Law Reform Commission of Canada
Commission de réforme du droit du Canada

REPORT

euthanasia, aiding suicide and cessation of treatment

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Canada

REPORT 20

EUTHANASIA, AIDING SUICIDE AND CESSATION OF TREATMENT

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REPORT

ON

EUTHANASIA,
AIDING SUICIDE
AND
CESSATION OF TREATMENT

July, 1983

The Honourable Mark MacGuigan, P.C., M.P.,
Minister of Justice
and Attorney General of Canada,
Ottawa, Canada.

Dear Mr. Minister:

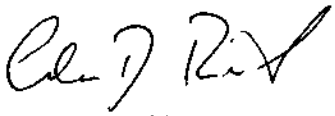
In accordance with the provisions of section 16 of the *Law Reform Commission Act*, we have the honour to submit herewith this report, with our recommendations on the studies undertaken by the Commission on euthanasia, aiding suicide and cessation of treatment.

Yours respectfully,

Francis C. Muldoon, Q.C.
President

Réjean F. Paul, Q.C.
Vice-President

Louise Lemelin, Q.C.
Commissioner



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Foreword

In the fall of 1982, the Law Reform Commission published Working Paper 28, entitled *Euthanasia, Aiding Suicide and Cessation of Treatment*.

Since then an extensive consultation took place with members of the public, the legal profession and representatives of the health sciences. Numerous conferences and seminars on these issues have afforded an opportunity to present and test the positions outlined in the Working Paper.

As a result of the many comments, suggestions and criticisms received from Canada and abroad, the Commission has been encouraged to re-evaluate some of its tentative positions, and it would like to extend its sincere thanks to all those individuals and organizations who responded so generously to our call for comments. This Report is a clear indication of the weight which the Commission attaches to those comments and suggestions.

Introduction

Two brief preliminary observations may serve as an introduction to the complex problems associated with euthanasia, aiding suicide and cessation of treatment.

First, the legislative recommendations contained in this Report to Parliament are clearly and unequivocally set within the framework of the criminal law. The Commission's primary objective, as represented by this Report, was to carry out a critical examination of certain provisions of the *Criminal Code* to determine whether they were adequate to deal with the problems raised by contemporary medical and technological advances. The reform proposed by the Commission is thus limited in its scope. It affects certain criminal law provisions without necessarily affecting other federal or provincial laws and regulations. The proposed reform in no way precludes a provincial legislature from regulating other aspects of the matter as it sees fit, within the ambit of its legislative jurisdiction. For example, when the Commission expressed the view in Working Paper 28 that an incompetent individual ought to have greater protection in decisions concerning his body, his life and his death, it proposed some general criteria but also referred to the fact that there are various provincial regulations respecting legal capacity. Similarly, when the Commission suggested that the physician should bear the ultimate responsibility for deciding to discontinue a treatment which had become medically useless, it assumed and stated that this decision should be made in consultation with the patient's next of kin, family or friends.

The Commission's role is the reform of federal law in general and criminal law in particular. With regard to the latter, the Commission's basic goal is to set out as clearly as possible the limits of what is humanly and socially acceptable, and to propose a minimum standard of conduct which could not be violated without incurring a sanction reflecting certain fundamental values embodied

in the law. The proposed reform is not designed to regulate the decision-making process in the area of cessation of treatment, nor to prevent individuals or institutions from setting up procedures to ensure not only a minimum of respect for the rules, but an optimum development of the values these rules represent.

For example, the Commission only establishes a minimum standard of criminal liability when it recommends that a physician not be deemed to have committed a criminal act because he discontinues treatment considered medically useless. This rule would not preclude a hospital setting up a consultation committee on the issue, or hospitals and health professions requiring in their codes of ethics or regulations that the doctor should formally consult the patient's family and obtain the advice of other physicians and health care professionals. The Commission is aware that hospital practice and various codes of ethics are already moving in this direction.

A second preliminary observation is also in order. The criminal law sets general standards of conduct for all citizens. It offers a relatively general guide to conduct, because it cannot always take into account particular circumstances. The fact that the Commission proposes certain amendments to the present *Criminal Code* does not mean that once these reforms have been adopted, the doctor, the nurse, the hospital, the lawyer or the patient will necessarily find therein a detailed guide for solving the complexities inherent in every individual case. In matters of life and death, of consent to acts involving the human body and of decisions to discontinue treatment, every case is special and generalization alone is not enough. It would be an illusion to believe that criminal law reform alone can provide a comprehensive guide for making medical decisions. The decision to treat or not treat must continue to be made in response to both general standards and the particular circumstances. Criminal law alone cannot provide a detailed road map for decision-making; it cannot prescribe all the factors which should be taken into account. It only establishes general rules of conduct at the "outer limits" of what society permits and forbids. That is both its usefulness and its limitation. Accordingly, it is important that this Report not be regarded as a comprehensive question-and-answer book or check-list for decision-making in every individual case. On the other hand, the Commission believes that its recommendations will eliminate some misunderstandings, that they will indicate what

weight should be attached to certain basic principles and legal rules and that they will assist those who must make this type of decision on a daily basis in difficult circumstances. These recommendations also attempt to clarify the rights of patients and enable them to know more readily what they are entitled to expect and insist upon from the medical profession.

PART ONE:

THE NEED FOR REFORM

The onus is on those suggesting a change, it is said, to show that the change is desirable and represents an improvement over the existing situation. The consultations held between the publication of Working Paper 28 and the drafting of this Report provide clear evidence that the legal profession, the public and those working in the health professions are in favour of legal reforms or at least clarifications in the area of euthanasia, aiding suicide and cessation of treatment.

Without necessarily espousing the views expressed in the Working Paper, lawyers, university professors and scholars who were consulted agreed that the present *Criminal Code* provisions are ambiguous and vague, and much in need of revision. The Bar of one province has even made a formal recommendation to that effect.

Certain provisions, including sections 14, 45, 198, 199 and 229 of the *Criminal Code*, were drafted at a time when the specific problems confronted in this paper had not then arisen. For example, modern medical technology was not yet available to the medical profession. Sophisticated and scientific palliative care was either unknown or at best in its infancy. Indeed, the very practice of medicine and hospital management was radically different from what it is now.

Those provisions, drafted in general language, were adequate to meet the problems of the era for which they were conceived. However, they were never supplemented, as they perhaps should have been, by amendments adapting them to changed realities. The Commission believes that these *Criminal Code* sections now need to be re-examined and revised in the light of current conditions and problems. Consultations carried out by the Commission have served to confirm this view. A legal scholar commenting on Working Paper 28 aptly observed that the legislator must now provide judges and courts with a clearer indication of legal policy in this area rather than forcing them to guess at it on the basis of outdated laws.

Moreover, the *Criminal Code* provisions which are the object of the Commission's reform proposals have never really been subjected to a sophisticated and clear judicial interpretation in the context of these life-and-death issues. It is possible to undertake a lengthy theoretical discussion to determine the interpretation which

the courts might apply to a given word or section of the *Criminal Code*. It may indeed constitute an interesting and stimulating exercise. However, in real life and perhaps to an even greater extent in criminal law, rules should have a certain degree of predictability, especially in matters as crucial as the life or death of an individual. The great majority of those consulted felt strongly that clarification of existing law was overdue. Moreover, many of those who were not convinced of the need for amendments nevertheless had to admit that they could not predict with any certainty what interpretation the courts might give to particular provisions if applied in the current medical context regarding a decision to cease life-supporting treatment.

The view that reform is needed and even urgent is shared by medical and hospital personnel and others working in the health professions.

Health care professionals, perhaps because they are less accustomed than lawyers to reading and interpreting legal provisions, have frequently indicated how ambiguous, imprecise and vague they find the existing provisions of the *Criminal Code*. They have also told us that a number of sections, namely sections 45 and 199, seem to cast real doubt on the legality of various medical and hospital practices. We believe that these concerns are genuine and serious and sometimes have a very negative impact on medical practice. The ambiguities and doubts encourage some physicians to be excessively conservative in the practice of medicine. As one of those consulted told us, referring to section 199 of the *Criminal Code*, there are two alternatives. One is to hope that the present law does not actually mean what is seems to say and to practice medicine as it should be practiced, that is, in the patient's best interests. The other is to believe that the law intends to say what it does and therefore to practice a defensive type of medicine, one which is not always in the best interests of the patient.

Even if in practice there are hardly any criminal prosecutions in the medical context, this legislative imprecision nevertheless encourages uncertainty and tension which is to everyone's benefit to eliminate.

In effect we were told by many of those consulted that on such important issues the law should not speak in riddles, but

rather should set out clearly and precisely, in language accessible to the general public, the exact parameters of permitted behaviour. The Commission agrees with that view.

The Commission believes that these reform proposals are useful and meet a genuine need. As will become apparent, these proposals do not represent a complete overhaul of the traditional legal rules, but rather a clarification and necessary supplement to them. The proposed reform will undoubtedly not completely eliminate the possibility of conflict and uncertainty. It would be naive to think so. The Commission believes, however, that the reform will have achieved its main objective if the proposed amendments allow everyone to better understand the limits governing conduct in these matters, and enable courts to identify more clearly the basic principles underlying the revised legislative policy.

These basic principles were discussed at length in Working Paper 28 and in other documents published by the Law Reform Commission in the *Protection of Life* series. They may be briefly summarized here. The first is that in the medical context the presumption in favour of life should always be recognized. Our law regards the protection of human life as a fundamental value. Any law reform must be based on that value. The proposed system of rules should never depart from the principle that in the absence of reasons to the contrary the patient should always be presumed to want to live, and that the patient would prefer life to death even when unable to express that preference. In practical terms, this principle may be expressed by the rule that if a treatment is reasonable and useful for the purpose of preserving the health or life of a human being, it should be assumed that a patient unable to express a choice would choose to receive the treatment and not to refuse it. Accordingly, a physician should normally have a duty to treat an unconscious patient admitted to hospital. This principle and presumption does not however oblige extraordinary measures. First of all, the presumption is not absolute and, secondly, it applies only if the proposed treatment is reasonable and useful. But according to this first principle the onus is on those who stop or do not initiate life-supporting treatment to provide justification for that decision.

The second principle is that of the patient's autonomy and right to self-determination. The Commission, which has repeatedly

upheld this principle, continues to be of the view that it should be explicitly affirmed in law. Within the bounds of public order, morality and the rights of others, human beings must remain masters of their fate. They should therefore have the right, based on the notion of free and informed consent, to make decisions concerning themselves. No one should have the right to impose such decisions on patients against their will. The law should clearly acknowledge this right to autonomy and self-determination, and penalize any interference with it.

It is interesting to note that only one person among those consulted argued in favour of compelling a competent patient to undergo treatment.

A third principle which any reform proposals 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. In the Commission's view such considerations should be respected. We believe that the law should now clearly recognize the right of patients, exercising their free and informed choice, not to undertake treatment if they feel it would deprive them of, or not provide, an adequate quality of life for the time remaining. Inasmuch as such a decision is based on a value-judgment, there is room for argument when patients are unable to express wishes because they are too young or too old, or are unconscious or mentally handicapped. As the Commission emphasized in its Working Paper, the law should provide special measures to protect the incompetent. It should also be noted that all provinces currently have specific provisions for the exercise of what is called in law substituted consent. It is not the Commission's task to scrutinize these laws and regulations or to substitute its judgment for that of the provincial legislators. The Commission can only lay down a rule or general standard of conduct for criminal law purposes. Incompetent patients in every province of Canada have various means to enforce their rights when they are infringed upon. Moreover, the very definition of what constitutes legal incapacity varies from province to province.

The Commission wishes to prevent the possibility that a patient's inability to give or refuse consent would seem to impose on the physician a legal duty to provide aggressive treatment. If

the quality of life is a value which the law should always respect, then it should also be respected and weighed when the patient is incompetent.

These are in brief the main principles underlying the proposed reform recommended by the Commission in Working Paper 28. Months of consultation have demonstrated that in Canada there currently exists a broad consensus regarding these principles. The dissenting views, which will be examined below, tend to apply especially to the question of enforcement. Some feel, for instance, that the principle of personal autonomy is so important that it would justify an individual's demand for assistance in committing suicide and that, therefore, such assistance should be completely decriminalized.

In concluding Part One of this Report, we should again recall the precise role played by legislative reform. One should not expect the lawmaker to provide a detailed and definitive guideline or manual to enable physicians to decide in a mechanical fashion whether he can or cannot discontinue treatment. All that the lawyer, or the health care professional, or the patient or the general public is entitled to expect from the legislator are general guidelines indicating the path to take and the path to avoid. Should a case involving these issues be brought before a court, it would be left to the court to determine whether or not the conduct of the accused conformed to the law by evaluating the special nature and circumstances of that case.

PART TWO:

THE PROPOSED REFORM

In its Working Paper, the Commission asked three basic questions:

(1) Should active euthanasia be legalized, or at least decriminalized?

(2) Should aiding suicide be decriminalized by the repeal of section 224 of the *Criminal Code*?

(3) Should sections 14, 45, 198, 199 and 229 of the *Criminal Code* be revised to define the legal parameters of the refusal and cessation of medical treatment?

Generally speaking the vast majority of those consulted believed that these questions were well formulated and to the point. In these final recommendations to Parliament, it is appropriate therefore to consider each of them again, partly in the light of the proposals and criticisms responding to the earlier Working Paper on these issues.

I. Euthanasia

The word "euthanasia" is somewhat ambiguous and has several possible meanings. Hence it is appropriate to explain what we mean by the term whenever it is used. For the purposes of this Report, euthanasia will mean the act of ending the life of a person, from compassionate motives, when he is already terminally ill or when his suffering has become unbearable.

A. The Voluntary Aspect

The Commission's final position remains that even if such a patient requests that he be killed, such an act should not be legalized. With few exceptions, the comments received have all supported the Commission's position in this matter. A country like Canada could not, without violating its social traditions and history, tolerate and give a legal veneer to a policy of active euthanasia, not even voluntary euthanasia.

The argument will undoubtedly be raised that if persons are the masters of their own bodies, they ought to have the right to demand that society allow someone else to end their life if it has become unbearable. We cannot and need not repeat and review here the pro and con arguments explored in detail in the Working Paper. As maintained in that Working Paper, the legalization of euthanasia is unacceptable to the Commission because it would indirectly condone murder, because it would be open to serious abuses, and because it appears to be morally unacceptable to the majority of the Canadian people. The Commission believes that there are better answers to the problems posed by the sufferings of the terminally ill. The development of palliative care and the search for effective pain control methods constitute a far more positive response to the problem than euthanasia on demand. To allow euthanasia to be legalized, directly or indirectly, would be to open the door to abuses, and hence indirectly weaken respect for human life.

The Commission therefore recommends against legalizing or decriminalizing voluntary active euthanasia in any form and is in favour of continuing to treat it as culpable homicide.

B. The Mercy Aspect

As the Commission stated in Working Paper 28, when the actor's chief motive for killing is compassion for that suffering person, there are three possible options by way of legal response: to preserve the status quo; to create a special category of homicide; or to add a specific provision aimed at mitigating the sentence.

The Commission received many comments on this subject. None were in favour of complete decriminalization. Responses favouring one or another of the three options were roughly equal in number, although the supporting arguments were quite varied.

Those in favour of the first and third options were agreed on one thing: a specific offence should definitely not be created. The reasons given were several. Some argued that a door to a number of problems and abuses would thereby be opened. Some maintained that the inclusion of motive as one of the elements of an offence would result in an extremely complex evidentiary

problem — that of reaching a precise determination of the "purity" of the motives of the accused. In the opinion of some this would be quite impossible. The Commission does not necessarily agree. It believes, and current criminal law in fact bears this out, that it is indeed legally possible, though difficult, to prove the motive behind an accused's act.

The creation of a specific offence for mercy killing is technically compatible with the present law. But is it compatible with our traditions? As one of our correspondents noted, adding another type of homicide to the *Criminal Code* is not really a solution, since the enforcement of such a provision is bound to create difficulties in practice. How could the offences of ordinary murder and mercy killing be effectively distinguished if the only real difference between the two is to be found not in the intent to kill but in the proof of motive? One group of scholars has suggested that mercy killing be made a lesser offence included in that of culpable homicide.

Many of our correspondents, however, especially those not belonging to the legal profession, were adamantly opposed to any change. A change either in the definition of the offence or in sentencing would, in their view, amount to accepting a devaluation of human life. The most prevalent fears were the dangers posed by any weakening of legislative policy. Proponents of the first option felt that any change would open the door to abuses of all sorts.

As previously stated in the Working Paper, the Commission feels that formulating a fair and just solution of this issue is far from easy. Each of the options has its defenders and arguments in its favour, and in the final analysis the choice is a matter of personal conviction, at least on an individual level. However, the choice of policy must be made in harmony with general legislative policy on the criminal law.

All things considered, the Commission agrees with those who feel that the law on this point should not be altered, and that mercy killing should not be treated as a separate or included offence, nor entail as of right a reduction of sentence. It should be recalled that our legal system has internal regulating mechanisms which offset the apparent harshness of the law. It is possible that in some circumstances the accused would be allowed to plead guilty to a lesser charge. We also feel that our trial system, and

the conclusions and verdicts reached by our juries, should be trusted. Finally, in truly exceptional cases, the authorities already have it within their discretion to decide not to prosecute.

The Commission therefore recommends that mercy killing not be made an offence separate from homicide and that there be no formal provision for special modes of sentencing for this type of homicide other than what is already provided for homicide.

II. Aiding Suicide

One of our correspondents brought to our attention an incident involving a charge laid under section 224 of the *Criminal Code* ("Counselling or Aiding Suicide"). Twenty years ago in Northern Canada charges were laid under that section against a certain Inuit. The accused had helped one of his elderly parents load the rifle with which the latter finally killed himself. The accused was found guilty and given a suspended sentence.

The Commission's tentative recommendation was that the offence of aiding suicide should be retained, even if in practice it is rarely invoked. To reinforce the present approach of restraint in appealing to this section of the *Code*, and to accentuate the exceptional nature of such a charge, the Commission recommended that prosecution on the basis of this section should be permitted only on written authorization from the Attorney General.

This recommendation touched off a lively debate among those we consulted or who sent us their reactions and observations. With two exceptions, all our correspondents were in agreement that the offence of aiding suicide should remain in the *Code*. A number of correspondents wrote in effect that although one may sympathize with a person who assists a terminally ill family member or friend to end his life, such sympathy should not necessarily be translated into an explicit approval of the legality of that assistance. Moreover, there can be other cases in which aiding suicide is done for far less altruistic motives, and which do warrant a legal penalty.

The Commission agrees with that view and does not recommend that aiding suicide be decriminalized.

What, however, of the recommendation requiring the written authorization of the Attorney General in order to prosecute? Contrary to the Commission's expectation when drafting the Working Paper, this suggestion encountered fairly strong opposition. These objections led the Commission to review its position and to withdraw this particular recommendation.

The first objection, cogently expressed by one of our legal correspondents, was that in this case it is preferable to let the law take its normal course. Decisions made by the Attorney General about whether or not to prosecute may be perceived, no doubt erroneously, as having political overtones. In life-and-death matters, it may not be advisable to make such a sensitive legal matter depend upon a decision which could be interpreted as politically motivated. Another correspondent suggested that the decision about whether or not to prosecute should not be left in the hands of the Attorney General himself, but rather with his regional representative. Although we agree that this suggestion could go a long way towards dispelling the above objection, we feel that it does not wholly remove the possibility of misunderstanding.

The second objection, which appears equally serious to the Commission, is that if prosecution of the offence were to depend on the Attorney General's authorization, significant differences in the manner in which the law is enforced in the various provinces could be expected. Here again, our correspondents felt that such differences involving fundamental issues and principles, might give the impression that life does not have the same value everywhere in Canada.

Finally, on a practical level, the Commission considers that since this offence is almost never prosecuted, requiring an additional procedure would amount to its *de facto* abolition. In conclusion, for the reasons given above and in the Working Paper, the Commission's view is that the offence should not be removed from the *Code* or revised.

The Commission therefore recommends retaining section 224 of the *Criminal Code* in its present form.

III. Cessation and Refusal of Treatment

The Commission found near unanimous approval for the proposal originally made in Working Paper 26 and repeated in Working Paper 28. Any competent person should have the right to refuse treatment of any kind and to insist that treatment already begun be discontinued either temporarily or permanently. In other words, treatment should never be imposed against a patient's will. The physician's duty in such a case is to inform the patient of the options open to him and of their consequences, and consent to treatment or to its discontinuance must adhere to the guidelines established by court decisions to date, that is, it should be informed and freely given. If these requirements are satisfied, then whatever personal reasons motivate a person to accept or refuse a given course of treatment should not be questioned by physicians or courts and the individual's freedom of choice should be universally respected.

Provision for the formal and explicit recognition of this principle in the *Criminal Code* was widely supported. The first subsection of the *Code* amendment proposed below, subsection 199.1(*a*), contains our recommended addition to do just that. However, it was not considered advisable to add a provision specifying that physicians who treat patients against their wishes commit a specific criminal offence. Treatment by force or the continuation of treatment already undertaken against the wishes of the patient constitutes an assault, an offence already provided for and penalized under the appropriate provisions of the *Criminal Code*. Furthermore, this act is also a tort, or a delict in civil law, giving rise to civil remedies.

Our recommendation concerning palliative care also received unanimous approval. Some felt that it was the most important recommendation in the Working Paper. It was brought to our attention however that palliative care may sometimes be very aggressive and that, here too, it is important to be assured of the patient's consent or the consent of those who are responsible for making decisions concerning that patient. Palliative care is subject, in fact, to all the rules governing medical treatment, including the requirements that it be reasonable and that consent must be sought and provided.

Some of our correspondents drew to our attention an infelicitous expression on page 71 in Working Paper 28 regarding palliative care. The Commission agrees with its correspondents that the current provisions of the *Criminal Code* should not prevent a physician from undertaking or continuing palliative care when necessary, only because it might have an effect on the patient's life expectancy. Our proposed section 199.2 now clearly accommodates the proposition just stated.

The Commission therefore recommends that it be specified in the *Criminal Code* that a physician cannot be held criminally liable merely for undertaking or continuing the administration of appropriate palliative care in order to eliminate or reduce the suffering of an individual, only because of the effect that this action might have on the latter's life expectancy.

If, as we believe, the opinion of our correspondents is representative of the Canadian people as a whole, it is clear that there is a desire to eliminate the ambiguity unintentionally created by the present wording of section 199. Interpreted literally, it appears to place an unqualified duty on the physician to continue treatment once he has begun it, even if the treatment in question has become useless or unreasonable. On this question, too, the Commission's proposals received the support and approval of our consultants, subject to certain objections pertaining to matters of form.

The Commission therefore recommends an amendment to the *Criminal Code* to remove the ambiguity created by some of the current provisions, in particular by section 199.

The longest and most complex discussions revolved around the problems posed by the non-initiation or the discontinuance of treatment with people who, because of their age, their state of unconsciousness or mental handicap are unable to give a valid consent. The recent *Dawson* case in British Columbia has fueled debate and has undoubtedly increased public awareness of the issues involved. Accordingly, a systematic review of the general principles which should govern any attempts to resolve these complex problems is in order.

On the basis of submissions from various organizations representing those suffering from mental handicaps, the

Commission remains convinced about the soundness of the tentative proposal in the Working Paper. The law must avoid and guard against any involuntary discrimination against handicapped people. A person's inability to give consent should not be invoked to deny to that person the rights granted to competent individuals. In the context of this discussion, a person's incompetence alone should not oblige or empower a physician to begin or continue a therapeutically useless treatment when its only result will be to prolong unnecessarily the patient's agony. Incompetent persons, like all others, have the right to die with dignity, assisted by whatever palliative care is needed. Accordingly, the law should attempt to eliminate any difference in that regard between a competent and an incompetent person. In either case, the continuance or initiation of useless or inappropriate medical treatment should not be promoted or condoned by criminal law. Heroic or aggressive therapeutic measures which would not be used in the case of a competent person, should also not be used in the case of an incompetent person.

The Commission also reaffirms the position it expressed on the subject of newborns in its Working Paper. The decision to treat or not to treat should be made on the basis of the medical facts of each case and in the best interests of that newborn patient, not for eugenic reasons. For example, the Commission feels that it is a physician's duty to perform corrective surgery for atresia of the digestive tract in the case of a trisomic newborn if the risks of the operation are acceptable and if, apart from the trisomy 21, there are no other serious and incurable defects. The decision ought to be made according to whether the problem can be corrected or not, and by considering the newborn's quality of life, just as would be the case for an adult patient. If, according to the present state of medical science, the seriously handicapped newborn is already dying, he or she should be treated in the same way one would treat a conscious or unconscious terminally ill adult. However, if the infant could benefit from a form of treatment which offers reasonable hope for an acceptable quality of life, then that treatment should be provided. The Commission is well aware of the ambiguity in the expression, "acceptable quality of life". In medical practice the resolution of this dilemma seems to present fewer difficulties for the adult patient. It also acknowledges that it is essentially a question of fact, the differences in each case making generalization impossible. It is as well a question of sound medical judgment based not only on medical experience, but also

on consultation with the appropriate party or parties, such as the parents, the spouse, the family and the next of kin. The purpose of criminal law is not to tell the physician how to act in each and every case. It exists only to draw general lines and punish abuses. In each particular case it is up to the courts to determine whether or not a particular decision was reasonable and acceptable under the circumstances. A decision that would only prolong the dying patient's agony would not be reasonable in the Commission's opinion; nor would a decision be reasonable which would force a newborn or adult to undergo an exceptional series of operations or treatments, resulting in great suffering, only to end up with a medically unacceptable quality of life. On the other hand, the mere existence of a physical or mental handicap in a newborn, even if serious, should not be a pretext to refuse treatment on the basis of what are essentially eugenic considerations.

A third question meriting discussion here is that of substituted consent for those incapable of expressing their wishes. It is a difficult problem and the Commission is particularly grateful to those correspondents who helped to shed light on the principles involved or who submitted a variety of typical cases for our consideration.

The Commission stated in its Working Paper that there are essentially three systems or mechanisms for ensuring consent to treatment or to discontinuance of treatment for persons themselves incapable of making or expressing that decision. We stated that we would take a definitive position on the question in the report to Parliament. The first mechanism could be called the "judicial model". The decision would be made either by a judge or by a quasi-judicial body, such as a hospital committee. A large majority of our correspondents were against resorting to institutionalizing such a system on the grounds that it can be unwieldy, complex and, above all, inappropriate for dealing with the type of decision which has to be made. The ideal decision-making model for such cases is in fact one which seeks a consensus among the various people involved (the physician, other involved health care professionals, the family and the next of kin). A confrontational model of the adversary sort is clearly not ideal under normal circumstances. Rejection of this first model as the normal decision-making mechanism does not mean, however, the elimination of any recourse to the courts. Should any of the parties be opposed to or in disagreement with a decision to treat or not to treat an

incompetent patient, it should always be possible to ask a court to resolve the conflict in order to provide the best available protection to the patient. But what we wish to emphasize is that, solely from the point of view of criminal law, there appears to be no point in requiring that every decision concerning the treatment of an incompetent person be automatically subject to a formal and initial order by a court or quasi-judicial body. We have no intention of excluding the involvement of courts in this type of decision when the exceptional need arises.

A second possible decision-making mechanism is to allow those who represent the incompetent person (e.g. next of kin, parents, curator, guardian and so forth) to make the decision by themselves alone for the incompetent person. This solution is favoured by a number of individuals and organizations in Canada at the present time. The Commission sees two possible dangers if this approach were to prevail. The first is the unfairness involved in placing an extremely heavy psychological burden on those who are perhaps not really in a position to bear it. The second is the possibility that conscious or unconscious conflicts of interest might arise, risking an injustice being done to the incompetent person.

This explains why the Commission recommended that the decision be primarily medical in nature, believing that there is no ideal solution and that, all things considered, this option remains the least unsatisfactory. It must be noted, however, that a rejection of the second solution as the basic legislative policy naturally does not mean the exclusion of those persons from the decision-making process. On the contrary, even if the physician must remain ultimately responsible for the decision in the eyes of the law, the decision must necessarily be made after discussion, explanation and consultation with those close to the patient. This option, which the Commission maintains in its final recommendations, merits further explanation.

In the first place, we do not intend and indeed we are not empowered to express an opinion on the matter as a whole. Many aspects of medical treatment for the incompetent come wholly or in part under provincial jurisdiction. Each province has particular laws and regulations relating to the rights and protection of infants, and which regulate the powers of parents, tutors and guardians. The Law Reform Commission therefore cannot and does not wish to express an opinion on the content of such provincial legislation.

The sole question which the Commission may ask itself is the following: When may a person be held criminally liable for discontinuing or failing to initiate medical treatment for an incompetent person? The Commission's answer is the following: Such liability should not exist when the discontinuance or non-initiation is based on a valid medical decision, that is, one which is reasonable in the circumstances, is in the best interests of the incompetent person and in conformity with other standards set by criminal law.

The requirement proposed by the Commission is therefore necessarily a minimum requirement, only what is necessary for an acceptable standard of criminal liability. As a minimum standard for purposes of criminal liability, it in no way precludes the adoption of more detailed and sophisticated formulas which could offer the incompetent patient more protection. Quite the contrary. The following are some examples. A formal decision regarding treatment must be made by the physician on the basis of medical facts and expertise, but it can and should be made after consultation with the family, the spouse, the next of kin or tutor, or guardian. Such a decision can also be made and normally is, after an independent second medical consultation. It may be made or contributed to by an interdisciplinary hospital committee. All that the criminal law seeks to ensure is that the physician has made a reasonable decision in terms of his expertise, the medical data and the particular circumstances. It is not within the scope of criminal law, which can only dictate a general standard of conduct, to say exactly how that decision should be reached, what advice may be sought and who may participate in the decision-making process.

Nothing of course should preclude anticipatory recourse to a court, as in the *Dawson* case, in order that the appropriateness and legality of a contemplated medical decision may be determined, especially when there is an obvious conflict of opinion among the interested parties about what should be done.

On the other hand, since it is physicians who normally bear the onerous burden of possible criminal liability, it is only fair to clarify for their sake the rather ambiguous provisions of the *Criminal Code*. We hope the proposed amendments do just that.

The Commission therefore recommends that a physician should not incur any criminal liability if he decides to discontinue or

not initiate treatment for an incompetent person, when that treatment is no longer therapeutically useful and is not in the person's best interest.

PART THREE:

SUMMARY OF RECOMMENDATIONS

AND

EXPLANATORY NOTES

I. Euthanasia

The Commission does not favour the legalization of euthanasia in any form. That is the view expressed in the following two recommendations, both discussed earlier in the Report:

> **The Commission recommends against legalizing or decriminalizing voluntary active euthanasia in any form and is in favour of continuing to treat it as culpable homicide.**
>
> **The Commission recommends that mercy killing not be made an offence separate from homicide and that there be no formal provision for special modes of sentencing for this type of homicide other than what is already provided for homicide.**

II. Aiding Suicide

The Commission does not favour decriminalizing the offence of aiding or counselling suicide. In Working Paper No. 28 it tentatively recommended that, "[n]o person shall be prosecuted for an offence under the present section without the personal written authorization of the Attorney General". However, in this Report, for reasons explained earlier, the Commission has omitted that particular recommendation. On the subject of aiding or counselling suicide, the following recommendation expresses the Commission's final position:

> **The Commission recommends that aiding suicide not be decriminalized, and that section 224 of the *Criminal Code* be retained in its present form.**

III. Cessation and Refusal of Treatment

The Commission recommends the following amendments to the *Criminal Code*:

> **199.1* Nothing in sections 14, 45, 198, 199 and 229 shall be interpreted as requiring a physician**
>
> > **(*a*) to continue to administer or to undertake medical treatment against the expressed wishes of the person for whom such treatment is intended;**
> >
> > **(*b*) to continue to administer or undertake medical treatment, when such treatment has become therapeutically useless in the circumstances and is not in the best interests of the person for whom it is intended.**

This provision is essentially similar to what the Commission proposed in Working Paper 28. The few changes which have been made merit brief commentary.

The addition of section 229 to the proposed section was made at the suggestion of one of the legal groups consulted. Section 229 of the *Criminal Code* creates the offence of administering noxious things or poison to someone. Although it is highly unlikely that this provision would be applied in medical matters, it was thought advisable to include it since it is at least potentially applicable.

The adverb "clearly" has been removed from both paragraphs of the proposed provision. In the Working Paper both paragraphs referred to, "...the clearly expressed wishes... ". Representatives of one of the provincial Bars convinced us that this word

* This provision was drafted in the context of the current *Criminal Code*. If the *Code* is completely revised, the provision will remain the same except that the beginning will be replaced by: "Nothing in this *Code* shall be interpreted...."

did not actually add anything and threatened to create difficulties in interpretation. Accordingly, we have omitted it from the final version.

Many of our correspondents criticized the use of the expression, "medically useless treatment", in the amendment proposed by the Working Paper. It was suggested that this expression has an excessively pejorative connotation used in this context, in that it implies that the general practice in medicine is to provide extraordinary treatment, or to "overtreat".

A treatment which is initially medically useful may become useless at a certain later point from the therapeutic perspective. To better express the idea that treatment is a continuum and to underline the notion that at a certain point in time the same treatment can become useless in terms of curing or improving the patient's condition, we changed the expression "medically useless treatment", to, "treatment [that] has become therapeutically useless". The word "therapeutically" is used here in its ordinary sense, that is, the intention is therapeutic when the aim is to treat the patient for the purpose of curing or ameliorating his condition.

It should be noted that we have retained as an additional condition, that the treatment in question is not required if it is not in the best interests of the patient. It can happen that a treatment that has become therapeutically useless, may nevertheless be justified on the grounds of patient interests other than treatment of the medical problem as such. The patient may, for example, wish more time in order to see a relative for one last time, prepare a will or put his or her affairs in order. These would be examples of what in our view can constitute the "best interests" of the patient in this context.

In response to another comment we decided to eliminate the phrase "... except in accordance with the expressed wishes of this person" from the second paragraph. It was felt that that phrase might have been wrongly interpreted to mean that a physician who refused to consent to a patient's express desire for a treatment that was medically counter-indicated in the circumstances could be held criminally liable just for not continuing it.

Basically, then, the proposed amendment incorporates the Commission's major recommendations. The first paragraph merely expresses the present legal rule. Patients are masters of their own decisions concerning themselves. If they have expressed a desire to discontinue treatment already in progress or not to undergo treatment, physicians must then respect that decision. This expression of will is a question of fact. The patient can express it orally or in writing, the latter for example by means of a "living will". Though such living wills are without any binding legal effect in Canadian jurisdictions, they may nevertheless serve as a basis for the interpretation of a patient's wishes. Sanctions that might be imposed on the physician if he bypasses the patient's wishes are already contained in various provisions of the *Criminal Code*. In any case, he could be charged with assault.

The second paragraph states the principle that a physician cannot be charged under the provisions of the *Criminal Code* if he ceases to administer a treatment or decides not to administer a treatment which, in the circumstances, has become therapeutically useless and not in the patient's interest. This would be the case, for example, where artificial ventilation was continued for a patient whose cerebral functions had already undergone irreversible cessation.

This would also be the case when a physician who, in order to avoid prolonging the death agony of one of his patients, decides to discontinue antibiotics being given to treat his pneumonia. A further example would be the case of a surgeon who decides not to operate to correct a newborn's deformity because, even if the operation were successful, the infant could not survive his other medical problems.

For reasons explained earlier, this provision applies equally to competent and incompetent patients. Moreover, it does not spell out in detail how the physician should make the decision nor who should be consulted. To comply with the general criminal law standard, those details are not relevant, as long as it can be shown that the treatment was therapeutically useful in the circumstances, made in the best interests of the patient, and not against that patient's wishes.

199.2* Nothing in sections 14, 45, 198, 199 and 229 shall be interpreted as preventing a physician from undertaking or obliging him to cease administering appropriate palliative care intended to eliminate or to relieve the suffering of a person, for the sole reason that such care or measures are likely to shorten the life expectancy of this person.

As explained above, this provision is intended to eliminate any ambiguity concerning the administration of palliative care. Thanks to a very pertinent suggestion by a medical association, the only change from the Working Paper formulation of this proposed subsection, is a slight grammatical modification in the wording to make it clear that the *Code* sections should not be interpreted as obliging a doctor to cease palliative care already commenced.

This proposal simply expresses the idea that the physician's duty is to provide patients with appropriate palliative care when further therapeutic treatment would serve no purpose. For palliative purposes, the appropriate use of drugs, medication or other pain control treatment is legal and legitimate even if they may have the effect of shortening the patient's life expectancy.

* What was said in the note regarding section 199.1 also applies here.