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Issues in Bioethics: advance directives in a Canadian-Croatian Perspective

“Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny.”
(Dworkin)¹

ABSTRACT:

The author gives an overview of the Canadian development and application of advance directives, a relatively young type of legal documents aimed at medical self-determination of patients anticipating their decisional incompetence. By reviewing their legal history in Canada, from their recognition in jurisprudence through application of common law principles, and across reception of such case-law in provincial legislations, the author identifies possible lessons for Croatia. In that regard, she discusses the extent of patient's consent in Croatia, as well as the possibility of developing advance directives as instruments legally accessible to terminal patients. By analyzing the jurisprudence of the European Court of Human Rights and Council of Europe documents, she argues Croatia already has a legal frame in place for such a development.

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¹ Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom*, Vintage Books (Vintage Series), Knopf Doubleday Publishing Group, 1994; p.217.

1. Advance directives:

A traditional view of physician-patient relationship has been a paternalistic one: “the doctor knows best”². European cultures traditionally tolerate a more parental role for physicians, while the North American population is “strongly impregnated by a culture of autonomy”³. Today prevalent is the approach of patient’s right to self-determination and informed consent⁴, promoting respect for the patient as a human being. This approach warrants that every medical procedure be based on assent of the patient, and has led to the development of a new legal instrument: an “**advance directive**” (AD). Increasingly, ADs are seen as facilitating discussions between patients and their families, and as providing guidance and support for substitute decision-makers regarding life-sustaining treatment⁵. There are two kinds of ADs: “living wills” and “power of attorney for health care”⁶. Living wills are classified as “instructional directives”⁷, where an individual sets out *what types* of treatment (s)he does or doesn’t want in the event that (s)he becomes incompetent. Powers of attorney are frequently called “proxy directives”, where the individual sets out *who* is to make health care decisions on his or her behalf⁸.

² Ksenija Turković, Informirani pristanak i pravo na odbijanje tretmana u RH (Informed consent and the right to refuse treatment in the Republic of Croatia), Dani bioetike na Medicinskom fakultetu u Rijeci, 9. Bioetički okrugli stol, Tema: Bioetika i medicinsko pravo, Rijeka, svibanj 2008.; (predavanje dostupno na www.pravo.hr/download/repository/NN_Pristanak-Turkovic.doc); str.1. “A physician can determine what is medically the best decision, but...it is but only one component, along with psychological, social, legal, religious, aesthetic, business and other [components], that only in conjunction make up the total of a patient’s interest” – *Ibid.*, str. 6.

³ Y.-L.C. Nguyen, F.B. Mayr, D.C. Angus, End-of-life Care in the ICU: Commonalities and Differences between North America and Europe, in: J.-L. Vincent (ed.), Yearbook of Intensive Care and Emergency Medicine Springer, 2010; p. 562-564. In 2001, a French study showed that all decisions to withhold or withdraw life sustaining treatments were made either by the medical staff or by the medical and nursing staff. Little importance was accorded either to a patient’s wishes or perception of his or her quality of life. Also, a European survey showed that end-of-life decisions were made entirely by the intensivist in Italy, Greece and Portugal (p.564). There was also a large variation across countries in the rate of transparent decisions for do-not-resuscitate orders: from 8% in Italy to 91% in the Netherlands (*ibid.*).

⁴ A right to “co-decision” according to Art.6 of the Croatian Law on the Protection of Patients’ Rights encompasses a patient’s right to be informed and accept or refuse a particular diagnostic or therapeutic procedure. (Official Gazette no. 169/04)

⁵ Marlisa Tiedemann, Dominique Valiquet, Law and Government Division, Euthanasia and assisted suicide in Canada, revised July 17, 2008; Background and analysis –(B) Legal Issues, 5. Advance Directives; document at: <http://www2.parl.gc.ca/content/LOP/ResearchPublications/919-e.htm#5advance>.

⁶ Steering Committee on Bioethics (CDBI), 35th meeting, Strasbourg, “The previously expressed wishes relating to health care: Common principles and differing rules in national legal systems” (Report prepared by Prof. Roberto Andorno), 2008; p.4. http://www.coe.int/t/dg3/healthbioethic/activities/09_euthanasia/CDBI_2008_29%20Andorno%20e.pdf (27.10.2010)

⁷ Marlisa Tiedemann, Dominique Valiquet, Euthanasia and assisted suicide in Canada (see fn.5).

⁸ *Ibid.*

This paper deals with negative ADs⁹ of **terminal patients**¹⁰, for the simple reason that we do not believe in such an universal applicability in other patients: “the interventions that one would want in the event of a medical crisis depend on the effects the patient has suffered; the extent, probability, and speed of their reversibility...directives that specify what procedures one wants under what contingencies cannot be sufficiently sensitive to these factors and thus put individuals in jeopardy of getting more or less care that they would want”¹¹. For terminal patients, the need for a negative AD is made more pressing by the practice of *dysthanasia*, i.e. “therapeutic stubbornness” (*l’acharnement thérapeutique*): a futile prolongation of suffering and delay of the patient’s death by disproportionate or unbalanced medical technologies and medications¹². *Dysthanasia* tends to focus on the *quantity* of life and aims to use all possible measures to extend the life span to a maximum¹³. Contrary to *dysthanasia*, *orthoathanasia* proposes a dignified natural death, with-

⁹ I.e., ADs refusing a particular treatment. A physician who honours such ADs, and thus fails to undertake all medically available procedures (that might stay off the hour of death) is committing “passive euthanasia”. The term is somewhat misleading, as a physician is merely letting the disease take its natural course, and is not actively contributing to the dying process – Marc Groenhuijsen, *Euthanasia and the criminal justice system: General Report on the state of the art in 14 jurisdictions*, in: Marc Groenhuijsen, Floris van Laanen (eds.), *Euthanasia in International and Comparative Perspective*, Wolf Legal Publishers (WLP), Nijmegen, December 2006.; p.6-8.

¹⁰ A terminal illness is a progressive and active disease for which curative treatment is neither possible nor appropriate, and from which death is certain and can reasonably be expected within 12 months (James Rafferty, *Health care needs assessment: Second Series*, Radcliffe Publishing, 1997; p.188). Some examples are motor-neuron diseases (e.g. ALS – amyotrophic lateral sclerosis), Alzheimer’s disease (and other forms of degenerative dementia), terminal cancers (lung, pancreas, acute lymphocytic leukemia), advanced heart diseases or idiopathic pulmonary fibrosis. Final stages of dementia render a patient incapable of making medical decisions on the course of his treatment. The same is true for the end-stages of other terminal diseases, since they require analgesia or even total sedation (as measures of *palliative* care). We do not agree with a definition of terminal illness that would encompass only those few days or weeks when death is *imminent*, since such a definition would give physicians “almost exclusive right to make treatment decisions until the very end of life” – Office of Technology Assessment, *Losing a Million Minds: Confronting the Tragedy of Alzheimer’s Disease and Other Dementias*, The Minerva Group, Inc., 2002; p.190. <http://books.google.hr/books?id=Bg4a3BvxffYC&pg=PA190&lp=PA190&dq=almost+exclusive+right+to+ma> (27.10.2010)

¹¹ Negative ADs reduce those risks, as “judgments about ends tend to be more stable than those about means”, but “it is notorious that persons often dramatically revise what they’ll accept when faced with the alternative of the eternal void” – Alister Browne, Bill Sullivan, *Advance Directives in Canada*, Cambridge Quarterly of Healthcare Ethics (2006), 15, 256-260 (Special Section: International Voices 2006); See also Emily Clough, *A Critique of Advance Directives Legislation, Appeal: Review of Current Law and Law Reform* (2006) 11, 16-38: “Even instructional directives that focus on specific interventions may fail to guide a physician because not all treatment situations fit neatly into one of the anticipated scenarios”.

¹² Aleksandra Frković, *Bioetički ogledi o kvaliteti života. Pitanje distanzije i eutanazije, Socijalna ekologija Zagreb*, (2007) Vol.16, No. 2-3; str. 215. A benchmark article on medical futility concludes that a futile treatment is one that “merely preserves permanent unconsciousness or that fails to end total dependence on intensive medical care” – L. Schneiderman, N. Jecker, A. Jonsen, *Medical futility: its meaning and ethical implications*, *Annals of Internal Medicine* (1990), 112; 949-54.

¹³ Leo Pessini, *Ethical Questions Related to End-of-Life Decisions: The Brazilian Reality*, in: Robert H. Blank, Janna C. Merrick (eds.), *End-of-life decision making: a cross-national study*, MIT Press, 2005; p.19.

out active shortening of life (*euthanasia*) nor its protraction (*dysthanasia*)¹⁴. ADs are, therefore, a legal way for ensuring such a “natural death”.

2. Canadian experience:

In popular use, the term “living will” (*testament de vie*) is in Canada synonymous with advance directive or exact provincial/territorial legislation terminology¹⁵. 10% of Canadians have completed an advance directive¹⁶, a number which corresponds to the 10% who discussed their end-decisions with their family physician. Among family members, only 40% of Canadians have discussed last wishes with their next of kin¹⁷. Even though little research has been done on the implementation and use of advance directives in the Canadian health care system¹⁸, in the legal arena the stance is being clarified through court rulings and subsequent provincial legislation. The medical profession is also following these developments, so the Canadian Medical Association advises physicians to assist their patients to complete advance directives if requested to do so and to honour these directives unless there are reasonable grounds to believe that the directives no longer represent the patients’ wishes¹⁹.

The concept of individual autonomy is deeply embedded in common law²⁰, and it is by applying this uncontested principle that the jurisprudence of Canadian courts has inspired legislative change. One of the precedential cases is *Malette v. Shulman*, which opened the doors to legal recognition of living wills, i.e. gave “the green light” to physi-

¹⁴ Leo Pessini, Christian De Paul De Barchifontaine, *Ibero-American Bioethics: History and Perspectives* (Volume 106 of *Ibero-American Bioethics*), Springer, 2009; p.83.

¹⁵ Advance care planning: the Glossary Project (Final Report), prepared by Janet Dunbrack for Health Canada, (p.4). Each year more than 248,000 Canadians die – by 2020, there will be an estimated 330,000 annual deaths (*ibid.*, p.5—citing Statistics Canada, Population Projects for Canada, Provinces and Territories – 2000-2006, Catalogue 91-520, p.124).

¹⁶ Alister Browne, Bill Sullivan, *Advance Directives in Canada* (see fn.11), p.259.

¹⁷ The Glossary Project (see fn.15), p.6.

¹⁸ D. William Molloy, Christine Harrison, Martin C. Farrugia, Alwin Cunje, *The Canadian Experience with Advance Treatment Directives, Humane Medicine Health Care – A Journal of the Art and Science of Medicine - Canadian Medical Association (CMAJ)* (2009), Volume 9, Number 1.

¹⁹ CMA Policy Summary: Advance directives for resuscitation and other life-saving or sustaining measures, *Can Med Assoc J* (1992), 146: 1072A.

²⁰ See e.g. Supreme Court case of *Ciarlariello v. Schacter* where Cory J., writing for the majority, restated that “It should not be forgotten that every patient has the right to bodily integrity...Everyone has the right to decide what is to be done to one’s own body... *This concept of individual autonomy is fundamental to the common law*” (emphasis added; *Ciarlariello v. Schacter* [1993], 2 S.C.R. 119, 135); <http://csc.lexum.umontreal.ca/en/1993/1993scr2-119/1993scr2-119.html> (27.10.2010.)

cians to honour these documents.²¹ “It is...that the physician who treats a patient in breach of the instructions contained therein had committed a battery...”²². This case settled that a “doctor is not free to disregard a patient’s advance instructions any more than he would be free to disregard instructions given at the time of the emergency”²³, because “The right to refuse treatment is an inherent component of the supremacy of the patient’s right over his own body”²⁴. *Fleming v. Reid* was decided the following year, and again stated that “every competent adult has the right to be free from unwanted medical treatment...It is the patient, not the doctor, who ultimately must decide is treatment...to be administered”²⁵. In the benchmark case of *Rodriguez v. British Columbia* the Supreme Court of Canada clearly states that this right of autonomy extends also to a decision to withhold/withdraw life-saving or life-prolonging treatment²⁶, notwithstanding respect for life as a fundamental value to the Canadian society²⁷.

²¹ Barney Sneiderman, The Shulman case and the right to refuse treatment, *Humane Medicine Health Care—A Journal of the Art and Science of Medicine - Canadian Medical Association (CMAJ)* (2007), Volume 7, Number 1. Even though this precedent is binding only in Ontario, principles of autonomy and self-determination are fundamental to common law, and it is unlikely the courts outside Ontario would arrive at a different conclusion.

²² Tort law defines battery as the non-consensual invasion of a person’s bodily integrity. The law does not require that the person be harmed in the process; further, it is beside the point that the patient benefitted from the offending treatment...The harm lies in the fact that the patient did not consent to the treatment (Sneiderman, *ibid.*).

²³ *Malette v. Shulman* [1990], 72 O.R. (2nd) 417 (Ontario Court of Appeal) was a case of a Jehovah’s witness whose wishes (a card identifying her as a Jehovah’s witness) not to be treated with blood products were ignored in the ER. The emergency doctrine is the exception to the legal requirement that patients cannot be treated without their consent—Sneiderman, *ibid.*

²⁴ *Malette v. Shulman* [1987], 47 Dominion Law Reports (4th) 18 (Ontario High Court of Justice) – “certain aspects of life are properly held to be more important than life itself”; http://as01.ucas.dal.ca/dhli/cmp_documents/documents/case_studies_2.pdf (27.10.2010.)

²⁵ *Fleming v. Reid* [1991], 4 Ontario Reports (3rd) 74 (Ontario Court of Appeal), dealt with a schizophrenics’ refusal to be treated with neuroleptic drugs. The Court of Appeal found that it is unconstitutional that a hospital review board had powers to disregard the patients’ previous instructions when deciding their “best interests”. It established that the Board had to take into account those instructions, even if they were not to be taken as determinative—*Conway v. Jacques* (2002), 214 Dominion Law Reports (4th) 67 (Ontario Court of Appeal); http://as01.ucas.dal.ca/dhli/cmp_documents/documents/case_studies_2.pdf 827. (27.10.2010.)

²⁶ *Rodriguez v. British Columbia (Attorney General)* [1993], 3 S.C.R. 519, dated September 30, 1993, at <http://csc.lexum.umontreal.ca/en/1993/1993scr3-519/1993scr3-519.pdf>; p.84-86. Patients undergoing life-support treatment may compel their physicians to discontinue such treatment even when such decisions may lead directly to death – *Nancy B. v. Hôtel-Dien de Québec* [1992], 86 D.L.R. (4th) 385 (Que. S.C.). A corresponding USA precedent was decided two years prior, in 1990. (*Cruzan v. Director, Missouri Health Department* [1990], 111 L. Ed. 2nd 224), 58USLW, 4916(USMO, June 25, 1990).

²⁷ *Rodriguez (ibid.)*, p.6 and 111.

There is no federal legislation regulating the use of advance directives in Canada²⁸. However, the current Criminal Code²⁹ in its par. 219(1) provides that a person is criminally negligent if (s)he omits to do something that is her/his duty to do, showing wanton disregard for the lives or safety of other persons. If death ensues, the person could be charged with criminal negligence causing death pursuant to s.220³⁰. Nevertheless, the Supreme Court's jurisprudence in applying s.7 of the Canadian Charter of Rights and Freedoms (security of the person) creates an exception to these incriminations, obviously being of the opinion that criminalization of a decision to withdraw or withhold treatment would not be in accordance with principles of fundamental justice³¹. Instead of federal legislation, there are 11 different provincial/territorial approaches to the matter of passive euthanasia³². They all provide either for both **proxy** and **instructional directives** (Alberta, Saskatchewan, Manitoba, Prince Edward Island, Newfoundland and Labrador, Northwest Territories), or provide only for designation of a proxy (British Columbia, Ontario, Quebec, Yukon) while simultaneously recognizing the binding nature of previously given "**instructions**". The latter provinces take two different approaches:

²⁸ Despite the ruling in *Rodriguez* (see fn.26) that "To allow physician-assisted suicide...would erode the belief in the sanctity of human life and suggest that the state condones suicide. Furthermore, concerns about abuse and the difficulty in establishing safeguards to prevent abuse make it necessary to prohibit assisted suicide", in 2009 a private-member's Bill C-384 (An Act to amend the Criminal Code) was introduced before the House of Commons, addressing medical-practitioner assisted suicide and its decriminalization – text at <http://www2.parl.gc.ca/HousePublications/Publication.aspx?DocId=3895681&Language=e&Mode=1&File=24>. The Bill was defeated by a 228-59 vote on April 21, 2010.

²⁹ Criminal Code, R.S.C., 1985, c. C-46; <http://www.canlii.org/en/ca/laws/stat/rsc-1985-c-c-46/latest/rsc-1985-c-c-46.html> (27.10.2010)

³⁰ Robert E. Astroff, *Who Lives, Who dies, Who decides?: Legal and Ethical Implications of Advance Directives* (January 1997), Windsor Review of Legal and Social Issues 1, p.10. (LexisNexis view). A private-member's bill C-203 ("An Act to amend the Criminal Code (Terminally Ill Persons)", 3rd Sess., 34th Parl., 1989-1991), calling for an amendment of these provisions of the Criminal Code to allow for decisions to forego life-sustaining treatment passed second reading, but died in a federal legislative committee after it held public meetings.

³¹ Such a patient's decision is in the ambit of the right to security of the person – *Rodriguez* (see fn. 13.). Pages 102-105 are dedicated to drawing a distinction between withdrawing treatment upon the patient's request (as an acceptable form of medical treatment) and assisted suicide (its criminalization being an infringement upon the right contained in s. 7 of the Charter, but *justified* regarding principles of fundamental justice).

³² Territories in question are Northwest Territories and Yukon. Substantial portion of data was collected from "A Summary of Canadian Legislation Concerning Advance Directives", a Dalhousie University "End of life project" report http://as01.ucis.dal.ca/dhli/cmp_documents/documents/ADsummary2006.pdf. The End of Life Project is a Dalhousie Health Institute research project with the objective of facilitating informed public policy debate regarding the withholding and withdrawal of potentially life-sustaining treatments.

- a) British Columbia³³, Ontario³⁴ and Yukon³⁵ charge the health care provider with the duty not to provide health care in emergency situations if he has “reasonable grounds to believe” that the person, while capable and after attaining 16 years of age expressed a wish or instruction “applicable to the circumstances to *refuse consent*”³⁶ of the health care. Such provinces (and a territory) learned from the controversy of *Malette v. Shulman*.
- b) Ontario and Quebec mandate that a proxy must adhere by the patient’s wishes or instructions, provided that they were made while capable and are applicable to the circumstances. A later wish/instruction in Ontario prevails over an earlier one, which also contributes to the only relatively binding nature of the power of attorney³⁷. Article 11 of the Quebec Civil Code³⁸ grants the right to refuse any treatment – if the decision is made by a person authorized by law or mandate (power of attorney) (s)he must act in the best interest of the person (Art.11/2), *taking into account (as far as possible)*³⁹ any wishes the latter may have expressed (Art.12.).

³³ S. 26 of the Health Care (Consent) and Care Facility (Admission) Act, RSBC 1996, c.181; http://www.qp.gov.bc.ca/stat_reg/sup_acts.htm (27.10.2010)

³⁴ These wishes may be expressed in a power of attorney, in a form prescribed by regulations, in any other written form, orally or in any other manner (s.5(2)). They are *only* binding in emergency situations, and are thus not to be considered as instructional directives; http://www.med.uottawa.ca/procedures/lp/e_informed_consent.htm (27.10.2010)

³⁵ S. 21(2) of the Care Consent Act, S.Y. 2003, c.21, Sched. B.; <http://www.gov.yk.ca/legislation/acts/dmspa.pdf#page=88> (27.10.2010)

³⁶ Emphasis added.

³⁷ S. 46(1), (2), s. 66(3), s. 67 of the Substitute Decisions Act, S.O. 1992, c. 30 as amended by 1994, c. 27, ss. 43(2) 62; 1996, c. 2, ss. 3-60; 1998, c. 26, s. 108. However, as case *Conway v. Jacques* shows, “the substitute decision-maker...[has] to attend to the prior competent wishes...in determining what is in their best interests. Yet prior wishes are not to be determinative as they are but one component to be considered in assessing best interests” (*Conway v. Jacques* [2002], 214 Dominion Law Reports (4th) 67 (Ontario Court of Appeal). Even though Manitoba and Prince Edward Island recognize instructional directives (in addition to proxy directives), s. 13(3) of the Health Care Directives Act and s. 13(c) of the Consent to Treatment and Health Care Directives Regulations also expressly provide that if the proxy knows of wishes applicable to the circumstances that the maker expressed when he had capacity, and believes the maker would still act on them if capable, and if the wishes are more recent than the decisions expressed in a directive, the wishes must be followed.; http://as01.ucis.dal.ca/dhli/cmp_documents/documents/case_studies_2.pdf (27.10.2010)

³⁸ Civil Code of Quebec, S.Q. 1991, c.64. Relevant articles are: Art.11-25 (Integrity of the Person – Care), Art.153 (Capacity), Art.256-297 (Protective Supervision of Persons of Full Age) and Art.2130-2185 (Mandate).; http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/CCQ/CCQ_A.html (27.10.2010)

³⁹ Cumulating expressions like “taking into account” and “as far as possible” leads us to the conclusion that previously expressed wishes (situation identical with the duties of proxies in Ontario) are only cursory in nature, especially seeing that the Civil Code doesn’t distinguish between a patient-appointed proxy and the statutory-de-

Regarding the formal requirements for directives' validity, the legislatures differ significantly on certain points. The first concern is **who** can make an AD – in Saskatchewan, Yukon, Ontario and Prince Edward Island the minimum age is set at 16 years⁴⁰, which is also the lower limit for proxies in Ontario and Prince Edward Island. While age is only of a cursory nature as to the maturity needed to exercise the right to medical self-autonomy, it is our opinion that 16-year olds cannot be charged with burdensome responsibilities of proxies, and that minimum age for such representatives should be at least 18 years, if not even 21. While **formalities** such as the written nature of the AD and the presence of witnesses are the norm, some states complicate the drawing of an AD further by requesting consultation with a lawyer (B.C. and Yukon), who then gives a **certificate** of advice. It is our opinion that, if a legislator should consider previous consultation obligatory, it would do well to require participation of a physician, not a legal expert. Quebec asks that the mandate be given by a notarial act *en minute* which must be homologized by the court before the mandate can be performed⁴¹. Since the provision in question is a civil-law norm, extending also to administration of property [sic!], it shows certain reluctance on the part of the legislator to enact a statute sensitive to the specifics of proxies in medical issues. Regarding the means of revoking an instructional AD, it is imperative that patients are not restricted by excessive formalities in medical exigencies: Saskatchewan expressly allows for an oral revocation, and Manitoba and Prince Edward Island subordinate an instructional AD to more recent wishes (expressed orally) of the patient.

The said differences between provinces are less significant than the fact that all of them have advance directives legislation in some form or the other. Nevertheless, they create problems with regard to accepting out-of-province directives. Currently, only 5 provinces (British Columbia, Saskatchewan, Manitoba, Ontario, Prince Edward Island) and 2 territories (Yukon and the Northwest Territories) have **reciprocity protocols** in place, providing that out-of-province advance directives must comply with the local formal requirements to have legal effect⁴².

signed substitute decision-maker who need not be familiar with the patient's instructions and personal convictions. Ibidem.

⁴⁰ Also, Manitoba and Newfoundland allow every *capable* (Manitoba) or *competent* (Newfoundland) person to make an advance directive. The law places a rebuttable assumption that anyone over 16 years of age is considered capable – s. 4(1), (2) of the Manitoba Health Care Directives Act, C.C.S.M. 1992, c. H27 (<http://web2.gov.mb.ca/laws/statutes/ccsm/h027e.php> (27.10.2010)), and s. 3(1) and s. 7 (b), (c) of the Newfoundland and Labrador Advance Health Care Directives and the Appointment of Substitute Decision Makers Act, S.N. 1995, C. A-4, 1.; <http://assembly.nl.ca/Legislation/sr/statutes/a04-1.htm#3> (27.10.2010)

⁴¹ C. 64, a. 2166 of the Quebec Civil Code; http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/CCQ/CCQ_A.html (27.10.2010)

⁴² The End of Life Project, http://as01.ucis.dal.ca/dhli/cmp_advdirectives_faq/default.cfm.

3. Croatian status quo and perspectives:

Quite contrary to the Canadian experience, not only does Croatia not recognize ADs, but the public debate on this question is virtually non-existent, concentrating what little attention is given to the end-of-life debate to academic articles on euthanasia and prospects of organizing palliative care⁴³. Mutually conflicting provisions of regulatory sources do not give firm guidance to members of the medical profession or to patients. Direct application of international law is uncommon among Croatian courts, and there is still no court decision that would offer clarification. To give a theoretical answer on the applicability of ADs in Croatia, we must first explore the extent of the right to refuse treatment in current Croatian law and practice.

3.1 *The right to refuse treatment:*

Regarding the terminal patient's right to refuse further treatment, the **Codex of medical ethics and deontology**⁴⁴ regulates procedure regarding "dying patients" in Art.4⁴⁵. While it expressly prohibits active euthanasia as contrary to medical ethics (Art.4/2), it takes a permissive stance with regard to passive euthanasia. The wishes of a well-informed patient, suffering from an incurable disease (if clearly stated while fully conscious), regarding "artificial prolongation of life" are to be respected "applying current statutory provisions"⁴⁶. To continue to treat intensively a patient in an irreversible terminal state is medically unfounded and excludes the right of the dying patient to a dignified death (Art.4/3). Such a decision opens the door to commencement of palliative care. A doctor who violates one of the provisions of the Codex is subject to disciplinary proceedings

⁴³ Even though The Croatian Society for Hospice and Palliative Care (CSHPC) was established in 1994, there are still no hospices in Croatia, despite 9,000 annual patients in need of such care. Only the city of Rijeka sponsors 2 palliative-care mobile teams (since 2008)—www.rijeka.hr/Default.aspx?art=14674. The Government's programme for 2008-2011 sets (p.79) the inclusion of the palliative care into the health care system (with December 2008 as the deadline for the promulgation of an act on palliative care), as one of its goals. Such legislation has still not been enacted.

⁴⁴ Official Gazette ("Narodne novine") 55/2008. The Codex was enacted by the Croatian Medical Chamber on June 10, 2006 pursuant to Art.38 of the Medical Profession Act (Official Gazette 121/03) and Art.14. of the Chamber's Statute. All doctors are under obligation to act pursuant to the Codex, or be subject to disciplinary proceedings (Art.10).

⁴⁵ Reading Art.4., it is clear that a "dying patient" is a patient in an irreversible terminal stage of his (incurable) disease (paras.2-3). As such, it applies not only to patients suffering from a terminal illness, but also to patients in a terminal stage of a chronic illness, e.g. diabetes, AIDS, non-terminal cancer or cardiovascular disease.

⁴⁶ Emphasis added. Such recognition of advance instructions may for now be just wishful thinking, unless an inventive and flexible application of "current statutory provisions" is used – see *infra*.

(Art.10.), which can result in revocation of his medical licence and, consequentially, permanent expulsion from the Chamber⁴⁷.

The stated position of the medical profession seems to be contradicted by the current Croatian **Law on the Protection of Patients' Rights**, which was enacted after a radical alteration in the course of legislative procedure. **The Draft Law**⁴⁸ proposed that a decisionally competent person could be limited in his right to refuse medical treatment only if this would endanger the life or security of other people or the safe delivery of the patient's baby (Art.17/1). Should he be suffering from a grave and incurable disease which would (according to current state of medicine) lead to death in a short time (even with adequate health-care), the patient can also refuse life-saving or life-prolonging interventions, provided that a body consisting of three medical doctors⁴⁹ issues a unanimous decision in writing, confirming the patient's awareness of the consequences. This refusal must be in the form of a notarial act, or a valid private document (Art.17/2). A patient could also make an advance directive in the form of a notarial act, refusing life-sustaining or -prolonging treatment should he become physically incapable of taking care of himself due to an incurable disease (Art.19/1). He could in the same way issue a proxy directive (Art.19/2). Both directives are valid only if a psychiatrist confirms the patient is making the decision of a sound mind – this he must do no later than 1 month before the patient makes his decision (Art.19/3).

Under pressure from conservative parties such as the HDZ and HSP, as well as from the Catholic Church, all provisions pertaining to passive euthanasia were cut⁵⁰. The Act as it stands today is ambiguous on the question of the extent of patients' right to self-determination and refusal of treatments. I.e., it provides that the patient has the right to accept or refuse a particular diagnostic or therapeutic procedure "except in the case of an **undeferrable**⁵¹ medical intervention whose non-initiation would endanger the life and health of the patient or produce permanent damage to his health" (Art.16/1). A legal represent-

⁴⁷ Bylaw on disciplinary procedure, June 14, 2008. While Art.4/3 defines a "grave infraction" of the Codex, Art.56. lists the applicable sanctions, including the possible permanent revocation of a medical licence (among other sanctions are a reprimand, a public reprimand, a fine and a temporary revocation of the licence to practice medicine independently ranging from one month to one year).

⁴⁸ The Draft was prepared by the Croatian Association for the Promotion of Patients' Rights in December of 2002, under the working title of "Act on patients' rights, obligations and responsibilities"; www.huzp.hr/zakonpacjent.doc (27.10.2010.)

⁴⁹ Those doctors are: the patient's attending physician, a specialist for the illness in question and a psychiatrist. Ibidem.

⁵⁰ Ksenija Turković, Euthanasia in Croatia, p.57, in: Marc Groenhuijsen, Floris van Laanen (eds.) (see fn.9).

⁵¹ Emphasis added.

ative or guardian of a patient is to make the necessary decisions when the latter is not conscious or is suffering from a grave psychiatric illness, if he is under age or otherwise without business capacity (Art.17/1). The problem posed is: what (and when?) will Croatian courts (and hence the medical profession) interpret as an undeferrable treatment? Croatian expert on criminal law, Prof. Ksenija Turković is of an opinion that, if faced with such a question, it is more likely that *Croatian courts would interpret vital treatment of terminal patients as undeferrable*, and therefore not subject to patient's consent⁵². To the extent that such vital treatment would encompass artificial life-support⁵³ or be by nature "intensive"⁵⁴, such an interpretation would be in conflict to the *supra* discussed Codex. Even though they are not by definition (but are by nature) "intensive", we should interpret the Codex provision as including dialysis, antibiotics and total (par)enteral nutrition among the prohibited treatments in the face of a terminal patient's objection.

In our opinion, however, there is no alternative but that the courts should interpret "undeferrable treatment" as synonymous with treatment in cases of exigency, where there is no *objective* possibility to sit down with a patient and offer him an extensive explanation of the procedure in order to obtain his informed consent. This would be saying nothing new, as emergency interventions are by their nature an exception to the patient's right of informed consent. Given also the position of the medical profession accrued in the Codex, we are convinced that no other approach would be consistent with documents and jurisprudence of the Council of Europe. Namely, the Croatian Constitution guarantees a basic right to respect of personal and family life, as well as dignity (Art.35.)—a corresponding Art.8 of the ECHR⁵⁵ (respect for private and family life) has been interpreted as encompassing "the physical and psychological integrity of a person"⁵⁶ and its interpre-

⁵² Ksenija Turković, Euthanasia in Croatia (see fn.51).

⁵³ Mechanical ventilation by way of a percutaneous tracheal device (PTD – a tracheotomy cannula) or endotracheal tube; Code of medical ethics and deontology, Official Gazette (Narodne novine) No 55/2008, art. 4.

⁵⁴ Circulatory support drugs (vasoactive drugs like norepinephrine, dopamine and noradrenalin to achieve vasoconstriction) for hemodynamic instability or insufficiency (hypo- or hypertension), "invasive monitoring" (direct circulatory and respiratory monitoring involving catheters, etc.) and hemofiltration (acute renal failure). Ibidem.

⁵⁵ The European Convention for the Protection of Human Rights and Fundamental Freedoms, CETS no.005 from November 4, 1950 (in force since September 3, 1953). Croatia ratified it on November 5, 1997; <http://conventions.coe.int/treaty/en/treaties/html/005.htm> (27.10.2010)

⁵⁶ Case of *X and Y v. the Netherlands*, judgment of March 26, 1985, Series A no.91, p.11, §22; <http://cmiskp.echr.coe.int/tkp197/view.asp?action=html&documentId=695480&portal=hbkm&source=externalbydocnumber&table=F69A27FD8FB86142BF01C1166DEA398649> (27.10.2010)

tation underlined by the notion of personal autonomy⁵⁷. Further, when Art.8 of the “Oviedo Convention”⁵⁸ provides an exception to a general Art.5 rule of obligatory patient’s consent⁵⁹, it defines an “emergency situation” as one where “the appropriate consent cannot be obtained”⁶⁰. As Croatia has not issued a reservation with regard to this Article, and since pursuant to Art.140 of the Croatian Constitution⁶¹ international agreements must be applied directly, it follows that to force vital treatment on terminal patients against their refusal would be illegal, and that the courts cannot arbitrarily create a separate category of “undeferrable treatment” in contravention of Croatia’s international obligations. Also, Recommendation 1418⁶² states that “Fundamental rights deriving from the dignity of the terminally ill or dying person are threatened today by...artificial prolongation of the dying process by either using disproportionate medical measures or by continuing treatment without a patient’s consent” (Art.7(iii)). It asks that Member States provide legal protection against prolongation of the dying process of a terminally ill or dying person against his or her will (Art.8(ii)).

That even a terminal patient has the right to refuse further treatment can also be read analogously from other provisions of the Patients’ Rights Act. Namely, Art.14 allows a patient to refuse to receive information of his health condition and expected outcome of medical procedures and measures⁶³, with only one exception: if he poses a danger to

⁵⁷ Case of *Pretty v. the United Kingdom* (app.no.2346/02 from April 29, 2002), §61. In this case, a statutory ban on assisted suicide has been found to infringe the guarantees of Art.8, but is justified under the proportionality test: it serves a pressing social need and is “necessary in a democratic society” (taking into account the margin of appreciation left to the national authorities)—§70. However, we are convinced that a ban on medical self-determination of terminal patients would not pass the proportionality test, as the private interests of an individual far outweigh the community’s interest in preserving the sanctity of life – see P. Havers, C. Neenan, Impact of the European Convention on Human Rights on medical law, *Postgrad Med J* 2002 78: 573-574; p.574.

⁵⁸ Convention for the Protection of Human Rights and Dignity of the Human Being with regard to Application of Biology and Medicine: Convention on human rights and biomedicine, CETS no.164 (1997). Croatian ratification was made on November 28, 2003, and the Convention entered into force for Croatia on March 1, 2004.; <http://conventions.coe.int/treaty/en/treaties/html/164.htm> (27.10.2010)

⁵⁹ Other exceptions are: Art.6 (persons not able to consent: minors, mentally disabled, etc.) and Art.7 (persons with a mental disorder). *Ibidem*.

⁶⁰ The accompanying Explanatory Report restricts this possibility of non-consensual intervention to “emergencies which prevent the practitioner from obtaining the appropriate consent”. It gives examples of a patient in a coma and the inability to track a legal representative of an incapacitated patient (paras.56-57). Furthermore, “Even in emergency situations, however, health care professionals must make every reasonable effort to determine what the patient would want” (emphasis added). *Ibidem*.

⁶¹ Official Gazette 55/01 (consolidated text).

⁶² Rec. 1418 (1999) of the Parliamentary Assembly of the Council of Europe, “Protection of the human rights and dignity of the terminally ill and the dying”; <http://assembly.coe.int/main.asp?link=/Documents/AdoptedText/ta99/EREC1418.htm> (27.10.2010).

⁶³ This he must do via a written and signed statement; Official Gazette (Narodne novine) No 169/2004

health of others (Art.15/1). With that, the possibility of obtaining *informed* consent is also precluded, and since the patient has no parallel obligation to nominate a proxy⁶⁴, we can arrive to a conclusion that: if a patient with a curable (even if it is life-threatening unless treated) condition can refuse even to know about that condition and consequently refuse all further treatment, it follows *a maiori ad minus* that the right to refuse treatment cannot be denied to a terminal patient. Should a physician withdraw or withhold medical treatment upon the request of a terminal patient, not only should he not be liable for “Killing on request”⁶⁵, he would rather be committing an offence of “Unauthorized Medical Treatment”⁶⁶ by not complying with such a request⁶⁷.

If we are then to conclude that a terminal patient cannot be treated against his will, the next question is could we include advance directives in the Croatian legal order? According to Art.16/4 of the Patients’ Rights Act, persons deemed to be “vulnerable” due to their physical condition (patients that are blind; deaf and cannot read; mute and cannot write or are blind *and* deaf) must give their consent or refusal in the form of a notarial act, or must nominate a proxy with decision-making powers in their stead in the presence of two witnesses. Since terminal patients also can be considered to be a “vulnerable” group of patients⁶⁸, most prudent choice would be to ask the same form of a notarial act⁶⁹ for advance directives. The content of this act would have to formally satisfy all the conditions of the bylaw proscribing the form of the statement of refusal⁷⁰. It would also

⁶⁴ Art.15/2 only allows the patient to nominate a person to be *informed* in his stead. This cannot, however, amount to transference of *decisional capacity* on the proxy, since only statutory representatives or court-appointed guardians have that authority. That a refusal to be informed doesn’t amount to waiver of the right to informed consent (assent or refusal), is also the conclusion of Prof. Turković (see fn.2), p.8.

⁶⁵ Art.94 of the Penal Code provides that “Whoever kills another upon his express and serious request, shall be punished with imprisonment for one to eight years”; Official Gazette (Narodne novine) No 110/1997

⁶⁶ Art.241 of the Penal Code: “A physician or a dentist who performs a surgical or other medical procedure on another’s body without his express and valid written consent, shall be punished with a fine or imprisonment for up to one year”. Ibidem.

⁶⁷ Ksenija Turković, Euthanasia in Croatia (see fn.51), p.62-63,

⁶⁸ To cite the European Court of Human Rights in *Pretty*: “Doubtless the condition of terminally ill individuals will vary. But many will be vulnerable and it is the vulnerability of the class which provides the rationale for the law in question.” (par.74.); <http://www.allbusiness.com/legal/3495547-1.html> (27.10.2010)

⁶⁹ For the same conclusion, see: Nenad Hlača, *Želje o prestanku života*, Medicina (2008), vol.44, no.2; str. 157. Comparatively, Art.22.1 of the Hungarian Health Care Act (Act CLIV of 1997) mandates a notarial form for refusing specified medical treatments (text at: http://www.szozolo.hu/53/rights_and_obligations_of_patients.htm). Art.22 is *identical* to *supra* discussed Art.19 of the Croatian Draft Law on Patients’ Rights (2002); www.huzp.hr/zakonpacient.doc (27.10.2010)

⁷⁰ Assent or refusal of a particular procedure must be expressed by means of a statutorily proscribed form – such a bylaw is issued by the Secretary of Health (Art16/2-3 of the Patients’ Rights Act); Official Gazette (Narodne novine) No 169/2004

contribute to legal safety should these directives be a part of an official register⁷¹, and be subject to mandatory renewal every 5 years⁷². An international legal frame is already in existence: Art.9. of the Oviedo Convention warrants that “The previously expressed wishes relating to a medical intervention by a patient who is not, at the time of the intervention, in a state to express his or her wishes shall be taken into account”. This norm is of great importance as it embodies the first significant effort made by European institutions to set up a binding legal framework⁷³ relating to advance health care documents⁷⁴—however, it only pertains to instructional directives and (more importantly) qualifies the obligation with the syntagm “shall be taken into account” (“*seront pris en compte*”). The Explanatory Report clarifies that this means that directives should not “necessarily be followed” – it offers an example of a directive “expressed a long time before the intervention and science has since progressed” (par.62.). The courts should therefore be very restrictive in allowing physicians latitude in disobeying an AD, especially as it is clear that terminal patients are highly unlikely to change their minds about their end-of-life decisions. In Europe, advance directives are indeed binding in Austria, Belgium, Germany, Finland, Hungary, Netherlands, Spain and the UK⁷⁵.

In treating terminal patients, there are no issues of informed consent (refusal) comparative to those of patients with curable conditions. While the latter can at best speculate as to their future medical conditions and chances of recovery, offering only broad and vague instructions in their advance directives (“no artificial life support” may not be sensible in a patient in a surgical ICU with a good recovery prognosis, and is very different from such an instruction in a patient with a degenerative motor-neuron disease). The Patients’

⁷¹ Starting with September 1, 2008, all positive advance directives in Belgium must be registered with the Service Population, using an ID number (given based on entry in the National registry) – Royal Decree from April 27, 2007. Although that is a registry of directives to perform *active* euthanasia, we feel that from the standpoint of legal security these criteria should also be applicable to directives to perform *passive* euthanasia. Art.11/5 of the Spanish Law no.41/2002 on Patient’s Autonomy and on the Rights and Obligations Concerning Health Information (November 14, 2002) created a National Registry for Advance Directives (text of the Law at: http://www.isciii.es/htdocs/terapia/legislacion/Terapia_Ley_41_2002.pdf).

⁷² Chapter III (The Advance Directive), Section 4, §1 of the Belgian Euthanasia Act (*Wet betreffende de euthanasie*, B.S., 2002, 28515) sets a five-year limit to the validity of a directive (to perform active euthanasia). Also setting 5 years as a standard is Sec. 7(1) of the Austrian Living Will Act (*Patientenverfügungsgesetz*—PatVG) of June 1, 2006 (text at: http://www.patientenanwalt.com/fileadmin/dokumente/09_english_documents/legal_information/FEDERAL_LAW_GAZETTE.pdf).

⁷³ Previously used instruments of choice were *soft-law* recommendations: Rec.779 (1976) on the rights of the sick and the dying (par.10/II) and Rec. 1418 (see fn.65) (par.9(b)(iv)); http://www.coe.int/t/dg3/healthbioethic/texts_and_documents/CDBI-INF%282000%291PrepConv.pdf (27.10.2010)

⁷⁴ Steering Committee on Bioethics (CDBI), Report prepared by Prof. Roberto Andorno (see fn.6), p.4.

⁷⁵ Andorno (*ibid.*), p.6-10.

Rights Act does not specify at what point the information should be dispensed. Regarding terminal patients, it is logically sound that they could be informed of their condition (including the medical assessment of results of a particular procedure) and of the advantages and risks of available procedures (Art.8), and upon that information refuse those procedures in advance (anticipating their incapacity for rendering medical decisions).

4. Conclusion:

The analysis above leads us to the conclusion that a Croatian criminal court willing to interpret national law in the light of our international obligations and comparative law, could acquit a physician accused of killing on request if the latter withdrew/withheld treatment from a terminal patient upon his advance request expressed in a notarial form⁷⁶. In this, Croatian courts could assume the role of motors of new legislation, looking up to the Canadian experience where it was the courts and common law that developed general principles further codified in provincial and territorial legislations. Even though Croatia is not part of a common law system, a carefully developed criminal law jurisprudence aided by the review functions of the Supreme Court could offer clear guidelines in the face of legislative silence on the question of passive euthanasia and ADs. Regulation of terminal patients' status must be complemented by a comprehensive policy on palliative care, starting with the enactment of legislation and institution of permanent palliative care units in all of Croatia's counties.

Canada is faced with different problems—due to its federal nature, we are convinced of further convergence of provincial and territorial acts, with reciprocity protocols representing but a first step of such development. Mobility of Canadian citizens warrants that end-of-life decisions should be complied with notwithstanding the province/territory of a patient's passing. In this, it would be advisable to set up a national register of ADs, guaranteeing easy access of physicians to relevant information. Finally, age-requirements of particular jurisdictions should be made more rigid, setting 18 or even 21 years of age for proxies. Provinces that set 16 as the age for drafting an AD should qualify this right as pertaining only to terminal patients, in order to minimize the risk of decisions thought through less than thoroughly.

⁷⁶ Of course, as discussed *supra*, the patient would have had to receive ample information on his future prospects and development of his illness, that would enable him to give his informed *pro futuro* refusal, and the circumstances of the withdrawal/withholding would have to substantially coincide with those foreseen in the directive, with no medical breakthroughs in the meantime.