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

PROTECTION OF LIFE

euthanasia, aiding suicide and cessation of treatment

Working Paper 28

Canada

EUTHANASIA, AIDING SUICIDE AND CESSATION OF TREATMENT

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1982

Notice

This Working Paper presents the views of the Commission at this time. The Commission's final views will be presented later in its Report to the Minister of Justice and Parliament, when the Commission has taken into account comments received in the meantime from the public.

The Commission would be grateful, therefore, if all comments could be sent in writing to:

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Foreword

The problems posed for law and morality by the interruption or cessation of medical treatment are extremely complex. They are of more than merely theoretical or academic interest, for they arise in situations experienced on a daily basis in Canada by the public, doctors and hospital staff.

The Law Reform Commission has already published a number of Working Papers and Study Papers in the *Protection of Life* series.[1] In addition, it has recently submitted to the Parliament of Canada its final recommendations on the criteria for the determination of death.[2]

When the research project was first designed in 1976, it soon became apparent that the question of cessation of treatment and, more generally, that of euthanasia, was a constant and urgent concern among members of the medical profession, a number of lawyers and a large proportion of the Canadian public. In order, then, to respond to what it perceived to be very real interest and need, the Commission has decided to publish a Working Paper on the problem.

Two very important warnings should however be expressed. The first concerns the approach taken by this paper and the second concerns its aims.

First of all, this paper makes no claim to represent a complete and exhaustive examination of the question. There is an impressive number of books, articles and documents on the question, dealing with it from the historical, moral, theological, social, literary, medical or legal viewpoints. The reader will find a short selected bibliography in the appendix. *This paper is thus essentially a synthesis, and a synthesis concerned with*

legislative policy in the broad sense of the term. Hence, the reader will not find in our paper an exhaustive analysis of these questions and should not expect a full compilation of all the information available on the subject.

Secondly, because of its particular focus, this paper has only two very specific objectives.

The first is to examine a number of moral and legal problems posed by the cessation of treatment and euthanasia, and to analyse the implications of these problems and acts for the present law and for the law as it might stand after reform.

At the same time, reform implies the acceptance of general social goals, of which legal rules are only one manifestation. Consequently, the second objective of this paper is to examine a number of fundamental questions of social policy and to promote open dialogue of the problem between specialists in the field and members of the Canadian public. Such a dialogue should provide the essential basis for possible law reform.

PART ONE

The Basic Questions

The protection of human life is a fundamental value for all modern legal systems. Law, whatever its specific variations and particular cultural, political or social context recognizes this value to various degrees by forbidding homicide and punishing acts which constitute a danger or serious threat to the lives of other human beings.

The preservation of life is not, however, an absolute value in itself, even for the Canadian legal system. If it were, of course, attempted suicide would not have been decriminalized, nor would self-defence be recognized as legitimate. However, instances in which the law fails to penalize actions intended to terminate human life, are rare and indeed exceptional in nature.

The provisions of the Canadian *Criminal Code* on the subject of homicide (sections 205 to 223), approach human life in an exclusively quantitative, rather than qualitative, sense. Homicide occurs with the death of the victim. Any act which puts an end to an individual's active life, which condemns him for the rest of his days to a very diminished style or quality of life, is punishable under other provisions such as assault. However, a person who, by his actions or inactions renders his victim incapable of leading a life of normal relationships is not considered a murderer.

Law in this respect faithfully reflects one of society's traditional attitudes. For our society recognizes that, morally, religiously, philosophically and socially, human life merits special protection. This recognition of life's fundamental impor-

tance has often been expressed through the concept of the sanctity of human life. One expression of this concept is that because life is God-given and we merely hold it in trust, we should not then interfere with it or put an end to it.

Obviously, any detailed analysis of this principle would be beyond the scope of the present paper. A study published by the Commission has already done so.[3] However, it may be useful to indicate briefly its meaning and implications.

Rigid application of the sanctity of life principle has given rise to an approach known as "vitalism". Vitalism has its supporters in literature, philosophy, religion, law and medicine. For those who support this thesis, (though with important nuances and distinctions), human life is an absolute value in itself and every effort must always be made not only to preserve it but to prolong it and hence to combat death with all available means. Considerations as to the quality of life become secondary and even unimportant. Life in the quantitative sense must be saved, maintained and prolonged because it represents a value in itself.

Vitalism has found some support within medical science and the medical profession. The first and traditional role of medicine has always been to save lives, and to try to prolong life by combating disease and death. But success or failure, according to one concept of medicine, is measured by the quality, strength and aggressiveness of the struggle waged. From this point of view, an aggressive struggle represents excellence in the practice of the art of medicine. This approach can hardly be criticized in itself, since it encourages doctors to fight disease and death, not to give up the struggle, and not to admit defeat prematurely. But insofar as some considered the value and prolongation of human life to be an absolute and inflexible policy, the evolution of the practice of medicine has now imposed a modification on that traditional stance.

Thanks to scientific and medical progress, it is now possible to treat conditions or diseases which once were considered incurable. To give a common example, antibiotics now make it

possible to cure pneumonia in a person suffering from terminal cancer. Before this discovery, the patient would have died of the pneumonia.

Medical technology too has developed an impressive array of machines and equipment for prolonging lives which once would have been given up for lost. Cardiac and respiratory arrest or kidney failure are no longer fatal. Medical technology in other words has considerably reduced the rate of premature mortality. But at the same time, it has substantially increased the number of individuals who, after receiving such treatment, can only hope to "survive" in a state marked by what is objectively an unsatisfactory quality of life. The classic example, of course, is that of those who have been saved by the last-minute use of a respirator, but have nonetheless suffered an irreversible cessation of certain brain functions and are condemned to a vegetative existence,[4] with no hope of ever regaining cognitive, relational life.

The evolution of medical science and technology obviously represent considerable progress for humanity. Yet this progress has further complicated human and legal problems related to death and dying. It has also imposed a serious reconsideration of the classic "vitalist" or absolute interpretation of the sanctity of life principle.

The number of people who die in hospitals has risen considerably. And, in the hospital context, a wide variety of medical technology is generally available. It is readily made use of, even sometimes where it serves no real therapeutic benefit but merely temporarily delays a death which has become imminent and inevitable. Prolonging the lives of certain terminally ill patients by these means may at a certain point become incompatible with considerations of the quality of the life remaining to them. Such prolongation may, in fact, considerably lessen the quality of the remaining period of life. The decision to make use of medical technology is, unfortunately, sometimes based largely on a technological criterion (whether it is technically possible), rather than on considerations for the patient himself (whether it is humanly desirable). An equation

is made between what *can* be done and what *should* be done. It is sometimes simply assumed that, in the struggle against death, the full technical arsenal should be deployed under all circumstances, with few or no "qualitative" considerations being taken into account. This obstinate refusal to admit "defeat" and insistence on using what are termed "heroic measures" has been severely criticized on the grounds that it often works against the patient's best interests, that it is dehumanizing, that it diverts technological progress from its primary aim, which is service to man, and that it tends to prolong the process of dying rather than life itself. The evolution of medical science and technology calls for serious reconsideration of the absolute nature of the classic vitalist option.

In recent years, particularly in the western world, a new approach has developed. This school of thought does not reject the idea that fundamentally human life is of important value and thus that medical and technological resources should be called into play to protect and prolong it. However, it does not subscribe to the vitalist interpretation of the sanctity of life principle. It tempers vitalism with considerations as to the quality of life. The great majority of doctors today appear to subscribe firmly to this approach, and a number of modern codes of medical ethics already reflect this change.[5] This evolution is based on a number of factors. The first is expressed in the phrase, "death with dignity". Patients may wish to eliminate from the process of dying the dehumanizing aspects sometimes imposed on it by the abusive or massive use of medical technology. The second is the greater insistence by patients on direct participation in the decision-making process regarding their medical treatment. Patients are increasingly refusing to consider the doctor as a sort of miracle worker, or to rely simply on what some have described as medical paternalism. Instead, they want to understand and decide freely about the proposed therapy. This should not be interpreted as a sign of lack of confidence in the medical profession, but rather as a healthy attitude by which the patient assumes his own responsibilities and, at the same time, it fosters a more human and professional relationship between himself and his doctor. Since patients increasingly insist that they be the ones who in the

final analysis make the choices, obviously they may knowingly refuse the assistance or support of medical technology or a particular treatment and decide in favour of a quantitatively shorter but qualitatively richer life.

The third factor is the relatively recent development of palliative care. The choice for some patients is no longer between continuation of useless treatment and total cessation of all care. It is now possible to discontinue treatment when the patient has reached the terminal stage, but to undertake palliative measures to relieve or eliminate pain, and thus to ease the passage between life and death.

The legal problems associated with the cessation of treatment are extremely complex, because they are also related to, and confused with, the sensitive and controversial question of euthanasia. The particular subject of euthanasia will also be examined in this paper. In addition there are three types of difficulties underlying the problem of cessation of treatment. It is important to identify and discuss these difficulties briefly before attempting to draw conclusions regarding legal rules of conduct.

The first difficulty is that societal views on these matters are currently evolving. This evolution includes attitudes towards life and death, towards science and towards the cessation of treatment. For example, many are still attempting to define more precisely attitudes and policies which not only acknowledge protection for human life, but yet take into consideration other values as well, including the individual's right to decisional autonomy and the individual's quality of life. We have not yet managed to resolve and balance the apparent contradictions between the protection of life itself and the protection and promotion of the quality of life. The question is made all the more difficult by the fact that, as far as the decision to provide or withhold treatment is concerned, no two cases are identical. The individual characteristics of each case make it extremely difficult to establish general norms which might seem more reassuring or provide a greater sense of security.

The second difficulty lies in the relationships between law and medicine. Legal rules, particularly those of criminal law, are designed to sanction conduct considered socially reprehensible. Their role is thus primarily repressive. Yet there is no record in Canadian case-law of a single conviction of a doctor for having shortened the life of one of his terminal patients by administering massive doses of pain-killing drugs. Nor have Canadian courts ever apparently convicted a doctor who has stopped a useless treatment for a dying patient. Finally, Canadian courts have never directly blamed a doctor for refusing to prolong a patient's agony by deciding not to treat him for a secondary complication.

This lack of legal proceedings and precedent does not of course mean that such acts have not and do not take place. Nor does it mean that the courts would necessarily have acquitted or convicted an individual so charged. In other words, the existing legal situation cannot be considered satisfactory solely because it has not given rise to legal proceedings. Because of this situation, a good proportion of the medical profession and of hospital personnel are in the unfortunate position of not knowing the precise content of their legal duties, and of being entirely dependent in this respect on the Crown's discretion not to initiate legal proceedings.

Legal rules, particularly in the area of criminal law, should also have a certain degree of predictability. Both physicians and patients should be able to predict with some degree of certainty the interpretation which the courts will give to the general rules contained in the *Criminal Code* and which govern behaviour in society.

At the present time, however, physicians and lawyers are generally unable to predict with any certainty how the provisions of the present *Criminal Code* would in fact be applied in a case involving cessation of treatment. A comparison with other sorts of cases may, as we shall see, allow some general conclusions as to the theoretical bases for criminal liability. However, the precise nature of this liability remains difficult to determine.

The third and final difficulty is the following. Independently of the inevitable and specific variations of each case, many are concerned that this apparent vacuum may reflect and promote major differences in medical practice and conduct across the country. In the absence of precise rules of conduct or at least of some type of guidance as to what courts would consider acceptable or unacceptable, it is feared that decisions will be based on essentially subjective and personal considerations, determined exclusively by the moral and ethical standards of the individual physician. Whether or not this fear is justified, the uncertainty and unpredictability permit a greater inequality in decisions and conduct, which may well vary from one institution to another, from one province to another, and from one socio-economic group to another.

In conclusion, the current assumption that medical personnel have little to fear in terms of criminal law is probably correct. However, this perception is far from certain and provides no real guarantee as to the meaning and application of the legal rules. It must be borne in mind as well that the present policy of not laying charges could change under the pressure of events. Should this happen, a number of doctors might have to serve as test cases in order to determine just what the current state of the law is. The question is far too important and far too fundamental to be left in such a state of uncertainty. The question of whether to terminate or not to initiate treatment arises particularly in two very specific contexts. Both will be described briefly.

I. The terminally ill patient

The first context is that of the terminally ill patient, namely one who has reached the stage where the administration of therapeutic care has become medically useless to bring about eventual recovery or even effective control of the disease. Beyond this point, the patient's interest lies in the alleviation, as far as possible, of the physical and mental suffering of the terminal phase. As many of the doctors whom we have consulted have confirmed, the patient's needs change once he

realizes with certainty that recovery is impossible and that death has become inevitable. Basically, what the patient then requires is effective control of his symptoms and the chance to live what remains of his life as comfortably as possible. For some, it is also important that the passage from life to death take place with dignity and lucidity and that surgical or other forms of intervention which are mutilating or perceived as degrading be avoided. The decision to discontinue a form of treatment perceived as useless and potentially degrading is often made on the suggestion of the patient.

Two particular problems may arise as regards the legal response to the above concerns.

The first is that, traditionally and in theory, once initiated, the cessation of a measure intended to save someone's life may serve as grounds for civil and criminal liability. In the case of an unconscious terminally ill patient, a doctor or a hospital might well delay the decision to cease useless treatment, or decide to continue it, for fear of possible prosecution. The result is quite absurd! To preserve life (in the quantitative sense of the word) and perhaps out of fear of the law, little or no value is assigned to the quality of the time remaining to that patient. These absurdities and fears, understandable given the vagueness of present law, give rise to legislative trends such as that which led to the California *Natural Death Act*. We think that it is both unnecessary and even dangerous to go to such extremes. Our legal system should be able to establish and protect the principle that a terminally ill patient has a right, not a secondary or subordinate right but a primary right, to die with dignity and not to fall victim to heroic measures. To allow practical enforcement of this right, it should be clearly stated that there would be nothing to fear from criminal or civil law when, in a patient's terminal phase, the physician stops or refuses to undertake medically useless treatment which will only prolong the process of dying, unless expressly requested to do so by the patient. Reform, in this case, reflects more a clarification of the true scope of the present law than any fundamental change.

The second problem is related to palliative care. Modern medicine has methods and medications capable of eliminating or reducing suffering to an acceptable level in the majority of cases. The experience of various specialized centres in Canada (particularly in Montréal) and in England has shown that this is possible. The only real limits to the wider use of pain control techniques result from a too-limited dissemination among the medical profession of the expertise already acquired and the need for a more systematic development of research in this field.

Control of pain often involves the use of narcotics or drugs to which the patient may eventually develop a tolerance. In addition, with the progression of the disease, it is often necessary to increase the dosage substantially. In time, then, a level of pain may be reached at which a higher dosage may have the secondary effect of shortening the life of the patient. Some doctors hesitate, for the same reasons as those described above out of fear of possible criminal, civil or disciplinary sanctions, should they give the terminal patient care which is effective on the strictly palliative level but which may reduce his life expectancy. Here again, in our opinion, ambiguity as to the scope of the existing legal responses may have the effect of encouraging poor medical practice, medicine which is no longer in the interests of the patient, by restricting the administration of effective palliative care.

In both cases, then, uncertainty can divert medical science from its normal, valid aims and objectives, objectives which should be clearly acknowledged and recognized by the law in order to remove this sword of Damocles.

II. The seriously defective newborn

The rate of infant mortality, a grim problem in Canada barely fifty years ago, has declined significantly since the mid-1950s. Several hospitals have set up intensive care for newborns, thus saving the lives of infants who, because of diseases, deformities or simple prematurity, would not normally have survived. In addition, neonatal surgery has made considerable

progress. It is now possible to treat cases which, a number of years ago, would have been considered terminal.

This institutional development, however, together with the progress of neonatological sciences, has also produced a series of new problems. Today, infants are surviving with birth defects which will make it impossible for them to develop normally. Some will have to be placed in institutions. Others may live with their families, but will impose heavy financial, emotional and psychological burdens on them.

The problem of seriously defective newborns is a complex one. The degrees of defectiveness may vary. There are chromosomal anomalies, the effects of which vary widely from one individual to another. For example, the term *spina bifida** covers a wide range, from an extremely serious handicap to one which is relatively mild.

In addition, two other considerations add to the complexity of the situation. First of all, the newborn, unlike the conscious adult patient, is incapable of making a decision for himself. Others (parents, guardian, doctor) are thus called upon to make it for him and on his behalf. Sometimes, this decision means allowing the child to die, assuming perhaps that if he, like the terminal patient, had been capable of making the decision himself, this is what he would have chosen. Secondly, a tragic and additional factor affecting the decision-maker's perception of the problem is that the seriously defective newborn is a human being who has only just achieved independent life and for whom death is nonetheless already a possibility.

Without attempting to generalize about situations which are always highly individual, the problem of seriously defective newborns arises in two different contexts in terms of law and morality.

The first involves the child who, at birth, suffers from defects so severe that, given the current state of medical science, it is certain that he will not survive more than a few

* Refer to Appendix II

hours or a few days. This is true, for example, with anencephaly* or severe cases of *spina bifida**. In this case, despite the seeming paradox, the child is, at birth, already engaged in the process of dying, and medical science is powerless. There is no appropriate treatment, or the treatments which could be applied appear to be medically useless. The problem then is identical to that of the terminally ill adult. The physician's duty is certainly not to abandon the child, any more than he would abandon a dying adult patient, but to provide appropriate palliative care and to avoid useless therapeutic measures.

The second case, which again admits of many variations in degree, involves the defective child who, without treatment, would probably die shortly, but for whom medicine can objectively do something. Here again, the great difficulty in analysis lies in the fact that treatment may vary widely in complexity, usualness or duration. As an illustration, consider the familiar example of a newborn suffering from trisomy 21* and atresia* of the digestive tract. If a surgical intervention, relatively minor and simple under normal circumstances, is not performed, the child will be unable to absorb nourishment and will die of starvation.

Generally speaking, two sorts of diagnoses are possible in these cases, each leading to different ethical and legal conclusions. A diagnosis in one case may indicate that the trisomic child has no other serious defects, only atresia* of the digestive tract. But a diagnosis in a second case may indicate that the child, in addition to this atresia*, suffers from other serious defects as well (cardiac malformation, etc.), for which there is no appropriate cure or which will necessitate a long series of surgical operations. Both cases clearly raise a problem of value judgment about the quality of the child's life. In practice, the parents, in collaboration with the doctor, will make the decision on whether or not to perform the operation. This decision is a direct reflection of a value judgment on the quality of the child's future life. Some will feel that the quality is not adequate and, in all honesty and good conscience, will refuse the operation. Others, on the contrary, will consent to it, knowing

* Refer to Appendix II

that it will restore a certain functional capacity but will do nothing to improve the child's general condition. In terms of both ethics and law (under present legal rules), it is clear that a refusal to provide treatment in the first case may be grounds for civil and criminal liability. The situation has apparently already arisen in Canada. Charges in a number of cases on this factual basis, notably in British Columbia, were eventually dropped.[6]

But the second type of diagnosis is very different. In fact, the question is no longer one of performing a single simple procedure to ensure survival, but of placing the decision in context. The problem would be the same for an adult: is there any purpose in treating pneumonia in a patient whose kidneys are no longer functioning, whose heart has shown signs of extreme weakness, and who would then need a kidney transplant and bypass surgery? Is there any purpose in performing a minor operation on a child who, because of cardiac or other defects, has a very reduced life expectancy, is completely paralyzed from the waist down, suffers from severe convulsions and, in his short life remaining, will require a series of painful operations, with no hope of ever developing in terms of communication with the outside world? It is probable that, in such a case, the law would not blame either a doctor or the parents for a decision not to subject the child to this process and hence to let nature take its course, while still providing all necessary palliative care.

From the physician's standpoint, the problem of the newborn has something in common with that of the terminal patient. Should he decide to undertake treatment, will not the law then require him to continue it, even when it ceases to be truly useful? Can he, without risk to himself, stop aggressive therapy and simply allow nature to take its course? Should he require the parents' consent? Is the decision theirs alone to make? These are all serious problems currently arising in hospital practice and for which the law admittedly fails to offer the precise responses which some would like to see. Here again, it would be socially most unfortunate if medical decisions were to be made solely on the basis of the possible threat of civil or criminal sanctions.

PART TWO

The Responses of Present Law

Part VI of the Canadian *Criminal Code*, dealing with offences against the person (sections 196 and following), contains a series of protective provisions for the life and physical security of individuals. It would be beyond the scope of the present document to offer a detailed analysis of the legislation and case-law on the subject. Most provisions are of a general nature and are not restricted simply to medical treatment. In addition, our Working Paper No. 26 on medical treatment and criminal law already contains an analysis of these provisions, which the reader may wish to consult.[7]

However, it is essential that we provide a brief synthesis and explanation of the scope of certain specific provisions directly related to the problems with which we are concerned, and also that we describe how these texts have been applied in practice up to now. Finally, a comparative law study should allow a more critical analysis of the situation.

I. The legislation

Section 197 of the *Criminal Code* imposes a legal duty on certain persons (parents, guardian, spouse, etc.) to provide necessaries of life for those dependent on them. Courts have interpreted this provision as being applicable to a member of the medical profession who neglects or refuses to provide a person with medical care, assuming that all the other conditions of the offence are also met,[8] and, in particular, that the person is incapable of taking care of himself. A doctor who fails to

provide treatment for an unconscious person might then, under certain circumstances, be liable to prosecution under section 197 of the *Criminal Code*.

Sections 198 and 199 of the *Criminal Code* deal with two types of duties. The first requires every one who undertakes to administer surgical or medical treatment which may endanger the life of another person to use reasonable knowledge, skill and care in so doing. The second requires every one who undertakes to do an act to continue it if an omission to do so may be dangerous to life.[9]

The use of the word "reasonable" in section 198 obviously leaves a great deal to the evaluation of the particular circumstances of each case. In medical terms, it therefore refers to medical practice and to what can be considered reasonable in the particular circumstances of the case. For instance, a court today would probably consider it reasonable for a doctor not to attempt to resuscitate a person in an irreversible coma. However, it is far less certain that it would absolve a doctor who, after undertaking to treat a defective newborn, subsequently decided not to perform a minor but life-saving surgical operation solely on the basis of a personal judgment as to the quality of life of the patient. Similarly, it can probably be assumed that "treatment" which imposes a disproportionate burden of discomfort or pain on a terminal patient would not be considered "reasonable".

Section 199 of the *Criminal Code* imposes the general duty to continue an act, once undertaken, if an omission to do the act may be dangerous to life. This requirement deserves some explanation. Our criminal law traditionally has not imposed criminal liability on a person who fails to act, to do something, to take positive action, except where this person falls under a specific duty imposed by law. Thus, while action is generally subject to criminalization, mere inaction or omission is not, unless a clear duty to act under specific circumstances has been provided for, and imposed by, law. In terms of medical treatment, then, this section is of great importance, particularly

when it is read in conjunction with section 198. In fact, cessation of treatment which may endanger the life of a patient (for example, turning off a respirator) *appears* to come directly under this provision of the criminal law. At least, this is the fear so often expressed by members of the medical profession.

Section 199 of the *Criminal Code*, read in isolation, seems to imply that a physician who has undertaken treatment is not permitted to terminate it if this involves a risk to the life of the patient. If this were the case, the law would require the use of aggressive and useless therapy. It would also have the effect, in many cases, of causing doctors to hesitate seriously before undertaking treatment, for fear of not being permitted to terminate it later, when it no longer appears to be useful. If this were the actual implication of the rule, then the rule would be absurd and would have disastrous effects on medical practice.

Section 199, however, must not be read in isolation, but rather in conjunction with the other provisions of the *Criminal Code*, particularly section 45 and those sections dealing with criminal negligence. Section 45 protects from criminal liability anyone who performs a surgical operation upon any person for the benefit of that person, when it is reasonable to perform the operation, having regard to the state of health of the patient. There again lies the main standard of conduct on which the law is based: the reasonableness of the act under the circumstances. Moreover, the legal provisions dealing with criminal negligence impose a very specific standard of conduct. The law does not criminalize every case of negligence and hence every cessation of treatment which may endanger life, but only those instances which demonstrate wanton or reckless disregard on the part of the agent.

An example may illustrate this distinction: a doctor turns off a respirator, knowing, as he does so, that the patient will no longer be ventilated and thus will probably die. Let us suppose, in one instance, that before doing so he has assured himself, using standard medical procedures and tests, that the patient is already in a state of irreversible coma. Here the act of turning off the respirator, while technically constituting a

positive act of cessation of treatment within the meaning of section 199, could not serve as a valid basis for criminal liability, and for two reasons. Firstly, the continuation of treatment is not reasonable in this case given the condition of the patient and, secondly, the cessation of treatment does not reflect wanton or reckless disregard for life on the part of the physician. But on the other hand, let us assume that this same doctor performs the same act without first assuring himself of the patient's condition. There would probably then be grounds for applying these provisions, since by ceasing treatment without taking the precaution of assuring himself that such cessation will not endanger the patient, he would be showing wanton or reckless disregard for the patient's life or safety.

Sections 202 to 223 of the *Criminal Code* deal with criminal negligence and various types of homicide. They are of particular importance within the context of the present discussion. We shall limit ourselves, here again, to a brief analysis of these provisions within our particular context. The forthcoming Commission Working Paper on homicide will contain a more detailed analysis. Every human death caused by another is not necessarily a case of culpable homicide. It is only so if caused by an unlawful act or by criminal negligence. Within the category of culpable homicide, the law further distinguishes between manslaughter and murder. The difference lies in the intent of the agent, which, in the case of murder, is to cause death or bodily harm that he knows is likely to cause death, being reckless whether death ensues or not.

In the case of murder, the legislator does not take into account the motives behind the act. Only the intent to cause death is taken into consideration. It is irrelevant whether a person killed for reasons of vengeance, profit, greed, compassion or charity. In every case, he is guilty of murder, if in fact he intended to cause death. Nor does our law take into account, as section 14 of the *Criminal Code* indicates, the fact that the victim may have consented to his own death. Such consent has no influence upon the criminal liability of the agent. A person who kills a loved one out of compassion, to put him out of his suffering, is therefore still guilty of murder,

even if it is shown that the victim wanted to die and in fact asked to be killed. Canadian law, like most other legal systems, thus prohibits active or positive euthanasia, and considers it to be simple murder.

Canadian law has recently decriminalized attempted suicide. However, section 224 of the *Criminal Code* still makes it an offence punishable by imprisonment for fourteen years for anyone to counsel or aid a person to commit suicide. This provision, similar to those found in British law and in most American states, has been strongly attacked recently by groups such as *Exit* or *Hemlock*, which seek the abolition of this type of prohibition in the name of the individual's right to self-determination. A review of Canadian cases shows that this provision is indeed very rarely invoked in practice. However, the difference between aiding suicide and direct participation in homicide is sometimes difficult to determine. Is there a difference, for example, between a person who, at a dying man's request, prepares a poison and leaves it on the bedside table for him to take, and a person who helps the patient to drink it or who administers it directly at the request of a dying person who is unable to take it himself?

Law thus makes a distinction between two types of conduct: the action of killing and the inaction of allowing to die. This distinction, which of course is fundamental, finds a parallel in morality and medical ethics. Wilful, deliberate killing means the direct elimination of all hope, all opportunity, all possibility, however remote, of recovery or a possible prolongation of life. The act is considered immoral, medically unethical and illegal. Allowing to die (in our context, for example, by interrupting a treatment which is no longer useful) does not necessarily deprive the patient of these possibilities. Cessation of treatment may simply restore the situation that existed before treatment was undertaken and allow nature to take its course.

In summary then, cessation of treatment, or its administration, may come under a relatively complex set of provisions of the *Criminal Code*, ranging from assault to homicide and

including failure to provide the necessaries of life, failure to use reasonable knowledge, skill and care, and aiding suicide. These various offences should not however be interpreted separately, but within the general context of the law. The sometimes vague terms in which they are formulated makes it difficult, admittedly, to define the exact scope of application in medical matters. It is this fact, far more than the provisions themselves and the values which they represent, which is the source of the present difficulties.

II. The enforcement of legislation

These various sections of the *Criminal Code* (particularly those concerning homicide and criminal negligence) have given rise to a great deal of case-law. However, it is interesting to note that precise instances of enforcement of these provisions, and of those concerning medical treatment, involving physicians or in matters arising directly out of a medical context are extremely rare, if not totally non-existent. The same is true, in Canada, of proceedings based on murder provisions in cases of compassionate murder or voluntary euthanasia.

This almost total lack of criminal proceedings against doctors or hospital personnel would seem to indicate that they have little to fear, in practice, in terms of possible criminal prosecution. This is reinforced by the fact that, as one author has rightly noted,[10] in the rare instances where charges have in fact been laid, the acquittal rate has been very high. Most of these cases involved errors in diagnosis or treatment as a cause of death. However, no case has been found involving the physician's obligation to continue treatment once undertaken. There appears therefore to be a wide gap between the apparent severity of the law and its lack of practical enforcement.

In the area of medical treatment, a number of reasons may explain this situation. The first is that the standard of negligence established by criminal law as a condition of criminal responsibility is not easily applicable in a medical context. Only serious, gross or intentional mistake or fault come under

the sanction of criminal law. The quality of medicine in Canada is high enough that such instances are fortunately scarce. In the case of a lesser violation, civil law and civil liability provide an adequate remedy by way of damages and compensation.

A second reason is that the prosecution of these cases encounters certain practical difficulties even when the criminal law standard is violated, particularly in establishing an adequate causal relationship between the act and the result of the act. The *St-Germain* case is a good illustration.[11]

A third reason, one which we sometimes tend to forget, is that our system of criminal justice has a series of built-in filtering processes. The Crown does not automatically prosecute every case actually discovered. There is, in this area, a substantial margin for discretion in the administration of criminal proceedings and only the most apparent abuses come to the attention of the authorities. Of these, only those in which the available evidence offers hope of conviction are actually prosecuted. The number of cases brought to the attention of the authorities is small to begin with. Obviously the number of prosecutions is even smaller.

The situation is practically the same for active euthanasia or compassionate murder. In Canada, prosecution is very rare. A recent Montréal case in which a person was found guilty of having killed a paraplegic friend, out of compassion and at his own request, was one of those rare exceptions.[11a] Yet this rarity is not specific to Canada. In the United States, a country much larger than our own, the legal cases involving active euthanasia can practically be counted on the fingers of one hand.

This absence of legal proceedings may reflect some ambiguity in the thinking and conduct of those responsible for the administration of the criminal justice system (witnesses, police officers, prosecutors, jurors, etc.). It may be that, in the case of a compassionate murder, witnesses aware of the fact will choose not to become involved and will not report the case to the authorities, while they would not hesitate to do so if the act were motivated, for example, by vengeance. It is also

possible that the police are not naturally inclined to lay charges in such cases; that the prosecution authorities are not anxious to handle them; that juries are reluctant to bring in a guilty verdict. We may assume, then, that, while the law itself is totally indifferent to motive, all these individuals deliberately or intuitively make an important distinction between ordinary murder and compassionate murder, and that the motives and circumstances involved make the agent in the latter case, in their eyes, not a real murderer who deserves the rigour of the law, but a person who has acted out of compassion or out of charity and whose conduct deserves at the very least tacit approval.

The lack of legal proceedings is, paradoxically, for members of both the legal and the medical professions, a serious handicap. Indeed, case-law and the accumulation of legal precedents make it possible at a certain point in time to determine the degree of social tolerance and, on the practical level, the exact content and intensity of legal duties. While it is probably relatively easy to establish the standard of behaviour that a Canadian driver must meet to avoid being charged with criminal negligence, it is, in contrast, extremely difficult to do so for a doctor or a nurse. Which does not at all mean that we would advocate an increase in the number of prosecutions against such people simply to ascertain the specific content of the legal rules.

III. Comparative law

A brief survey of the solutions offered for these various problems by the legal systems of other countries is instructive.

In a first group, composed primarily of common-law jurisdictions, the solutions are largely the same as those provided by Canadian law. A 1957 case in Great Britain, unfortunately unreported, shed some light on possible limits to the administration of medical treatment. In the *Adams* case, a doctor was accused of murder for having administered a high dose of a pain-killing drug to one of his terminal patients. The Court

acquitted the doctor and expressed the following opinion on the state of the law:

> If the first purpose of medicine – the restoration of health – could no longer be achieved, there was still much for the doctor to do, and he was entitled to do all that was proper and necessary to relieve pain and suffering even if the measures he took might incidentally shorten life . . .[11b]

This is however an isolated opinion and not a rule developed by a long line of authority. Moreover it is not certain that it does accurately represent the state of the common law.

In Great Britain as well, several attempts have been made to introduce legislation legalizing active euthanasia under certain conditions and thus decriminalizing the act of aiding suicide and compassionate murder. The first of these attempts appeared in the early 1930s with the founding of the English Euthanasia Society.[12] After a long interruption, the movement became active again during the early 1950s, when Lord Chorley initiated a debate in the House of Lords on the question. In 1958, Glanville Williams published his famous work favouring voluntary and positive euthanasia.[13] Since then, the debate has grown in intensity although, on the medical side, the British Medical Association severely condemned the practice in 1971. A number of attempts to introduce legislation on the subject have been made, notably in 1950, 1969 and 1976, but with no concrete results. It is worth noting, however, that whereas in 1953 the Royal Commission on Capital Punishment concluded that it was dangerous to make compassionate murder an offence distinct from ordinary murder, the Criminal Law Revision Committee in 1976 made a recommendation to the contrary, which however was not adopted.

In the United States, a number of well known cases, including the *Quinlan* and the *Saikewicz* cases, allowed the courts to define somewhat more clearly the exact limitations on the duty to provide treatment, and to determine, with more accuracy, the circumstances under which termination of care can be considered legal. It must be borne in mind, however, that each of these cases involved a number of specific individual characteristics making it difficult to generalize from them a rule of universal application.

In 1970, a new trend began to appear in the United States. This trend materialized in the form of a *Natural Death Act* in California, legislation which was subsequently initiated by other States.[14] However, none of these various Bills, contrary to what is sometimes thought, advocated the recognition of euthanasia. All of them deal with a different problem: the cessation of treatment. As the preamble of the California legislation clearly indicates, the primary goal of the law is to respond to a concrete problem: how to assure to everyone the power of decision-making regarding the continuation or cessation of medical treatment, and how to eliminate existing uncertainty regarding the extent of a physician's obligation to provide care.

The *Natural Death Act* allows a patient to make a written and juridically valid directive (living will), containing instructions to the effect that he does not wish to be provided with artificial means of prolonging life if he has a terminal illness (as defined by the law) and is unable to express his wishes. The law provides that these directives may be revoked. The principal impact of the law as regards doctors and hospital personnel, is to protect them from civil or criminal liability on the basis of refusal to initiate or to continue treatment. Several other American states have introduced similar legislation.[15] Similar efforts in the same direction have been made in Canada,[16] but no legislation has yet been adopted. The *Natural Death Act* and its possible application to Canada will be discussed in another part of this paper (p. 69 and following).

Insofar as compassionate murder and the use of aggressive therapy are concerned, American law has witnessed a number of interesting developments. Until recently, there were approximately sixteen reported cases of active euthanasia in the United States. Without going into the details of each of these cases, the contrast between the apparent severity of the criminal laws (of the same type and tradition as our own) and their practical application is striking. Out of these sixteen cases, ten ended in acquittals, six on the grounds of temporary insanity. Of the six remaining cases, a single life sentence was handed down, one life sentence was completely suspended, and two suspended sentences of five to ten years and three to six years

were imposed. In the other two cases, the charges were immediately dismissed.

However, a number of groups in the United States as well have advocated legislative recognition of voluntary euthanasia. Various proposals have recently been submitted in Idaho, Montana and Oregon. All of them are based more or less on the model of the British Bill of 1969. In addition, certain groups, such as *Hemlock*, are currently fighting for decriminalization of acts of aiding the terminally ill to commit suicide.

A second group of countries takes an approach which is very different from that of the common-law tradition. This group consists of those (primarily European) countries which, in one or another, separate ordinary murder from compassionate murder, lessen the gravity of the offence or shorten the sentence attached to it. This group includes Germany, among others. The homicide classification system of the present German Criminal Code makes a distinct category of compassionate murder. The act, however, still remains a criminal offence (murder on request), but the law takes into account the perpetrator's motivation and thus permits a substantial reduction in sentence.

In Switzerland, the Criminal Code provides that the judge may reduce the sentence if the accused had an "honourable" motive for committing the act. Also, a doctor who, out of compassion, assists his patient to commit suicide is apparently not subject to criminal prosecution. He may, for example, give poison to his patient but is not allowed to administer it himself. In 1977, in the Canton of Zurich, a referendum on the possibility of allowing formal legislation permitting a doctor to perform an act of positive euthanasia at the request of a patient suffering from an incurable illness received a strong majority of assenting votes. However, no legislation has yet been introduced.

In such countries as Norway and Uruguay, the problem is dealt with not at the level of classification of the various types of homicide, but rather at the level of sentencing. The judge may either reduce the sentence or set it aside entirely.[17]

Two observations, then, may be made by way of conclusion to this brief study of existing law.

First, there is a definite uncertainty at present with regard to the cessation and interruption of medical treatment. This uncertainty arises fundamentally not primarily from any absence of legislative enactments or dissatisfaction with the way in which they are ordered. It exists essentially because of two factors. The first is that these enactments were not specifically designed to cover the social situation especially in the modern context in which medical and technological progress make possible an often useless, unwanted and painful prolongation of life. The second is that these provisions, for various reasons, have never really been tested before the courts making it impossible to know with any reasonable certainty how the courts would apply them to the medical context. While it is certainly possible to raise hypotheses and possible interpretations, and to note certain tendencies, one must nevertheless admit that uncertainty reigns. Uncertainty is not desirable. It can have a detrimental impact on medical behaviour in that it promotes social tension and anguish, and because it leaves the lawyer in constant uncertainty as to the appropriate legal solutions to this crucial problem.

A second observation is that all legal systems, in one way or another, have refused to allow active and voluntary euthanasia. Some punish compassionate murder as a form of murder; others compromise by taking into account the agent's motives, either through the definition of the offence or at the sentencing level. In all cases, however, case-law in every country reveals an obvious paradox and contradiction between the apparent severity of the law and its application in practice. The offenders are seldom brought before the courts. When they are, they are rarely found guilty, and when found guilty they receive very light sentences.

PART THREE

The Necessity, Objectives and Imperatives of Reform

In matters as difficult and as complex as the cessation of treatment, euthanasia and suicide, two preliminary questions can be asked. Firstly, why a reform in this area? Secondly, what benefit can the Canadian criminal-law system reasonably hope to draw from a legislative reform?

I. The necessity of reform

Some argue, with some logic on their side, that legislative reform in this area is not necessary. They point out, more particularly, that the sections of the *Criminal Code* which we have analysed, unlike other sections of the *Code*, have not yet raised any serious problems in terms of practical application. Why change provisions which are creating no difficulties in terms of judicial interpretation?

Moreover, as we have seen, these provisions are very rarely applied to the medical and hospital context. It is a fact that there have been practically no prosecutions of doctors, nurses and hospital staff under these provisions. It is also a fact that aiding suicide remains largely a crime with no practical application. Why then waste time settling a purely theoretical problem? Would not a change in the law increase the risk of prosecution?

It is the Commission's opinion, however, that none of these arguments rules out the need for reform, at least the sort

of reform envisaged by the Commission. Reform is not necessarily equivalent to eliminating already acquired solutions and starting again from scratch. Proper law reform may consist simply in a reorganization of, or addition to, existing legislation. A number of serious reasons militate for reform.

First, as we have seen, the Canadian medical and social contexts have greatly evolved since the present sections of the *Criminal Code* came into force. These provisions have successfully resisted the inevitable erosion of time because they are drafted in general terms and set standards that are so broad they do not quickly become outdated. However, this generality, while it is a great advantage in terms of the risk of rapid obsolescence, is at the same time a failing when it generates uncertainty, with respect to new situations. These provisions would be adequate if we could be reasonably certain of their ability to settle actual concrete situations without requiring lawyers, judges or juries to twist their meaning or to seek byzantine interpretations, sometimes quite literally deforming the sections in order to force their meaning. All of this without any certainty that the suggested interpretation is correct, given the lack of guidance in case-law.

One author has been particularly critical in this regard, accusing the law of closing its eyes to the realities of medical practice and everyday life, and obliging judges and juries to find technical and sometimes even acrobatic reasons for mitigating the apparent severity of the law.[18] This charge is probably too strong. It overlooks the other functions of the law besides mere repression in the sense that it may play a preventive role as well. The difference between the law as expressed in legislation and the law experienced in judicial reality may be wide; it is not necessarily undesirable or senseless.

However, as the Commission has readily observed, there is, rightly or wrongly, some uneasiness among medical specialists and the public in general. This uneasiness lies particularly in the perception that present legislation casts serious doubt on the legality of certain current medical or hospital practices. Since legal precedents regarding these questions are almost

non-existent, the degree of uncertainty is all the greater. This uncertainty is serious, because it may lead to a complete split between legal practice and the legal rule, with practice proceeding as if the legal rule did not exist. It may also give rise to the opposite phenomenon. In an effort to avoid risks, medical practice could remain extremely conservative and conform to the strictest standard which it believes the law establishes.

Medical practice does not generally wait for the legislator. Hospitals, for instance, have not waited for legislation before implementing certain practices with respect to the dying or to seriously defective newborns. Doctors model their conduct on what they believe to be just and ethical under the circumstances, on the basis of their own expertise and the standards established by their codes of ethics. However, it would seem logical and in keeping with our tradition, for the law, at one point or another in its evolution, to take a position and to clearly indicate whether a given medical practice is acceptable. Where human life is concerned, constant temporizing and making do with hypotheses seem unjustified. It is true, of course, that the law can never speak in the singular and give a clear, neat, precise answer to each doctor on each act he performs for each of his patients. Law, however, can speak in the plural and establish certain general parameters, which are still specific enough within the existing context to delineate clearly between what it considers acceptable and what, on the other hand, it considers unacceptable.

For instance, today, many wonder whether it is legal, to use a vernacular expression, to "pull the plug" on an individual. A practice has developed in hospitals, in this connection, based on certain ethical and medical standards. The fact that these practices are found everywhere, have multiplied since the appearance of respirators and are being applied every day without interference from the law, appears to confer on them a certain *a priori* legitimacy and legality. Many believe that there is no longer any problem: the practice is legal because it exists, because it occurs every day and because the law has never seen fit to intervene. The law's silence is thus interpreted as an endorsement or tacit consent on its part.

Current hospital practices involving the turning off of respirators probably do not go against fundamental legal norms. However, other situations do raise the issue. A newborn suffering from trisomy 21,* who has no other serious defects but does have atresia* of the digestive tract, poses a serious problem.

The development of different practices across the country, in the same province or even the same city is probably inevitable. However, when human life is at stake, law should do everything within its power to clarify the situation and to define as precisely as possible the minimal limits which our society considers acceptable.

The Commission believes that it would be burying its head in the sand not to raise the problem of the need for reform, not to examine whether the situation can be improved, and to see whether the veil of uncertainty cannot be raised.

II. The objectives of reform

The identification, within such a controversial field, of the benefits that reform may offer the Canadian community involves, first, identifying the role to be played by law, and, more importantly, learning to recognize its limits.

As the Commission has often stated in the numerous Reports and Working Papers which it has produced over the past ten years, the role of criminal law is not merely to punish the individual. This punitive role does obviously exist. It may even be its most apparent role. However, criminal law is not only punishment oriented.

It also plays an important preventive role when examined within the context of medical practice, cessation of treatment and assisting suicide. The fact that it punishes armed robbery or murder with severity will probably not prevent the perpetration of those crimes. However strict or refined the legislation

* Refer to Appendix II

may be, society must expect a certain number of cases to continue to occur. However, when the law deals with a specific category of well-informed and educated professionals such as physicians and hospital personnel, likely to understand more readily than others the parameters of the law, and dedicated to an ideal of altruistic service, the probability is much greater that their conduct will conform to legally-established standards if they are sufficiently clear and explicit. For example, if the legislator or the courts were to decide tomorrow that failure to operate on a trisomic newborn suffering merely from atresia* constitutes a criminal act, it is most likely that any physicians currently following this practice would abandon it immediately.

Criminal law is also a powerful educative tool. In theory at least, its rules are the expression of a certain social consensus. Any attempt to change the rule or to clarify it should allow for a good measure of discussion within those groups affected by the change and the public in general, and hence a greater awareness of the dimension of problems created by cessation of treatment, euthanasia and aiding suicide. These discussions and the expression of the various opinions on the subject may then generate a certain number of rules based on a measure of social consensus. Such an approach may appear useless or superfluous to some observers. The Commission, however, considers that it is both useful and necessary. In fact, this was one of the clearly defined objectives of the Protection of Life research project which produced this paper.

At the same time, it is important to remember that, in such a complex and controversial matter, unanimous support for any reform is most unlikely if not impossible. The questions which this paper raises are deeply rooted in individual morality, behaviour, experience and psychology. Thus we cannot hope for either a miracle solution or a solution which will please everyone. However, this is not a sufficient reason for abandoning the task.

Finally, legislative reform is not an end in itself, but rather the beginning of the real reform. Changing the law is one thing,

* Refer to Appendix II

but changing attitudes, conduct, forms of behaviour is another, and one over which the legislator often has very little control. To achieve the desired results, social and institutional policy reforms must accompany specific legislative reforms where necessary.

III. The imperatives of reform

Reforming the criminal law in the areas dealt with in this paper involves asking three very specific questions:

(1) Should the legislator, in one way or another, legalize or at least decriminalize certain forms of active euthanasia, such as compassionate murder?

(2) Should the legislator decriminalize the act of aiding suicide by repealing section 224 of the *Criminal Code*?

(3) Should the legislator intervene within the framework of sections 14, 45, 198 and 199 to define the legal limits of the refusal and cessation of medical treatment?

The answers to these three questions are complex and not clear cut. The issues involved have been examined extensively in the literature on the subject. It is not the Commission's intention once more to deal exhaustively and analytically with them. Rather, it is our intention to discuss the choices and options only in terms of legislative policy applicable to Canadian law, in the light of its basic philosophy.

In order to retain an internal logic essential to reform, we believe that some preliminary reflection is necessary in order to identify the categorical imperatives of this reform. In other words, it is important to ask the following question: what are the principles or fundamental rules on which any reform of the law should be based?

These imperatives are of two types. The first has to do with the nature of the reform, the other with its content.

As regards the nature of the reform, it is essential that any reform be sensitive to the intrinsic limits of criminal law. As the Commission has frequently pointed out elsewhere, criminal law is merely one instrument of social control among others, and a very imperfect one at that. One cannot expect a criminal law reform to serve as a universal panacea; one cannot expect criminal law to provide a miraculous or permanent solution to all problems. Criminal law exists solely to check the most serious and gross abuses. Whatever the reform, it must come to terms with usage and judicial practice, which alone will eventually determine its true scope.

Secondly, the solutions proposed must retain a great deal of flexibility if they are to adapt to the specific circumstances of each case and not to impede the continuing evolution of science, medicine and society. One should therefore be wary of extreme or inflexible solutions incapable of adapting to other realities.

Thirdly, it is best to seek solutions which, wherever possible, fit harmoniously into the existing socio-judicial context and do not represent a radical upheaval of all the basic principles and institutions of our law.

In terms of content, a number of fundamental principles should guide the process of reform. The reform should not be based on a categorization of nebulous, unscientific or discriminatory concepts.

A. *Person and non-person*

First of all, it would be unthinkable to base reform on the recognition of two categories of beings: those recognized as human persons and those not so recognized. History reveals too clearly the dangers of such categorization. Qualifying a human being as "non-person" has frequently been the pretext or justification for considering him an outlaw (in the literal sense of the term), placing him outside the law and thus refusing to apply to him the basic protections which the law grants to all human beings. To give one concrete example, to

deny an anencephalic newborn the status of a human person could be used to justify denying him the protection of the law as well, and thus provide grounds for arguments that killing him directly constitutes neither murder nor criminal negligence. History is filled with cases in which witches, the mentally ill, various ethnic groups and entire races have been eliminated after having first been categorized as non-persons. The Commission asserts that the law should continue to be based on the fundamental rule now recognized by our criminal law: everyone born of human parents is equally human. In terms of the exercise of subjective rights, we consider that we must continue to respect at least the basic rule of the *Criminal Code* to the effect that a human being is one who has completely proceeded, in a living state, from the body of his or her mother, and must firmly disagree that any such distinction as that between person and non-person should be applied to living humans. Every human person, whatever his degree of handicap, is entitled to the protection of the law. This is particularly important within the context of medical treatment. This point, moreover, governed the articulation of the reform proposed by the Commission regarding the criteria for the determination of death.[18a]

B. *Ordinary and extraordinary means*

It does not seem useful for the purposes of reform, to adopt the common distinction between ordinary and extraordinary means.

It is customary to trace the origin of this distinction to a response given by Pope Pius XII to a group of anaesthetists in 1957. The Pope, on this occasion, expressed the opinion that a physician was morally obliged to use only ordinary means to preserve life and health, that is, means which do not involve any serious inconvenience for the patient. These terms have received a variety of interpretations. The most commonly known involves a distinction between treatment which is strictly necessary and usual and treatment which is experimental or

* Refer to Appendix II

uncommon in the particular circumstances. A doctor is therefore required to use all usual or "ordinary" means, but not those which are unusual or "extraordinary".

This distinction itself was intended to be a clarification. Yet, it still retains a degree of imprecision, making it difficult to use as a criterion for reform. If the word "ordinary" is taken in its most common sense, that of usual, the distinction is meaningless. Medicine is not a stable, fixed science, but a science in constant evolution. What is usual today was not usual a few years ago. Moreover, what may be usual in a given area or well-equipped hospital centre is probably not usual in some other area or poorly-equipped centre. For example, in our times, placing a person in a state of respiratory arrest on a respirator would probably be objectively considered a usual or ordinary procedure. This was certainly not the case in the years immediately following the development of this equipment. Nor is it yet the case in some isolated areas far from any modern hospital facilities. It is therefore difficult to distinguish what is "usual" from what is not, the difference remaining largely arbitrary and fluid. If a doctor owed his patient only usual care, he would be hopelessly condemned to the *status quo* and hence to an extremely conservative practice of medicine. Doctors, of course, have clearly recognized the difficulty, and to them the word "ordinary" always designates what is ordinary according to the particular circumstances of each case.

Others have therefore proposed that one interpret the words "ordinary" and "extraordinary" in a sense other than strictly objective. "Ordinary" treatment would be treatment offering a *reasonable* hope of success and not involving any undue suffering or burden for the patient. "Extraordinary" treatment on the contrary would be treatment offering no reasonable hope of recovery or relief, or that involving unbearable suffering or other burden for the patient. A close scrutiny of this new interpretation reveals that, though it is much more realistic, it does not make the distinction much more useful for purposes of legislative reform. It merely describes true medical treatment in the first case and unwarranted aggressive therapy

in the second. In our opinion, while this distinction may be useful for other purposes, it remains too ambiguous to serve as a solid basis for any precise description of the scope of the physician's legal duty to his patient and therefore to serve as a good basis for reform.

C. *The presumption in favour of life*

Preservation of human life is ackowledged to be a fundamental value of our society. Historically, our criminal law has changed very little on this point. Generally speaking, it sanctions the principle of the sanctity of human life. Over the years, however, law has come to temper the apparent absolutism of the principle, to delineate its intrinsic limitations and to define its true dimensions.

The Commission believes that any reform having to do with human life must begin by admitting a firm presumption in favour of life. In other words, the intent of a terminally ill patient to give up life should normally not be assumed without a clear, free and informed expression of the will to do so. This rule is of considerable importance. It may sometimes be impossible to determine whether a person no longer wishes to live or whether, in contrast, he wishes every effort to be made to prolong an already seriously endangered life. This is particularly true of those who have lost the ability to make decisions (for example, the comatose patient). As a general rule then, the only valid legislative policy for respecting life and avoiding abuses is to assume what common sense dictates, that under normal circumstances every human being prefers life to death.

However, and this is where the real problems arise, this presumption in favour of life cannot stand without further qualification. It would be disastrous, for example, if this presumption had the effect of obliging a physician always to use aggressive measures in cases where the patient is incapable of expressing his wishes. Such an application of the principle could lead to intolerable abuses and discrimination against incompetent or handicapped persons.

This presumption in favour of life must therefore be further qualified in the following manner: *if treatment can reasonably be applied to preserve a person's life or health, it should be assumed that this person's choice, if he could express it, would be to receive treatment and not to refuse it*. In practice, of course, this rule is applied every day to emergency cases. When a patient arrives unconscious at a hospital's emergency ward, the physician will normally treat him. He cannot assume, even in the case of an apparent attempted suicide, that the person truly wants to die. Yet, this presumption in favour of life does not oblige that physician to give an unconscious patient a treatment which, under the circumstances, appears unreasonable or useless. The practical effect of such a presumption in favour of life is to place the burden of proof on those proposing a course of action or inaction which will *not* prolong or maintain human life.

D. *Personal autonomy and self-determination*

Law must also recognize, as it now does implicitly, the principle of personal autonomy and self-determination, the right of every human being to have his wishes respected in decisions involving his own body. It is essential to recognize that every human being is, in principle, master of his own destiny. He may, of course, for moral or religious reasons, impose restrictions or limits on his own right of self-determination. However, these limits must not be imposed on him by the law except in cases where the exercise of this right is likely to affect public order or the rights of others.

Our legal system already recognizes that principle. To acknowledge it formally as a basis for reform thus involves no challenge to existing law. In 1972, the criminal offence of attempted suicide was repealed. This was not equivalent to a legislative approval or endorsement of an act which most people regard as profoundly contrary to human nature. It simply meant that our legislators no longer considered the act sufficiently asocial to warrant criminal prosecution. Parliament adopted an essentially pragmatic attitude towards this question. Since in the case of attempted suicide the offender and the

victim are the same person, criminal punishment in this case seems somewhat misplaced. Since the person concerned probably needs help and certainly not punishment, prosecution would be inhuman. However, the act continues to be illicit in the broad sense of the term, even though no longer illegal.

The case-law rule that an individual of sound mind is free to refuse treatment takes a similar approach. An adult Jehovah's Witness who refuses a blood transfusion, knowing that it is probably the only means of avoiding death, exercises his right to self-determination. The same is true of the cancer patient who rejects treatment which could prolong his life. In its Working Paper No. 26 on treatment, the Commission recommended the formal legislative recognition of this right to refuse treatment.

Here again, the Commission believes that personal moral choices should be respected by law as long as they do not interfere with public order and morality. It thus believes that the law should not make the preservation of life an absolute principle. Rather, it should continue to respect man's right to self-determination over his own existence, while protecting and promoting the maintenance of life as a fundamental value.

E. *Quality of life criteria*

As already noted, criminal law tends to value human life essentially from the quantitative point of view. It punishes severely those who take or shorten life. A Study Paper prepared in connection with the Protection of Life project has shown the origin of this tendency,[19] the evolution it has undergone and the often artificial nature of the distinction between quantity and quality of life, between the sanctity of life and its quality. We therefore refer the reader to that document for further analysis.

The Commission believes that any reform must recognize something more than a merely quantitative aspect to human life and that considerations of quality of life can be legitimate factors in decision-making and valid criteria in justifying certain

acts which may appear to be threats to life seen from an exclusively quantitative perspective.

In medical law, this has already long been recognized in practice. It is for the sake of the quality of their lives that some patients freely refuse treatment and that this choice is respected by doctors. It is also for the sake of the quality of their patient's life that some physicians will decide to stop or not initiate a given form of treatment. The autonomous person has the right to define his own priorities and requirements in terms of the effects of treatment or non-treatment upon the quality of his life. Others should respect these priorities. If the person is not autonomous, others must determine these priorities, taking into account the utility of the act in the light of the benefit to the person involved.

In other words, in formulating a policy for reform, the legislator should not systematically exclude values relating to the quality of life, favouring exclusively the quantitative preservation of life as an absolute value. The law, then, must not interfere with the patient's right to refuse further treatment and with his right to live the time remaining to him with sufficient quality.

F. *Special protection for the incompetent*

The law should protect all citizens equally. Law is also intended to provide additional protection for those who are weaker or whose rights may be more readily violated or ignored. To a certain extent, then, we may say that the law should be prejudiced in their favour. In terms of the protection of life, this prejudice should be maintained, if not reinforced.

A very serious dilemma arises in terms of legislative policy regarding those who are incapable, because of unconsciousness, infancy or a mental handicap, of exercising any effective power of decision. These persons need protection. Federal and provincial laws all recognize this fact and provide legal mechanisms for protection. These provisions normally require some other person (parent, guardian) to give consent on behalf of the

incompetent individual. This is of relatively little consequence in the exercise of property or economic interests. However, deciding for another person when this decision affects his health, his physical integrity or his life involves a responsibility of a completely different nature and value. The Commission has recognized the complexity of this question in a Working Paper on the sterilization of the mentally retarded and mentally ill.[20]

It should also be noted that most provincial laws provide some mechanism for resolving possible disputes between parents and doctors over treatment. In Québec, for instance, the law provides that if the parent's consent, when required, is refused or cannot be obtained, a substitute consent may be given by a judge of the Superior Court and that parental consent is not required when the life of the child is in danger.[20a] In the common-law provinces, the law also provides that the child may be placed under the protection of the Court.[20b]

The main difficulty arises from the fact that, since any decision about life or health is essentially of a personal nature, substituted consent could be considered by some to be a totally inappropriate mechanism. If one accepted this principle, one could not allow anyone else (a guardian, for example) to make such decisions. As a result, the incompetent person would be placed in a disadvantaged position compared to that of the competent person, in that decisions may be made against what may appear to be in his best interests. On the other hand, treating an incompetent person on exactly the same footing as one who is fully competent is not a valid solution either, since the incompetent person may not be able to understand the implications and exact consequences of his actions or decisions.

An example may illustrate the problem. A competent person makes a decision not to undergo chemotherapy, because he feels that it is more important not to trade the quality of the life remaining to him for prolonged survival. In this case, the physician should respect that decision. However, when the person is totally incapable of expressing a choice or giving

valid consent, the dilemma is that either the doctor aggressively treats the incompetent patient, regardless of the fact that the quality of his life will be radically diminished, or he chooses not to treat him basing his decision largely on his personal value judgment. It is not certain, in other words, that this would or could have been the patient's decision.

The Commission believes that the solution to the dilemma sometimes lies in the development of rules designed to ensure that the substituted decision is in the best interests of the incompetent patient. His "best" interests do not *necessarily* involve the initiation or continuation of treatment. As the Commission pointed out in its document on sterilization, additional protective rules should be established. If adequate rules exist, there should be less hesitation in permitting the cessation of treatment of the incompetent, under the same circumstances in which it would appear legitimate to do so for a person in full possession of his faculties. No rule however is perfect and it is humanly impossible to eliminate all errors. The objective should be to reduce the possibility of their occurrence to an absolute minimum.

PART FOUR

The Proposed Reform

As already indicated earlier, the legislative policy questions regarding possible revisions of the Canadian *Criminal Code* may be reduced to these three:

(1) Should certain forms of active euthanasia such as compassionate murder 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 and 199 of the *Criminal Code* be revised to define the legal parameters of the refusal and cessation of medical treatment?

I. Euthanasia

Our first task is to offer some clarification of the terminology used, particularly the meaning of the word "euthanasia" as understood in this paper. This word is often used with very different meanings and acts in mind.

Positive, direct, or active euthanasia is usually contrasted with negative, indirect, or passive euthanasia. The difference between the two concepts is one of action as opposed to omission or inaction. For the purpose of this paper, we shall use the word euthanasia in a very specific sense; it will designate exclusively the positive act of causing a person's death

for compassionate motives. The obvious example is the administration of poison to end someone's life.

Voluntary euthanasia is also contrasted with involuntary euthanasia, using as the criterion for distinction the fact that the "victim" did or did not consent to his death, whether caused by some positive act or by an omission. For the purposes of this paper, we shall use the word euthanasia to mean voluntary euthanasia only, that is, the killing of the patient at the patient's explicit request, or when the consent to his killing could be implied from the circumstances of the case on grounds of benefit to the patient.

A. *The legalization of euthanasia*

A number of very eloquent arguments have been advanced to persuade legislators to permit positive euthanasia on the request of the terminally ill patient. A text by Glanville Williams is considered a classic of its kind.[21] Williams attempts to show that law and society are hypocritical and inhuman in refusing to comply with the request of a person dying with excruciating pain that he be killed to put an end to his suffering.

This type of argument is not new. It is found, for example, in the well-known German work published in 1920 by Binding and Hoche.[22] Essentially the same argument is found in all writings advocating the recognition or decriminalization of euthanasia. It would, however, be erroneous and unfair to pretend that all advocates of euthanasia seek the "improvement of the race" or the "elimination of useless or undesirable social elements". Nor should we cloud the issues by focusing only on the euthanasia atrocities of the Nazis. On the other hand, they should not be passed over lightly as they provide important historical lessons.

Many arguments have been advanced in support of legalizing euthanasia. It is not our intention to refer to all of them here. The reader will find additional details in the literature on the subject.[23] Certain points, however, deserve closer examination by us.

One of the points most frequently argued is that the existing rules of law are illogical and cynical. Society recognizes the patient's right to refuse treatment or to request that it be halted, so as not to prolong his agony. The patient, we say, is master of any decisions involving his own body and his own life. Most legal systems even provide penalties against a physician who, disregarding his patient's expressed wishes, administers treatment against the patient's wish. If law now recognizes the patient's decisional autonomy and self-determination as justification for a physician's inaction, would it not be consistent to recognize the same grounds for the positive act of killing as well? What is the essential difference, in fact, between discontinuing aggressive treatment and providing a fatal injection at the patient's request, such that the law should absolve the former but treat the latter as a criminal act?

More importantly, the advocates of euthanasia argue that since the law no longer punishes attempted suicide, it implicitly allows the terminally ill patient to take his own life. Would it not be more compassionate, for those who wish to kill themselves but are physically unable to do so, and for those who wish to have help in doing so under the best possible conditions, to allow death to be administered in some scientific, medically certain and humanly acceptable manner? Would not the legalization of active and voluntary euthanasia be essentially realistic? Would it not represent respect for individual freedom and all its consequences?

A number of legislative proposals for the legalization of euthanasia have been made in Britain and the United States. Without exception, they all propose to limit its availability only to those suffering from an incurable or terminal disease. At the same time, they make every effort to establish some system of determining the person's wishes and obtaining a declaration of his intention. Most provide severe penalties for anyone falsely creating the impression that another person desires euthanasia. Most of the proposals also require that the act of euthanasia be performed by a doctor or be done under medical supervision. They provide that, if all the established conditions are met, a physician acting in good faith does not commit murder and is not liable to criminal or civil prosecution.

The best known examples of this type of legislation are the *British Voluntary Euthanasia Act* of 1936 and 1969, the *Euthanasia Society of America Bill* (Nebraska 1938), and a series of proposals introduced more recently in the legislatures of the states of New York (1947), Oregon (1973), Idaho (1969), Montana (1973) and Florida (1973, 1976).

The Commission recognizes the very laudable intentions behind these recommendations. However, from both the legal and social policy points of view, we believe that legislation legalizing voluntary active euthanasia would be quite unacceptable.

Legalizing euthanasia, given current social conditions, would mean far too great a risk in relation to any possible benefit to our society and its members. First of all, there is the risk of error and accident, since an incorrect diagnosis is always a possibility. In addition, there remains the possibility that a new treatment or the refinement of a known treatment, which will permit either survival or recovery, can never be completely ruled out. This is an important consideration, and one that is too familiar to require further development.

The principal consideration in terms of legislative policy, and the deciding one for the Commission, remains that of possible abuses. There is, first of all, a real danger that the procedure developed to allow the death of those who are a burden to themselves may be gradually diverted from its original purpose and eventually used as well to eliminate those who are a burden to others or to society. There is also the constant danger that the subject's consent to euthanasia may not really be a perfectly free and voluntary act. Medical opposition to euthanasia has often, and with reason, focused on these two considerations.

In fact, there can often be serious doubt as to the psychological and legal value of such a request by a terminally ill patient. The system which the advocates of euthanasia propose would perhaps be arguable if it were possible in each case to be absolutely sure that requests to be killed were free,

voluntary and informed. The assumption behind these proposals is always that terminally ill patients are at once lucid, intelligent, informed and courageous. We forget too readily that, while this type of patient does exist, there are others whose faculties have been weakened by disease or drugs, who are suffering anguish and who may see themselves as a burden on their loved ones. This is not at all to imply that a terminally ill patient is never capable of making an informed decision. However, despite all the legal precautions proposed by the proponents of euthanasia, there remain grounds for suspicions that requests to be killed may not reflect the real and stable wishes of those making the request, and may be too easily influenced by circumstances and external pressures.

A further argument against legalizing euthanasia is one made by Kamisar[24] in response to Glanville Williams. A patient seeking active euthanasia clearly does not wish to prolong his agony, but seeks a quick end to his suffering. Yet any proposal for the legalization of euthanasia must necessarily include some process of ensuring that the patient is in fact suffering from an incurable disease and that his decision is free, voluntary and informed. Any such procedures would have to be carefully followed and the results painstakingly confirmed. All this would demand time and by wrapping the decision-making process in red-tape, create the very delays which the euthanasia movement seeks to avoid. Moreover, the medical profession exists to provide important professional services, and does not wish to be nor should be involved in this kind of bureaucratic activity.

In the Commission's view, a final and decisive argument should be made against the legalization of euthanasia. In any law reform, there should be some acceptable proportion established between, on the one hand, the evils to be avoided or the difficulties to be remedied, and on the other hand, the new risks which the reform is likely to produce. In our view, the new risks created by legalizing euthanasia would be greater and more serious than the benefits to be gained.

It would be incorrect to maintain that there is an insistent demand or strong social pressure in Canadian society today for

the legalization of euthanasia. As in other countries, the various groups or movements advocating the practice of euthanasia have been very active but have not, on the whole, succeeded in rallying a large proportion of the population to their cause. There appears to be no discernible degree of social unanimity on the question.

Law exists to meet real needs. The Commission has concluded, independently of all other arguments, that in Canada today, there are neither wrongs nor needs sufficiently great to justify overturning a well-established tradition based on time-honoured morality. The extraordinary development of palliative care and pain control in recent years is certainly a safer and far more positive response to the problem of pain and suffering for the terminally or incurably ill.

B. *The decriminalization of compassionate murder*

As we have already noted, Canadian criminal law does not take into account the motive of the person who commits homicide. Only the fact that he did or did not mean to cause death is considered relevant. The motive behind this intention is of little significance from the legal point of view.

In this approach, Canadian law follows the common-law tradition and differs sharply from most of the continental legal systems. These latter distinguish, at least at the point of sentencing if not in terms of the classification of the offence itself, between murder committed for a morally reprehensible motive (for example, the hope of gain) and murder committed for a humanly excusable motive (for example, compassion for suffering).

The choice in terms of legislative policy is clear. Three options are available: to continue with the present stance which ignores motive; to, in one way or another, create a special category of homicide for cases in which the motive can serve as an excuse; or to retain the existing offence but take the motive into account in the sentence.

The creation of a specific offence of compassionate murder is not an acceptable solution, and for two reasons. Firstly, there may be some question as to the practical necessity of such a step. Whether the offence is described as homicide, murder or something else, is, in fact, of little practical importance. What is of interest is only the consequences and legal effects which Parliament assigns to it. In the case of compassionate murder, it is obviously in relation to whether or not to criminalize it, and to the existence or severity of the sentence that the question arises. The problem, then, is not whether the act should be described as murder, homicide, euthanasia or some other name, but whether, in this case, the law should provide for acquittal or acknowledge that extenuating circumstances could justify a lighter sentence than in the case of a truly sordid murder.

Secondly, compassion for the dying is probably not the only valid motive which the law could recognize in connection with homicide. What, for example, of killing in the heat of passion, of killing done out of "necessity", of politically motivated killing, and so forth? The problem thus goes far beyond the simple case of active euthanasia. It is the entire structure of the law on homicide which might require review. Should such a review lead to the conclusion that motive *in general* should be taken into consideration for homicide, it might then be logical to include the motive of mercy, among others, as at least partial justification for violations of the prohibition against killing.

Subject then to the recommendations which the Commission may make in its forthcoming Working Paper on homicide, we think at this time that to create a specific offence for compassionate murder would not represent a practical or valid solution to the problem within the context of Canada's present-day criminal law.

A second solution would retain the present system but allow the court to reduce the minimum sentence by taking into consideration the compassionate motive which inspired the act. One could, for example, make compassionate murder a "third"

degree of murder. This solution, as we have seen, has already been adopted by several jurisdictions. Yet the act itself is still considered murder.

The preliminary consultations which the Commission has held on the subject show that this would probably be the most acceptable solution to the public. The public, of course, does not tend to judge these acts by strict legal norms, but rather considers the acts from the moral perspective. It appears to have difficulty granting that a truly compassionate killing, motivated essentially by altruism, should be punished as severely as killing out of vengeance or greed. There is therefore little doubt that legal recognition of this perception would meet with public approval.

The adoption of this solution, however, still leaves a number of complex problems. Firstly, it remains difficult to isolate compassion towards the terminally ill as the one and only case of premeditated homicide in which the law should take motive into account. What of the premeditated murder motivated by passion? What of murder committed in order to escape from mistreatment by another person, the murder committed in the defence of "higher national interests", etc.? Here again it is impossible to isolate compassion for the dying as the only potentially acceptable motive. To be consistent, any such reform would have to recognize that other motives or other reasons may be of equal or greater merit.

Secondly, it is always very difficult to assess the real motives behind homicide. The problem is often discussed in terms of just one type of example: the dying man who begs one of his loved ones to end his suffering for him; the loved one puts aside his reluctance out of love and compassion, and in an act of sublime courage, kills the dying person. The Commission does not deny that there have been real life cases along these lines. But in addition to these clear-cut cases there are others in which the purity and disinterested nature of the motive are far less evident. The infliction of death may be inspired by infinitely more complex and mixed motives. For example, there may be a degree of compassion, but also a

desire to put an end to a psychologically and physically difficult and exhausting period for oneself. How can the complexity of human motivation be determined by others with certainty, or even with probability?

Thirdly, the difficulty, again in terms of legislative policy, is the possibility of abuse which may be created by a substantial reduction in the law's traditional protection for human life and integrity. The danger exists at two levels. The first is that true murders may be committed and then disguised as compassionate murders. Since it can be safely assumed that in most cases the act will not be public, one can never be truly certain of either the purity of the motive or of the victim's consent. Would not allowing the motive to reduce the sentence encourage the killing of those who are a burden to the agent, or of those in whose deaths he has some interest? The second danger, which at this point is difficult to evaluate, is that of the imitation effect. Is there not some risk that such a liberalization of the law would promote imitation killings for questionable motives?

It is therefore the Commission's view that, at this time, a legislated reform allowing motive to reduce the sentence would be dangerous. We recognize, however, that such an approach is conceivable and that certain guarantees and measures could be adopted to reduce the risks involved. For example, the act could continue to be treated as murder in terms of sentencing, unless the agent himself demonstrates convincingly that he was guided solely by motives of mercy.

It is essential to consider this question not only within the perspective of the *Criminal Code* and the various offence sections, but also within the perspective of the criminal justice system as a whole. This system has a number of internal mechanisms which generally make it possible to correct inequitable or otherwise unacceptable results of the strict application of the law in individual cases. The experience of certain countries with legal systems similar to ours demonstrates that the actual cases of mercy killing, in which charges are in fact laid, guilty verdicts brought and maximum sentences imposed,

are rare, if non-existent. The prosecutor's decision not to prosecute, or the defendant's decision to plead guilty to a lesser offence are two means in actual practice of moderating the apparent severity of the law. Some will claim that the law, as a result, is both hypocritical and illogical in treating mercy killing as pure and simple murder in written law, while refusing to do so in practice in terms of prosecution. In theory there may be some merit to this observation. However, the decision not to prosecute in a case of compassionate killing need not detract from the credibility of the criminal law. Rather, it may show that in the enforcement of the law, the justice system is capable of considering the humanitarian and mitigating aspects of these cases in its exercise of discretion.

Our conclusion is that the existing situation, in which the *Criminal Code* makes no allowance for compassionate murder on the basis of motive, is the least unsatisfactory solution, given the general context of Canadian criminal law. This does not however mean that the Commission finally and irrevocably rules out such a recognition. We continue to welcome the reactions of the Canadian public on this point.

II. Aiding suicide

Section 224 of the *Criminal Code* states that anyone who aids, abets or counsels a person to commit suicide is liable to imprisonment for fourteen years. The criminal offence of attempted suicide was abolished in 1972.

Decriminalization of the act of aiding suicide has often been proposed as a necessary next step. After all, it is argued, a person who seeks to end his life is legally free to do so, since the law today, no longer punishes attempted suicide. If the person is unable to perform the act himself, is it not illogical to treat the one who assists him as a criminal? Assistance is not murder because there is no positive causal act. Moreover, the person involved is always free to change his mind. Why, then, this severity towards those who help others to commit suicide?

For some years now, in the United States, Britain and other European countries, and now in Canada, various groups have been calling for decriminalization of aiding the terminally ill to commit suicide. These associations do not, as some have claimed, advocate suicide. They are simply demanding what seems to them the necessary corollary to the individual's right to commit suicide: the right to assistance.

At first view, it seems highly incongruous to regard as criminal the participation in an act which itself is no longer criminal. The case is somewhat unique in criminal law. Moreover, what real difference is there on the practical level between watching a terminally ill person swallow poison he has obtained himself and has taken with no assistance, and watching him doing so after having provided him with the poison in question? Some ethicists argue that both of these acts are reprehensible or both are not. Why does the law establish such a fundamental distinction between two such similar types of behaviour?

This distinction is difficult to justify on grounds of logic alone. However, a more convincing response may be made on the basis of legislative policy and the practical consequences entailed in decriminalization of the act of aiding suicide.

First of all, the prohibition in section 224 is not restricted solely to the case of the terminally ill patient, for whom we can only have sympathy, or solely to his physician or a member of his family who helps him to put an end to his suffering. The section is more general and applies to a variety of situations for which it is much more difficult to feel sympathy. Consider, for example, a recent incident, that of inciting to mass suicide. What of the person who takes advantage of another's depressed state to encourage him to commit suicide, for his own financial benefit? What of the person who, knowing an adolescent's suicidal tendencies, provides him with large enough quantities of drugs to kill him? The "accomplice" in these cases cannot be considered morally blameless. Nor can one conclude that the criminal law should not punish such conduct. To decriminalize completely the act of aiding, abetting or

counselling suicide would therefore not be a valid legislative policy. But could it be in the case of the terminally ill?

The probable reason why legislation has not made an exception for the terminally ill lies in the fear of the excesses or abuses to which liberalization of the existing law could lead. As in the case of "compassionate murder", decriminalization of aiding suicide would be based on the humanitarian nature of the motive leading the person to provide such aid, counsel or encouragement. As in the case of compassionate murder, moreover, the law may legitimately fear the difficulties involved in determining the true motivation of the person committing the act.

Aiding or counselling a person to commit suicide, on the one hand, and homicide, on the other, are sometimes extremely closely related. Consider, for example, the doctor who holds the glass of poison and pours the contents into the patient's mouth. Is he aiding him to commit suicide? Or is he committing homicide, since the victim's willingness to die is legally immaterial? There is reason to fear that homicide of the terminally ill for ignoble motives may readily be disguised as aiding suicide.

It may be useful to note that there are various legislative reactions to this problem. Some countries, including Britain and the United States, consider aiding suicide a distinct offence, and punish it less severely than homicide. Others do not recognize this offence as such, but may punish this form of behaviour as homicide by extending the concept of causality.

It should also be pointed out that cases involving truly altruistic assistance to a terminally ill patient who wishes to die are very rarely prosecuted.

Assuming that the law continues to discount the motive in homicide, the Commission's view is that no exception should be made in the case of aiding suicide. However, in order to further strengthen the present self-restraint of criminal prosecution in these cases, and their exceptional nature, the

Commission would be prepared to recommend an amendment to section 224 of the *Criminal Code*. This amendment would permit prosecution only on written authorization from the Attorney General. The 1961 amendments to the *British Suicide Act* include this same safety precaution.

III. Cessation and refusal of treatment

As previously noted in this document, there is a considerable gap at present between actual medical practice and what a literal and restrictive interpretation of the *Criminal Code*'s sections relevant to medical treatment might impose. As also observed, the almost total absence of legal precedent in this connection creates a state of uncertainty and ambiguity for patients, members of the medical profession, lawyers and the public. Law cannot speak in ambiguities, particularly on a question of this importance, without the risk of losing credibility and respect.

In a Working Paper published in 1980 entitled *Medical Treatment and Criminal Law*, the Commission already dealt with medical treatment in general. It proposed a number of law reforms touching upon medical treatment. The purpose of the present paper is simply to add to that analysis now in relation to the very specific aspect of cessation and refusal of treatment. Proposals for overall reform will be included in the Commission's Report to Parliament. Solutions to the problem of cessation and refusal of treatment will be examined from two distinct perspectives. Firstly, that of the patient capable of expressing his wishes, and secondly the more exceptional one of the patient who, for one reason or another, is unable to express his wishes.

A. *The competent person*

In its Working Paper No. 26, *Medical Treatment and Criminal Law*, the Commission stated and defended its view that the competent patient should be considered by the law as the absolute master of decisions regarding his own body. In

doing so, the Commission was not formulating a new and revolutionary rule, but merely advocating legislative recognition of the common-law rule on this point. The Commission has not changed its opinion that a competent person should have and should retain the right to refuse any form of treatment whatsoever, and to demand that any treatment undertaken be stopped either temporarily or permanently.

However, present law, because of the distinctions which it makes between act and omission and because in theory it requires the continuation of any treatment undertaken if its interruption constitutes a threat to life, clearly promotes certain biases in favour of heroic or aggressive treatment, or at least creates a legal climate likely to encourage this approach.

Medicine's first duty is to fight for life and against death. No one will seriously dispute this fact. Medicine, like law for that matter, must however recognize that at a given point the optimal treatment for a patient is no longer to struggle to maintain a purely vegetative or clinical life but to allow death to occur, while providing the individual with all the palliative care required to relieve his pain. A person who is conscious and capable of expressing his informed wishes should be the sole master of this decision.

This principle is often expressed by the expression "death with dignity". The patient, as master of his own life within certain limits and under certain conditions, should also be master of his death. He should be able to exercise a constant choice over the way in which he intends to die and, in particular, over the way in which he intends to live his final moments. Heroic or aggressive measures, when not requested by the patient, violate this right by imposing on him a constraint which in fact fails to take into consideration his wishes and desires. The law should clearly establish the corollaries which follow: first of all, the physician should not have to risk criminal liability simply because he respects his patient's wish to have medical treatment stopped or not initiated. And secondly, a doctor who proceeds to treat a patient against that patient's clearly expressed wishes should be subject to the

provisions of the *Criminal Code* on assault, to say nothing, of course, of any other civil or disciplinary actions. These two rules are consistent with existing law, but have not yet been expressed in the form of legislation.

To recognize these rules is not however equivalent to legalizing euthanasia. There is a fundamental difference, as we have noted, between causing death by a positive, deliberate act and stopping treatment at a patient's request. The first is morally and legally unacceptable and should continue to be subject to criminal penalties. The second, however, is perfectly justified in the name of personal autonomy and the right to self-determination. Respect for this principle demands that present criminal law not be interpreted to impose on the doctor a duty to provide treatment which conflicts with the patient's right to refuse it.

As a result, the Commission therefore proposes that *legislation should clearly and formally recognize the competent patient's absolute right to refuse medical treatment or to demand its cessation*. This refusal or cessation should, in all cases, take precedence over the doctor's duty to undertake or to continue treatment already undertaken.

B. *The incompetent person*

It is regarding the person incapable of expressing his wishes that the truly difficult problems arise. By an incompetent person, we mean here anyone who, because of infancy, temporary or permanent unconsciousness or some other handicap, is unable to express his wishes, make an informed decision, or exercise choice. A number of preliminary observations should be made.

First of all, law should strenuously avoid and forbid any form of discrimination against such persons. Insistence on heroic but useless measures is no more justified for the incompetent patient than it is for the competent. In other words, an individual's incapacity should not serve as a basis or pretext for denying him the fundamental right or opportunity available

to the competent patient to exercise choice. It would be regrettable and absurd if, because a person is incompetent, his attending physician were legally obliged to continue or to undertake useless treatment and required to prolong his patient's suffering to no avail. It would be unthinkable that a person should lose his right to die with dignity as soon as one becomes incapable of expressing wishes.

However, the incompetent clearly require additional protection. All modern legal systems, both criminal and civil, have established protective mechanisms such as the appointing of guardians, whose decisions on behalf of the incompetent are carefully controlled by a number of formal requirements. Since we are dealing here with the highest values of life and death, the obvious goal lies in the development of protective measures which leave as little room as possible for error and arbitrary decisions. The solution does not lie in the recognition of some difference in nature between the competent person and the incompetent person. The incompetent must continue to receive protection, but to be in need of protection must not be used to allow the rights of the individual concerned to be weakened or eliminated, nor to make his situation more difficult in the face of death.

Secondly, the law must recognize what is now a medical and scientific reality. It must admit that the cessation or non-initiation of treatment which offers no chance of success is *a good decision and one based on sound medical practice*. Treatment is a measure designed to help the patient recover from his illness, to halt its progress at least temporarily or to relieve its symptoms. It is selected and administered in an effort to protect or to extend life. The competent patient must be free, as we have seen, to refuse the benefit of treatment. With a competent patient, the doctor has the opportunity to explain the prognosis and the likelihood of success of a treatment. With an incompetent patient this dialogue is by definition impossible. The doctor thus cannot count on any communication by the patient of his wishes.

Some will conclude that since there must always be a presumption in favour of life, it is the doctor's solemn duty in

the case of the incompetent patient to initiate and to continue treatment in all cases. To do otherwise, they claim, would amount to "negative" euthanasia. In our view, as already indicated, this position is erroneous. Erroneous because it overlooks the fact that the guiding principle for medical decision-making is not life in itself as an absolute value, but the patient's overall welfare. In most instances, this welfare imposes the maintenance of life, but this is not always the case. It is not the case when the prolonging of life has become purely artificial. It is not the case when the maintenance of life can only be achieved by an undue prolongation of the patient's agony. It is not the case when the maintenance of life results only in the infliction of additional suffering. In other words, it is not the case when treatment is diverted from its proper end and merely prolongs the dying process rather than life itself. The competent patient makes a decision on the basis of his own interests. He may, in rare cases, choose to have his life artificially maintained, or to prolong his agony or suffering. In this case, the doctor has little choice. He should respect the terminally ill patient's stated wishes and initiate or continue treatment independently of his own personal views if the circumstances allow, that is, if it is not unreasonable.

However, in the case of the incompetent patient, it is neither legally required nor sound medical practice to transpose the general situation to an exceptional one and to assume that, because the person is incompetent, he would have chosen to have his life artificially maintained, his agony prolonged or his suffering extended. Hence, the law must recognize that even in the case of an incompetent person, the cessation or non-initiation of medical treatment may objectively constitute good medical practice and should not be subject to criminal sanctions.

A third rule merits legal recognition as well. Regarding the incompetent, it is essential to distinguish between two situations which unfortunately are often confused. The first is the one we have just described, involving the stopping or non-initiating of treatment because it offers no reasonable hope of improvement and merely prolongs the dying process rather than life itself. In this case, as we have said, the cessation or

non-initiation of treatment is legitimate and should be recognized as legal. The second is the case in which treatment is not undertaken or continued only because the prognosis of the incompetent patient does not measure up to the "accepted norm". These examples will illustrate this difference.

The decision not to undertake treatment in the case of an anencephalic newborn is medically justified since there is no treatment at the present time which can remedy this condition and save that newborn's life. Proceeding with an operation for atresia* of the digestive tract in such a case would be futile and would only prolong the inevitable suffering. It is the physician's duty in this case to ensure that the inevitable death occurs under the best possible conditions. It is not a question of assisting nature, but of allowing nature to take its course, while providing the infant with adequate palliative care.

In contrast, it is just as obviously the physician's duty, in the case of an otherwise normal child suffering from atresia,* to perform the corrective surgery which will enable him to absorb nourishment.

Finally, what is the legal duty in the case of a child born with the characteristics of trisomy 21 (Down's syndrome or mongolism)* and also suffering from atresia* of the digestive tract? In the Commission's view, this child should be treated for the atresia*. To abandon the child and allow him to die of starvation is unacceptable and contrary to the norms of criminal law. A decision not to provide treatment in this case is not based on the absence of any hope of improvement (repairing the atresia* will, in fact, solve that problem). The decision is based rather on the fact that treatment will not change the child's mental handicap. The decision is thus based on a value judgment as to the quality of the infant's present or future life. It is equivalent to a death sentence based on the child's handicap. We are well aware of tragic difficulties created by the birth of a child suffering from serious defects, of the tragic consequences it can have on a couple or family. But in our view the appropriate response lies both in more preventive

* Refer to Appendix II

measures such as better prenatal care and diagnosis, and the assistance and material support which society as a whole should provide for parents after birth.

One important qualification, however, must be made. If the trisomic and atresic child is also suffering from other serious defects for which treatment is useless or inappropriate under the particular circumstances of the case, the decision to withhold treatment should then be considered legitimate. In this case, it is based not on the existence of trisomy,* but on the decision not to prolong a dying process already initiated, as in the first case. The Commission thus proposes that we accept as fundamental the principle of non-discrimination between the competent person and the incompetent, on the one hand, and on the other hand, the rule that when it is impossible to obtain an expression of the patient's wishes, life-saving treatment should be administered, providing it is medically useful.

If these principles are accepted, the problem then becomes one of determining the presumed wishes of the incompetent patient. On what basis and according to what criteria should another person make the decision for him to terminate or not to initiate treatment which is apparently useless? In our opinion, it is often important to apply a distinction between incompetent persons who have previously had the opportunity to express their wishes and those who have never had or never will have that opportunity.

In the first category, we may place the adult who, at some given point, becomes unconscious or incompetent, but who had previously expressed his wishes regarding treatment. This may have occurred in the course of a discussion with his doctor, or a relative or a friend. The refusal of treatment may have been expressed more formally in a letter or document such as a "living will". In this case, these wishes should be respected and the doctor is required to adopt the same position as if his patient were conscious and competent. By treatment, of course, we mean treatment which offers no further reasonable hope of recovery or improvement in the condition of the

* Refer to Appendix II

patient. However, if treatment offers such hope, it is then the physician's duty to initiate or to continue it unless he has been forbidden very clearly to do so by the patient. Any other decision creates a vicious circle and may lead to the absurd situation which in fact has been largely responsible for the development of the living will systems: as soon as the patient becomes unconscious or incompetent, whatever his previous condition or wishes, the doctor may feel himself allowed or obliged to continue or to initiate treatment, even when it is hopeless!

The situation is somewhat different in the case of a patient who, because of infancy or some mental handicap, is totally unable to express his wishes. This is the case with newborns, the severely retarded, and comatose patients who have never previously expressed their wishes. These cases can be described as "neutral", in the sense that we have no indication of what the wishes of the person involved might be or might have been. The only reasonable conclusion possible under these circumstances is that the decision must be made by someone else. The difficulty then lies in determining who this someone else should be, and on what criteria the decision should be based.

Three approaches are conceivable: the first is to leave everything to the physician's judgment, leaving to him the responsibility of judging each case on the basis of the particular circumstances involved and for making the final decision on his own. Naturally, he can and indeed should seek expert advice as required in each case. Obviously, too, he should consult the patient's family and next of kin, if possible, and involve them in the actual decision-making process.

Some are vehemently opposed to this solution and for two reasons. Firstly, it would require giving society a sort of *carte blanche* as a whole to medical science, with no guarantee that the result would be objectively valid. This, it is argued, amounts to allowing doctors to play God. Moreover, it assigns medicine a role which it should not have. This first objection is closely linked to an attitude of trust or mistrust towards medical

practice and doctors. The objection also assumes that by giving the power of decision to the physician, we automatically eliminate all forms of societal control. But this need not be so. In giving doctors the final decision-making power, we do not confer on them absolute immunity for the consequences of their decisions. The criminal law, as one of many mechanisms of control, would still punish abuses of professional duty.

Secondly, it is argued that leaving to physicians the decision-making power merely perpetuates the existing situation. Since medical and hospital practices vary considerably from one area to another and from one individual to another, it is feared that decisions will continue to be made on a largely subjective basis and that certain undesirable practices, such as the unjustified use of aggressive measures, will be perpetuated.

There are a number of answers to this second objection. First, one must recognize and accept the fact that it is impossible to eliminate completely all subjectivity or individual judgment. Nor is it desirable to do so. If medicine were to be completely standardized, and medical judgment severely restricted, the quality of practice would suffer. As well, in our view, much of the variation in current practice can be explained by the uncertainty surrounding the state of the law. It is likely that excessive caution and continued use of aggressive measures are due far more to the fear of legal liability and prosecution than to the deliberate and intentional intrusion of the physician's personal attitudes and philosophies. We can reasonably conclude that the removal of these ambiguities and uncertainties will produce correspondingly greater uniformity in medical practice.

A second possible approach would involve the "judicialization" of the decision-making process including within it a wide range of variations. For example, we could have a process in which *any* decision as to the continuation or cessation of treatment for an incompetent person must necessarily be the subject of a judicial or quasi-judicial decision by a court or administrative agency. Or these decisions could be made by hospital committees.

A number of committee processes and purposes are possible. The function of this committee could be to determine and establish, for both competent and incompetent patients, the conditions under which treatment should be either halted or not initiated. Another would be simply to ensure that one or two independent physicians participate in the decision. The committee system has certain advantages, but some practical disadvantages as well. The Commission has not made any firm decision on this matter, preferring to reserve it for its final recommendations. It thus welcomes reactions and comments on this issue from doctors, hospital staff and the general public.

The Commission does not deny the essential role of judicial decision-making in settling disputes. Such decisions offer a guarantee of impartiality and natural justice. At the same time, one would not wish to over-burden the courts by systematically referring to them each and every decision regarding the cessation of treatment for the incompetent. Such a course of action would of course be unrealistic. One would also not wish to judicialize and hence to make adversarial a decision-making process which should be based more on consensus than confrontation. A judicial decision is necessary when there is some real conflict. It may be superfluous when it is used merely to formalize a decision which has already been made and which no one has challenged and which involves no real dispute, controversy or conflict. If, for example, a physician decides, on the basis of his best medical judgment, that under the circumstances further treatment is useless, while the patient's family is adamantly opposed to the cessation of treatment, then and only then the best way of settling the matter would appear to be a judicial decision. Each of the two parties, in fact, interprets the interests of the incompetent patient in a different way. Only an impartial arbitrator can decide. The fact that the decision is a judicial one also implies that it will be based on the best interests of the incompetent patient and that in time the accumulation of such decisions will permit the development of a number of decision-making criteria. At the present time these criteria still seem somewhat vague. In the Commission's views, therefore, the judicial model is valid, but only under the conditions and limitations described above.

The third possibility is to allow the next of kin, family or representative of the incompetent patient (curator, guardian, tutor) to make the decision independently. At first sight, this solution may appear to be the best one. Presumably, these people know the patient and are therefore in a better position to assess the subjective elements involved. It can also be assumed that they will usually have the patient's best interests at heart. All this is true. However, two objections are regularly made to this third approach. The first is that making such a decision normally creates feelings of guilt, no matter what decision is eventually reached. The question then is whether it is really fair to impose the burden for decisions to terminate treatment on people who, unlike doctors, are not prepared by their profession to deal with it. The second is that, in the case of an incompetent person, it may be preferable for the decision to be made by a person other than the next of kin or a family member, less because of the danger of conflicts of interest, than because of the need to surround the decision with as much objectivity as possible, providing the utmost protection for the rights of the incompetent person involved. However, the Commission recognizes, once again, that these people should be involved at some stage in the decision process.

Finally, we are well aware that there is unfortunately no miraculous solution capable of minimizing all the disadvantages, eliminating all the difficulties and achieving universal support. The choice is thus limited. It is a question of finding the solution which, in our particular context, is the least unsatisfactory. The first possibility (i.e. a judgment by the physician) appears to us to meet this criterion.

At this stage, it may be useful to summarize the tentative conclusions which the Commission has reached to date. These conclusions are as follows:

(1) *the law should recognize the competent patient's wishes and respect them as regards the cessation or non-initiation of treatment*;

(2) *the law should clearly state that a physician acts legally when he decides to terminate or not to initiate*

treatment which is useless or which no longer offers reasonable hope, unless the patient has expressed his wishes to the contrary;

(3) *the law should recognize that the prolonging of life is not an absolute value in itself and that therefore a physician does not act illegally when he fails to take measures to achieve this end, if these measures are useless or contrary to the patient's wishes or interests;*

(4) *the law should recognize that a physician who continues to treat a patient against his wishes is subject to the provisions of the* Criminal Code;

(5) *the law should recognize that the incapacity of a person to express his wishes is not sufficient a reason to oblige a physician to administer useless treatment for the purpose of prolonging his life;*

(6) *the law should recognize that in the case of an unconscious or incompetent patient, a physician incurs no criminal responsibility by terminating treatment which has become useless.*

PART FIVE

The Formulation of the Reform

It may be useful at this point in our analysis, and before presenting the actual formula for reform, to review a number of earlier findings and limitations. No reform, whatever its nature, can solve every problem. The law cannot provide the public or the physician with a complete guide to life and death decision-making based on entirely objective criteria. Reform can only help to dissipate some of the ambiguities involved.

Criminal-law reform cannot realistically judicialize the decision-making process to make it possible to determine *a priori* the validity of every given decision to undertake or to cease treatment. As noted earlier, the purpose of criminal law is only to sanction the most flagrant abuses. Its control over the legality or illegality of a given act must therefore remain largely an *a posteriori* control. In this sense, the law does not and cannot with infallibility reassure the physician or others before they make all treatment decisions. Physicians must make the decision to the best of their ability and their knowledge of their ethical, medical and legal duties. Should the decision taken prove to make one criminally liable for a breach of duty, one must expect to suffer the legal consequences. However, while it is both impossible and undesirable to bypass medical responsibility, judgment and liability, it is possible to clarify in advance the fundamental bases on which the law feels that these decisions should be made.

No reform including that which follows will ever be greeted with universal approval. Moreover, the aim of the present document is not so much to reflect a consensus on this very

controversial question as to propose a number of reasonable solutions for discussion and criticism, before submitting final recommendations to the Parliament of Canada in a later Report.

Finally, the proposed reform should not be assessed in a vacuum. Legislation cannot codify the whole of medical and hospital practice. It can only attempt to influence it and help to create a climate which will encourage the protection of certain fundamental human rights and principles. The reader should not therefore expect to find a thorough and comprehensive blueprint for reform in the proposals which follow. These law reform proposals must be complemented by, and placed within, the larger social, cultural and medical contexts.

I. Euthanasia

The Commission does not favour the legalization of active euthanasia in any form. *It therefore recommends that the existing prohibitions of the* Criminal Code *concerning homicide be maintained.* As regards the act of compassionate murder, the Commission believes that it should continue to be a punishable offence under the law. However, if in the Commission's forthcoming proposals for reform with regard to homicide, it concludes that motive should now be taken into account, then and only then may the motive of compassion be taken into consideration as a reason to mitigate sentence.

II. Aiding suicide

The Commission does not favour the *complete decriminalization of the act of aiding or counselling suicide.* In our view, this would be inappropriate and dangerous within the existing context. In so deciding, the Commission does not seek to deny or limit personal autonomy and the right to self-determination. It merely proposes the maintenance of the present prohibition of the Canadian *Criminal Code*, in view of the possibilities for serious abuse which decriminalization might entail.

At the same time, in order to acknowledge more fully the undeniable element of altruism and compassion involved in some cases of assistance provided to a terminally ill loved one, and because we are not convinced that the imposition of a criminal sentence is appropriate in such a case, *the Commission proposes the addition to section 224 of the present* Criminal Code *of a second subsection as follows*:

> *224. (2) No person shall be prosecuted for an offence under the present section without the personal written authorization of the Attorney General.*

III. Cessation and refusal of treatment

In considering the problem of the cessation of treatment, the Commission has studied at some length the approach taken by certain American states, such as California, and has weighed the possibility of suggesting the adoption in Canada of an equivalent to the *Natural Death Act*.

This option, however, has been rejected for the following reasons. We believe that it would risk the reversal of the already-established rule that there should be no duty to initiate or maintain treatment when it is useless to do so. The living-will approach begins from the opposite principle, since it requires that the patient's wishes be formally expressed in writing in order to authorize the physician not to prolong that patient's agony and death. This approach may be arguable in the context and legal systems of California and other States, but we do not feel it is an arguable reform for Canada.

The decision to terminate or not to initiate useless treatment is sound medical practice and should be legally recognized as such. The law, then, should not begin from the principle that a doctor who fails to prolong life acts illegally, but rather from the principle that a doctor acts legally if he does not prolong death.

It is the Commission's view that this already recognized common-law principle can and should be clearly expressed

within the existing *Criminal Code*. Similarly, to repeat in the framework of the present document a suggestion contained in Working Paper No. 26, the Commission also proposes that criminal law should formally recognize in the *Criminal Code* the principle that a competent person has the right to refuse treatment or to demand that it be stopped.

In the case of a person who is incapable of expressing his wishes, the Commission proposes that the decision to halt or not to undertake treatment should be based on two criteria. The first is a criterion of a medical nature and concerns the utility or non-utility of the administration of treatment. The second criterion is based upon the wishes of the person prior to becoming incompetent, or upon his best interests determined by others in the event that that person is not or has never been capable of expressing his wishes. The Commission believes that the "best interests" of the person may in some cases indicate the prolongation of life, but in others the cessation of treatment in order to protect the incompetent person's right to a peaceful death with dignity. In the event of a conflict between, for example, the physician and family, as to the best interests of the patient, the courts should be called upon, as they are today, to settle the dispute. *On this point, then, the Commission proposes the maintenance of existing law and practice*.

Finally, as regards the question of the administration of palliative care, the Commission believes that a doctor must never refuse to administer pain-killing treatment, drugs or similar forms of treatment to a terminally ill patient only because the effective pain-killing dosage may hasten death.

The Commission therefore suggests the addition to the *Criminal Code* of the following texts:

1. *Nothing in sections 14, 45, 198 and 199 of the* Criminal Code *shall be interpreted as requiring a physician*

(a) to continue to administer or to undertake medical treatment against the clearly expressed wishes of the person for whom such treatment is intended;

(b) to continue to administer or to undertake medical treatment, when such treatment is medically useless and is not in the best interests of the person for whom it is intended, except in accordance with the clearly expressed wishes of this person.

2. *Nothing in sections 14, 45, 198 and 199 of the* Criminal Code *shall be interpreted as preventing a physician from undertaking or ceasing to administer palliative care and measures 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.*

Endnotes

1. The Working Papers are: *Criteria for the Determination of Death*, Working Paper No. 23; *Sterilization*, Working Paper No. 24; *Medical Treatment and Criminal Law*, Working Paper No. 26. The Study Papers are: *Consent to Medical Treatment*; *Sanctity of Life or Quality of Life*.

2. *Criteria for the Determination of Death*, Report No. 15.

3. E. Keyserlingk. *Sanctity of Life or Quality of Life*, Study Paper. Law Reform Commission of Canada, Ottawa: DSS, 1979.

4. See, Law Reform Commission of Canada. *Criteria for the Determination of Death*, Report No. 15. Ottawa: DSS, 1981.

5. See, *inter alia*, the code of ethics of the Canadian Medical Association.

6. *Globe and Mail*, August 16, 1978, "Probe continues in death of baby at B.C. hospital". In this case, however, we have been unable to determine accurately the exact degree of the child's deformity. See also *In re B (A Minor)* (1981) 1 W.L.R. 1421.

7. Law Reform Commission of Canada. *Medical Treatment and Criminal Law*, Working Paper No. 26. Ottawa: DSS, 1980.

8. See *Medical Treatment and Criminal Law*, *op. cit.*, note 7, pp. 25 and 26.

9. For a more detailed analysis of these provisions, see *Medical Treatment and Criminal Law*, *op. cit.*, note 7, pp. 26 and following.

10. H. Picard. *Legal Liability of Doctors and Hospitals in Canada*. Toronto: Carswell, 1978, p. 298.

11. *R.* v. *St-Germain* (1976) C.A. 185. In this case, it will be recalled, a doctor had been accused of criminal negligence for refusing to treat a patient in serious condition in the emergency ward of a Montréal hospital.

11a. *The Queen* v. *Milliard*, Court of the Sessions of the Peace, Montréal, No. 01-001050-803, March 7, 1980.

11b. H. Palmer. "Dr. Adams' Trial for Murder" (1957) *Criminal Law Review* 365, p. 375.

12. On the history of these movements in Great Britain and the United States, see R. Kaplan. "Euthanasia Legislation: A Survey and a Model Act" (1976) 2 *Am. J. of Law and Med.* 41, p. 52 and following.

13. G. Williams. *The Sanctity of Life and the Criminal Law*. London: Faber and Faber, 1958; also, "Euthanasia" (1973) 41 *Medicolegal Journal* 14.

14. California Health and Safety Code #7185 and following (1976).

15. Oregon, New Mexico, Nevada, Arkansas, North Carolina, Idaho and Texas.

16. Private Member's Bill No. 3, entitled "An Act Respecting the Withholding or Withdrawal of Treatment where Death Is Inevitable", 4th Session, 30th Legislature of Ontario (1973).

17. For details concerning these various forms of legislation, see H. Silving. "Euthanasia: A Study in Comparative Criminal Law" (1954) 103 *U. of Penn. Law Rev.* 350, and D. Maguire. *Death by Choice*. New York: Schocken, 1975.

18. See Maguire, *ibid.*, ch. 2, p. 22.

18a. See Law Reform Commission, Report No. 15.

19. E. Keyserlingk. *Sanctity of Life or Quality of Life*. Law Reform Commission of Canada, Ottawa: DSS, 1979.

20. Law Reform Commission of Canada. *Sterilization*, Working Paper No. 24. Ottawa: DSS, 1979.

20a. *Public Health Protection Act*, R.S.Q. 1977, c. P-35, ss. 42 and 43.

20b. See, for example, the *Child Welfare Act*, R.S.O. 1970, c. 64; the *Child Welfare Act*, R.S.A. 1970, c. 45.

21. See note 13.

22. K. Binding and A. Hoche. *The Release or the Destruction of Life Devoid of Value*. Los Angeles: R. Sassone, 1975 (Original German book published in 1920).

23. See *infra* Appendix I for a selected bibliography.

24. Y. Kamisar. "Some Non-Religious Views against Proposed 'Mercy-Killing' Legislation" (1958) 42 *Min. Law Rev.* 969.

APPENDIX I

Selected Bibliography

BARRIÈRE, I., and LALOU, E. *Le dossier confidentiel de l'euthanasie*. Paris: Stock, 1962.

BEAUCHAMP, T., and DAVIDSON, R. "The Definition of Euthanasia" (1979) 4 *J. of Medicine and Philosophy* 294.

BEHNKE, J. A., and BOK, S., eds. *The Dilemmas of Euthanasia*. New York: Anchor Books, 1975.

BINDING, K., and HOCHE, A. *The Release or the Destruction of Life Devoid of Value*. Los Angeles: R. Sassone, 1975 (Original German book published in 1920).

CHORON, J. *Suicide*. New York: Scribners, 1972.

CRANE, D. "Physicians' Attitudes toward the Treatment of Critically Ill Patients" (1973) 23 *Bio. Sc.* 471.

DELAGLANDE, J., and ARNAUD, R. «Réflexions sur l'euthanasie» (1962) *Études* 305.

DICKENS, B. "The Role of the Family in Surrogate Medical Consent" (1980) 1 *Health Law in Canada* 49.

"The Right to Natural Death" (1981) 26 *Mc Gill Law Journal* 847.

DOWNING, A., ed. *Euthanasia and the Right to Death*. London: Owen, 1977.

FLETCHER, G. "Prolonging Life" (1967) 42 *Wash. L. Rev.* 999.

FLETCHER, John. "Attitudes toward Defective Newborns" (1974) 2 *Hastings Center Studies* 21.

"Abortion, Euthanasia and Case of Defective Newborns" (1975) 292 *New England Journal of Medicine* 75.

FLETCHER, Joseph. "Ethics and Euthanasia" in Robert H. Williams, ed. *To Live and to Die: When, Why and How*. New York: Springer-Verlag, 1973, pp. 113 and following.

"The 'Right' to Live and the 'Right' to Die: A Protestant View of Euthanasia" (1974) 34 *Humanist* 12.

GARLAND, M. "Politics, Legislation and Natural Death" (1976) 6 *Hastings Center Report* 5.

HARRISON, C. "Medicine, Terminal Illness and the Law" (1977) 3 *Can. Med. Ass. J.* 177.

HORAN, D., and MALL, D. *Death, Dying and Euthanasia*. Washington D.C.: University Publications of America, 1977.

HUNTER, R. "Euthanasia" (1980) 25 *Can. J. Psych.* 439.

JARETZKI, A. "Death with Dignity — Passive Euthanasia: Guide to the Physician dealing with Dying Patients" (1976) 76 *N.Y. St. J. of Med.* 539.

JONAS, H. "The Right to Die" (1978) 8 *Hastings Center Report* 35.

KAMISAR, Y. "Some Non-Religious Views against Proposed 'Mercy-Killing' Legislation" (1958) 42 *Min. Law Rev.* 969.

KAPLAN, R. "Euthanasia Legislation: A Survey and a Model Act" (1976) 2 *Am. J. of Law and Med.* 41.

KENNEDY, I. "The Legal Effects of Requests by the Terminally Ill and Aged not to Receive further Treatment from Doctors" (1976) *Crim. L. Rev.* 217.

KEYSERLINGK, E. *Sanctity of Life or Quality of Life*, Study Paper. Law Reform Commission of Canada, Ottawa: DSS, 1979.

«Le testament de vie» (1979) 14 *Méd. du Québec* 63.

KLUGE, E. *The Practice of Death*. New Haven: Yale University Press, 1975.

The Ethics of Deliberate Death. Port Washington N.Y.: National University Publications, 1981.

KOHL, M. *The Morality of Killing*. London: Owen, 1974.

KOZA, P. "Euthanasia: Some Legal Considerations" (1976) 1 *Essence* 79.

KRAUSS, A. "Patients Who Want to Die: A Survey" (1977) *Can. Fam. Physician* 63.

KUBLER-ROSS, E. *On Death and Dying*. New York: MacMillan, 1969.

LAW REFORM COMMISSION OF CANADA. *Medical Treatment and Criminal Law*, Working Paper No. 26. Ottawa: DSS, 1980.

Criteria for the Determination of Death, Report to Parliament No. 15. Ottawa: DSS, 1981.

Definition of Death – Euthanasia. A study prepared by the Institute for Research on Contemporary Interpretations of Man, University of Sudbury, 1975.

LEVASSEUR, G. «Suicide et euthanasie en regard du droit pénal» (1957) 32 *Lumière et Vie* 183.

LOUISELL, D. "Euthanasia and Biothanasia: On Dying and Killing" (1973) 22 *Cath. U. L. Rev.* 723.

MAGUIRE, D. *Death by Choice*. New York: Schocken, 1975.

MANTOUT, P. «L'Euthanasie» (1973) 2 *Vie Méd.* 136.

MORRIS, A. "Voluntary Euthanasia" (1970) 45 *Wash. L. Rev.* 247.

NOLAN-HALEY, J. "Defective Children, Their Parents and the Death Decision" (1976) 4 *J. of Leg. Med.* 9.

NOTE. "The Tragic Choice: Termination of Care for Patients in a Permanent Vegetative State" (1976) 51 *N.Y.U. Law Rev.* 285.

PICARD, H. *Legal Liability of Doctors and Hospitals in Canada*. Toronto: Carswell, 1978.

RAMSEY, P. "Prolonged Dying: Not Medically Indicated" (1976) *Hastings Center Report* 14.

REIGH, W. "On the Birth of a Severely Handicapped Infant" (1973) 9 *Hastings Center Report* 10.

ROBERTSON, J. "Involuntary Euthanasia of Defective Newborns: A Legal Analysis" (1975) 27 *Stanford Law Rev.* 213.

SANDERS, J. "Euthanasia: None Dare Call It Murder" (1969) 60 *J. Crim. L. C. and P. S.* 351.

SILVING, H. "Euthanasia: A Study in Comparative Criminal Law" (1954) 103 *U. of Penn. L. Rev.* 350.

SKEGG, P. "Informed Consent to Medical Procedures" (1975) 15 *Med. Sc. and Law* 124.

SPORKEN, P. *Le droit de mourir*. Paris: Dexlée de Brower, 1974.

STARKMAN, B. "The Control of Life: Unexamined Law and the Life Worth Living" (1973) 11 *Osgoode Hall L.J.* 175.

"A Defence to Criminal Responsibility for Performing Surgical Operations: Section 45 of the *Criminal Code*" (1981) 26 *McGill Law Journal* 1048.

STEINBERG, M. "The California Natural Death Act — A Failure to Provide for Adequate Patient Safeguards and Individual Autonomy" (1977) 9 *Conn. Law Rev.* 203.

STEINFELS, P. and VEATCH, R. *Death Inside Out*. New York: Harper and Row, 1974.

TROWELL, H. *The Unfinished Debate on Euthanasia*. London: S.C.M. Press, 1973.

VAUGHAN, N.L. "The Right to Die" (1974) 10 *Cal. West. L. Rev.* 613.

VEATCH, R. "Death and Dying: The Legislative Option" (1977) *Hastings Center Report* 5.

WILLIAMS, G. "Euthanasia" (1973) 41 *Med. Leg. J.* 14.

The Sanctity of Life and the Criminal Law. London: Faber and Faber, 1958.