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## Informed Consent:

### The Right of Psychiatric Patients to Refuse Treatment

Sarah MacKenzie\*

*The right to refuse treatment, whether in physical or mental illness, is clearly established in common law and protected under s. 7 of the Charter. Some provincial statutes, such as the Nova Scotia Hospitals Act, expressly or implicitly violate this right of psychiatric patients. In most cases, legislation does not provide sufficient guidance to the medical profession to protect these rights in practice. It is recommended that reform is needed in mental health law, particularly with respect to informed consent, the meaning and limit of emergency treatment, therapeutic privilege, and the process of determining substitute consent-givers. Legislatures and courts must strike a balance between the relief from suffering and the right to liberty and self-determination when dealing with the medical treatment of psychiatric patients.*

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*Le droit de refuser un traitement, que ce soit pour un problème physique ou mental, est clairement établi par le droit commun et protégé par l'article 7 de la Charte. Certaines lois provinciales telles que la Loi sur les Hôpitaux en Nouvelle-Ecosse, explicitement ou implicitement transgressent ce droit qu'ont les patients psychiatriques. En pratique, dans la plupart des cas, la législation ne fournit pas suffisamment de direction à la profession médicale pour protéger ces droits. Des réformes sont recommandées dans le domaine du droit de la santé mentale, particulièrement en ce qui concerne l'obtention du consentement du patient en connaissance de cause, la définition et les limites du traitement d'urgence, le privilège thérapeutique, et les personnes aptes à donner le consentement requis si le patient, lui-même, ne peut pas. Les législatures et les cours doivent trouver une balance entre le soulagement de la souffrance et le droit à la liberté et l'auto-détermination lorsqu'il s'agit du traitement médical des patients psychiatriques.*

The right to refuse medical treatment is a well-established principle in common law,<sup>1</sup> and, since the entrenchment of the *Charter*,<sup>2</sup> a constitutional imperative.<sup>3</sup> A physician who fails to obtain an informed consent prior to treatment is liable for

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<sup>1</sup> *Malette v. Schulman* (1990), 72 O.R. (2d) 417 (C.A.).

<sup>2</sup> *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982*, (U.K.), 1982, c. 11. [hereinafter *Charter*].

<sup>3</sup> *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (C.A.).

a civil action in battery or negligence.<sup>4</sup> Legislation that expressly or implicitly permits forcible treatment is ripe for constitutional challenge.

The care of mental health patients in Canadian provinces and in both territories is presently governed by legislation. Although ten years have passed since the *Charter* was adopted and twelve years since the Supreme Court set out the requirements for informed consent in *Reibl v. Hughes*,<sup>5</sup> most provincial legislation concerned with mental health care continues to violate the patient's fundamental right to bodily integrity.<sup>6</sup>

This discrepancy between principle and practice is a result of two main factors. On the one hand, civil actions in battery and negligence and challenges to unconstitutional legislation have been few and far between, primarily as a result of the disempowered position of the mental health consumer. On the other hand, provincial legislatures have failed to take a proactive stance towards reform in the area of mental health law. This neglect is likely attributable both to the stigma associated with mental illness and the enduring tradition of paternalism in the medical profession itself.<sup>7</sup>

The exercise by the state of its *parens patriae* power<sup>8</sup> fulfills a legitimate need; individuals suffering from psychiatric disorders or emotional disturbances are vulnerable and often require protection. In Canada, however, the trend towards greater patient autonomy compels the circumscription of this power by the legal right to refuse treatment.<sup>9</sup> In the words of one author, "elitism and

<sup>4</sup> *Reibl v. Hughes*, [1980] 2 S.C.R. 880.

<sup>5</sup> *Ibid.*

<sup>6</sup> See Appendix for summary; *Mental Health Act*, R.S.N.W.T. 1988, c. M-10; *Mental Health Act*, R.S.Y.T. 1986, c. 115; *Mental Health Act*, R.S.P.E.I. 1988, c. M-6; *Mental Patients Protection Act*, R.S.Q. 1977, c. P-41; *Mental Health Act*, S.A. 1988, c. M-13.1; *Mental Health Act*, R.S.B.C. 1979, c. 256, as am. S.B.C. 1981, c. 21; *Mental Health Act*, R.S.M. 1987, c. M-110 as am. S.M. 1987-88, c. 56, S.M. 1991-92, c. 4; *Mental Health Act*, R.S.N.B. 1973, c. M-10 as am. S.N.B. 1989, c. 23; *Mental Health Act*, R.S.N. 1990, c. M-9.

<sup>7</sup> Paternalism has been a dominant feature of medical practice since its inception. In *On Decorum*, Hippocrates advised physicians to "perform [their duties] calmly and adroitly, concealing most things from the patient while you are attending to him." [Decorum XVI of the Hippocratic Corpus, vol. 2, trans. Jones (1923), p. 297.]

<sup>8</sup> The traditional justification for the infringement of the rights of the mentally ill is 1) the need to protect society as a whole from imminent danger ("police power"), and 2) the obligation of the state to care for those members of society unable to care for themselves (*parens patriae*). The latter justification is most frequently invoked. See *E. (Mrs.) v. E.*, [1986] 2 S.C.R. 388 for a discussion of the application of this doctrine in Canada.

<sup>9</sup> I have attempted to limit the scope of my research to Canadian sources. Much of the material written on this subject has focused on American precedent due to the deluge of cases dealing with these issues in the U.S. (e.g. *Rogers v. Okin*, 478 F. Supp. 1342; *Rennie v. Klein* 462 F. Supp. 1294). However, over the past decade there has been significant development in the case law in Canada, aspects of which are distinct from the American

paternalism are out, individualism and self-determination are in.”<sup>10</sup> A conflict exists between the power of the state, exercised through the agency of psychiatrists, and the liberty of the individual, espoused by the common law and entrenched in the *Charter*. Provincial legislatures, accordingly, must engage in the difficult task of balancing patient rights with patient needs.

This paper examines the statutory consent process, outlined in the Nova Scotia *Hospitals Act*,<sup>11</sup> after the preliminary determinations of admission status and competency have been made. On its face, the statute adheres to the requirements of the *Charter* and respects the common law right to self-determination. The consent of the competent psychiatric patient, or the consent of a proxy if the patient is incompetent, is required before treatment can be administered, even if the patient has been committed involuntarily.<sup>12</sup> Nevertheless, these provisions do not adequately protect the right to refuse treatment; a gap exists between the *prima facie* intent of the legislation and its impact in operation. The written law in Nova Scotia must be compared with its practical effect in order to identify the deficiencies in the legislation and suggest avenues for reform.

## THE COMMON LAW

### The Right to Refuse Treatment

The common law principle that no person may invade the bodily integrity of another without their consent<sup>13</sup> was recently affirmed by the Ontario Court of Appeal in *Malette v. Schulman*.<sup>14</sup> A physician who disregarded an express refusal of blood transfusions – written on a card in the patient’s purse – was found liable for battery even though the treatment had saved the woman’s life. Justice Robins clearly set out the law on this issue:

A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternate form of treatment, even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community. Regardless of the doctor’s opinion, it is the patient who has the final say on whether to

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approach. Therefore, there is a need for a survey of Canadian cases and commentary in order to identify the state of the law in this area at present.

<sup>10</sup> Davies, “The Quality of Consent for Health Care: Rationalizing What is Ideal with What is Achievable” (1986) 7 *Health Law in Canada* 3.

<sup>11</sup> *Hospitals Act*, R.S.N.S. 1989, c. 208.

<sup>12</sup> *Ibid.* ss. 52(2) and 36(2).

<sup>13</sup> *Mulloy v. Hop Sang*, [1935] 1 W.W.R. 714 (Alta. C.A.).

<sup>14</sup> *Supra* note 1.

undergo the treatment.<sup>15</sup>

The right of a competent adult to refuse treatment, regardless of the consequences, is an undisputed issue.

### Consent

Underlying this right is the physician's obligation to obtain the patient's consent prior to treatment. A valid consent must be specific, voluntary, given by a competent person, and informed.<sup>16</sup>

*Specific* – The consent must be specific to the procedure performed; a general consent authorizing a physician to perform any necessary procedures is not by itself legally valid. It may be used as evidence that a properly informed consent has been obtained, but it is not conclusive.<sup>17</sup>

*Voluntary* – The consent must be free of undue influence either in the form of a sanction or reward. It may be argued that it is impossible to obtain a truly voluntary consent in an institutional setting, such as a prison or mental hospital, because of the coercion inherent in such an environment. In the view of one psychiatric nurse, a coercive approach is frequently taken to administer medication:

At present, we cannot force a competent patient who refuses it to take medication. Yet it is not an uncommon practice for a nurse to offer this same patient medication in his or her room, in the presence of several other staff members. Compulsory treatment? Maybe. Coercive? Probably. But in the clinical judgement of many nurses, not taking such actions would leave them vulnerable to potential injury as well as accusations of neglect.<sup>18</sup>

*Competence* – Only a competent person can give a valid consent to treatment. Competence has been defined as “the intellectual ability to reach a reasoned choice about treatment.”<sup>19</sup> Generally, a “reasoned choice” requires the ability to appreciate the nature and consequences of the proposed treatment.<sup>20</sup>

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<sup>15</sup> *Ibid.* at 10.

<sup>16</sup> Savage & McKague, *Mental Health Law in Canada* (Toronto: Butterworths, 1987) at 100-105; see also Rozovsky & Rozovsky, *Canadian Law of Consent to Treatment* (Toronto: Butterworths, 1990) at 2-3.

<sup>17</sup> Savage, *Ibid.* at 101; Rozovsky, *Ibid.* at 12.

<sup>18</sup> Schreiber, “Compulsory Treatment of Schizophrenia: A Nurse’s Perspective” (1988), 9 *Health Law in Canada* 18.

<sup>19</sup> Rozovsky, *supra* note 16 at 5.

<sup>20</sup> Most provincial statutes contain these criteria for the determination of competence. Section 52(2) of Nova Scotia’s *Hospitals Act* also requires an assessment of “whether or

*Information* – A physician is required to disclose any risks of the proposed treatment that would be material to a reasonable person in the patient's position in making his or her decision. In addition, the physician must inform the patient of special or unusual risks as well as answer any questions he or she may have.<sup>21</sup> Common risks, or risks of which the doctor knows the patient is aware, need not be disclosed unless there is a specific inquiry.<sup>22</sup>

### The Requirement of Information

The Supreme Court of Canada, in *Hopp v. Lepp*, imposed an obligation on Canadian physicians to disclose "the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation."<sup>23</sup> In a subsequent decision, *Reibl v. Hughes*,<sup>24</sup> the Supreme Court applied this standard of disclosure and proceeded to make three further changes in the law.<sup>25</sup> First, aside from a claim for battery where no consent had been obtained at all, an action for negligence could be brought if the patient consented on the basis of inadequate information, provided by the physician, on the material risks of the treatment. Second, after *Reibl v. Hughes*, the appropriate test to assess the quantity and quality of information to provide was no longer what a reasonable physician would decide to disclose,<sup>26</sup> but rather what a reasonable person in the patient's position would want to know. Finally, to establish negligence, the Court required the plaintiff to prove that the failure to inform caused the damage suffered. In making this assessment, the Court proposed the use of an objective standard; would a reasonable person in the same position as the patient not have undergone the treatment if they had been properly informed of the risks?

Subsequent case law has further refined the definition of the proper standard of disclosure.<sup>27</sup> Material risks are "significant risks that pose a real threat to the

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not his ability to consent is affected by his condition."

<sup>21</sup> *Hopp v. Lepp*, [1980] 2 S.C.R. 192; *Reibl v. Hughes*, *supra* note 4.

<sup>22</sup> In *Anderson v. Grace Maternity Hospital et al.* (1990), 93 N.S.R. 141 (S.C.T.D.) the court held that the possibility of a Cesarean delivery, and the risks involved in that procedure, were not required to be disclosed because certain risks are inherent in giving birth and the plaintiff was a nurse with special knowledge of such matters.

<sup>23</sup> *Hopp v. Lepp*, *supra* note 21 at 210.

<sup>24</sup> *Supra* note 4.

<sup>25</sup> Robertson, "Informed Consent Ten Years Later: The Impact of *Reibl v. Hughes*." (1991) 70(3) Can. Bar Rev. 423 at 424.

<sup>26</sup> See e.g. *McLean v. Weir* (1977), 3 C.C.L.T. 87 (B.C.S.C.).

<sup>27</sup> *White v. Turner* (1981), 120 D.L.R.(3d) 269 at 284 (Ont. H.C.); *Videto v. Kennedy* (1981), 125 D.L.R.(3d) 127 at 133 (Ont. C.A.); *Casey v. Provan* (1984), 11 D.L.R.(4th) 708 (Ont. H.C.J.); *Stamos v. Davies* (1985), 21 D.L.R. (4th) 507 (Ont. H.C.J.); *Haughian*

patient's life, health or comfort,"<sup>28</sup> although a slight chance of serious injury may also be considered a material risk requiring disclosure.<sup>29</sup> Special or unusual risks, while not "material," are nevertheless risks of which a reasonable person in the patient's position would want to be informed. The Supreme Court seemed unsure of the scope of this last category in *Hopp v. Lepp*,<sup>30</sup> and failed to clarify the issue in *Reibl v. Hughes*.<sup>31</sup> Some guidance has been provided by the Ontario High Court in *White v. Turner*:

As for "unusual or special risks," these are those that are not ordinary, common, everyday matters. These are risks that are somewhat extraordinary, uncommon, and not encountered every day, but they are known to occur occasionally. Though rare occurrences, because of their unusual or special character, the Supreme Court has declared that they should be described to a reasonable patient, even though they may not be "material." There may, of course be an overlap between "material risks" and "unusual or special risks." If a special or unusual risk is quite dangerous and fairly frequently encountered, it could be classified as a material risk. But even if it is not very dangerous or common, an unusual or special risk must be disclosed.<sup>32</sup>

The distinction between material and special risks remains unclear and the definition, particularly of special risks, will vary according to the source.<sup>33</sup>

The physician must consider the patient's personal characteristics when determining what degree of disclosure is required to satisfy the subjective component of the above-noted "reasonable patient" test. The patient's perception of his or her best interests, the patient's lifestyle, emotional sensitivities, or religious convictions affect what constitutes "material" information in each case. The physician's duty is not merely to inform:

The true requirement...is that the physician learn enough about

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v. *Paine* (1987), 37 D.L.R.(4th) 624 (Sask. C.A.); The judgement in *Reibl v. Hughes* has been consistently employed by Nova Scotia courts: *Considine v. Camp Hill Hospital* (1982), 50 N.S.R. (2d) 631 (S.C.T.D.); *Goguen v. Crowe* (1988), 80 N.S.R. 36 (S.C.T.D.); *Anderson v. Grace Maternity Hospital et al.* (1990), 93 N.S.R.(2d)141 (S.C.T.D.).

<sup>28</sup> *White v. Turner*, *ibid.* at 284.

<sup>29</sup> *Hopp v. Lepp*, *supra* note 21 at 209.

<sup>30</sup> *Ibid.*

<sup>31</sup> *Supra* note 4.

<sup>32</sup> *White v. Turner*, *supra* note 27 at 289.

<sup>33</sup> For example, in *Rozovsky*, *supra* note 16 at 8, the authors describe special risks as including "probable risks" and "possible risks" that have the potential for serious consequences.

the patient reasonably to know what information is material to the patient. This may require the physician to become reasonably informed and to ask questions and initiate dialogue.<sup>34</sup>

The objective test of causation places the burden on the plaintiff to establish not only that he or she would not have consented to the procedure had this information been provided, but that a reasonable person in the same position would have made that same choice. Therefore, these subjective considerations must be reasonably based.

### **Informed Consent in the Psychiatric Setting**

The proper standard of disclosure to apply to the consent process in the mental health field has been a matter of controversy. One view is that it is inappropriate to give to psychiatric patients the same type of information given to non-psychiatric patients on the grounds that most mental illnesses impair judgment.<sup>35</sup> Concern has been raised that the standard definition of competency fails to consider the emotional distress suffered by the majority of mental health patients:

This definition [of competency] has been the subject of some criticism, particularly by physicians who feel it is inappropriate when applied to psychiatric patients. They describe it as having an intellectual bias, and not sufficiently taking into account the patient's emotional state. For example, it is argued that a particular patient may fully understand his or her situation, the proposed treatment, and the probable outcome, but may:

1. refuse to make a decision at all because of emotional distress;
2. continually alter the decision, providing no consistent basis for treatment;
3. refuse or accept treatment believing the route chosen to be the least likely to help, because of overpowering guilt feelings and a desire to be punished; or
4. make a decision on some totally irrelevant criterion, such as at the command of 'voices.'<sup>36</sup>

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<sup>34</sup> Dickens, "Informed Choice in Medical Care", in R.S. Abella & M.L. Rothman, (eds.), *Justice Beyond Orwell* (Montreal: Editions Y. Blais, 1985) 250.

<sup>35</sup> Dr. W.O. McCormick, "'Informed Consent' in Psychiatric Practice"(1980), 1 *Health Law in Canada* 53. Dr. McCormick is presently Medical/Clinical Director at the Nova Scotia Hospital.

<sup>36</sup> Savage, *supra* note 16 at 116-117.



This view was clearly rejected in the recent case of *Fleming v. Reid*.<sup>37</sup> Justice Robins discussed the common law principles supporting the right to refuse treatment, espoused in his earlier decision in *Malette v. Shulman*:<sup>38</sup>

[T]hese traditional common law principles extend to mentally competent patients in psychiatric facilities. They, like competent adults generally, are entitled to control the course of their medical treatment. Their right of self-determination is not forfeited when they enter a psychiatric facility. They may, if they wish, reject their doctor's psychiatric advice and refuse to take psychotropic drugs, just as patients with other forms of illness may reject their doctor's advice and refuse, for instance, to take insulin or undergo chemotherapy. The fact that these patients, whether voluntarily or involuntarily, are hospitalized in a mental institution in order to obtain care and treatment for a mental disorder, does not necessarily render them incompetent to make psychiatric treatment decisions.<sup>39</sup>

This statement of the law dispels any notion that the doctrine of informed consent does not apply to the psychiatric setting, and it implicitly rejects the use of different criteria when assessing the mental health patient's competence to consent.

### Exceptions

Every competent adult has the right to refuse treatment, whether he or she is suffering from a mental illness or from a physical illness. The judgment in *Fleming v. Reid*<sup>40</sup> makes it clear that a patient does not forfeit this right as a result of his or her status as an involuntary patient. There are, however, four situations in which exception is made to the informed consent rule: incompetency, emergency, waiver and therapeutic privilege.

#### Incompetency<sup>41</sup>

The common law is silent as to the proper course of action in the case of an incompetent patient in need of treatment. An incompetent person cannot consent to treatment; therefore, if this were the only source of law, such a patient

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<sup>37</sup> *Supra* note 3.

<sup>38</sup> *Supra* note 1.

<sup>39</sup> *Supra* note 3 at 86.

<sup>40</sup> *Supra* note 3.

<sup>41</sup> Competency is a criteria for a valid consent. As such, it is not an exception to the right to refuse treatment, but rather a condition precedent to that right. It is noted here, however, because it is occasionally referred to as an exception in legal commentary.

(in a non-emergency situation) would simply not be treated until he or she had regained sufficient capacity to consent. Most jurisdictions have passed legislation investing a public official with the authority to consent on behalf of an incompetent patient, although in practice the physician usually secures consent from a spouse or next-of-kin.

The issue of competency is of particular importance in the mental health field as many psychiatric illnesses impair cognitive functioning; however, many do not. As discussed above, the autonomy of the mental health patient is threatened by the mistaken view that rationality is a component of competence and that a patient's distress may justify limiting the right to refuse treatment.<sup>42</sup> The fact that the majority of Canadian provinces permit the forcible treatment of competent involuntary patients stems from this view.<sup>43</sup> Incompetence is a legitimate exception to the physician's duty to obtain informed consent from the patient, but in the case of the competent psychiatric patient his or her common law right to refuse treatment is, more often than not, abrogated by statute.

### Emergency

At common law, if a delay in treatment will threaten the life or health of the patient, the physician may proceed without obtaining consent.<sup>44</sup> This exception does not apply if the patient is competent or has expressed his or her wishes while capable of consenting.<sup>45</sup> Because the classification of a situation as an "emergency" absolves the physician of the responsibility to obtain consent, this exception has significant repercussions on the right to refuse treatment.

### Waiver and Therapeutic Privilege

The following remarks from *Reibl v. Hughes* have been relied on as a justification for limiting the scope of information given to a patient:

It is, of course, possible that a particular patient may waive aside any question of risks and be quite prepared to submit to the surgery or treatment, whatever they may be. Such a situation presents no difficulty. Again, it may be the case that a particular patient may, because of emotional factors, be unable to cope with facts relevant to recommended surgery or treatment and the doctor may, in such a case, be justified in

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<sup>42</sup> This approach was employed in *Institut Philippe Pinel de Montreal v. Dion* (1983), 2 D.L.R.(4th) 234; the Quebec Superior Court considered the patient's "irrational" refusal of treatment as evidence of his incapacity to consent.

<sup>43</sup> *Supra* note 6.

<sup>44</sup> *Marshall v. Curry*, [1933] 3 D.L.R. 260 (N.S.S.C.).

<sup>45</sup> *Malette v. Shulman*, *supra* note 1.

withholding or generalizing information as to which he would otherwise be required to be more specific.<sup>46</sup>

In this statement, the Court makes two exceptions to the general duty to obtain informed consent. First, a physician is excused from his or her obligation in circumstances where the patient waives the right to disclosure of material risks. This exception recognizes that in addition to the right to refuse treatment, the patient may choose to consent without considering all the available information. The waiver must be voluntary and "informed," that is, the patient must be aware that information is being withheld.<sup>47</sup>

Second, it is suggested that the normal standard of disclosure may be restricted where a patient is unable to cope with the facts due to emotional distress, a doctrine commonly referred to as "therapeutic privilege." The term is taken from an American rule excusing physicians from the obligation to disclose the material risks of a procedure when this information could have an adverse effect on the psychological health of the patient.<sup>48</sup> Doubt has been cast on the legitimacy of the doctrine of "therapeutic privilege" in Canada. In *Hopp v. Lepp*,<sup>49</sup> the Supreme Court recommended that a physician respond to an apprehensive patient not by withholding information, but by giving a particularly detailed explanation of the proposed treatment to lessen his or her anxiety. Case law after *Reibl v. Hughes*<sup>50</sup> has been inconsistent. The Saskatchewan Court of Appeal in *Haughian v. Paine*<sup>51</sup> referred to the doctrine but declined to acknowledge its place in Canadian law. A similar approach was taken by the Ontario High Court in *Casey v. Provan* and in *White v. Turner*,<sup>52</sup> although in *Hajgato v. London Health Assn.*<sup>53</sup> a physician's use of therapeutic privilege was found to be justified. The clearest statement on this issue is contained in the recent decision of *Meyer v. Rogers*.<sup>54</sup> After a thorough review of American, British, and Canadian sources, the court reached the conclusion that the doctrine is not applicable in Canada:

The therapeutic privilege exception does not presently form part of the law of Canada. Furthermore, I do not believe that it

<sup>46</sup> *Reibl v. Hughes*, *supra* note 4 at 895.

<sup>47</sup> Somerville, "Therapeutic Privilege: Variations on the Theme of Informed Consent" (1984), 12 *Law, Medicine & Health Care* 4 at 6.

<sup>48</sup> See *Canterbury v. Spence*, 464 F. 2d 772 at 788 (1972).

<sup>49</sup> *Supra* note 21 at 205.

<sup>50</sup> *Supra* note 4.

<sup>51</sup> *Supra* note 27 at 644.

<sup>52</sup> *Casey v. Provan*, *supra* note 27 at 718; *White v. Turner*, *supra* note 27 at 289.

<sup>53</sup> (1982), 36 O.R.(2d) 669 at 678 (H.C.).

<sup>54</sup> (1991), 78 D.L.R.(4th) 307(Ont.H.C.).

should become part of our law because, as I have said, there has already been an unwarranted extension of the privilege beyond its original scope which protected patients only from potential psychological harm....[T]he privilege has the potential to 'swallow' the doctor's obligation of disclosure and thus to override the requirement for informed consent.<sup>55</sup>

Legal commentators have offered support for the application of therapeutic privilege in very limited circumstances. Margaret Somerville argues the exception may be invoked only when certain conditions are met:

[I]f the information, normally required would, on the balance of probabilities, *in itself*, physically or mentally harm the particular patient in a serious way and to a significant degree...the privilege would not be available unless the suffering avoided by applying the doctrine at least outweighed the suffering that resulted from the failure to obtain informed consent.<sup>56</sup>

Similarly, in *Canadian Law of Consent to Treatment*,<sup>57</sup> the authors assert that information ought to be withheld or modified when its effect on the patient's emotional state would increase the risk of the procedure. It must not be withheld merely because it might upset the patient, or result in the refusal of treatment.<sup>58</sup>

The therapeutic privilege doctrine is of particular concern in the mental health field. Dr. W.O. McCormick, currently the Medical/Clinical Director of the Nova Scotia Hospital, supports "therapeutic privilege" in the psychiatric setting whenever the patient is "likely to be made anxious by full disclosure."<sup>59</sup> This approach infringes unreasonably on patient autonomy. Intense distress may in fact render a patient incompetent to consent if it has impeded his or her ability to understand the nature and consequences of treatment, but if this threshold is not reached, therapeutic privilege should be invoked only when the patient's emotional state is such that the receipt of the information itself would be harmful. It is not justified as a means to circumvent a treatment decision with which the physician disagrees or considers irrational.

## THE CHARTER

Until the adoption of the *Charter of Rights and Freedoms*<sup>60</sup> in 1982, the

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<sup>55</sup> *Ibid.* at 316.

<sup>56</sup> Somerville, *supra* note 47 at 4-5.

<sup>57</sup> Rozovsky & Rozovsky, *supra* note 16.

<sup>58</sup> *Ibid.* at 22.

<sup>59</sup> *Supra* note 35 at 55.

<sup>60</sup> *Supra* note 2.

development of Canadian mental health law was confined to legislative reform and statutory interpretation. In contrast, the American *Bill of Rights*<sup>61</sup> gave rise to considerable litigation on the rights of psychiatric patients during the 1960s and 70s, resulting in significant changes to both federal and state legislation. Few constitutional challenges to mental health legislation in Canada have been launched in the past decade despite the potential protection of the right to refuse treatment offered by the *Charter*, particularly in sections 2(b), 12, 15 and 7.

### Sections 2(b), 12, 15 and 7

It may be argued that the purpose or effect of legislation authorizing compulsory psychiatric treatment is to restrict thought, belief, opinion, or expression without the patient's consent, thereby violating the patient's fundamental rights protected under section 2(b):

Everyone has the following fundamental freedoms:

...

(b) freedom of thought, belief, opinion and expression, including freedom of the press and other media of communication.

Although this argument has not yet been used in health-related litigation in Canada, the First Amendment to the American *Bill of Rights*, guaranteeing the right to free speech, was cited by a U.S. court as one ground underlying the unconstitutionality of involuntary psychosurgery.<sup>62</sup> Section 2(b) of the *Charter* extends beyond free speech to include thought, belief, and opinion, and, therefore, the connection between speech and thought, required in the case of the First Amendment argument, would be unnecessary in the Canadian context.

Section 12 may also be of some use in challenging provincial health legislation. The section states:

Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.

In a series of cases during the 1970s, the U.S. Constitutional guarantee of freedom from cruel and unusual punishment was used to oppose psychiatric treatments considered particularly intrusive, such as electro-convulsive therapy (ECT or "shock treatment") and psychosurgery.<sup>63</sup> While several provincial

<sup>61</sup> U.S. Const. Amend. I-X

<sup>62</sup> *Kaimowitz v. Department of Mental Health*, 42 U.S.L.W. 2063 (July 10, 1973).

<sup>63</sup> See eg. *Mackey v. Proconier*, 477 F. 2d 877 (9th Circ. 1973); *Knecht v. Gillman*, 488 F. 2d 1136(8th Circ. 1973); *Sawyer v. Sigler*, 320 F. Supp. 690 (D. Neb. 1970); *Nelson v. Heyne*, 491 F. 2d 352 (7th Circ. 1974.).

statutes in Canada contain special consent provisions to limit the use of these treatments in the absence of the patient's consent,<sup>64</sup> most do not. Furthermore, it is arguable that other more routine treatment – for example, neuroleptic drug therapy or solitary isolation – could also be considered “cruel and unusual” when administered involuntarily. Finally, section 12 of the Canadian *Charter* could be used with greater ease than the analogous protection in the American *Bill of Rights* as there is no necessity of equating a “treatment” with a “punishment” – both are expressly included in the *Charter*.

The disparity between the right of the mentally ill and the right of the physically ill to refuse treatment may support a *Charter* challenge on the basis of Section 15(1):

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on...mental or physical disability.

As noted above, competency is a criterion for a valid consent. In the majority of provinces, however, incompetence to consent is expressly or implicitly presumed in the case of involuntary commitment. This presumption is made even when incompetency is not a prerequisite to a patient's involuntary commitment. Statutes that abrogate the common law right to refuse treatment of competent, although involuntarily detained, psychiatric patients, discriminate on the basis of mental disability and, therefore, may infringe section 15 of the *Charter*.

Although the potential impact of the above-noted *Charter* provisions on provincial mental health legislation has yet to be tested before the courts, in the recent case of *Fleming v. Reid*,<sup>65</sup> the Ontario Court of Appeal found that freedom from compulsory treatment, including psychiatric treatment, is constitutionally protected under section 7. The section guarantees that,

Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

The Court found that a legislative provision authorizing the Review Board of a psychiatric facility to treat an incompetent involuntary patient,<sup>66</sup> despite the refusal of the patient's proxy, infringed the patient's section 7 right to security:

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<sup>64</sup> *Hospitals Act*, *supra* note 11, s. 60; *Consent to Treatment Act*, 1992, S.O. 1992, c. 31, s. 14; *Mental Health Services Act*, S.S. 1985-85, c. M-13.1, s. 25(5); *Mental Health Act*, R.S.N.W.T. 1988, c. M-10, s. 22.

<sup>65</sup> *Supra* note 3.

<sup>66</sup> *Mental Health Act*, R.S.O. 1980, c. 262, s. 35a.

The common law right to bodily integrity and personal autonomy is so entrenched in the traditions of our law as to be ranked as fundamental and deserving of the highest order of protection. This right forms an essential part of an individual's security of the person and must be included in the liberty interests protected by s. 7. Indeed, in my view, the common law right to determine what shall be done with one's own body and the constitutional right to security of the person, both of which are founded on the belief in the dignity and autonomy of the individual, can be treated as coextensive.<sup>67</sup>

*Fleming v. Reid* is the first Canadian decision to clearly extend the common law right to refuse treatment to mentally ill patients and the first to protect that right under section 7 of the *Charter*.

The protection offered by section 7 is subject to restrictions which are "in accordance with the principles of fundamental justice." Justice Robins commented that the offending provision might have been upheld had the patient been provided with a fair hearing, including a consideration of the patient's wishes while competent, prior to the intervention by the Review Board.<sup>68</sup> The degree of procedural protection required to meet this standard will depend on the severity of the infringement in each case.

A summary of legislation provided in the Appendix gives examples of procedures required by the provinces which restrict or deny the right to refuse treatment of the mental health patient. Legislation in Manitoba and Alberta contain provisions similar to the one struck down by the Ontario Court of Appeal.<sup>69</sup> Several other provinces, such as P.E.I. and Quebec, are silent on the need to obtain consent for treatment, leaving the determination of patients' rights to hospital policy. In P.E.I., the only recourse available to involuntary patients is a review of their admission status. In Quebec, the statute provides no procedural protection of any kind. The statutes in British Columbia and Newfoundland expressly deny any right to refuse treatment to involuntary patients, the only relief available being a successful bid to the Review Board for a discharge. In the Northwest Territories, a refusal of treatment by the competent involuntary patient can be overridden by a proxy, and again, the only recourse is an application for a review of status. This brief review of the provincial mental health legislation demonstrates that the procedural safeguards they provide are

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<sup>67</sup> *Fleming, supra* note 3 at 88.

<sup>68</sup> *Ibid.* at 93.

<sup>69</sup> Sections 49-50 of the Ontario *Mental Health Act*, R.S.O. 1990, c. M.7 (previously R.S.O. 1980, c. 262, s. 35), which authorized the review board to order treatment despite the refusal of the proxy, were repealed by the *Consent and Capacity Statute Law*, S.O. 1992, c. 32.

inadequate and do not accord with the principles of fundamental justice.

## Section 1

The rights set out in the *Charter* are subject to “such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.”<sup>70</sup> In order to satisfy this test, the government must establish, first, that underlying the legislation is a pressing and substantial objective, and second, that the ends are proportional to the means. To meet the standard of proportionality, there must be a rational connection to the objective, a minimal impairment of the right in question, and a balance between the importance of the objective and the severity of the effects.<sup>71</sup> An infringement of sections 2(b), 12, 15(1), or 7 can only be justified by meeting the demands of this test.<sup>72</sup> A court trying to assess whether the compulsory treatment of involuntary patients is a “reasonable limit” on the rights of the mentally ill must come to terms with a dilemma basic to the psychiatric patient’s situation; in the words of Michael Bay, “a psychiatric patient has two potentially conflicting interests, namely, the right to safety and treatment and relief from suffering on the one hand, and the right to liberty, autonomy and self-determination on the other.”<sup>73</sup> It is the responsibility of the provincial legislatures to balance these interests in mental health care legislation.

Undoubtedly, the government objective, in expressly restricting the right to refuse treatment or failing to entrench the requirement to obtain consent in legislation, is to ensure the “safety and treatment and relief from suffering” of patients who may be unable to care for themselves or make competent treatment decisions. The alternative is to permit individuals to languish in mental institutions without the treatment that could lead to their release. Presumably, the courts would consider the relief of mental and physical suffering an objective of “pressing and substantial” importance.

The real debate is likely to be on the proportionality of the legislation to this objective. First, the legislation must be rationally connected to the objective; the onus is on the government to establish both that the legislation is carefully designed to alleviate the suffering of mental health patients and that it actually achieves this end. Compulsory treatment, authorized by statute, is likely to have

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<sup>70</sup> *Supra* note 2, s.1.

<sup>71</sup> *R. v. Oakes*, [1986] 1 S.C.R. 103.

<sup>72</sup> For the purposes of brevity, the discussion will focus on the traditional formulation of the *Oakes* test. It is worth noting, however, that the analysis may vary depending on the nature of the infringement.

<sup>73</sup> Bay, “Treatment and the *Mental Health Act*: A Review Board Perspective”(1991) 12 *Health Law in Canada* 3 at 12.



positive effects on the health of some mental health patients – although it may be overinclusive – and therefore, is related to the objective of alleviating pain. However, a statute that ignores the issue of consent,<sup>74</sup> or expressly abrogates the patient's right to refuse treatment without establishing guidelines on how treatment decisions can be made on behalf of the patient,<sup>75</sup> is not carefully designed to meet this objective.

Second, the means must minimally impair the right or freedom in question. If the government's only objective is to protect patients who are not competent to make treatment decisions for themselves, the legislation in seven out of the ten provinces, and in both Territories, is overinclusive because it also permits compulsory treatment of competent patients.

Finally, the severity of the effects must also be proportional to the objective. Justice Robins in *Fleming v. Reid* stated that "the common law right to bodily integrity and personal autonomy is...fundamental and deserving of the highest protection."<sup>76</sup> Although the objective may be "pressing and substantial," the means chosen by the government must be sufficiently connected to this objective to justify such a serious infringement of the rights of mental health patients.

In conclusion, the *Charter* may offer substantial protection to psychiatric patients, particularly since the decision of the Ontario Court of Appeal in *Fleming v. Reid*.<sup>77</sup> If the Legislatures fail to take the initiative in bringing mental health legislation in line with the *Charter*, it is safe to predict that more constitutional litigation on the rights of the mentally ill to refuse treatment is in store in the near future.

## LAW REFORM AND THE NOVA SCOTIA HOSPITALS ACT

Most Canadian provinces either implicitly or explicitly authorize the compulsory treatment of involuntary patients regardless of competency to consent.<sup>78</sup> Mental health legislation in Saskatchewan, Nova Scotia, and Ontario,<sup>79</sup> however, offer three different models for the protection of the right to refuse treatment.

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<sup>74</sup> *i.e.*, *Mental Health Act*, R.S.N. 1990, c. M-9; *Mental Health Act*, R.S.P.E.I. 1988, M-6; *Mental Patients Protection Act*, R.S.Q. 1977, c. P-41; *Mental Health Act*, R.S.Y.T. 1986, c. 115.

<sup>75</sup> *i.e.*, *Mental Health Act*, R.S.B.C. 1979, c. 256; *Hospitals Act*, R.S.N.S. 1989, c. 208; *Mental Health Act*, R.S.N.W.T. 1988, c. M-10.

<sup>76</sup> *Supra* note 3 at 88.

<sup>77</sup> *Ibid.*

<sup>78</sup> *Supra* note 6.

<sup>79</sup> *Mental Health Services Act*, S.S. 1984-5, c. M 13-1; *Hospitals Act*, R.S.N.S. 1989, c. 208; *Mental Health Act*, R.S.O. 1990, c. M-7.

Under the Saskatchewan *Mental Health Services Act*,<sup>80</sup> incompetency is a criterion for involuntary commitment, and therefore, the issue of compulsory treatment of competent involuntary patients does not arise. The physician must obtain the consent of the voluntary patient, if competent to consent, and if incompetent, the consent of the patient's nearest relative.<sup>81</sup> The difficulty with this approach is twofold. First, under section 25(2) of the Act, the attending physician may treat an involuntary patient – by definition incompetent – without the consent of any other person acting on the patient's behalf.<sup>82</sup> The right to refuse treatment loses all meaning since the physician, not having to rely on an independent patient representative or "substitute consent-giver," has unfettered discretion to administer treatment. An ethical dilemma may arise as a result of the potential conflict of interest between the physician's roles as care-giver and proxy for the patient. Second, a patient's capacity to consent may fluctuate; the patient may be incompetent when admitted on an involuntary basis, but may have intervals of competency during his or her term of detainment. The dilemma here is whether the hospital ought to grant voluntary status temporarily to the patient during periods of lucidity or run the risk of forcibly treating a competent patient.

In Nova Scotia, no treatment may be administered without the consent of the competent patient,<sup>83</sup> and, if the patient is incompetent, consent must be given by his or her legal guardian, spouse, next of kin, or the Public Trustee.<sup>84</sup> In short, the *Hospitals Act* acknowledges the right of the competent adult to refuse treatment and therefore is not *prima facie* unconstitutional. The Act, however, is not sufficiently comprehensive to protect this right in practice. Section 54 of the Act reads:

54 (1) No person admitted to a hospital shall receive treatment unless he consents to such treatment.

(2) If a person in a hospital is found by declaration of incapacity to be incapable of consenting to treatment then that person may be treated either upon obtaining the consent of the guardian of that person, if he has one, or if he has not a guardian upon obtaining the consent of his spouse or next of kin and where the spouse or next of kin is not available or

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<sup>80</sup> *Mental Health Services Act*, *Ibid.* s. 24(2).

<sup>81</sup> *Ibid.* s. 25(1).

<sup>82</sup> *Ibid.* s. 25(2).

<sup>83</sup> The Nova Scotia *Hospitals Act* uses the words "competence" to administer one's estate (s.52(3)) and "capacity" to consent to treatment (s.52(2)). This paper employs these terms interchangeably in reference to the right to refuse treatment.

<sup>84</sup> *Hospitals Act*, *supra* note 11, s. 54.

consent is unable to be obtained upon the consent of the Public Trustee.<sup>85</sup>

This provision contains several fundamental deficiencies. First, it fails to define the scope of informed consent. Second, it lacks criteria or guidelines for choosing an appropriate proxy to assume decision-making responsibility on behalf of the patient. In addition, section 54(2) permits the Public Trustee to override a refusal of treatment by the proxy. Finally, the Act fails to define what constitutes a true "emergency" situation in which consent is not required.<sup>86</sup>

The Ontario *Mental Health Act*,<sup>87</sup> in conjunction with the new *Consent to Treatment Act 1992*,<sup>88</sup> is the most effective legislation in Canada on the right of the mentally ill to refuse treatment. These statutes contain many of the guiding principles that are lacking in the Nova Scotia *Hospitals Act*.<sup>89</sup> In passing the *Consent to Treatment Act, 1992*, the Ontario Legislature acknowledged the need to codify the consent process in order to protect the patient's right to make informed treatment choices. It is a well-crafted piece of legislation that will significantly strengthen the rights of the mentally ill to refuse treatment in that province and provides an excellent model for law reform in Nova Scotia.

The deficiencies in the consent process are examined in detail below with a view to suggesting ways in which the rights of the mentally ill in Nova Scotia may be strengthened.

### Informed Consent

Section 54(1) calls for "consent" but does not require that it be informed. Since adequate information is a criterion for valid consent under the common law, it may be inferred that where the statute is silent as to the requisite quantity or quality of information, the standard of disclosure set out in *Reibl v. Hughes*<sup>90</sup> applies. Two faulty assumptions underlie the proposition that this framework offers sufficient protection. The first is that physicians incorporate common law principles into their practice as a matter of course, and, second, that the psychiatric patient has recourse to legal action in the event of a physician failing to meet his or her legal obligation.

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<sup>85</sup> *Ibid.* s. 54.

<sup>86</sup> Rozovsky & Rozovsky, *supra* note 16.

<sup>87</sup> *Mental Health Act*, R.S.O. 1980, c. 262.

<sup>88</sup> *Consent to Treatment Act 1992*, *supra* note 64. In recent amendments to the *Mental Health Act*, made in the *Consent and Capacity Statute Law*, S.O. 1992, c. 32, consent-related provisions (i.e. ss. 2-5 and 49-50) were repealed and replaced with references to the provisions of the new *Consent to Treatment Act, 1992*.

<sup>89</sup> *Supra* note 11.

<sup>90</sup> *Supra* note 4.

With respect to the physician's perception of the law on consent, Michael Bay noted:

Experience indicates that many physicians hold the belief that they do not require informed consent. They are of the view that acquiescence is sufficient and that they are entitled to turn a blind eye to the issue of competence so long as the patient does not resist treatment.<sup>91</sup>

An empirical study conducted in 1983 indicates that, at that time, 74% of physicians had never heard of *Reibl v. Hughes*.<sup>92</sup> Of those doctors who were aware of the case, 41% responded that it had had no effect on their practice.<sup>93</sup> The author of the study concluded: "*Riebl v. Hughes* has had little impact on medical practice with regard to disclosure of risks to patients."<sup>94</sup>

The *Medical Staff Policy* of the Nova Scotia Hospital<sup>95</sup> requires "informed consent" prior to treatment and emphasizes the importance of ensuring that the patient understands the information. "Informed consent" is defined as the disclosure of the "nature of the treatment" which includes the "procedures involved, risks and benefits associated with it, and the probable outcome."<sup>96</sup> In contrast, the Abbie J. Lane Hospital has no written policy supplementing the provisions of the *Hospitals Act*,<sup>97</sup> in each case, the standard of disclosure is left to the clinical judgment of the psychiatrist.<sup>98</sup>

The fact that the doctrine of informed consent is incorporated into the formal operating policy of at least one of the two main psychiatric hospitals in Nova Scotia is encouraging. Nevertheless, it is an inadequate tool for safeguarding the legal rights of one of the most vulnerable segments of the population. Despite the current debate over the use of "therapeutic privilege," the practice is accepted at the N.S. Hospital.<sup>99</sup> Furthermore, many hospitals

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<sup>91</sup> *Supra* note 73.

<sup>92</sup> *Supra* note 4.

<sup>93</sup> Robertson, "Informed Consent in Canada: An Empirical Study" (1984) 22 *Osgoode Hall* 139.

<sup>94</sup> *Ibid.* at 159. Two American studies came to a similar conclusion regarding the practice of obtaining informed consent among physicians: Lidz, Charles et al., *Informed Consent: A Study of Decision-Making in Psychiatry*, (New York: The Guildford Press), 1984, at 321; K.M. Taylor, M. Kelner, "Informed Consent: The Physician's Perspective" (1987) 24 *Social Science and Medicine* 135.

<sup>95</sup> *Medical Staff Policy: Consent for Treatment*, Medical Advisory Committee, Nova Scotia Hospital, December 13, 1989.

<sup>96</sup> *Ibid.* at 2.

<sup>97</sup> *Supra* note 11.

<sup>98</sup> Interview with Dr. M. Tihan, Deputy Chief of Psychiatry, Abbie J. Lane Hospital (March 24, 1992) Halifax.

<sup>99</sup> *Medical Staff Policy: Examination for Capacity*, Office of the Medical/Clinical

draw a distinction between treatments that require informed consent and more "routine" procedures that do not, such as behaviour therapy. This type of classification is common to all hospitals but the issue of where the line is to be drawn is a matter of some controversy. In this author's opinion, statutory guidelines are needed to define the scope of informed consent and provide uniform protection to psychiatric patients throughout the province.

One may argue that regulating psychiatric practice in this manner is an unreasonable and impractical restriction on clinical judgment, and that current statutory provisions, supplemented by the psychiatric patient's right to take legal action in case of a physician's failure to disclose, provide adequate protection. The assumption, however, that the right to litigate acts as a deterrent to negligence fails to take into account the disempowerment of the mentally ill in our society. Archibald Kaiser made the following observations, from a lawyer's perspective, on the disadvantages of the mentally ill in attempting to defend their legal rights:

The social class variable intrudes to render the poor client likely less efficiently communicative, more unsure of the desired outcome, and either oblivious to attempts at direction or perhaps unduly eager to follow the lawyer's advice. The disabilities of the mentally ill client include these problems but are complicated by her emotional suffering, instability and the objective existential difficulties of being delegitimized by being labelled mentally ill and severed from regular contact with the outside world by institutionalization or treatment.<sup>100</sup>

Psychiatric patients are frequently unaware of their rights<sup>101</sup> or, if they are aware, often do not have the financial means or personal volition to assert them.

Formal legal rights do not always have their intended impact. In May 1991, a conference, entitled "Voices for Choices: Mental Health Consumers Speak Out," was held to identify the key mental health issues from the patients' perspective:

Consumers felt that they were seldom made aware of

Director, Nova Scotia Hospital, November 6, 1989.

<sup>100</sup> H.A. Kaiser, "Legal Services for the Mentally Ill: A Polemic and A Plea" (1986) 35 U.N.B.L.J. 89 at 96.

<sup>101</sup> A brochure titled the "Rights of Patients and Persons Under Observation" is distributed to all patients upon admission at the N.S. Hospital. The potential effectiveness of this document is weakened by the use of legalistic wording. Further, it is noted that the brochure does not contain any reference to the physician's duty to disclose the material risks of proposed treatment. The rights listed are taken directly from the statute (rather than from the common law), an additional indication that statutory guidelines are required on the scope of informed consent.

alternative approaches or of the benefits and risks of various treatments they were offered....Consumers emphasized again and again that the operative word in treatment must be well-informed *choice*.<sup>102</sup>

Although the *Hospitals Act*<sup>103</sup> adheres to the principles of common law and, *prima facie*, does not violate the *Charter*, its practical effect on constitutionally guaranteed rights is nonetheless subject to scrutiny:

Either an unconstitutional purpose or an unconstitutional effect can invalidate legislation. All legislation is animated by an object the legislature intends to achieve. This object is realized through the impact produced by the operation and application of the legislation.<sup>104</sup>

The statute requires "consent" but does not provide a definition, and the experience of mental health consumers in Nova Scotia shows that adequate information is not being provided prior to treatment, consequently nullifying their right to choose. The assumption that psychiatry is practised in accordance with the common law where the statute is silent is not borne out. It is recommended that the *Hospitals Act*<sup>105</sup> be amended to provide guidelines for physicians on the proper standard of disclosure.

Only the Ontario *Consent to Treatment Act, 1992*,<sup>106</sup> which applies equally to patients governed by the *Mental Health Act*,<sup>107</sup> provides guidelines for obtaining informed consent:

5.- (1) The following are the elements required for consent to treatment:

1. The consent must relate to the treatment.
2. The consent must be informed.
3. The consent must be given voluntarily.
4. The consent must not have been obtained through misrepresentation or fraud.

- (2) A consent is informed if, before giving it,  
 (a) the person received the information about the

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<sup>102</sup> Mental Health Consumer Advocacy Network Nova Scotia, "Burning Issues"(draft), October, 1991, at 2. mhCANns has undertaken a "Consumer-Citizen Community Mobilization Project" aimed at surveying the needs and attitudes of consumers on a variety of mental health issues. The results of this study should be very helpful in identifying problems in the present legislation.

<sup>103</sup> *Supra* note 11.

<sup>104</sup> *R. v. Big M Drug Mart*, [1985] 1 S.C.R. 295 at 331.

<sup>105</sup> *Supra* note 11.

<sup>106</sup> S.O. 1992, c.31.

<sup>107</sup> R.S.O. 1990, c. M.7

- treatment, alternative courses of action, the material effects, risks and side effects in each case and the consequences of not having the treatment that a reasonable person in the same circumstances would require in order to make a decision; and
- (b) the health practitioner responded to the person's requests for other information about the treatment, alternative courses of action, material effects, risks and side effects, and consequences of not having the treatment.<sup>108</sup>

This section contains the requisite elements of consent and defines its scope in accordance with the common law principles set out in *Hopp v. Lepp*<sup>109</sup> and *Reibl v. Hughes*.<sup>110</sup> The mental health legislation in Nova Scotia ought to be revised to include similar guidelines on the standard of disclosure to ensure that psychiatric patients receive the information needed to make an informed choice with respect to treatment.

### Substitute Decision-Maker

If a patient is declared incapable of consenting to treatment under section 52(2) of the *Hospitals Act*,<sup>111</sup> the consent of his or her legal guardian, spouse, next of kin, or the Public Trustee must be obtained to administer treatment.<sup>112</sup> Since the common law does not recognize the need for a proxy to consent on behalf of an incompetent patient, this statutory provision allows for the treatment of incompetent patients before an emergency situation arises. Granting the power of consent to a family member or neutral party,<sup>113</sup> rather than to the physician or hospital, is preferable for two reasons: first, a family member is likely to have better knowledge of the patient's wishes, and, second, a third party proxy avoids the inherent conflict of interest where the physician acts both as care-giver and consent-giver.

Section 52(2), however, harbours several fundamental flaws. No criteria are provided to determine an appropriate proxy; an abusive or mentally incompetent spouse or relative could be granted the power to consent. Other jurisdictions – New Brunswick,<sup>114</sup> Alberta<sup>115</sup> and Ontario<sup>116</sup> – have enumerated qualifications

<sup>108</sup> S.O. 1992, c. 31, s. 5.

<sup>109</sup> *Supra* note 21.

<sup>110</sup> *Supra* note 4.

<sup>111</sup> *Supra* note 11.

<sup>112</sup> *Supra* note 11, s. 54(2).

<sup>113</sup> Whether the Public Trustee is in fact neutral is a debatable issue.

<sup>114</sup> *Mental Health Act*, R.S.N.B. 1973, c. M-110 as am. S.N.B. 1989, c. 23, s. 8.6(7).

<sup>115</sup> *Mental Health Act*, S.A. 1988, c. M-13.1, s. 28 (2). Note that s. 29(3) permits a

for the consent-giver. In light of these examples, the following amendments to section 54(2) of the *Hospitals Act*<sup>117</sup> are recommended: the proxy must be mentally competent and over the age of sixteen, in personal contact with the patient within the preceding twelve months, and willing to assume the responsibility for making the treatment decision. He or she must identify, in a written statement, his or her relationship with the patient and indicate that there is no reason to believe that the patient might object to the proxy giving or withholding substitute consent. The Nova Scotia legislation should also rank potential consent-givers in order to avoid a conflict between family members claiming this authority and to prevent a physician from responding to a refusal by seeking out a more cooperative proxy. The priority of claims should be defined in the following order: legal guardian, appointed representative,<sup>118</sup> spouse, child, parent, brother or sister, any other next of kin, and finally the Public Trustee.

It is crucial that where a proxy refuses treatment on the patient's behalf, the subsequent consent of a person further down the list not be considered valid. In *Re. Boudreau*,<sup>119</sup> the Nova Scotia Supreme Court interpreted the words in section 54(2), "consent is unable to be obtained," to mean that the Public Trustee has the authority to consent if the next of kin is unavailable or refuses treatment. In practice, this route is considered a last resort due to the substantial documentation required for an application to the Public Trustee.<sup>120</sup> Nevertheless, the statutory power given to the Public Trustee to override the authority of the next of kin whenever consent is withheld grossly undermines the family's role in the treatment of an incompetent patient. Furthermore, the recent judgment in *Fleming v. Reid*<sup>121</sup> indicates that the absence of procedural safeguards is probably unconstitutional. The discretion granted to the Public Trustee is unfettered: no hearing is needed to justify the Trustee's interference and,

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statutory review panel to override the refusal of a competent involuntary patient or proxy for an incompetent involuntary patient, if the panel considers it to be in that patient's best interests. This is similar to the provision in the Ontario *Mental Health Act* struck down by the Court of Appeal in *Fleming v. Reid*, *supra* note 3 (except the offending provision in the Ontario statute applied only to incompetent, involuntary patients). This same power is granted to a review board by the Manitoba *Mental Health Act*, R.S.M. 1987, c. M-110, s. 25(1) as am. S.M. 1987-88, c. 56.

<sup>116</sup> *Consent to Treatment Act, 1992*, *supra* note 64, s. 17.

<sup>117</sup> *Supra* note 11.

<sup>118</sup> Pursuant to the *Medical Consent Act*, R.S.N.S. 1989, c.279.

<sup>119</sup> *Re. Boudreau* (1981), 43 N.S.R.(2d) 212 (S.C.T.D.).

<sup>120</sup> Interview with E. Theriault, Public Trustee (9 March, 1992) Halifax. This view was also put forth in an interview with the Director of Clinical/Medical Services at the Nova Scotia Hospital (18 March, 1992) Halifax.

<sup>121</sup> *Supra* note 3.



although submissions are required from the doctor and hospital, no formal policy or statutory guidelines are available to assist the Public Trustee in reaching a decision.<sup>122</sup>

The Nova Scotia *Medical Consent Act*<sup>123</sup> is designed to avoid the practical difficulties related to substitute consent by authorizing the appointment of a proxy by a competent adult in case he or she becomes incapable of giving a valid consent to treatment. While it is a step in the right direction, the Act sanctions only “proxy directives,” not “instruction directives”<sup>124</sup> – otherwise known as “living wills.” The proxy may be appointed but is not bound by statute to follow directions given by the person on whose behalf he or she is acting.<sup>125</sup> Case law suggests, however, that such a document might be binding at common law. The Ontario Court of Appeal ruled in *Malette v. Shulman*<sup>126</sup> that a written advance directive constitutes a refusal of treatment which the physician is legally obligated to respect. In *Fleming v. Reid*,<sup>127</sup> the same court decided that a patient’s prior wishes must be taken into consideration when determining his or her “best interests.”

Nevertheless, given the uncertainty as to the legal effect of an instruction directive, the *Hospitals Act*<sup>128</sup> ought to provide more precise guidelines for substitute decision-making. Two standards may be used in establishing such guidelines: “best interests” – that is, an objective assessment of what is in the patient’s best interests – and “substituted judgment” – where the proxy is required to “stand in the shoes” of the patient. To stand in the patient’s shoes the proxy must follow explicit instructions, and if the wishes of the patient are not known, the proxy must then draw on his or her personal knowledge of the patient to make the decision the patient would have made if competent. Only if the proxy has no such knowledge should the decision then be made according to the patient’s “best interests.”

Three provinces – Ontario, New Brunswick, and Alberta – have adopted guidelines concerning substitute consent. Alberta and New Brunswick use similar tests based on the strict “best interests” model. The Alberta legislation contains the following provision:

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<sup>122</sup> *Supra* note 120.

<sup>123</sup> *Medical Consent Act*, R.S.N.S. 1989, c. 279.

<sup>124</sup> Downie, “‘Where There is a Will, There May Be a Better Way’: Legislating Advance Directives” (1992), 12 *Health Law in Canada* 73.

<sup>125</sup> The *Substitute Decisions Act*, 1992, S.O. 1992, C. 30 is the only Canadian legislation which, in conjunction with the *Consent to Treatment Act*, 1992, enforces “living wills.”

<sup>126</sup> *Supra* note 1.

<sup>127</sup> *Supra* note 3.

<sup>128</sup> *Supra* note 11.

Sec. 28 (3) A person authorized by subsection (1)(b) to make treatment decisions on behalf of a formal patient shall make the decisions in accordance with what the person believes to be the best interest of the patient.

(4) In order to determine the best interest of the formal patient in relation to treatment, a person referred to in subsection (1)(b) shall have regard to the following:

- (a) whether or not the mental condition of the patient will be or is likely to be improved by the treatment;
- (b) whether the patient's condition will deteriorate or is likely to deteriorate without the treatment;
- (c) whether or not the anticipated benefit from the treatment outweighs the risk of harm to the patient;
- (d) whether or not the treatment is the least restrictive and least intrusive treatment that meets the requirements of clauses (a),(b) and (c).<sup>129</sup>

Personal characteristics that may have influenced the patient's choice had he or she been competent to consent are not considered; rather, what is determinative are those factors which a reasonable physician would take into account when making a decision to treat.

In Ontario, the decision-maker is to act in the patient's "best interests" only if there is no knowledge of instructions or wishes regarding treatment:

13.-(1) A person who gives or refuses consent on an incapable person's behalf shall do so in accordance with the following principles:

1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining sixteen years of age, the person shall give or refuse consent in accordance with the wish.
2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining sixteen years of age, the person shall act in the incapable person's best interests.

Furthermore, the definition of "best interests" is not restricted to what is best to preserve the physical health of the patient:

13.-(2) In deciding what an incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

- (a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;

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<sup>129</sup> *Mental Health Act*, S.A. 1988, c. M-13.1, s. 28(3) and (4).

(b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and

(c) the following factors:

1. Whether the incapable person's condition or well-being is likely to be improved by the treatment.
2. Whether the person's condition or well-being is likely to improve without the treatment.
3. Whether the benefit the person is expected to obtain from the treatment outweighs the risk of harm to him or her.
4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.<sup>130</sup>

This approach reflects the recognition by the Ontario Court of Appeal, in *Malette v. Schulman*<sup>131</sup> and *Fleming v. Reid*,<sup>132</sup> that a person's physical health is not necessarily one's primary concern and that the right to refuse treatment is not limited by an objective assessment of the rationality of that decision.

The *Hospitals Act*<sup>133</sup> does not provide any guidance of this kind, and the Public Trustee is not directed to take any particular factors into consideration in making a decision. During an interview, the current Public Trustee indicated that she will usually assess the recommended treatment based on the anticipated consequences of giving or refusing consent to the health of the patient. These factors reflect a "best interests" standard.<sup>134</sup> The appropriate criteria for making such a decision is clearly a matter of public policy and ought to be addressed in the statute in order to preclude the risk of an arbitrary veto by the Public Trustee of a proxy's refusal to consent. It should not be left to the judgment of one individual.<sup>135</sup> The *Hospitals Act*<sup>136</sup> must enumerate the duties of any substitute consent-giver, whether family member, proxy, or Public Trustee, in order to protect the interests of the incompetent patient.

## Emergency

At common law, consent need not be obtained in an emergency.<sup>137</sup> This exception is a form of implied consent; therefore, the physician cannot proceed

<sup>130</sup> *Consent to Treatment Act, 1992*, S.O. 1992, c. 31, s.13.

<sup>131</sup> *Supra* note 1.

<sup>132</sup> *Supra* note 3.

<sup>133</sup> *Supra* note 11.

<sup>134</sup> *Supra* note 120.

<sup>135</sup> The Public Trustee must obtain the permission of the Supreme Court to consent on an *ex parte* application pursuant to s. 9(1) of the *Hospitals Act*.

<sup>136</sup> *Supra* note 11.

<sup>137</sup> *Marshall v. Curry*, *supra* note 44.

in the face of an express refusal of the treatment.<sup>138</sup> If a situation is classified as an emergency, none of the issues discussed above regarding informed consent are relevant, and hence, the definition of this term is particularly important if patient autonomy is to be preserved.

Generally, an "emergency" is defined as "a life- or health-threatening situation requiring immediate treatment."<sup>139</sup> It is not sufficient that immediate treatment is more convenient or medically proper; treatment must be delayed until consent can be obtained unless the delay would threaten the life or health of the patient. If the definition of "threat" is construed broadly, it could be taken to mean that an emergency situation arises whenever a delay in treatment would result in any deterioration in the patient's condition, allowing the physician to forcibly administer treatment without seeking the consent of a proxy. Statutory guidance is required to narrow the discretion conferred on the attending physician in deciding when "emergency" treatment is justified.

The *Hospitals Act*<sup>140</sup> does not make any reference to emergency treatment, let alone define its meaning. A definition is provided, however, in the *Medical Staff Policy* of the Nova Scotia Hospital:

Consent for treatment is not required for a psychiatric or medical emergency. For treatment purposes, a medical or psychiatric emergency is a situation where the withholding of treatment, in the clinical judgement of the physician would lead to:

- i) Imminent danger of violence to other persons or the patient's environment or to the patient himself, *or*
- ii) Serious or permanent impairment of the patient's own health, *or*
- iii) Substantial deterioration in the patient's condition which is likely to lead to either (i) or (ii) in the immediate future.<sup>141</sup>

The practice at the N.S. Hospital is to forcibly treat a patient if the failure to do so would result in a deterioration of the patient's health or an increase in the risk of violence. On these grounds a competent patient who withholds consent could be forcibly treated, a practice clearly contrary to the decision in *Malette v. Schulman*<sup>142</sup> recognizing the right of the competent individual to refuse treatment

<sup>138</sup> *Malette v. Schulman*, *supra* note 1.

<sup>139</sup> Rozovsky & Rozovsky, *supra* note 16 at 19.

<sup>140</sup> *Supra* note 11.

<sup>141</sup> *Medical Staff Policy: Consent for Treatment*, Medical Advisory Committee, Nova Scotia Hospital, 13 December, 1989. The Abbie J. Lane Hospital has no formal policy supplementing the terms of the *Hospitals Act*. (Dr. Michael Tihan, interviewed 24 March, 1992).

<sup>142</sup> *Supra* note 1.

regardless of the consequences.

The mental health legislation in the Northwest Territories, Manitoba, and Ontario define the scope of the "emergency" exception. In the N.W.T. *Mental Health Act*, emergency treatment is permitted in the following circumstances:

20(1) A medical practitioner who examines a person under section 13 or assesses a person under section 8, 9, 10, 11 or 12 may administer emergency medical or psychiatric treatment to the person being examined or assessed where....

- (b) the person has attained the age of majority and is mentally competent to give a valid consent, and refuses to consent or, where the person has not attained the age of majority or is not mentally competent to give a valid consent, and the person's nearest relative refuses to consent and
  - (i) the treatment is necessary to preserve the life or mental or physical health of that person,
  - (ii) the failure to give the treatment or delay in giving the treatment would create a reasonably foreseeable risk of injury to that person or any other person, and
  - (iii) the treatment cannot reasonably be delayed through alternative means of detention.<sup>143</sup>

Certain flaws in this provision lessen its usefulness as a model for law reform. The section permits forcible treatment in the event of an express refusal which is clearly contrary to the common law<sup>144</sup> and violates section 7 of the *Charter*.<sup>145</sup> In addition, the physician may proceed without consent if the treatment is deemed necessary to preserve the patient's health and failure to proceed would likely result in injury. Yet the type of foreseeable injury sufficient to invoke the provision is not defined. Non-consensual treatment is an extraordinary remedy which should only be used in extreme circumstances, but this view is not reflected in the wording of the legislation.

The Ontario *Consent to Treatment Act, 1992*<sup>146</sup> contains certain elements recommended for inclusion in the Nova Scotia *Hospitals Act*:

23. (1) Despite sections 4 and 21, a health practitioner may administer treatment to a person without consent if, in his or

<sup>143</sup> *Mental Health Act*, R.S.N.W.T. 1988, c. M-10, s. 20(1). A similar provision is contained in the *Mental Health Act*, R.S.Y.T. 1986, c. 115, s. 7; that statute, however, does not expressly require consent to treat any patient, and does not clearly distinguish between competence and incompetence.

<sup>144</sup> *Malette v. Schulman*, *supra* note 1.

<sup>145</sup> *Fleming v. Reid*, *supra* note 3.

<sup>146</sup> S.O. 1992, c. 31.

her opinion,

- (a) the person is incapable with respect to the treatment;
- (b) the person is experiencing severe suffering or is at risk, if the treatment is not administered promptly, of suffering serious bodily harm; and
- (c) it is not reasonably possible to obtain a consent or refusal on the person's behalf, or the delay required to do so will prolong the suffering that the person is experiencing or will put the person at risk of suffering serious bodily harm.<sup>147</sup>

While the scope of the "emergency" described in this legislation limits its application to persons incapable of consenting, it is not as precise as the definition given in the Manitoba *Mental Health Act*<sup>148</sup> regarding the degree of foreseeable bodily harm necessary to justify intervention. The Manitoba Act excuses the physician from seeking consent from a patient who is mentally incompetent or under the age of 18 if there is "imminent and serious danger to the life, a limb or a vital organ of the patient requiring immediate treatment,"<sup>149</sup> and thus confines the applicability of this exception to extreme circumstances.

Several other provisions in the Ontario statute strengthen the protection offered to patients in the "emergency" situation. The physician must make efforts to find a person authorized to consent and may continue emergency treatment for as long as is reasonably necessary to find a willing proxy.<sup>150</sup> In addition, emergency treatment is not authorized if the physician has reasonable grounds to believe that the patient expressed a wish, while capable, to refuse treatment in those circumstances.<sup>151</sup> Finally, the physician is permitted to override the refusal of a proxy only if an emergency situation exists and if the physician believes that the person who refused consent failed to follow the guidelines for substitute decision-making set out in section 13 of the Act.<sup>152</sup>

The scope of the "emergency" exception is a legal, not a medical issue. Its application must be governed by the law and not by the policies of individual hospitals or the clinical judgment of physicians. The *Hospitals Act*<sup>153</sup> should be amended to include a definition of "emergency" similar to that in Ontario legislation, but supplemented by a more precise definition of "serious bodily harm" such as that found in the Manitoba *Mental Health Act*, in order to ensure that the patient's right to self-determination will be respected in practice.

<sup>147</sup> *Supra* note 11, s. 23(1).

<sup>148</sup> *Mental Health Act*, R.S.M. 1987, c. M-110.

<sup>149</sup> *Ibid.* s. 24(7).

<sup>150</sup> *Consent to Treatment Act, 1992*, *supra* note 64, ss. 23(6), 23(7).

<sup>151</sup> *Ibid.* s. 24.

<sup>152</sup> *Ibid.* s. 25.

<sup>153</sup> *Supra* note 11.

## CONCLUSION AND RECOMMENDATIONS

Unlike the mental health legislation in other Canadian provinces, the *Hospitals Act*,<sup>154</sup> *prima facie*, does not violate the *Charter* or counter the long-standing common law right to refuse treatment. While the Act appears to resolve fundamental questions of social policy, it does not provide the means to carry that policy into practice. A wide discretion is conferred on physicians in conducting the consent process, the majority of whom, evidence shows,<sup>155</sup> are unaware or unaffected by the judgments of the Supreme Court on informed consent.<sup>156</sup> The failure of the *Hospitals Act*<sup>157</sup> to provide guidance to physicians results in inconsistent and inadequate protection of the rights of psychiatric patients in Nova Scotia. To remedy this situation, it is advised that the following recommendations be adopted:

1. Amendment of section 54 to require "informed consent" to be obtained from the competent patient, or substitute decision-maker in the case of an incompetent patient.

2. Enumeration of the elements of consent.

*Model:*

- a) The consent must relate to the particular treatment.
- b) The consent must be informed.
- c) The consent must be voluntary.

3. Enumeration of the standard of disclosure.

*Model:*

- a) Material risks and side effects.
- b) Benefits of the treatment.
- c) Alternative courses of action.
- d) Any other information that a reasonable person in the same circumstances would require to make an informed decision.

4. Explicit rejection of the "therapeutic privilege" doctrine.

5. Enumeration of prerequisites required of a proxy chosen under s. 54(2).

*Model:*

- a) Mentally competent.
- b) Over the age of sixteen.
- c) In personal contact with the patient within the preceding

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<sup>154</sup> *Ibid.*

<sup>155</sup> G. Robertson, *supra* note 25.

<sup>156</sup> *Reibl v. Hughes*, *supra* note 4; *Hopp v. Lepp*, *supra* note 21.

<sup>157</sup> *Supra* note 11.

twelve months.

- d) Willing to assume responsibility for treatment decision.
- e) No reason to believe that the patient would object to the appointment.

6. Prioritized listing of potential candidates for proxy.

*Model:*

- a) legal guardian
- b) appointed representative under *Medical Consent Act*
- c) spouse
- d) child
- e) parent
- f) brother or sister
- g) any other next of kin
- h) Public Trustee

7. Declaration that if one candidate for proxy refuses the treatment and another consents, the decision of the person who appears first on the above-noted list is valid and final.

8. Amendment of the *Medical Consent Act* to ensure that the instructions given by a competent person to his or her appointed representative will be followed.

9. Enumeration of the duties of a proxy.

*Model:*

- a) Must follow written instructions drafted pursuant to the *Medical Consent Act* (amended).
- b) If no written instructions, must follow the patient's wishes while competent, if known.
- c) If the specific wishes of the patient are not known, act in accordance with the values and beliefs of the patient.
- d) If none of the information above is available, act in accordance with the best interests.
- e) The patient's best interests are to be determined by
  - i) whether the mental condition of the patient will be or is likely to be improved by the treatment;
  - ii) whether the patient's condition will deteriorate or is likely to deteriorate without treatment;
  - iii) whether the anticipated benefit from the treatment outweighs the risk of harm to the patient;
  - iv) whether the treatment is the least restrictive and least intrusive treatment that meets the requirements of clauses (i), (ii) and (iii).

10. Definition of the "emergency" exception.



*Model:*

- a) Patient incompetent or incapable of consenting.
- b) Patient likely to suffer serious bodily harm if treatment delayed.
- c) "Serious bodily harm" is a serious danger to the life, limb, or a vital organ of the patient.
- d) The physician is not permitted to proceed if the patient has expressly refused the treatment while competent.

Affirming the absolute right of the competent psychiatric patient to refuse treatment under any circumstances, providing guidance for substitute decision-making, and limiting the application of "emergency treatment" are steps recommended in order to empower a highly vulnerable and stigmatized group in modern society. The purpose of these recommendations is not to abolish the power of the state but rather to maximize patient autonomy. It is the responsibility of the Nova Scotia Legislature to balance the potential conflict between "the right to safety and treatment and relief from suffering on the one hand, and the right to liberty, autonomy and self-determination on the other."<sup>158</sup> These proposals are aimed at achieving that balance.

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<sup>158</sup> Bay, *supra* note 73 at 12.

**APPENDIX****Summary of Provincial Statutes that Abrogate Common Law Rights**

1) *Mental Health Act*, R.S.B.C. 1979, c. 256 as am. S.B.C. 1981, c. 21, s. 48: This legislation contains no provision for assessment of competency. Under section 25.2, however, if a patient is involuntarily detained, "treatment authorized by the director shall be deemed to be given with the consent of the person." The patient may apply to provincial court for a discharge from the facility (s. 27), but no mechanism is provided for challenging treatment decisions.

2) *Mental Health Act*, R.S.M. 1987, c.M-110 as am. S.M. 1987-88, c. 56, S.M. 1991-92, c. 4: The patient, or proxy for the incompetent patient (s. 24.2(1)), has the right to refuse treatment under s. 24(1); however, if an involuntary patient withholds consent, the physician may apply to the Review Board for authorization to forcibly administer treatment(s. 25(1)). Application may be made by the patient to the Review Board regarding the patient's status or the determination of incompetency(26.5(1)).

3) *Mental Health Act*, R.S.N.B. 1973, c. M-10, as am. S.N.B. 1989, c. 23: "Routine clinical medical treatment" may be given to a competent involuntary patient without consent if it is considered in the patient's "best interests"(s. 8.11). The patient (or a representative) may apply for a review of his or her status(s. 31(1)) or challenge whether the treatment given is in fact "routine clinical treatment"(s. 31.1(1)).

4) *Mental Health Act*, R.S.N. 1990, c. M-9: Anyone involuntarily detained under this legislation may also be forcibly treated(s. 6). The patient may file an application for a discharge from the institution with the review board(s. 16).

5) *Mental Health Act*, S.A. 1988,c. M-13.1: The competent patient is given the right to make treatment decisions; however, refusal of treatment by an involuntary patient may be overridden by the review board if the treatment is considered to be in the patient's "best interests"(s. 29).

6) *Mental Health Act*, R.S.P.E.I. 1988, c. M-6: No reference is made to competence or the need for consent to treatment in this legislation. The power to forcibly administer treatment to patients held against their will can be implied. An involuntary patient may apply to the review board to determine whether he

or she meets the criteria for compulsory admission(s. 25).

7) *Mental Patients Protection Act*, R.S.Q. 1977, c. P-41: The need to obtain consent for treatment is not referred to in this legislation, although the rights of patients are enumerated. The power to impose treatment on involuntary patients may be implied by the use of the term "close treatment" to describe compulsory admission.

8) *Mental Health Act*, R.S.N.W.T. 1988, c. M-10: Competent patients have the right to refuse treatment (s. 21(a)); however, if an involuntary patient withholds consent, regardless of competence, the treatment may be administered with the consent of an appointed proxy(s. 21(b)). Further, the hospital may proceed with emergency treatment of a competent involuntary patient regardless of his or her refusal(s.20(1)(b)). An application may be made to the Supreme Court to review the decision to involuntarily detain a patient(s. 26).

9) *Mental Health Act*, R.S.Y.T. 1986, c. 115: The general requirement to obtain consent from competent patients is not explicit but may be implied from the exceptions enumerated in the legislation. One such exception is the power to administer emergency treatment to the involuntary patient without his or her consent, regardless of competence (s. 7(1)). The patient may apply to the review board for an inquiry into his or her detention (s. 8(2)).