

An Alternative to Medical Assistance in Dying? The Legal Status of Voluntary Stopping Eating and Drinking (VSED)

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Résumé de l'article

L'assistance médicale à mourir (AMM) a reçu beaucoup d'attention de la part de nombreux acteurs dans le domaine de la bioéthique. Des philosophes, des théologiens, des avocats et des cliniciens de toutes sortes ont abordé de nombreux aspects difficiles de cette question. Le débat public, la politique publique et la loi ont été renforcés par des analyses disciplinaires variées. Avec la légalisation du AMM au Canada, on s'intéresse maintenant à des questions qui ont toujours été éclipsées par le débat sur l'autorisation de l'AMM. Un de ces problèmes est l'arrêt volontaire de manger et boire (AVMB) comme une alternative à l'AMM. Dans cet article, je vais appliquer une perspective légale à la question. Une compréhension des aspects légaux de l'AVMB permet d'établir les fondements d'une réflexion éthique au sujet de son autorisation. Est-il permis pour ceux qui préfèrent l'AVMB à l'AMM? Est-il permis pour ceux qui ne sont pas admissibles à l'AMM en vertu de notre législation actuelle – pour ceux qui n'ont pas de maladie grave et irréversible, pour les mineurs matures, pour les personnes dont la seule condition médicale sous-jacente est un trouble mental et qui ne rencontrent pas les critères d'admissibilité, et pour les personnes ayant perdu leur capacité, mais ayant rempli une directive préalable?



ARTICLE (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

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Jocelyn Downie¹

Résumé

L'assistance médicale à mourir (AMM) a reçu beaucoup d'attention de la part de nombreux acteurs dans le domaine de la bioéthique. Des philosophes, des théologiens, des avocats et des cliniciens de toutes sortes ont abordé de nombreux aspects difficiles de cette question. Le débat public, la politique publique et la loi ont été renforcés par des analyses disciplinaires variées. Avec la légalisation de l'AMM au Canada, on s'intéresse maintenant à des questions qui ont toujours été éclipsées par le débat sur l'autorisation de l'AMM. Un de ces problèmes est l'arrêt volontaire de manger et boire (AVMB) comme une alternative à l'AMM. Dans cet article, je vais appliquer une perspective légale à la question. Une compréhension des aspects légaux de l'AVMB permet d'établir les fondements d'une réflexion éthique au sujet de son autorisation. Est-il permis pour ceux qui préfèrent l'AVMB à l'AMM? Est-il permis pour ceux qui ne sont pas admissibles à l'AMM en vertu de notre législation actuelle – pour ceux qui n'ont pas de maladie grave et irréversible, pour les mineurs matures, pour les personnes dont la seule condition médicale sous-jacente est un trouble mental et qui ne rencontrent pas les critères d'admissibilité, et pour les personnes ayant perdu leur capacité, mais ayant rempli une directive préalable?

Mots clés

aide médicale à mourir, arrêt volontaire de manger et de boire, nutrition orale et hydratation

Abstract

Medical assistance in dying (MAiD) has received considerable attention from many in the field of bioethics. Philosophers, theologians, lawyers, and clinicians of all sorts have engaged with many challenging aspects of this issue. Public debate, public policy, and the law have been enhanced by the varied disciplinary analyses. With the legalization of MAiD in Canada, some attention is now being turned to issues that have historically been overshadowed by the debate about whether to permit MAiD. One such issue is voluntary stopping eating and drinking (VSED) as an alternative to MAiD. In this paper, I will apply a legal lens to the issue. An understanding of whether VSED is legal provides a foundation for ethical reflection on whether it ought to be permitted. Is it permitted for those who prefer VSED to MAiD? Is it permitted for those who do not qualify for MAiD under our current legislation – for those who do not have a grievous and irremediable medical condition, for mature minors, for individuals whose sole underlying medical condition is a mental disorder and who do not otherwise meet the eligibility criteria, and for individuals who have lost capacity but had completed an advance directive?

Keywords

medical assistance in dying, voluntary stopping eating and drinking, oral nutrition and hydration

Introduction

Medical assistance in dying (MAiD) has received considerable attention from many in the field of bioethics. Philosophers, theologians, lawyers, and clinicians of all sorts have engaged with many challenging aspects of this issue. Public debate, public policy, and the law have been enhanced by the varied disciplinary analyses. With the legalization of MAiD in Canada, some attention is now being turned to issues that have historically been overshadowed by the debate about whether to permit MAiD. One such issue is the use of voluntary stopping eating and drinking (VSED) as an alternative to MAiD. In this paper, I will apply a legal lens to the issue [1-3]. An understanding of whether VSED is legal provides a foundation for ethical reflection on whether it ought to be permitted. Is it permitted for those who prefer VSED to MAiD? Is it permitted for those who do not qualify for MAiD under our current legislation – for those who do not have a grievous and irremediable medical condition, for mature minors, for individuals whose sole underlying medical condition is a mental disorder and who do not otherwise meet the eligibility criteria, and for individuals who have lost capacity but had completed an advance directive?

The Canadian federal legislation regulating MAiD came into force on June 17, 2016. This legislation establishes the eligibility criteria and procedural safeguards for MAiD under the Canadian *Criminal Code*. Notably, it allows access only to individuals who meet the following conditions:

- Are eligible for health services funded by government in Canada (or would be but for a minimum period of residence or a waiting period);
- Are at least 18 years old;
- Are capable of making decisions with respect to their health;
- Made a voluntary request;
- Gave informed consent to receive MAiD after having been informed of means available to relieve suffering, including palliative care;
- Have a grievous and irremediable medical condition meaning:
 - they have a serious and incurable illness, disease or disability;
 - they are in an advanced state of irreversible decline in capability;
 - that illness, disease, or disability, or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and

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- their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.
- Have waited ten days between the day their formal request for MAiD was signed and day MAiD is provided (unless this waiting period has been abbreviated due to imminent death or imminent loss of capacity);
- Have given explicit consent immediately before the provision of MAiD.

The cumulative effect of these requirements is that there are individuals who are experiencing enduring and intolerable suffering who are, or are going to be, ineligible for access to MAiD and so are seeking an alternative path to end their suffering. For example:

- A patient with Alzheimer's disease who, by the time their state of decline is advanced and suffering is intolerable, will no longer have decision-making capacity;
- A patient who has had a debilitating stroke but for whom natural death is not "reasonably foreseeable";
- A patient with an intractable mental illness causing enduring and intolerable suffering but for whom natural death is not "reasonably foreseeable";
- A patient with severe and debilitating chronic pain who is experiencing enduring and intolerable suffering but for whom natural death is not "reasonably foreseeable."

There are also individuals who are experiencing enduring and intolerable suffering and could meet the eligibility criteria for MAiD, but who would not have access to it (e.g., because there are no willing providers or institutions where they live, and they are unable to travel) or who would not choose it (e.g., because it is contrary to their religion or conscience). Of course, every effort should be made to offer such individuals access to resources and interventions that might alleviate their suffering without ending their lives. Palliative care is an obvious example of such an intervention. However, there are times when these resources and interventions are not able to alleviate the person's suffering. There are also times when such resources and interventions are not accessible or acceptable to the person who is suffering. It is in the face of such circumstances that the issue of Voluntary Stopping Eating and Drinking (VSED) arises.¹

For the purposes of this paper, VSED involves either: 1) a competent individual stopping eating and drinking and indicating that, when they become incompetent (because of having stopped drinking), they do not want to be given oral or artificial nutrition and hydration; or 2) a previously competent individual refusing oral and artificial nutrition and hydration through a prior capable expressed wish.

In this paper, I will address a number of legal questions that can be asked about VSED:

- Is a competent person legally permitted to cause their own death through VSED (either through a refusal while competent or through a refusal made in advance of loss of capacity)?
- Must health care providers respect a previously competent person's prior expressed wishes not to be offered or given oral or artificial nutrition or hydration after losing capacity?
- What are health care providers' legal obligations to a previously competent person who, when capable, expressed a desire not to be offered or given oral or artificial nutrition or hydration, and then, once incapable, requests oral or artificial nutrition or hydration?
- Is a health care provider legally permitted to tell patients about VSED as a possible pathway to death?

I seek to answer these questions using Nova Scotia as the case study.² I also provide, in Annex 1, a template institutional policy developed on the bases of the analysis presented in this paper.

Three additional questions fall outside the scope of this paper. *First*: what are the legal implications if an individual seeking MAiD plays a role in their death's reasonable foreseeability? In other words, can an individual whose medical circumstances do not make their natural death reasonably foreseeable commence VSED as a way of causing their natural death to *become* reasonably foreseeable? [5,6] This paper focuses solely on individuals pursuing VSED all the way to death (i.e., not as a way to access MAiD). The question of VSED as a path to eligibility for MAiD is the subject of a separate paper. *Second*: are mature minors legally permitted to cause their own deaths through VSED? Space constraints preclude adequately representing the nuances of statutory differences between provinces and territories with respect to the role of a best interests analysis when considering mature minors' decision-making authority [7]. *Third*: is a health care provider legally permitted to help patients to cause their own death through VSED? This question is addressed in a separate paper [8].

¹ This is also sometimes referred to as Voluntary Refusal of Food and Fluids (VRFF) [4].

² The full analysis must be done on a provincial/territorial level because, while there are some common law principles that operate at the national level, there are also provincial/territorial statutes that must be considered. Conclusions about other provinces and territories can be drawn following an analysis of the significance of any differences in provincial or territorial consent to treatment, substitute decision-making, and advance directives legislation.

Is a person legally permitted to cause their own death through VSED?

Common law

It is very clear that competent adult patients have a legal right to refuse any or all *medical treatment* even where the consequence of the refusal is or may be death:

The law has long protected patient autonomy in medical decision-making. In *A.C. v. Manitoba (Director of Child and Family Services)*, [2009 SCC 30 \(CanLII\)](#), [2009] 2 S.C.R. 181, a majority of this Court, per Abella J. (the dissent not disagreeing on this point), endorsed the “tenacious relevance in our legal system of the principle that competent individuals are — and should be — free to make decisions about their bodily integrity” (para. 39). This right to “decide one’s own fate” entitles adults to direct the course of their own medical care (para. 40): it is this principle that underlies the concept of “informed consent” and is protected by s. 7’s guarantee of liberty and security of the person (para. 100; see also *R. v. Parker* (2000), [2000 CanLII 5762 \(ON CA\)](#), 49 O.R. (3d) 481 (C.A.)). As noted in *Fleming v. Reid* (1991), [1991 CanLII 2728 \(ON CA\)](#), 4 O.R. (3d) 74 (C.A.), *the right of medical self-determination is not vitiated by the fact that serious risks or consequences, including death, may flow from the patient’s decision. It is this same principle that is at work in the cases dealing with the right to refuse consent to medical treatment, or to demand that treatment be withdrawn or discontinued: see, e.g., Ciarlariello v. Schacter*, [1993 CanLII 138 \(SCC\)](#), [1993] 2 S.C.R. 119; *Malette v. Shulman* (1990), [1990 CanLII 6868 \(ON CA\)](#), 72 O.R. (2d) 417 (C.A.); and *Nancy B. v. Hôtel-Dieu de Québec* (1992), [1992 CanLII 8511 \(QC CS\)](#), 86 D.L.R. (4th) 385 (Que. Sup. Ct.). [9]

While we do not have any Supreme Court of Canada decisions turning on the issue of the right to refuse oral or artificial nutrition and hydration, it is reasonable to extrapolate from their discussions of the right to refuse medical treatment. There is no reason to believe that the Supreme Court of Canada, presented with a case turning on the issue of the right to refuse oral or artificial nutrition and hydration, would do anything other than point, yet again, to its commitment to the principle of bodily integrity and respect for autonomy and conclude that competent adult patients have a legal right to refuse oral or artificial nutrition and hydration, even where a potential or certain consequence of the refusal is death.

This conclusion is supported by comments made about the right to refuse *oral or artificial* nutrition and hydration in some lower, albeit not binding, court decisions. As noted by Justice Smith in *Carter v Canada*:

To summarize, the law in Canada is that:

(a) Patients are not required to submit to medical interventions (*including artificial provision of nutrition and hydration*), even where their refusal of or withdrawal from treatment will hasten their deaths, and physicians must respect their patients’ wishes about refusal of or withdrawal from treatment. [10]³

Again in *Carter*, Justice Smith noted that the Attorney General of British Columbia “submits that ‘the able bodied and the disabled can equally commit suicide *by refusing to eat or drink* or by refusing provision of *artificial nutrition or hydration*.’” [9] Justice Smith did not take issue with this submission; indeed, she relied upon it in her argument against the absolute ban on assisted dying. Similarly, in *Bentley v Maplewood Seniors Care Society*, Justice Greyell noted that, “adults have a common law right to consent or refuse consent to *personal care services* [including *oral* nutrition and hydration]” [12]⁴:

[T]here is common law authority for the proposition that it is necessary to obtain consent before providing personal care or basic care. Indeed, intentional non-consensual touching can amount to the tort of battery (*Malette* at 327; *Norberg v. Wynrib*, [1992 CanLII 65 \(SCC\)](#), [1992] 2 S.C.R. 226 at 246). Although most cases relating to consent rights have been decided in the context of a right to consent or refuse consent for health care treatment, the principles on which that right is based is the general right to personal autonomy and bodily integrity.

For instance, in *Ciarlariello v. Schacter*, [1993 CanLII 138 \(SCC\)](#), [1993] 2 S.C.R. 119 at 135 Cory J. said for the Court: “Everyone has the right to decide what is to be done to one’s own body.” Similarly, in *Fleming* at 312 Robins J.A. observed that “[t]he 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.” These statements recognizing the common law right to be free from non-consensual touching or care of one’s body must encompass the right to consent or refuse consent to personal care or basic care. For consent to personal care to be meaningful, the decision must be made by someone who is capable of understanding the proposed care and who is free from undue influence or coercion. [12]⁵

³ See also [11]

⁴ It is important to note that the BCCA in *Bentley* agreed with the trial judge that Margot Bentley was making a presently competent decision so this was not, in the end, a case of a presently *incompetent* vs. previously *competent* person. Rather, it was a case of presently competent vs. previously competent person. Thus, the common law principles expressed above were endorsed in *Bentley* even though the result in the case was that Bentley continued to receive oral nutrition and hydration. See [13].

⁵ Of course this is a trial level decision in one province and so is not a binding authority. It does, however, accurately reflect the Supreme Court of Canada’s position on the philosophy underlying the common law position re: bodily integrity and autonomy.

It is also clear that *previously competent* adult patients have a common law right, through prior expressed wishes, to refuse any or all *medical treatment* even where a potential or certain consequence of the refusal is death. The philosophy underlying this principle is, as the Ontario Court of Appeal stated in *Fleming v Reid* (and the Supreme Court of Canada endorsed in *Rodriguez v British Columbia* [14] and *Carter* [9]):

A patient, in anticipation of circumstances wherein he or she may be unconscious or otherwise incapacitated and thus unable to contemporaneously express his or her wishes about a particular form of medical treatment, may specify in advance his or her refusal to consent to the proposed treatment. A doctor is not free to disregard such advance instructions, even in an emergency. The patient's right to forgo treatment, in the absence of some overriding societal interest, is paramount to the doctor's obligation to provide medical care. This right must be honoured, even though the treatment may be beneficial or necessary to preserve the patient's life or health, and regardless of how ill-advised the patient's decision may appear to others. [15]

Again, we do not have any Supreme Court of Canada decisions turning on the issue of the right to refuse oral or artificial nutrition and hydration through prior expressed wishes. However, it is reasonable to extrapolate from their discussions of the right of a competent adult to refuse treatment and conclude that, presented with a case turning on the issue of the right to refuse oral or artificial nutrition and hydration through a prior express wish, the Supreme Court of Canada would point to its commitment to the principle of bodily integrity and respect for autonomy.

Thus it can be concluded that competent adults and previously competent adults whose prior capable informed expressed wishes are known, have a *common law* right to refuse oral and artificial nutrition or hydration.

Nova Scotia legislation

Under the *Hospitals Act* [16], no patient in a hospital shall be treated without consent to such treatment. If a patient is incapable of consenting to treatment, consent may be given or refused by a substitute decision-maker. Substitute decision-makers must make decisions "in relation to specified medical treatment" on behalf of the person according to the person's "prior capable expressed wishes." [16, s 54A(a)] If these are not known, then the decision must be made "in accordance with what the substitute decision-maker believes the wishes of the patient would be based on what the substitute decision-maker knows of the values and beliefs of the patient and from any other written or oral instructions." [16, s 54A(b)] If these are also not known, then the decision must be made "in accordance with what the substitute decision-maker believes to be in the best interest of the patient." [16, s 54A(c)]

It must be noted here that the *Hospitals Act* likely does not authorize substitute decision-makers to refuse care as opposed to treatment. The definition of "substitute decision-maker" is "a person who is given the authority to make admission, care or treatment decisions on behalf of a patient under this Act or a voluntary patient." [16, s 2(w)] However, the subsequent provisions dealing with the authority and basis for substitute decision-making do not make reference to care but rather only treatment. It seems reasonable to interpret the *Hospitals Act* as covering artificial hydration and nutrition (as treatment) but not oral nutrition and hydration (as care). Further, under the *Personal Directives Act*, a person may name a delegate to make decisions on her behalf about health and personal care (when she has lost decision-making capacity) [17]. There is no reason to believe that health care does not include artificial nutrition and hydration and personal care explicitly includes oral nutrition and hydration [17].

Thus, it can be concluded that competent adults have a statutory right to refuse artificial nutrition or hydration.⁶ Previously competent adults have a statutory right to refuse oral and artificial nutrition and hydration through a personal directive.

Must health care providers respect a previously competent person's prior capable expressed wish not to be offered or given oral and artificial nutrition or hydration after losing capacity?

Health care providers have a duty to respect patient refusals. Physicians are required by law to respect such refusals. For example, to touch a person against the person's wishes would constitute battery⁷ or assault [18]. Therefore, health care providers risk civil and criminal liability for forcing artificial nutrition or hydration against a competent adult's wishes, a valid personal directive, or a substitute decision-maker basing a refusal of consent on prior capable informed expressed wishes of a previously competent adult. Health care providers also risk civil and criminal liability should they force oral nutrition or hydration against a competent adult's wishes or a valid personal directive of a previously competent adult.

It must be noted here that some have suggested that, in the context of VSED, failure to provide oral or artificial nutrition or hydration could constitute the *Criminal Code* offence of "failure to provide the necessaries of life." [12] However, this fails to

⁶ There is one somewhat bizarre exception to this general conclusion in Nova Scotia as the *Involuntary Psychiatric Treatment Act*, SNS 2005, c 42, s 39 establishes that an advance directive made by a person while capable but now an involuntary patient, can be made in accordance with the substitute decision-maker's belief in the person's best interests "if following the patient's prior capable informed expressed wish would endanger the physical or mental health or safety of the patient or another person, in accordance with what the substitute decision-maker believes to be in the patient's best interests." Many people have argued that this provision is unconstitutional (violating s 15 of the *Charter*) but to this day it remains the law.

⁷ The Supreme Court of Canada has clearly endorsed the view that the common law concept of bodily integrity requires that health care providers not touch patients without their consent. Starting or continuing treatment would be considered touching and, if done against a patient's wishes, would be considered tortious battery. See, for example, *Ciarlariello v Schacter* [1993] 2 SCR 119.

recognize two things: 1) there is a duty to provide the necessities of life only where the patient (directly or through their substitute decision-maker) is unable to remove themselves from the physician's charge and is unable to provide themselves with the necessities of life; and 2) there is an offence only where the health care provider is under a duty and fails without legal excuse to perform that duty [18].

I would argue that, when a person or their substitute decision-maker has the decision-making capacity and legal authority to refuse oral nutrition or hydration and is refusing it, then that person will not be under the charge of the physician. Being "under the charge of" entails "the exercise of an element of control by one person and a dependency on the part of the other." [19, at 42]. It does not make sense to consider a person to be under the control of a physician in relation to the unwanted provision of treatment when the physician is legally prohibited from touching them without their consent or to consider someone to be dependent on a physician for nutrition and hydration that they do not want (and that they or their proxy have the legal authority to refuse). In such a case, there is no duty to provide the necessities of life.

I would also argue that, even assuming for the sake of argument there is a duty, a valid refusal in a VSED case constitutes a lawful excuse for not meeting that duty because administering oral or artificial nutrition or hydration in the circumstances of a valid refusal would constitute tortious battery and criminal assault, and because provincial/territorial consent legislation across Canada allows patients or substitute decision-makers to refuse consent to treatment (covering artificial nutrition and hydration) [20-22].

It can therefore be concluded that health care providers have a legal obligation to respect a previously competent person's prior capable informed expressed wishes not to be offered or given oral or artificial nutrition or hydration after losing capacity.

What are health care providers' legal obligations if a previously competent person, when capable, expressed a desire not to be offered or given oral or artificial nutrition or hydration, and then, once incapable, requests oral or artificial nutrition or hydration?

Under the *Hospitals Act*, the incompetent person's substitute decision-maker must make the decision about whether to give consent to the provision of artificial nutrition or hydration:

- (a) in accordance with the patient's prior capable informed expressed wishes unless
 - (i) technological changes or medical advances make the prior expressed wishes inappropriate in a way that is contrary to the intentions of the patient, or
 - (ii) circumstances exist that would have caused the patient to set out different instructions had the circumstances been known based on what the substitute decision-maker knows of the values and beliefs of the patient and from any other written or oral instructions [16, s 54A].

Therefore, if subsections (i) or (ii) are not met, the substitute decision-maker must, despite the request from the incompetent person, refuse consent to artificial nutrition or hydration in accordance with that person's prior capable expressed wishes; further, the health care providers must respect that refusal [17, s 15(2)(a)].⁸

Under the *Personal Directives Act*, the substitute decision-maker ("delegate") is required to act in accordance with instructions in a personal directive unless:

- (i) there were expressions of a contrary wish made subsequently by the maker who had capacity,
- (ii) technological changes or medical advances make the instruction inappropriate in a way that is contrary to the intentions of the maker, or
- (iii) circumstances exist that would have caused the maker to set out different instructions had the circumstances been known based on what the delegate knows of the values and beliefs of the maker and from any other written or oral instructions. [17, s 15(2)(a)]

In turn, a court may "vary, confirm or rescind a personal-care decision, in whole or in part, made by a delegate or statutory decision-maker" [17, s 31(1)(d)] or "order that all or part of a personal directive ceases to have effect." [17, s 31(1)(i)] However, this power is limited by the fact that "the court may not add to or alter the intent of an instruction contained in a personal directive unless the court is satisfied that the maker's instruction or wishes changed subsequent to the making of the instruction." [17, s 31(3)] Again, if the exceptions are not met, the delegate must, despite the request from the incompetent person, refuse consent to oral or artificial nutrition or hydration, the court must not intervene, and the health care providers must respect that refusal.

Finally, under the common law, an express refusal of oral or artificial nutrition and hydration made by an individual while competent overrides a request for oral or artificial nutrition and hydration made while incompetent unless there is a basis for concluding that the person had changed their views while they were still competent [23].

⁸ It is possible that (iii) might be met in some circumstances – if, for example, the substitute decision-maker believes the process of dying by starvation or dehydration is different than the person anticipated and that, had the person known what it would be like, they would not have refused nutrition and hydration.

Is a health care provider legally permitted to tell patients about VSED as a possible pathway to death?

To answer this question, we must determine whether death by VSED is suicide and, if so, whether telling patients about VSED as a possible pathway to death constitutes counselling, abetting, or aiding suicide under the *Criminal Code*.

The *Criminal Code* establishes the following:

- 241 (1) Everyone is guilty of an indictable offence and liable to imprisonment for a term of not more than 14 years who, whether suicide ensues or not,
- (a) counsels a person to die by suicide or abets a person in dying by suicide; or
 - (b) aids a person to die by suicide.

Is death by VSED suicide?

It is unclear whether death by VSED is always, sometimes, or ever to be considered suicide. A detailed discussion of this issue is available in “The legal status of deep and continuous palliative sedation without artificial nutrition and hydration” [8] and “Is refusing care a legal pathway to medical assistance in dying?” [24] The conclusion drawn, based on a review of the case law as well as a review of instructions for and practices with respect to the completion of medical certificates of death (including when the manner of death is to be certified “suicide”), is that we cannot in all cases confidently state whether or when death by VSED is suicide. In the face of such uncertainty and in light of the seriousness of the possible consequences of criminal charges, it seems prudent to assume for the sake of argument that death by VSED is suicide and therefore to explore whether telling patients about VSED as a possible pathway to death constitutes counselling, abetting, or aiding suicide under the *Criminal Code*.

Counselling

There are no Supreme Court of Canada decisions on the meaning of “counselling” in the context of s.241(1) of the *Criminal Code*. Based on the available lower court decisions in this context and other court decisions about counselling in other contexts, it seems very unlikely that a health care provider would be convicted of counselling suicide for telling a patient about VSED as a possible pathway to death or for advising them on how to follow this pathway *unless*:

- the health care provider wanted to induce the patient to stop eating and drinking as a means of committing suicide.
- the health care provider wanted to use her influence to induce the patient to pursue death through VSED.
- the health care provider sought to convince or persuade the patient to pursue death through VSED.

As concluded by Justice Christine Gosselin of the Court of Quebec (QCCQ) in *R v Morin*, after summarizing the relevant Supreme Court of Canada (SCC) jurisprudence, “counselling” for the purposes of s.241(1) “concerns speech that, assessed objectively, aims to induce, persuade or convince a person to commit suicide.” [25]⁹ Health care providers in the context of VSED would be telling a patient about VSED as a possible pathway to death because they have an obligation to disclose all treatment options and alternatives; VSED is an alternative. They would not be wanting to induce, influence, convince, or persuade the patient to follow VSED. Therefore, they should not face criminal liability for counselling suicide.

Abetting

Abetting suicide likely requires “encouraging, instigating, promoting or procuring the crime to be committed.” [30]¹⁰ Again, as with counselling, health care providers in the context of VSED would not be aiming to encourage, instigate, promote or procure suicide. Therefore, they should not face criminal liability for abetting suicide.

Aiding

Aiding suicide likely requires that the accused assist or help the person who commits suicide. A health care provider who merely tells a patient about VSED as a pathway to death is not assisting or helping the patient to follow that path. Therefore, they should not face criminal liability for aiding suicide.

Conclusion

It can be concluded that VSED is a legal pathway to a hastened death. As noted earlier, it may be of particular interest for those individuals who would not qualify for MAiD or who are experiencing enduring and intolerable suffering and could meet the eligibility criteria for MAiD, but who would not have access to it (e.g., because there are no willing providers where they live and they are unable to travel) or who would not choose it (e.g., because it is contrary to their religion or conscience). Individuals can: 1) refuse oral and artificial nutrition and hydration while capable; and 2) state a very clear informed refusal of oral and artificial nutrition and hydration through a prior capable expressed wish. These refusals must, in almost all

⁹ See also [26-29].

¹⁰ “The *actus reus* of aiding or abetting is doing (or, in some circumstances, omitting to do) something that assists or encourages the perpetrator to commit the offence. While it is common to speak of aiding and abetting together, the two concepts are distinct, and liability can flow from either one. Broadly speaking, “[t]o aid under s. 21(1)(b) means to assist or help the actor. . . . To abet within the meaning of s. 21(1)(c) includes encouraging, instigating, promoting or procuring the crime to be committed”: *R v Greyeyes*, [1997 CanLII 313 \(SCC\)](#), [1997] 2 SCR 825, at para 26.”

circumstances,¹¹ be respected. It can also be concluded that health care providers are legally permitted to inform patients about VSED as a pathway to death.¹²

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Conflit d'intérêts

Aucun déclaré

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Conflicts of Interest

None to declare

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Les évaluations des examinateurs externes sont prises en considération de façon sérieuse par les éditeurs et les auteurs dans la préparation des manuscrits pour publication. Toutefois, être nommé comme examinateur n'indique pas nécessairement l'approbation de ce manuscrit. Les éditeurs de *Revue canadienne de bioéthique* assument la responsabilité entière de l'acceptation finale et la publication d'un article.

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¹¹ The exceptions being when there is good reason to believe that the presently incompetent patient changed their mind while competent or would have come to a different conclusion while competent had they had the information available to substitute decision-makers, health care providers, and judges in the present.

¹² Institutions wishing to reflect these conclusions in policy are directed to Annex 1.

26. [Mugesera v Canada](#) (Minister of Citizenship and Immigration), 2005 SCC 40 (CanLII), [2005] 2 SCR 100.
27. [R v Déry](#), 2006 SCC 53 (CanLII), [2006] 2 SCR 669.
28. [R v Hamilton](#), 2005 SCC 47 (CanLII), [2005] 2 SCR 432.
29. [R v Sharpe](#), 2001 SCC 2 (CanLII), [2001] 1 SCR 45.
30. [R v Briscoe](#), 2010 SCC 13, [2010] 1 SCR 411.

Annex 1.

TEMPLATE INSTITUTIONAL POLICY ON VOLUNTARY STOPPING EATING AND DRINKING (Nova Scotia version)¹³

Purpose

The purpose of this policy is to provide guidance to health care providers, their patients, and others involved with decisions about stopping oral nutrition and hydration when individuals or their delegates refuse oral nutrition and hydration. It describes the legal context for stopping oral nutrition and hydration in such circumstances and sets out the institutional commitments as well as the process that must be followed when such a decision is being made about stopping oral nutrition and hydration.

Limitations on scope

A choice to stop oral nutrition and hydration is legally distinct from medical assistance in dying (MAiD).¹⁴ For policy and procedure on how to respond to a request for MAiD, see [insert link to institution's MAiD policy and procedure].

Withholding or withdrawal of artificial nutrition and hydration falls within the well-settled legal right of patients and their substitute decision-makers to refuse health care. For policy and procedure on how to respond to a refusal of artificial nutrition and hydration, see [insert link to institution's withholding and withdrawal of treatment policy and procedure].

Terminology

"capacity" means the ability to understand information that is relevant to the making of a personal-care decision and the ability to appreciate the reasonably foreseeable consequences of a decision or lack of a decision;

"delegate" means a person authorized under a personal directive to make, on the maker's behalf, decisions concerning the maker's personal care;

"health care provider" includes a person licensed or registered under Provincial legislation to provide health care;

"nearest relative" means, with respect to any person, the relative of that person first listed in the following subclauses:

- (i) spouse,
- (ii) child,
- (iii) parent,
- (iv) person standing in loco parentis,
- (v) sibling,
- (vi) grandparent,
- (vii) grandchild,
- (viii) aunt or uncle,
- (ix) niece or nephew,
- (x) other relative,

who, except in the case of a minor spouse, is of the age of majority;

"personal care" includes, but is not limited to, health care, **nutrition, hydration**, shelter, residence, clothing, hygiene, safety, comfort, recreation, social activities, support services and any other personal matter that is prescribed by the regulations; [emphasis added]

"spouse" means, with respect to any person, a person who is cohabiting with that person in a conjugal relationship as married spouse, registered domestic partner or common-law partner;

"statutory decision-maker" means a nearest relative or the Public Trustee authorized under Section 14 of the Personal Directives Act.

Legal context

- Patients/delegates can refuse oral nutrition and hydration

¹³ This policy was developed by the author based on the analysis presented in this paper.

¹⁴ "medical assistance in dying" means

(a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or
(b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death. (*aide médicale à mourir*) s.241.1 *Criminal Code*

- Health care professionals and institutions must respect decisions about oral nutrition and hydration made by capable patients (directly or through valid personal directives when the maker becomes incapable) or incapable patients' delegates except where the delegate is acting outside their authority.¹⁵

Institutional commitments

It is central to the philosophy of [institution name] that its staff shall identify, assess, and respond to each patient's situation in a manner consistent with the patient's wishes and best practices.

[Institution name] recognizes the right of patients to exercise their autonomy by making decisions regarding their care at the end of life, including decisions to stop oral nutrition and hydration. Such decisions may be made at the time of the proposed provision or through a personal directive in advance of loss of capacity.

[Institution name] also recognizes the obligation of an incapable patient's delegate to make decisions on behalf of the patient according to the patient's prior expressed wishes (if any) or values and beliefs relevant to the specific decision (if known), or best interests (if wishes, values, and beliefs relevant to the specific decision are not known). This includes decisions to stop oral nutrition and hydration. The exception to this rule comes when there is good reason to believe that a presently incapable patient changed their mind while capable or would have come to a different conclusion while capable had they had the information available to their delegate.

[Institution name] also recognizes that health care providers have an obligation to respect refusals of oral nutrition and hydration (from capable patients or through instructions in previously capable patients' valid personal directives or through instructions given by patients' delegates). An exception to this rule comes when there is good reason to believe that a delegate is acting outside their authority in which case the health care providers should make an application to the Supreme Court of Nova Scotia.

[Institution name] also recognizes that health care providers have a right to refuse to participate in the stopping of oral nutrition and hydration so long as this refusal is expressed in a way that does not harm the patient and alternative health care providers can be provided by the institution.

Process

1. Realize there is a decision to be made about continuation of oral nutrition and hydration
2. Assess decision-making capacity of patient to make decision re: oral nutrition and hydration
 - a. If patient is capable, ensure decision is free and informed
 - i. If free and informed, respect the patient's decision
 - ii. If not informed, inform the patient and then respect the patient's decision
 - iii. If not free, take steps needed to remove undue inducement/coercion and then respect the patient's decision
 - b. If patient is not capable, determine whether there is a valid personal directive with instructions that apply in the circumstances¹⁶
 - i. If there is a valid personal directive with instructions that apply in the circumstances, follow the instructions
 - ii. If there is no valid personal directive with instructions that apply in the circumstances, determine whether there is a valid personal directive appointing a delegate
 1. If there is a valid personal directive appointing a delegate, respect the decision of the delegate unless they are acting outside their authority¹⁷

¹⁵ In making any decision, a delegate shall

(a) follow any instructions in a personal directive unless

(i) there were expressions of a contrary wish made subsequently by the maker who had capacity,
(ii) technological changes or medical advances make the instruction inappropriate in a way that is contrary to the intentions of the maker, or
(iii) circumstances exist that would have caused the maker to set out different instructions had the circumstances been known based on what the

delegate knows of the values and beliefs of the maker and from any other written or oral instructions;

(b) in the absence of instructions, act according to what the delegate believes the wishes of the maker would be based on what the delegate knows of the values and beliefs of the maker and from any other written or oral instructions; and

(c) where the delegate does not know the wishes, values and beliefs of the maker, make the personal-care decision that the delegate believes would be in the best interests of the maker.

¹⁶ "applies in the circumstances" means provides clear direction as to the patient's wishes and there is no good reason to believe that the presently incapable patient changed their mind while capable or would have come to a different conclusion while capable had they had the information available to delegates, health care providers, and judges in the present.

¹⁷ "acting outside their authority" means the delegate is not acting in accordance with the patient's prior expressed wishes, beliefs, or values or, if those are not known, is not acting in the best interests of the patient.

- a. If the delegate is acting outside their authority, make an application to the Supreme Court of Nova Scotia¹⁸
3. Provide high quality care to the patient making them as comfortable and safe as possible within any constraints of the decision made.

Special Notes

It is essential to remember that the determination of decision-making capacity must be made relative to the decision to be made. Where the patient is refusing oral nutrition and hydration, capacity to make that decision includes the ability to understand and appreciate that this will result in death.

It is essential that health care providers assessing whether a decision is free have an understanding of the ways in which responding to offers of oral nutrition and hydration (e.g., a spoon being placed on lip) can be a reflex rather than a sign of a free decision.

It is essential that all those advising patients about end of life decision-making advise them that if they want someone to be able to decline oral nutrition and hydration on their behalf should they become incapable, they need to appoint a delegate. They should be advised that statutory decision-makers do not have the authority to decline oral nutrition and hydration (although they do have the authority to consent to or refuse artificial nutrition and hydration).

It is essential that all those advising patients on completion of personal directives advise them on the need to be as clear and specific as possible. Patients should be encouraged to reflect on the potential future decision of whether to have oral nutrition and hydration and, if someone knows that they want to decline oral nutrition and hydration even in the face of the consequence of death, they should be encouraged to state that clearly and explicitly.

It may be psychologically difficult for staff and patients' families to observe a patient not being given oral nutrition and hydration. Resources are available to support staff and patients' families [insert link to institutional supports].

¹⁸ 31(1) The court may, on hearing an application under Section 29, do any one or more of the following:

(a) where a court is satisfied that a writing embodies the intentions of the maker, the court may, notwithstanding that the writing was not executed in compliance with the requirements of this Act, order that the writing is valid and fully effective as a personal directive as if it had been executed in compliance with the requirements of this Act;

(b) make a determination of capacity of the maker or person represented or a delegate or statutory decision-maker after considering a report made under subsection (2)(b);

(c) determine the validity of a personal directive or any part of it;

(d) based on instructions contained in a personal directive or other evidence of the maker's instructions or wishes made while the maker had capacity, vary, confirm or rescind a personal-care decision, in whole or in part, made by a delegate or statutory decision-maker;

(e) determine the authority of a delegate or statutory decision-maker;

(f) provide advice and directions;

(g) stay a decision of a delegate or statutory decision-maker;

(h) substitute another person as delegate;

(i) order that all or part of a personal directive ceases to have effect;

(j) order that costs of the proceeding be paid from the estate of the maker or person represented;

(k) make any other order that the court considers appropriate.

(2) For the purpose of assisting the court in making a decision under subsection (1), the court may

(a) require a delegate or statutory decision-maker to provide to the court a report of personal-care decisions made by the delegate or statutory decision-maker; or

(b) order that a report on the capacity of a maker or person represented or a delegate or statutory decision-maker be prepared.

(3) In making a decision under subsection (1), the court may not add to or alter the intent of an instruction contained in a personal directive unless the court is satisfied that the maker's instruction or wishes changed subsequent to the making of the instruction. 2008, c. 8, s. 31.