a level, may be the last remnant of our ability to retain our humanity.” See Kenneth M. Flegel & Noni MacDonald, “Decision-Making Capacity in an Age of Control”, Editorial, (2008) 178 *Canadian Medical Association Journal* 127.

23 We comment (see text accompanying note 28) on the significance to our analysis of a publicly funded system of health care.

24 Berlin, “Two Concepts”, *supra* note 19 at 179. Berlin uses the term “public health” which strongly suggests that he was referring to threats to the overall health of a community such as the outbreak of infectious disease. While this is

of a patient (even for his or her own sake) on the basis that a rational patient would act reasonably by acquiescing to the proposed treatment (including dietary regimen) is an appropriation of the patient's "personhood,"²⁵ understood as the ability to make informed decisions about one's bodily integrity. This interest is so closely associated with the law's protective force that it furnished the paradigm cited by Thomas Aquinas in elucidating the Aristotelian justification for what we now understand as a private law duty.²⁶ Law, then – in all its forms – is fundamentally concerned with maintaining a realm for personal – and negative – liberty.

C. Demand for Medical Care

So much for the first question: a patient's right to eschew medically necessary dietary advice derives from his or her autonomy, understood as "negative liberty." The high degree of abstraction inherent in "negative liberty," however, leaves open the question of whether negative and positive liberties are totally incompatible. For example, can (or even *must*) negative liberty's autonomy interest accommodate a measure of positive liberty's concern for the "authentic" person? Or, do the two forms of liberty represent a mutually exclusive set of choices?²⁷ This brings us to the second problem that we have posed. Having refused to follow a recommended dietary choice, what are the medical professional's options where the patient then demands an alternative – and contra-indicated – dietary option? More to the point, can the medical professional refuse to comply? In our view, a patient cannot hope simultaneously to assert his or her autonomy from the medical professional and to make an alternative demand of the medical professional and, as such, cannot reasonably expect a medical professional to accede to such a demand. Our justification illuminates the inherent limits in a liberal order of "negative liberty."

obviously distinct from the overall provision of health care, the publicly funded nature of the health care system, as we will discuss, implicates the same concerns that impelled Berlin to cite this example.

25 Margaret Jane Radin, "Property and Personhood" (1982) 34 Stan. L. Rev. 957.

26 James Gordley, "Tort Law in the Aristotelian Tradition" in David G. Owen, ed., *Philosophical Foundations of Tort Law* (Oxford: Clarendon Press, 1995) 131 at 137-40.

27 See the discussion in Michael Ignatieff, *Isaiah Berlin: A Life* (London: Penguin Books, 1998) at 229.

Before explicating those limits, however, we should make express a complicating aspect of our inquiry, which is the public system of health care and its implications for a patient's autonomy (to which we have already averred).²⁸ Were we to ignore this political context in which the problems under discussion arise, our solution would obviously lie with the free market (as is the case, for example, with the provision of legal services). Subject to any stipulations to which the patient and medical professional have freely contracted (as well as to any extra-contractual but nonetheless legal impositions, such as those impressed upon physicians by fiduciary law and tort law), then, the patient would be entitled not only to resist a prescribed dietary regimen, but also to demand and receive whatever dietary preferences he or she makes known. Where, however, health care is furnished within an involuntary, non-alternative state-imposed context, reconciliation must be achieved of the supposed primacy of the patient's negative liberty – his or her *private* self – with a publicly funded health care system, instantiating the state's imposition of a *public* self.

While Berlin's bifurcated understanding of liberty is a salutary reminder that the socialization of services such as health care effectively limit a person's capacity to do whatever he or she likes, our starting point is that negative and positive liberties are not necessarily counterpoints, but rather mutually dependent. Berlin's (well-placed) fear was, of course, that positive liberty was at the root of all utopian theories and certain dystopian historical realities of politics, rationalizing a person's forcible "emancipation" from his or her lower passions by "re-education" to a person's authentic self and therefore to his or her "true" needs. In a liberal order, however, the two forms of liberty need not reflect some tragic choice between the incompatible values held by free and totalitarian societies. Rather, positive liberty can be understood as the condition that makes negative liberty universally possible.²⁹

Berlin himself recognized that totalitarian states are perversions of positive liberty. His statement, however, is revealing and highly relevant to the health care setting:

Claims can be balanced, compromises can be reached: in concrete situations not every claim is of equal force – so much liberty and

28 See the text accompanying note 23.

29 Here we are agreeing with Shklar, "Positive Liberty, Negative Liberty", *supra* note 21 at 114.

so much equality; so much for sharp moral condemnation, and so much for understanding a given human situation; so much for the full force of the law, and so much for the prerogative of mercy; for feeding the hungry, clothing the naked, healing the sick, sheltering the homeless. Priorities, never full and absolute, must be established.

... So we must engage in what are called trade-offs – rules, values, principles must yield to each other in varying degrees in specific situations. Utilitarian solutions are sometimes wrong, but, I suspect, more often beneficent.³⁰

In other words, an (albeit uneasy) equilibrium is struck to foster decent society, which is a precondition to achieving the objects of one's negative liberty.

Here is the limit of negative liberty. A hard libertarian view of the individual's relationship with others fails, in the case of a public health care system such as Canada's, to account for the necessity of forced transfers of negative liberty. By "forced transfers," we refer to the forced surrender of certain aspects of a person's autonomy in exchange for a measure of conventional public goods. They are, in short, the means by which people move from voluntary associations to political organization. It is, after all, only when individuals are forced to surrender certain individual rights in exchange for state protection that the state, even in its most minimal form, becomes possible.³¹

Berlin's concession to "beneficent[ce]," then, is really one to the public good, but as we will show the concession is not made for the sake of the public *qua* public, but for the sake of the public *qua* individual persons, all of whom (like the recalcitrant patient) are attempting to live their respective ideas of the good life. Here we must admit to treading dangerous ground, as Ronald Dworkin's observation brings home:

30 Isaiah Berlin, "The Pursuit of the Ideal" in Isaiah Berlin, *The Crooked Timber of Humanity*, ed. by Henry Hardy (Princeton: Princeton University Press, 1990) 1 at 17. [Emphasis added].

31 Richard A. Epstein, "One Step Beyond Nozick's Minimal State: The Role of Forced Exchanges in Political Theory" in Ellen Frankel Paul, Fred D. Miller, Jr., & Jeffrey Paul, eds., *Natural Rights Liberalism from Locke to Nozick* (Cambridge: Cambridge University Press, 2005) 286 at 287.

[S]omeone with a vivid sense of his own critical interests is inevitably thwarted when his community fails in its responsibilities of justice, and this is so even when he, for his own part, has done all he personally can to encourage it to succeed. Each of us shares that powerful reason for wanting our community to be a just one.... So our private lives, our success or failure in leading the lives people like us should have, are in that limited but powerful way parasitic on our success together in politics. Political community has that ethical primacy over our individual lives.³²

The very idea of the private life being parasitic to the political life should give pause. It represents not a reconciliation of autonomy with public welfare, but rather the priority of social imperatives over the autonomy of the individual. Berlin's invocation of "utilitarian solutions" also suggests a privileging of the collective interest at the expense of an individual's autonomy.³³ On such an understanding, the patient's interests would be subordinated to those of the health care system and its frontline overseer, the medical professional.³⁴

We nonetheless maintain that a true reconciliation of the private self with the state's imposition of a public self, accounting for both the private and public imperatives while compromising neither, is viable. Here our understanding of public entitlements and responsibilities are informed by John Rawls' idea of a division of responsibility between individuals and the state, by which society is responsible for preserving basic liberties and equality of opportunity, while individuals within society are responsible for directing the course of their lives and for the outcomes.³⁵ Residual to a person's autonomy, therefore, are resources in which from a public standpoint all can share, and in respect of which the person is forced to conform to the public

32 Ronald Dworkin, "Liberal Community" (1989) 77:3 California Law Review 479 at 504.

33 See the quotation at 525-526, above.

34 This is not, of course, to suggest that the medical professional is an agent in a legal sense for the health care system, but rather to point out that he or she must be an advocate for his or her patient. See *Law Estate v. Simice* (1994), 21 C.C.L.T. (2d) 228 at para. 28, [1994] B.C.J. No. 979 (S.C.).

35 John Rawls, *A Theory of Justice*, rev.ed. (Oxford: Oxford University Press, 1999) [Rawls, *A Theory of Justice*]. See also John Rawls, "Social Unity and Primary Goods" in Amartya Sen & Bernard Williams, eds., *Utilitarianism and Beyond* (Cambridge: Cambridge University Press, 1982) 159.

choice. Such limitations to autonomy are justified because they are “essential conditions to the very possibility of enforceable rights, because they are moral prerequisites for a shared public sphere.”³⁶ Charged with the responsibility to protect liberty and opportunities, society has established institutions of social cooperation that anyone seeking to enforce an individual right must be able to presuppose. Individuals, in turn, are expected not only to take responsibility for the course of their own lives, but also to avoid making excessive demands on such institutions.³⁷ They are taken as having implicitly accepted as necessary a scheme of mutual aid reflective of a principle of equal liberty, restraining the pursuit of their own ends by refraining from pressing claims which violate that principle.³⁸

In short, the preservation of one’s own autonomy requires institutions which all of us are taken to have agreed *ab initio* to support by refraining from conduct that interferes with the rights of others to pursue their own opportunities. We suggest that examining the health care setting elucidates Rawls’ point and, more particularly, the problem we have posed of a contra-indicated diet. Assuming for our purposes that health care represents an aspect of a scheme of social cooperation that is a prerequisite to an acceptable life for all,³⁹ then all citizens have a responsibility to sustain the provision of health care to all. They do so because illness and injury represent a kind of misfortune or obstacle to pursuing one’s course in life such that they ought to be held in common as everyone’s problem. As such, citizens ought to adjust their expectations in light of their own fair share of the health care resource. Similarly, they must also avoid externalizing the costs of their own choices by unduly displacing such costs onto others.⁴⁰

Note that this does not implicate at all our answer to the prior question of a patient’s refusal to observe a recommended dietary regimen. He or she is perfectly entitled, as an autonomous individual, to choose that course in

36 Arthur Ripstein, “Private Order and Public Justice: Kant and Rawls” (2006) 92 Va. L. Rev. 1391 at 1394.

37 Arthur Ripstein, “Three Duties to Rescue: Moral, Civil and Criminal” (2000) 19 Law & Phil. 751 at 756 [Ripstein, “Three Duties”].

38 Rawls, *A Theory of Justice*, *supra* note 35 at 27.

39 Rawls’ model is conceived in this way in Ripstein, “Three Duties”, *supra* note 37 at 757.

40 Any public system, of course, inevitably results in externalization of costs. By referring to “undue” displacement, we are confining our concern to cost displacement resulting from a patient’s insistence on a contra-indicated diet.

life. No imposition is made on others by, for example, taking up the health care system's valuable resources and thereby precluding it from assisting others as it otherwise would. The patient is internalizing the costs because he or she is solely responsible for the outcome. Where, however, that patient then demands an alternative but potentially harmful dietary choice which the medical professional cannot support, the stakes are higher because the autonomy interests of others are implicated. In short, it is no longer just about the needy patient. If health care is a prerequisite to equality of opportunity that enables everyone to follow their respective courses in life, then a citizen's ability to be self-directing in health care ("I don't want dietary choice 'A' – give me dietary choice 'B'") must be constrained.

Our concern is not about the *scale* of such interference, but its *quality*. As such, our conclusion is driven not by the numbers of persons whose access to health care is impeded by a patient's contra-indicated demands, but by the nature of their interest that is being obstructed. The patient is asserting a place in the public order which, if respected, will prevent others from accessing the necessities for following their own course in life. In sapping more resources than necessary from the system by making himself or herself even sicker, he or she is forcing the medical professional to divert resources from others to the patient's recovery from this self-aggravated condition. The better position is that the medical professional can – indeed, *must* – ignore contra-indicated dietary requests. Otherwise, the patient's self-direction will be effectively interfering with the self-directing ability of other patients.

This limited understanding of the patient's autonomy is not reflective, then, of some externally imposed, policy-driven or otherwise arbitrary constraint. Rather, it instantiates an inherent delimitation of autonomy's original scope. This delimitation, moreover, is profoundly legal in character. The normative presupposition of legal rights is that a person's self-directed acts must allow for the co-existence of the purposiveness of others. Hence Judith Shklar's statement, which we have already cited,⁴¹ carefully conditions a person's autonomous decision-making power on what "is compatible with the like freedom of [others]." ⁴² Or, as Ernest Weinrib has more recently observed:

41 *Supra* note 22.

42 Hence also the pithy statement popularly attributed Oliver Wendell Holmes, Jr. that "the right to swing my fist ends where the other man's nose begins."

As juridical manifestations of self-determining freedom, rights provide the space within which all right holders may pursue ends of their own. Such ends are consistent with the self-determining freedom of others only if the point of pursuing them is independent of the adverse effect on someone else. When all act to pursue ends of their own in this sense, they all rank equally as persons whose activities can coexist within the system of rights. Conversely, if the freedom to perform an act merely to frustrate the purposes of another were legitimate, rights would be transformed from markers of mutual freedom to instruments of subordination.⁴³

While, then, law's fundamental concern is, as we have already described, to maintain a realm for autonomy, it does so by reference to a juridical yardstick of rights and in a setting occupied by multiple and competing rights-holders. While privileging the autonomy of all, a truly legal account of those relations thus requires – *not* as a function of non-legal, instrumental concerns, but as a constitutive aspect of the right at issue – that a person's exercise of his or her autonomy permit other patients the opportunity to pursue their lives' ambitions.

A longstanding instance of this principle at work in the law is the judicial invocation of "public policy" to prevent, for example, immoral purposes from being advanced by legal device, such as through a racist condition to a testamentary disposition. The legal prohibition against such conditions is a means by which the law precludes persons from using their rights in a manner that interferes with the rights of others (specifically, in this example, the right to acquire property).⁴⁴ Again, this requirement is not a limitation superimposed on an otherwise unfettered right, but rather is the natural outcome of the right's innate dimensions. "Public policy" in this sense represents the same exercise in discernment and enforcement of that innate

43 Ernest J. Weinrib, "Two Conceptions of Remedies" in C. Rickett, ed., *Justifying Remedies in the Law of Obligations* Cambridge University Press [forthcoming in 2008].

44 Immanuel Kant, *The Metaphysics of Morals*, ed. & trans. by Mary Gregor (Cambridge: Cambridge University Press, 1996) at 24-25. See also Joseph William Singer, "Things that We Would Like to Take for Granted: Minimum Standards for the Legal Framework of a Free and Democratic Society" Harvard Public Law Working paper No. 136, Harvard Law and Policy Review [forthcoming], online: Social Science Research Network <http://papers.ssrn.com/sol3/papers.cfm?abstract_id=946108>.

limitation that we suggest should inform the law's response to the patient who requests contra-indicated nourishment.

As we have already stipulated, our analysis presupposes that the alternative dietary choice is truly unacceptable – that is, that its provision would fall outside an appropriate standard of medical care (or that it is not otherwise unreasonable).⁴⁵ Indeed, negligence law binds medical professionals to a duty to provide an appropriate standard of care, failing which they are liable for any resulting harm to patients.⁴⁶ Even where the patient's refusal of a recommended regimen is combined with a requested alternative diet which is benign, the medical professional is still under no legal obligation to provide it if it is not a commonly available option. It follows therefore that, *a fortiori*, where the medical professional is aware that the requested alternative will harm the patient, his or her obligation is to refuse that request.

D. The Model Applied

We have, at an admittedly abstract level, justified (1) honouring a patient's refusal to conform to medically necessary dietary advice, while (2) withholding from a patient his or her requested but potentially harmful dietary alternative to the recommended dietary plan which the patient has chosen not to follow. We now move from the abstract to the particular, elucidating the operational significance of our normative justificatory structure by applying it to a concrete and common fact situation. Assume that a capacitated adult patient is known to have swallowing difficulties that will lead to choking and possibly death. The medical professional prescribes a pureed diet, accompanied by strict directions to avoid solid food. The patient is also

45 For example, the patient's choice, while not harmful, might implicate resource issues. Here too, the patient's private ordering is justified only so long as it does not impede the interests of others who depend on the scheme of mutual aid. We discuss such middle-ground scenarios at the text accompanying note 47.

46 An "appropriate standard of care" means generally, conduct which conforms with a recognized and respectable practice of a profession, "assessed in the light of the conduct of ordinary specialists [possessed of] a reasonable level of knowledge, competence and skill expected of professionals ... in that field." See *ter Neuzen v. Korn*, [1995] 3 S.C.R. 674 at para. 33, 127 D.L.R. (4th) 577; *Lapointe v. Hôpital Le Gardeur*, [1992] 1 S.C.R. 351, 90 D.L.R. (4th) 7.

presented with all material information relating to the medical professional's advice. She nonetheless refuses and requests solid food only.⁴⁷

At this point, three issues arise. First, can the medical professional force the patient to receive pureed food? The answer is clearly no. The only autonomy interest implicated here is the patient's and, as such, it must prevail as an instance of her negative liberty to live life as she chooses. Second, must the medical professional accede to the patient's request for solid food, despite (for example) the clear risk that the patient will aggravate his or her condition (for example, by non-fatal asphyxiation)? The answer is that the autonomy interests of other users of the health care system require that the medical professional refrain from running the risk of diverting yet further resources to the recalcitrant patient at the expense of others who depend upon the system for necessary assistance. If, after all, a patient can impose unreasonable demands on a public system designed to enable her *and others* to make their own course in life, those others could not justly be held responsible for their own lives.

Our framework for analysis, we suggest, also provides guidance where the alternatives demanded by the patient are less stark than those which we have considered – for example, (1) where a patient demands treatment that is benign (in the sense that it does no harm) but costly, or (2) where a patient demands treatment that poses a risk of harm but which is cost-neutral.⁴⁸ In our view, only treatment that is *both* benign (or merely less effective) *and* cost-neutral may be provided by the medical professional at the patient's request as an alternative to the medical professional's recommended treatment choice. It might be tempting to extend treatment in scenarios (1) and (2) by rationalizing the decision to treat on the basis that the treatment is either merely less effective (while still costly) or cost-neutral (while still risky). Here, however, normative and doctrinal problems intersect to make it legally impossible in either scenario for a medical professional to honour those demands. The normative problem arises, as we have shown, wherever a medical professional administers treatment whose cost operates to deprive others of their autonomy interest. The doctrinal problem is that the provision of harmful treatment runs counter to the tort law standard of care.

47 See the discussion accompanying note 1.

48 See *supra* note 44.

That doctrinal concern leads us to the third issue because it forces us to shift our attention from the question of other users' rights and raises the more functional concern of whether a medical professional would be violating the *patient's* rights by acceding to his or her request for solid food. This goes, of course, to the purely legal question of the standard of care to be observed by the professional. This in turn engages, *inter alia*, questions of reasonable, professional practice.⁴⁹ It seems inconceivable that the medical profession would consider it appropriate to offer solid food to a patient who is at high risk of choking from swallowing. This is not some elective procedure, but rather a potentially harmful option, similar to (for example) providing a patient suffering from chronic renal failure more fluids than the recommended daily allowance. As Ellen Picard and Gerald Robertson have noted,

If a patient requests treatment which the doctor considers to be inappropriate and potentially harmful, the doctor's overriding duty to act in the patient's best interest dictates that the treatment be withheld. A doctor who accedes to a patient's request (or demand) and performs treatment which he or she knows, or ought to know, is contra-indicated and not in the patient's best interests, may be held liable for any injury which the patient suffers as a result of the treatment.⁵⁰

A medical professional's duty to dishonour requests for harmful treatment, including dietary preferences, then, is grounded not only in coherent, fundamental norms which inform widely accepted notions of liberty in Western civil society, but also in positive Canadian law. As such, the legal position of medical professionals who receive and refuse such requests seems secure.

E. Conclusion

As we have confined our discussion in this paper to the narrow questions posed at the outset, our answers have a similarly narrow focus. A capacitated adult patient has an unfettered choice between accepting or refusing a recommended dietary regimen. And, his or her medical professional must therefore honour that choice, even where the choice is refusal and

49 See *supra* note 46.

50 Picard & Robertson, *supra* note 2 at 345-46.

even where it is made for reasons that seem to the medical professional to be irrational or unfounded. Such power of choice is an incident of the patient's autonomy interest, understood as the negative liberty to live life as one chooses, without external coercion. Conversely, the patient's autonomy is inherently limited by the autonomy interests of others who require health care in order to have the opportunity to live life as they choose. Consequently, where the patient combines his or her refusal with demands for a contra-indicated diet that might take the medical professional from other patients or cause the patient to be a further drain on the health care system, the autonomy interests of others in need of professional medical care require that such demands be refused.

In setting out our answer to the discrete problem of refusal of health care and contra-indicated demands, we have relied upon a largely Rawlsian justificatory model that potentially transcends our narrow questions, implicating other contemporary health care issues. At the very least, we suggest that it offers the prospect of a framework for analysis by which we can see old conundrums in a new light. Patient demands for alternative medical therapies, prioritizing allocation of limited health care resources, patients' right to self-regulation of medical care, and the request for treatment considered medically futile or unreasonable – all issues that generate controversy about the nature of the relationship between patient and care provider – seem, at least at first glance, promising subjects for our overarching juridical framework.

Among those issues, cases of "medical futility" – medical care that the medical professional considers useless, ineffective, or improbable to succeed⁵¹ – and the current prevailing view (that there is no obligation to offer futile care to patients or to provide it if demanded by the patient)⁵² seem particularly apt for future consideration.⁵³ The typical rationale for this view is that futile care transcends the boundary of standard medical care and thus a medical professional is legally and ethically precluded from providing such

51 The scope of treatments covered by the term "medical futility" is subject to various interpretations. For a discussion of the various meanings of the term, see Menikoff, *supra* note 2.

52 Menikoff, *ibid.*; Picard & Robertson, *supra* note 2; Weijer *et al.*, *supra* note 2; Luce, *supra* note 2. Menikoff's position merits particular mention. According to him, all "futile treatment", however defined, is extra-standard care and, reasonable or not, a medical professional is legally obligated not to provide it.

53 We are grateful to Timothy Caulfield for this insight.

care.⁵⁴ This rationale has been criticized, however, as ignoring patient values and constituting a breach of an autonomy-based right to regulate their own medical care.⁵⁵ While we do not purport here to give serious consideration to this debate, it is worth noting that our justificatory model allows for a principled examination and, possibly, accommodation of both the patient's autonomy interests *and* the operational requirements of a system that also fields demands from others for care. The debate about the appropriate response to requests for futile treatment would thus be framed not as a choice between acquiescence and denial (or between harsher and softer denials⁵⁶), but as a coherent and principled juridical process of discerning whose autonomy interests are implicated: the requesting patient's, or others who require their slice of the limited health care pie?

54 *Ibid.*

55 Weijer *et al.*, *supra* note 2;

56 Weijer *et al.*, *ibid.*; Luce, *supra* note 2.

