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Behaviour Alteration, the Law Reform Commission and the Courts: An Ethical Perspective

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I. *Introduction*

The Law Reform Commission of Canada, in its Working Paper 43 *Behaviour Alteration and the Criminal Law*,¹ addresses the issue of the deliberate modification of human behaviour by medical means. It does so vis-à-vis non-consensual treatment prescribed in the purely therapeutic setting as well as with respect to such treatment imposed by way of sentencing. The Commission focuses its deliberations around three questions:²

1. Do present laws provide sufficient protection against involuntary or non-consensual administration of behaviour alteration treatment?
2. Should psychological integrity be protected by the *Criminal Code* as physical integrity already is?
3. Should the law legitimate the use of these techniques for purposes of criminal sanction as a matter of social control?

During the course of its deliberations the Commission comes to the conclusion that while current statutes do offer “adequate protection against assaults on human physical integrity . . . the situation is otherwise regarding psychological integrity.”³ In response to question 2, therefore, it recommends that the *Criminal Code* should be amended to protect the psychological integrity of the person; *i.e.*, it recommends that “the criminal law affirm the right of a psychiatric patient not to be treated against his will, and to have treatment already under way stopped, with the reservation of the usual exceptions already acknowledged by law, that is, in cases of emergency or when the absence of treatment creates a serious risk for the life and safety of the patient or others”.⁴ As to the third question and addressing itself explicitly to the criminal context, the Commission argues that while “curing behavioural problems not only benefits the incarcerated individual but also society as a whole,”⁵ “to

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1. Law Reform Commission of Canada, (Working Paper 43) *Behaviour Alteration and the Criminal Law* (Ottawa, 1985).

2. *Id.*, at 4.

3. *Id.*, at 2.

4. *Id.*, at 37.

5. *Id.*, at 42.

make a direct link between sentencing and psychiatric treatment is to fall into a trap leading to confusion between treatment and punishment.”⁶ Consequently, it recommends that “except in cases of emergency, or when the individual is completely unable to give consent, psychiatric treatment should never be undertaken without the patient’s expressed authorization.”⁷

These recommendations, as well as the Commissions’ reasoning in support of them, seem eminently reasonable. Nevertheless, they may be criticized on two grounds: on a general level, they reflect a stance on behaviour modification as a medical procedure that is incompatible with the Commission’s own view, expressed elsewhere and reaffirmed here, that the autonomy of the individual in matters medical is a value that must not be compromised; and on a more particular plane, the recommendation concerning the criminal context stands in fundamental opposition to the ethics of the health care professions as such.

These are serious charges. What makes them more serious still is that the views expressed in this Working Paper appear to be representative of a position on behaviour alteration that is fairly widespread in the legal community. The present critique should therefore be seen as being at the same time an expression of unease with the current views on the subject as a whole. However, it should also be noted that this unease is not rooted in legal considerations, although these will be adduced when and where relevant. Instead, it is centered in ethical considerations that derive from one of the most fundamental ethical principals of deontological ethics: the principal of autonomy and respect for persons.⁸ In that sense, it will be an ethically oriented critique.

II. *The Non-Criminal Context*

Considered by itself, the Commission’s first recommendation is unobjectionable. With the exception of but a few carefully delineated circumstances, it affirms the principle of autonomy and recognizes the right of competent and informed consent as supreme. However, it is precisely these exceptive circumstances that constitute the problem. The Commission’s characterization of them is as follows: when the patient’s “condition presents a danger to the life or health of that person or others; . . . [when] the patient is totally incapable of taking care of himself; . . . [and when dealing with an] involuntarily hospitalized patient who has

6. *Id.*

7. *Id.*, at 43.

8. *Cf.*, R.M. Hare, *The Language of Morals* (New York: Oxford University Press, 1964), at 70, 196, *et pass.*; John Rawls, *A Theory of Justice*, (Cambridge, Mass.: Harvard University Press, 1971), Chapter IX *et pass.*

lucid intervals.”⁹ In these cases, so the Commission contends, non-consensual psychiatric treatment focusing in behaviour alteration is justified because “Protection of the life and health of others must take precedence over an absolute right to autonomy.”¹⁰ The Commission then draws an analogy to the case of the person “who is suffering from a contagious disease but refuses to be treated”,¹¹ in order to buttress its stance.

The principle involved here is ethically sound. Autonomy is a fundamental value of Anglo-American culture, and may not be compromised except for the most weighty of reasons: public interest, the safety of others, and the like. Both ethical reasoning and legal opinion agree on this point.¹² However, even when such a compromise is mandated, it may occur when and only when it can be shown that public interest constitutes a greater right and is not merely a matter of greater convenience; that the safety of others does not require the violation of a fundamental right of the individual himself; and in general, that the compromise of autonomy as such is the result of a balancing of the rights of the individual against those of others.¹³ This is what characterizes our system of laws as deontological, rather than utilitarian in nature.¹⁴

In this sense, therefore, the third-party exceptions mentioned by the Commission are unexceptionable and the analogy it draws to argue the point is compelling. *Tarasoff v. Regents of the University of California*¹⁵ provides a good example. It is the second-person exceptions that pose the problem: the individual who is episodically psychotic, and the person who constitutes a danger to his own life and health. Here the analogy drawn by the Commission breaks down, and from a purely logical perspective there exists a probative *lacuna*.

III. *The Episodic Patient*

One could, of course, attempt to fill the gap by turning to what the Commission says elsewhere. For instance, focusing explicitly on the

9. Working Paper 23, at 36.

10. *Id.*

11. *Id.*

12. For an extended discussion of this and related problems, see Stephan L. Chorover, “Violence: A Localizable Problem?” in E.S. Valenstein, ed., *The Psychosurgery Debate: Scientific, Legal and Ethical Perspectives* (San Francisco, 1980) at 334-347.

13. *Re Eve* (1979), 10 R.F.L. (2) 317 (P.E.I.S.C. Fam.Div.) (McQuaid, J.), reversed on other grounds (1980), 74 A.P.R. 87, 27 N. & P.E.I.R. 97 (P.E.I.C.A.), reaffirmed (1986), 31 D.L.R. (4th) 1 (S.C.C.).

14. For a trenchant discussion of the distinction between the two types of approaches from a purely theoretical perspective, see R. B. Brandt, *Ethical Theory* (Prentice-Hall, 1959).

15. 131 California Reporter 14, decided July 1, 1976; 529 P.(2d) 553 (C.S.C.).

patient whose psychosis is of an episodic nature, the Commission argues that such a person, while in the psychotic state, must be considered "a person [temporarily] deprived of his mental ability . . . of the ability both to understand what is happening to him and to exercise a rational and informed judgment." Such a case, so the Commission continues, is "analogous to that of the highway accident victim brought unconscious to a hospital emergency ward. . . . [I]n such circumstances the presumption must be in favour of life and health. Medical authorities should have the right to provide treatment and should not have to presume that if the person were conscious, he would refuse treatment."¹⁶

However, the Commission's reasoning on this point is unacceptable because the analogy on which it is based does not hold. The point of our first objection is perhaps best brought out by way of example. Consider the case of a declared and known Christian Scientist. Let us suppose that this person is brought unconscious into an emergency ward. If there is present clear and incontrovertible evidence immediately apparent to the health care professionals that this individual, while competent, and prior to the accident, had stated a settled and considered will to refuse all conventional life-saving or other medical treatment, neither the fact of emergency nor that of life-threatening circumstances will ethically allow the medical authorities to ignore such a disposition, the fact of present unconsciousness notwithstanding.¹⁷ Similarly, let us suppose that a person brought unconscious into a hospital emergency ward per I.D. check is found to be a Jehovah's Witness. Let us suppose further that he has with his I.D. a properly executed affidavit requesting that no blood transfusion be given even though his life be in peril. In that case, too, it is ethically clear that neither the fact of emergency nor the fact of

16. Working Paper 43, at 21.

17. Cf. Law Reform Commission of Canada, Working Paper 26. *Medical Treatment and Criminal Law* (Ottawa, 1980) at 70-73. *But see: Attorney General of B.C. v. Astoroff*, [1984] 4 W.W.R. 385 (B.C.C.A.), affirming [1983] 6 W.W.R. 322, 47 B.C.L.R. 217 (B.C.S.C.) which states that an incarcerated person has the right to refuse life-sustaining treatment. However the court then argued that:

If she [Astoroff] becomes unconscious or incapable of making a rational decision, that is another matter. Then she will be unable to make a free choice. But while she is lucid no law compels the prison officers to apply force to her against her will.

at 327 (W.W.R.). This suggests that the courts might consider the fact of incompetence to extinguish the competent's right of refusal. However, in 1985 Mary Astoroff died of self-imposed starvation while imprisoned. This seems to suggest that the decision was not read in this fashion by the provincial authorities. The case of Elizabeth Bouvia may be thought an exception (*Bouvia v. Company of Riverside*, No. 159780, Supreme Court, Riverside County, California, December 16, 1983, Transaction 1238 - 1250). However, it should be recalled that Bouvia was self-admitted for treatment of suicidal depression.

unconsciousness nor the threat to his life will allow the attending physician to ignore this request and proceed with a transfusion.¹⁸ The Commission itself, in an earlier Working Paper,¹⁹ agreed with and indeed was quite clear on that point. Consequently, if the analogy to the emergency ward situation is to be taken at all seriously, consistency requires that the Commission not proceed differently in this case. It must limit the generality of its recommendation by acknowledging that an episodic psychotic individual has the right, when competent, to declare whether or not and in what fashion he wishes to be treated should he, at some time in the future, become psychotic and endanger his life or health.²⁰ Nor would it be possible to escape this inference by arguing that the very fact of such a declared intention by the patient when allegedly competent *eo ipso* constitutes non-rebuttable evidence for the claim that competence did not in fact obtain. Not only would that be a most flagrant example of *post hoc, ergo propter hoc* reasoning, it would also contradict the Commission's own declared position elsewhere.²¹

This line of reasoning also has another facet. The Commission itself, echoing *Quinlan*²² and *Colyer*,²³ continues that "incompetence should

18. Cf. Ruth Macklin, "Consent, Coercion, and Conflict of Rights" (1973), 20 *Perspectives in Biology and Medicine* 370-371; N. L. Cantor, "A Patient's Decision to Decline Lifesaving Medical Treatment: Bodily Integrity Versus the Preservation of Life" (1973), 26 *Rutgers Law Review* 228-261. For a relevant guiding opinion, see *Re Farrell*, [1987] 529 A. 2d 404: "... it is the patient's preference . . . that should control. The privacy that we accord medical decisions does not vanish with the patient's *condition* or progress." (emphasis added).

19. Cf. Working Paper 26 at 64-73. In note 375 the Commission here lists a series of cases in support of its position that:

... the preponderance of legislative, judicial, professional, and public attitudes favour the recognition of the right to refuse treatment. The general approach of the *Criminal Code* is supported by the Common Law dealing with private matters. The overwhelming majority of these cases support the right of a competent adult to refuse treatment. This right is also preserved in the medical Code of Ethics and recognized in the hospital patients' bill of rights.

20. For a discussion of analogous considerations, see H.T. Howell, R.J. Diamond, and D. Wikler, "Is there a Case for Voluntary Commitment?" in T.L. Beauchamp and L. Walters, *Contemporary Issues in Bioethics* (Wadsworth, 1982) at 163-168, esp. at 165. We adopt the concept of a "Ulysses contract" here proposed as extended to include not simply acceptance of treatment when incompetent in the future, but also refusal. See also Rebecca Dresser, "Bound to Treatment: The Ulysses Contract" (1984), 14 *The Hastings Center Report* 13-16.

21. Working Paper 43 at 19. See also D.F. Greenberg, "Interference With a Suicide Attempt" (1974), 49 *New York University Law Review* at 227-229. While Greenberg recommends initial interference, he argues that the choice of death may not be irrational and evidence of incompetence and therefore limits the restraint to a time period not exceeding 24 hours. See also R.B. Brandt, "The Morality and Rationality of Suicide", in S. Perlin, ed. *A Handbook for the Study of Suicide* (Oxford University Press, 1975).

22. *Matter of Quinlan*, 305A. (2d) 647, 70N.J. 10355A (2d) 647 (N.J.1976), N.E. (2d) 918 (1972).

23. *Matter of Welfare of Colyer*, 660 P.(2d) 735 (Supreme Court of Washington 1983)

never be taken to imply the complete deprivation of the person's right, and more specifically, the person's right to refuse treatment."²⁴ If the Commission insisted that the wish of an episodic patient that he not be treated (expressed when competent) need not be honoured when he is incompetent, then it would be guilty of contradicting just that injunction. Either that, or we should have to assume that the Commission holds as a matter of general policy that the dispositions of a competent person are effective only for as long as the person is competent. The whole concept of prior determination would then lose all relevance. It is difficult to see which of these alternatives is the less defensible.²⁵

IV. *The Analogy of Emergency*

The emergency ward analogy itself is also beset with problems. While it may hold for the incompetent psychotic without a readily available history who is brought in for the first time, it is inappropriate both for the patient who has been institutionalized before or for whom there is a readily available history, as well as for the episodic patient whose episodes are known. In all of these cases there is an available fund of data that the health care professional can draw on, even in case of an emergency. In case of the episodic patient there is even an element of predictability. Unlike the highway accident case, the occurrence of the emergency itself is neither unique nor unexpected. In fact, the professional can prepare for the eventuality by eliciting the wishes of the patient while he is competent as to what should be done with him were he to become incompetent once again. Failure to do so would actually constitute an omission that denied the autonomy of the patient, and ethically speaking would amount to unprofessional conduct.

The point can be argued somewhat differently by focusing on the concept of emergency itself. We can distinguish two kinds of emergencies:²⁶ those that require an immediate response but whose occurrences, either as to onset or as to particular nature, are unforeseen and unforeseeable;²⁷ and those that require an immediate response but

24. Working Paper 43, at 36.

25. For a brief analysis of different views, see Ellen Picard, *Legal Liability of Doctors and Hospitals in Canada* (Toronto: The Carswell Company Ltd., 1978), at 69-70; and Law Reform Commission of Canada Working Paper 26, *Medical Treatment and the Criminal Law* (Ottawa: Supply and Services, 1980).

26. For an analysis involving further distinctions, see J.E. Magnet and E.W. Kluge, *Withholding Treatment from Defective Newborn Children* (Brown Legal Publications, 1985), at 163-164.

27. The two are logically distinct (see note 26, *supra*); but the distinction here makes no real difference if we assume reasonable care.

whose occurrences can in fact be reasonably foreseen. The emergency ward situation envisioned by the Commission in its analogy is, *ceteris paribus*, of the former variety; the case of the episodic psychotic (or of the patient, who, although institutionalized, is not wholly incompetent although progressing in that direction)²⁸ is of the latter. While the doctrine of emergency applies to instances of the first sort, it does not apply to examples of the second. The distinguishing feature — the inherent inability to obtain a prior competent consent — is missing.

The very nature of behaviour modification itself entails that the relevant therapy cannot be an emergency situation response. By definition, an emergency action is an action whose primary purpose is to ameliorate those parameters that require immediate attention so that more measured steps can be taken. Its primary purpose is to buy time, so that the situation itself can be appropriately attacked at its causative roots. Even where the emergency action and the long-term treatment are materially the same, this time-buying purpose is primary. What characterizes the situation as emergency is that time is of the essence.

By its very nature, therefore, an emergency treatment cannot be protracted or involve separate sessions with time intervening. That, however, is precisely what characterizes the temporal framework of behaviour alteration techniques. Psychiatric and behaviour therapy, electroconvulsive therapy and electrical stimulation of the brain — even psychosurgery — all either require extended time in their planning and execution or involve a protracted and temporally separated series of treatments. Even drug therapy is no exception. While behaviour-altering drugs can be administered on an emergency basis, they will have the desired behaviour-altering effect only when they are part of an extended course of treatment. This removes them from the realm of emergency ministrations. In all of these cases, therefore, there will be time to determine whether the patient, when competent, has previously expressed any relevant wishes; or, failing that, time to engage the proxy decision-making machinery that is otherwise considered appropriate in the case of incompetent persons. The comparison to the highway accident victim who arrives in the emergency ward, therefore, fails even from the side of the action.

V. *The Vitalistic Presumption*

The fact that time is not of the essence in the employment of these procedures entails another point of difficulty: the claim that the

28. In other words, a patient who is progressively deteriorating in mental capability and acuity.

presumption must be in favour of life and health cannot here be upheld in quite as absolute a fashion as the Commission contends.

By itself of course, as a procedural maxim where all other things are equal, the principle holds; and the actions it mandates must be pursued with full force. However, what is covered by the *ceteris paribus* clause is a series of assumptions: that time is of the essence, that there are no known (or reasonably knowable) prior determinations of a competent nature, and that there is no expectation that the quality of life to be faced by the patient as a result of the procedure will be unacceptably low, so low as to constitute what in the words of one commentator amounts to an "injury of continued existence".²⁹

It is the quality-of-life parameter that is the problem. It is universally agreed that a competent decision-maker may reasonably appeal to such considerations to defend the acceptability of a particular decision, either for or against a medical treatment.³⁰ In the case of the episodic incompetent patient, of course, and especially in the case of the episodic incompetent who either did not or could not engage in such considerations, such a reasoning process will not obtain. It is here that the proxy decision-maker must step in. Acting, as it were, in *statu personae*, he must engage in the relevant decision-making process for the patient, lest the patient lose his rights because of his handicap.

The Commission has gone on record in defence of the proposition that the rights of the incompetent must not be less than the rights of the competent solely because of his incompetence. In the present context this means that the decision-making process of the proxy decision-maker must not differ from that of the competent person to such a degree that the right of the incompetent is in fact lessened. This, however, entails two conclusions. *First*, as to the case of the episodically incompetent whose value-system when competent is known, it entails that the proxy decision-maker must employ these values when attempting to arrive at a decision. There must be no attempt either to ignore or to subvert them simply because they disagree with those of the rest of the society or the proxy decision-maker himself. *Second*, for the case of the episodically incompetent whose value-system is not known, it entails that the proxy

29. H.T. Engelhardt, Jr., "Euthanasia and Children: The Injury of Continued Existence" (1973), 83 *Journal of Pediatrics* 170.

30. Law Reform Commission of Canada Report 20, *Euthanasia, Aiding Suicide and Cessation of Treatment* (Ottawa, 1983) at 12:

A third principle which any reform proposal should acknowledge is that human life should be considered not only from the "quantitative" perspective, but also from the "qualitative" perspective. When patients freely choose to refuse treatment, their choice is often based upon quality-of-life considerations.

decision-maker must attempt to elicit it through consideration of the pattern of previous decision and actions. When that fails he must employ those values that are normally adopted by the reasonable person in society, and must reach a decision on that basis — even if it disagrees with his own personal predilections.³¹ In this last sort of case in particular, the considerations will usually involve quality-of-life parameters simply because these are usually addressed by the reasonable person when evaluating serious medical alternatives. Finally, it entails that the proxy decision-maker must survey the whole range of decision options that are otherwise open to the competent person. That means that the option of non-treatment must not be foreclosed *a priori*.

“The presumption must be in favour of life.” Indeed, but it is a rebuttable presumption; and what is more, it is a presumption which, given the available time-frame in each instance, must in fact be examined. Failure to do so, and refraining from doing so as a matter of principle, would constitute the height of discrimination.

VI. *The Congenitally Incompetent Patient*

The preceding considerations, which centre on the possibility/fact of a previous and competent determination, clearly do not apply to the congenitally incompetent.³² *Ex hypothesi*, there is no previous competent behaviour pattern from which a value-system could be elicited, nor is there a previous competent determination that must now be applied. It is tempting, therefore, to argue that here the Commission’s reasoning applies with full force, that here the presumption must be in favour of treatment because this alone would reflect the current social and legal inclination in favour of life and health.

Such an argument would have a point, but once again, it would not hold absolutely. There would still be conditions. These would focus on the requirements that hold, both ethically and legally, for a proxy decision-maker as such. To be more specific, it is agreed on all hands that the proxy decision-maker, whoever he may happen to be,³³ must evaluate

31. Cf. *Natanson v. Kline*, 186 Kansas 393, 350 P.(2d) 1093, cert. den. 187 Kansas. 186, 354, P.(2d) 670 (1960); *Cobb v. Grant*, 8 Cal. (3d) 229, 502 P.(2d) 1, 107 Cal. Rep. 505 (1972).

32. We are here considering the congenitally incompetent who is so incapacitated that, in the Commission’s words, he is “always incapable of giving valid consent”; and what is more, is conceptually so limited that no relevant opinion or preference can reasonably be elicited either from his actions or his words, if they exist at all. Those congenitally incompetent who do not fall under this severe rubric must be considered on a special case-by-case basis. This also includes the episodically incompetent who has made no prior determination and whose values cannot be determined from his prior *habitus*.

33. For an extended discussion of the ethics of proxy decision-making, see Magnet and Kluge (1985), *supra*, note 26, Chapter Two: I & II and Chapter Three: III.

and choose among alternative courses of action not haphazardly or on the basis of whim, but reasonably — on the basis of criteria and values. It is also agreed that these latter must not be idiosyncratic to the proxy decision-maker himself, reflective only of his own particular stance. After all, there is no guarantee that the latter will be consonant with the prevailing standards of society, in which case the incompetent, were he to be served in this fashion, might well become the victim of circumstance. He would be penalized for his bad fortune of having been assigned this particular proxy. Instead, the proxy decision-maker must decide on the basis of criteria and of values that embody the standards adhered to by the reasonable person under those conditions.³⁴

This, however, once again undercuts the absolutistic stance of the Commission. Specifically, it means that here, too, the option of non-treatment cannot be ruled out on an *a priori* basis, nor can quality-of-life considerations be deemed irrelevant. Consequently, it may well happen that from this reasonable-person perspective, which includes quality-of-life considerations that trade appreciably lowered intellectual acumen, flattened effect, reduced capability for social interaction and no great likelihood of cure for the patient against greater manageability of the patient for the health-care professional, the option of non-treatment is the only acceptable choice.³⁵

This is not to say that non-treatment is always the reasonable choice, or, for that matter, that it is the reasonable choice in the preponderance of cases. It is merely to say that the options must be evaluated independently and anew on each occasion and that the Commission's blanket injunction cannot be supported as a matter of rule. The proxy decision-maker must look and see. Otherwise what has almost universally been condemned in other health-care contexts may well occur here: treatment without regard for the rights of the individual, and without due consideration of quality of life.

VII. *The Criminal Context*

The Commission's recommendations concerning the criminal context present another array of difficulties, both as to consistency with the Commission's overall position as well as with respect to ethical tenability.

34. Here arises another problem. How far may/must a proxy decision-maker go in order that his decision be so reflective? What if the societal norm of reasonableness is in fact ethically reprehensible? We shall not address the issue here.

35. This would be in keeping with the criteria for life-saving intervention proposed by A.R. Jonsen, R.H. Phibbs, W.W. Tooley and M.J. Garlan, "Critical Issues in Newborn Intensive Care: A Conference Report and Policy Proposal" (1975), 55 *Pediatrics* 760. See also R. Veatch, *Death, Dying, and the Biological Revolution: Our Last Quest for Responsibility* (Yale, 1976) at 122-144.

As was mentioned at the outset, the Commission asserts the supreme right of the individual, even when sentenced and incarcerated, to complete self-determination in matters medical. Psychiatric treatment is not excluded: "Except in cases of emergency, or when the individual is completely unable to give consent, psychiatric treatment should not be undertaken without the patient's express authorization".³⁶ But how is this to be reconciled with the very acceptance of court-imposed treatment for convicted offenders? It would seem scarcely plausible to suggest that in such cases the offender has voluntarily (and competently) agreed to the relevant course of treatment independently of and prior to the judicial order; and that the latter constitutes no more than a judicial note-taking of a decision reached independently by the offender.

But even outside of the sentencing context, there is the question of voluntariness, of the uncoerced acceptance of behaviour modification treatment by the prisoner while in the prison setting. The genuineness of such a decision can be and has been questioned. The classic statement of this is the U.S. case of *Kaimowitz v. Department of Mental Health*.³⁷ The thrust of that decision was that the freedom-impairing parameters operative in the prison setting are so pervasive and so severe that as a matter of principle, despite the prisoner's avowed consent and despite scientific scrutiny, the voluntariness of such a decision cannot be established with sufficient degree of certitude.

The Commission is not unaware of this case. In fact, it takes explicit cognizance of it, only to reject it: "This position . . . appears to us too extreme . . . It is difficult to generalize and to conclude that a person incarcerated is thereby always incapable of giving valid consent. . . . In the Commission's view, the mere existence of difficulties relating to a prisoner's consent is not sufficient reason for systematically eliminating psychological treatment programmes from the institutional *milieu*".³⁸

This stance is consistent with the Commission's earlier expressions on the subject, *viz.* its Working Paper 26, *Medical Treatment and the Criminal Law*.³⁹ While the Commission acknowledged that "more subtle coercion exists in the treatment environment such as . . . the institutional setting, and the influence of other patients and staff,"⁴⁰ it refused to deny the impossibility of truly voluntary acceptance. In a similar fashion Margaret Somerville, in a Study Paper prepared for the Commission,

36. Working Paper 43, at 43.

37. *Kaimowitz v. Department of Mental Health*, 42 U.S.L.W. 2063 (Cir. Ct. Wayne County, Michigan, 1973).

38. Working Paper 43 at 30.

39. See note 17, *supra*.

40. Working Paper 26 at 66.

Consent to Medical Care,⁴¹ highlights the dangers but does not rule out voluntary consent. She merely sounds a severe warning: "The coercive factors which have been identified in prison life are multiple, and the very fact of institutionalization may lead to an inability to make decisions and a dependence on those in authority"⁴² (in a word, what is sometimes called extreme compliance, or the Stockholm Syndrome⁴³).

However, contrary to the impression that may be fostered by these sober reflections, *Kaimowitz* is not a panic phenomenon nor does it stand alone. Its most prestigious support comes from the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research which, in 1977,⁴⁴ in a Report to the President of the U.S., Congress and H.E.W., recommended that:

Because institutionalized persons may be vulnerable as a consequence of their disability or the dependence and depersonalization which often results from confinement, the [Institutional Review Board] should scrutinize with care the consent of such persons to determine whether it is adequate. If the I.R.B. has good reason to believe a patient is unable to give consent to psychosurgery, the provisions of Recommendation (3) will apply.

Recommendation (3) A psychosurgical procedure should not be permitted on an adult patient who (i) is a prisoner, (ii) is involuntarily committed to a mental institution, (iii) has a legal guardian of the person, or (iv) is believed by the Institutional Review Board (I.R.B.) to be incapable of giving informed consent to such procedure, unless all of the following conditions are satisfied. (A) A national psychosurgery advisory board has determined that the specific psychosurgical procedure has demonstrable benefit for the treatment of an individual with the psychiatric symptom or disorder of the patient; . . . (C) The conditions of recommendation (2) are fulfilled at the institution where the operation is to be performed, and such institution is separate from any prison or institution where the patient is regularly confined; (D) The patient has given informed consent or, if the patient is believed by the I.R.B. to be incapable of giving informed consent, the patient's guardian of the person has given informed consent and the patient does not object; and (E) A court in which the patient had legal representation has approved the performance of the operation.

While this does not go as far as *Kaimowitz*, it goes very much further than the Commission. Furthermore, the Commission might do well to consider more seriously a remark made by Professor Somerville:⁴⁵

41. Margaret Somerville, *Consent to Medical Care*, Study Paper for the Law Reform Commission of Canada (Ottawa, 1980).

42. *Id.*, at 101.

43. The usual health care term is "extreme compliance". See also G. Bach-y-Rita, "The Prisoner as an Experimental Subject" (1974), 229 J.A.M.A. 45 *et pass*.

44. DHEW Publication No. (OS) 77-0001.

45. Somerville, *supra*, note 41 at 181.

Loss of freedom of choice of his physician may have a coercive effect apart from that represented by loss of this liberty itself. If the treating physician is seen by the prisoner as part of the prison institution, because the physician is chosen or employed by the prison, the prisoner may feel compelled to consent to recommended treatment, for fear of receiving a "bad mark", or an unfavourable medical report, which may count against him in such matters as parole decisions.

The freedom-impairing parameters in the prison setting are overwhelming:⁴⁶ not simply the fact of physical confinement — although that should not be underestimated⁴⁷ — but the fact that the offender finds himself in a setting where his contact with the professional is not on a personal level but on a plane where the professional operates as the embodiment of the profession itself. Each such individual enters upon the scene as part of an organized administrative framework, having a specific status, wielding certain powers, and playing a specific role. Whatever the offender's relationship with these officials otherwise may be, in this setting it is defined by the role that the professionals play. They are representatives and embodiments of their professions, and what is more, it is as officials that they suggest, advise or counsel, with the full weight of profession and institution behind them. That fact is recognized in *Kaimowitz*, and forms the basis of *Therens*⁴⁸ and *Dedman*.⁴⁹

The Commission attempts to blunt the edge of these considerations by drawing a comparison to the pressures operative in the ordinary physician/patient relationship in the usual hospital setting: "In the usual hospital setting, a patient may be in a somewhat similar situation when the doctor explains that a cure to a certain illness cannot be achieved unless he consents to a particular operation."⁵⁰ This comparison, however, fails on several counts. First, the types of pressures that are operative are entirely different in nature. The physician/patient pressure in the usual hospital setting can be described as paternalistic. While the patient may feel pressured, his perception of that pressure includes the integral and indeed fundamental presumption that the physician's recommendations are motivated solely by considerations of what is in the best interest of the patient himself. This is not true in the prison setting. The type of pressure that is operative here is better described as coercive.

46. We have not focussed on the question whether prisoner's consent is, or can be, truly informed. For studies on this, see Somerville, *supra*, note 41, at 100; and D.C. Martin, J.D. Arnold, T.F. Zimmerman, R.H. Richart, "Human Subjects in Clinical Research — A Report of Three Studies" (1968), 279 N.E.J.M. 1426.

47. Cf. Somerville, *supra*, note 46, at 181 note 656.

48. *R. v. Therens*, [1983] 33 C.R. (3rd) 204.

49. *R. v. Dedman*, [1980] 15 C.R. (3rd) 261.

50. Working Paper 43 at 30-31.

The offender feels compelled to accede to the recommendations because of the fear that refusal to do so will have punitive repercussions. Second, in the hospital setting there is an immediate and causal connection between treatment and discharge. The Commission itself repudiates any similar connection between acceptance of treatment and length/fact of sentence. The rationale for the pressure, therefore, is entirely different.

Finally, the comparison between the two kinds of settings is itself wide of the mark. In the first place, the patient usually enters the hospital voluntarily and deliberately. He voluntarily and deliberately puts himself into a situation where he knows that he will be presented with a more or less limited range of options. He also knows that in order to attain the goal for which he entered this setting he will have to choose from this limited range. In other words, it is a purposive delimitation defined by the goals of the patient, and the patient himself ultimately controls the fact of choice by voluntarily entering the setting. By contrast, the institutionalized offender finds himself in an entirely different situation. *Ceteris paribus*, he has not voluntarily, deliberately and purposefully entered the setting. Nor, consequently, is the necessity of choice a fact of his own choosing. The entire framework of choice, therefore, quite irrespective of the number of available options, is quite different; and the types of pressures that are operative — to say nothing about their intensity — are of a different order from those that obtain in the usual hospital setting. Second, the patient is not locked into the hospital setting. In principal at least, he has the right to discharge himself without availing himself of any of the choices that are offered. Therefore while it is undoubtedly true that “the patient’s choice is . . . limited and the pressure on him can be very powerful”⁵¹ he may always escape it by leaving. The general and overall freedom-impairing parameter that defines the criminal institutional context is therefore missing. This lends an entirely different air to the situation.

VIII. *Non-Consensual Imposition*

As for the non-consensual imposition of treatment by way of sentencing, the matter is still different. The Commission does not reject such an imposition as unethical. In its concluding paragraph it “recalls one of its recommendations made in 1976 which argued for the introduction of hospital orders into our law. Whatever the technical modalities, this reform should allow a court to order a prisoner to serve part of his sentence in a hospital so that he may receive needed psychiatric treatment.”⁵²

51. *Id.*, at 31.

52. *Id.*, at 43.

This recommendation does not become less problematic for having been made before. Then as now, it stands in flagrant opposition to the Commission's own injunction, restated explicitly here, that "psychiatric treatment should never be undertaken without the patient's express authorization".⁵³ Are we to assume, then, that incarceration *ipso facto* renders the offender incompetent, leaves the courts in the role of proxy decision-maker and that the order constitutes judicial proxy authorization? It is difficult to conceive of any relevant supportive reasoning for such a contention, especially as the Commission itself is unwilling to tie incompetence to incarceration.⁵⁴

Or are we to assume that the fact of an order itself changes the mind of the prisoner so that he now — sometimes despite his overt protestations — voluntarily and competently agrees to what he rejected before? Somehow, that does not seem quite persuasive, to say nothing about the fact that it recalls our previous considerations about the freedom-impairing effect of authority and institutionalization.

Or are we to understand that the prisoner voluntarily and competently agrees to such an order, once made, because it would go to the extent and nature of his sentence? That would be to make "a direct link between sentencing and psychiatric treatment" in the very fashion the Commission condemns.⁵⁵

Finally, it should be noted that aside from all else, the point of the Commission's very advocacy of court-imposed treatment contradicts its injunctions that "treatment should . . . never be indirectly imposed."⁵⁶ Surely the point here is not that direct imposition, by contrast, is ethically acceptable. Or does the Commission wish to defend an ethics that prohibits the indirect violation of individual autonomy but that approves of the direct? Or have we wholly misunderstood its position? Does the Commission really have in mind the thesis that judicial *fiat* can turn something that is unethical *per se* into something that is ethically acceptable? Does the sentence determine the ethics — or the ethics the sentence?

IX. *Benefit v. Right*

If we step back from the details of the Commission's reasoning, we are struck by its extreme ambivalence even in the matter of rights. On the

53. *Id.*

54. This follows from two facts. First, The Commission is unwilling to accept the thesis that voluntary consent is not possible in the prison setting, as *viz.* its rejection of *Kaimowitz*; second it rejects the thesis that truly informed consent is not possible, as *viz. id.* at 24, 30-31, *et pass.*

55. *Id.*, at 42. *See also* pp. 31 and 33.

56. *Id.*, at 31.

one hand, the Commission insists on the primacy of individual autonomy; on the other, it contends that the benefit that non-consensual treatment may have for the whole of society may be an overriding consideration⁵⁷. It is, of course, traditional and entirely appropriate to argue that the exercise of individual autonomy may legitimately be limited by considerations of social justice and the rights of others. Such an argument, however, is fundamentally distinct from one that centres on benefit. It focuses on the interplay of rights. Therefore, in order to reconcile these two disparate strands, the Commission would have to show that the failure to order behaviour-alteration treatment (and an offender's refusal to accept it) and the concomitant failure to bring about what is of maximal social benefit in fact constitutes an unjustified infringement on the rights of others taken either individually or as a group. Again, we face a probative *lacuna*.

There exists the possibility that this is not really the core of the Commission's reasoning with respect to rights. It is possible that what the Commission is really arguing is that the socially unacceptable behaviour of the convicted offender has reduced the strength of his right to autonomy to such a degree that society's right to safety and protection takes precedence; that, consequently, treatment is ethically mandated and therefore may be imposed by way of sentence to correct an existing medical problem which gave rise to the infringement of the rights of others in the first instance. Non-consensual treatment by way of sentence therefore, so the Commission may be arguing, is mandated not as a matter of maximal social benefit but as a function of greater rights.

As a defense, however, this, too, would fail, and for reasons that take us to the very heart of the issue of court-imposed psychiatric treatment. The question of whose right takes priority is certainly important, and all other things being equal, may well decide the issue. However, before it can even be raised we must resolve the question whether it is ethically appropriate to proceed by way of sentence in the first instance. Is the act of the offender the result of a medical condition that is psychiatric in nature, or is it the outcome of an ethically reprehensible stance on part of the offender? If the former, then the very fact that we are dealing with a medical condition that has causative impact on the individual's behaviour would rule out any presumption of competence on the part of the offender and with it any ascription of guilt. The fact that we should be dealing with a medical condition would, ethically, mandate a diversion from the judicial process and make medical treatment appropriate — in this case, psychiatric. By that very token, however, it would be morally

57. Cf. *id.*, at 15-16, 42, *et pass.*

unacceptable to impose such treatment by way of sentence, in utter disregard of the ethical principles that govern medical treatment *per se*. The only legitimate way in which the courts could here become involved would be in the role of proxy decision-makers or as guarantors of the rights/obligations of the patient; in other words, in the very same way in which they become involved in other medical cases. This, however, would place the whole situation on an entirely different footing from the one adopted by the Commission.

On the other hand, if the act is a result/expression of an ethically reprehensible outlook or decision on part of the offender, then these considerations will not apply. The criminal process will be entirely appropriate and sentencing will be the correct way to proceed. However, this would still not legitimate the imposition of psychiatric treatment by way of sentencing. The reason lies in the nature and role of medicine. As the Commission repeatedly avers, while medicine in general and treatment in particular fulfill a social *function* in that they are designed to meet legitimate health care needs, they are not intended as instruments of social *reform*.⁵⁸ To use them in that fashion would be to pervert their very nature, and the ethics of the medical profession. To impose medical behaviour alteration therapy by way of sentence, however, would be to do just that. Consequently, while behaviour alteration treatment may be effective in producing certain socially very desirable results, to impose it through sentencing would be to turn the physician into a jailer.

The point is worth restating from a different perspective; that of the function of sentencing and of incarceration. There is a fatal procedural flaw in the Commission's overall approach. The Commission never addresses the question of the purpose of sentencing and incarceration. That issue, however, is crucially implicated. Whatever the ultimate outcome of the debate over the issue may be, we can identify four major functions: to provide retribution, to protect society, to serve as an example, and to reform the offender. It may be that, ultimately, an element of all four is involved. However, no matter which of them is highlighted or which one is considered central, the actual expression of such a function in terms of legal action must not stand in conflict with the fundamental presumption of Anglo-American law: the principle of autonomy. The individual person is assumed to be an autonomous decision-maker, an independent moral agent; and although the *expression* of that autonomy may not amount to licence — it may be

58. Cf. *id.*, at 17, 28-33, esp. pp. 29. We find the Commission's own words of supreme importance: "... society should also question its motives when it attempts to use them as a methods of social control." (at 29).

curtailed when it interferes with the legitimate rights of others — the *fact* of autonomy, the nature of the individual as moral agent, may not be abridged.⁵⁹

That is to say, none of the four functions just mentioned by themselves violate the principle of autonomy. However, there are certain kinds of material acts which, even when considered as expressions of these legitimate functions, do have that effect — namely, those that interfere with the basis of the individual's autonomy as rooted in his personality: in short, behaviour, alteration techniques. As their very name indicates, their *raison d'être* is to alter the behaviour that society finds unacceptable. Another way of putting this is to say that the function of behaviour modification *per se* is to make it impossible for the individual to exercise his autonomy in the direction of reprehensible acts by curtailing either his internal ability to choose such an alternative, his ability to conceptualize it, or his ability to express an action that otherwise he would still choose.⁶⁰ The special feature of medical behaviour modification is that it attempts to effect this by an interference with the physiological basis of the individual's personality and behaviour. Consequently, it is an interference with and sometimes even a total abrogation of the basis of the individual's autonomy. In that sense, and to that degree, it is fundamentally at variance with the purpose of sentencing and the fundamental principle of Anglo-American law. The function of sentencing and incarceration can never be to produce individuals who automatically and without genuine choice do what is socially acceptable.⁶¹ That would be to confuse the desirability of properly programmed automata with the value of moral beings. Instead, it is to encourage the adoption of a morally praiseworthy — which is to say, competently and voluntarily adopted — ethical stance. That may not

59. To quote the Commission itself: "The notion of personal autonomy is fundamental." (at 15). While the Commission argues that "The legislator may sometimes, in the name of public good or of the related rights of others, limit or restrict it to varying degrees" (at 16), "sanctions applied for breaching the law do not in principle go so far as to completely suppress freedom of choice" (at 29) and a society that subverts that is deemed ethically remiss.

60. Or, of course, a combination of these. The Commission itself explicitly rejects this in section III, "The Use of Behaviour Alteration Techniques as a Sanction or Method of Social Control Within the Context of Criminal Law", esp. at 28-29. Unfortunately, the Commission's treatment of the issues involved here is far too brief.

61. Cf. Report of the Canadian Sentencing Commission, *Sentencing Reform: A Canadian Approach* (Ottawa, 1987), which insists on the "principles of fundamental justice" as constituting the governing parameters of all sentencing, and sees a primary purpose of sentencing to be "promoting a *sense of responsibility* on part of offenders" (at 155, emphasis added). It is in this sense that we are to understand the statement that "The fundamental purpose of sentencing is to preserve the authority of and promote respect for the law through the imposition of just sanctions."

always be possible. The principle of autonomy, however, requires that the ideal of moral responsibility cannot be sacrificed to the expediency of acceptable action. Genuine autonomy entails that the possibility of evil must always be open. The desideratum of having a citizenry who does what is acceptable cannot, therefore, be achieved by turning those very citizens into ethical eunuchs.⁶²

Does this mean that a prisoner can never be the subject of behaviour modification therapy? To answer unqualifiedly in the affirmative would be to miss the whole point of the focus on autonomy. It depends on whether being subjected to such therapy, voluntarily, is ethically appropriate for someone who is not incarcerated. After all, being guilty, ethically as well as legally, and being incarcerated are not medical conditions. It does not, therefore, call for medical treatment, whether that be agreed to *in propria persona* or by proxy.

At the same time, however, this does not mean that the prisoner has no medical needs at all, or that some of these may not be psychiatric. The real question is, would participation in such a regimen, when agreed to voluntarily as a matter of purely medical concern and without involvement of the courts or of the judicial process, constitute an injury to a *bona fide* patient? If the answer is yes, then it may not be offered in the prison setting either. That setting, after all, does not alter the fact of injury should it otherwise obtain.

Non-injury in the ordinary setting, therefore, is a necessary condition. Is it sufficient? Our previous discussion suggests two considerations. First, if the condition for which the treatment is prescribed is one for which it is otherwise considered appropriate, and if, furthermore, it has nothing to do with the reason why the individual is incarcerated, then in principle there can be no objection, provided, of course, that the strict requirements of voluntary, informed and competent consent have been met.⁶³ An example would be treatment that is intended for and appropriate to pedophilia, whereas the prisoner is serving a sentence for grand larceny but has, of his own free will and initiative, requested the treatment in question.

Second, if the treatment in question is supposed to alter/eliminate the sort of activity that is the reason for the incarceration itself, then it may not ethically be offered to the prisoner while incarcerated even if it is demonstrably effective. The freedom-impairing parameters on which we

62. The Commission appears to favour a citizenry that is *able* to do evil — free in a moral sense, but unwilling to do so as *viz.* pp. 28-29. It never really comes to grips with the question of how this stance is compatible with non-consensual imposition of behaviour alteration.

63. This is not to imply that we reserve our earlier stand on the subject. It is merely the examination of a logical possibility.

have already focussed are far too powerful. However, this does not mean that they may not be offered at all. Once the prisoner has served his sentence they should be made available to him as a way of allowing him a means of achieving freedom from recidivism. In other words, they should be offered to him in the same way in which other non-therapeutic medical techniques are made available to ordinary citizens as medical techniques whose purpose is to allow the individual greater control over his own life by limiting the material expression of certain functions.⁶⁴ Voluntary sterilization may serve as a model in this regard, as may voluntary acceptance of antiabuse treatment. It will be clear that the offer of any such service must be free from and entirely independent of any involvement by the judiciary or the correctional services, and that it may not fall under their aegis. The only way in which the judiciary may be associated is in the very same manner in which it is involved in providing other medical services — as an agency of government that monitors the legality of medical services *per se*.

X. Conclusion

It would be ludicrous to assume that our discussion has touched on, let alone dealt adequately with, all of the issues that are raised by *Behaviour Alteration*.⁶⁵ Nor have we addressed the question of the consistency of the Commission's overall ethical stance. For instance, the Commission vacillates between benefit and rights considerations: between a utilitarian and a deontological perspective. This issue is of particular importance because of the ethical inconsistencies that result on particular points. We have picked up on some of these. In fact, if we were to look for a single cause of the majority of problems that we have discussed, we should locate it in the lack of consistency (and clarity) in the Commission's overall ethical position. To pursue the matter here, however, would go too far.

At the same time, to conclude without giving praise where praise is due would be misleading and unfair. The Commission's final call for the drafting of a code of ethics governing medical treatment in the prison

64. See Working Paper 26 at 57 *et pass.*, with respect to voluntary sterilization. The concept of a Ulysses contract is also relevant here. See also note 13, *supra*.

65. For instance, we have not dealt with the Commission's conception of competence, which plays such a crucial role in these matters. Following its earlier lead (Working Paper 26, esp. at 59., 67., *et pass.*), the Commission characterizes it as an essentially cognitive matter (Working Paper 43, at 19-24). We consider this a mistake. Competence is a multimodal affair that also involves emotive, mnemonic and valuational parameters. We also have not dealt with its position on the nature and justification of punishment, or its claim that behaviour alteration does not threaten individual autonomy (at 16), to mention but a few issues.

setting is to be commended. To this should be added institutional ethics committees to serve as guiding forces in the implementation of such a code. The ethics committees currently being set up in the hospital sector might here serve as guidelines.⁶⁶

66. Such a committee typically includes an administrator, a lawyer, a physician, a nurse, a handicapped person, an ordinary citizen, and someone trained in ethics. Suitably adjusted to the prison setting, a committee could include an administrative official, a lawyer, a psychiatrist, a psychiatric nurse, a former inmate, an ethicist, and someone from the public at large.