

The Right to Die: A Policy Proposal for Euthanasia and Aid in Dying

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[The author notes that this paper was written before the death of Sue Rodriguez on February 12, 1994 and does not take into account the political events following her death.]

Le droit à la mort, l'euthanasie, et le suicide assisté est probablement la question morale par excellence des années 1990. Les avances technologiques amplifient les problèmes des soins aux gens mourant qui veulent accélérer leur mort. Cet article entreprend la revue de plusieurs politiques canadiennes et internationales ainsi que les développements clés dans le débat du droit à la mort. Le principe du droit à la mort connaît une certaine reconnaissance par la législation de testament euthanasique, le droit jurisprudentiel, et des mouvements sociaux défenseurs de l'euthanasie. Toutefois, peu d'attention a été confié à la formulation et la proposition d'une politique légalisant l'euthanasie, sur laquelle on peut concentrer l'évaluation de politiques. Avec l'absence de politique sur l'euthanasie, les tribunaux sont placés dans la position de forcer des changements de procédure. La politique proposée, par le biais de la création de la commission d'Aide-aux-Mourants, déplace l'attention présentement portée au système judiciaire et à la culpabilité des médecins vers une responsabilité du parlement et du patient. Un modèle de législation est proposé en ce qui concerne l'arrêt de traitements médicaux, et l'euthanasie active et volontaire.

The right to die, euthanasia, and assisted suicide may be the moral issue of the 1990s. Advances in medical technology have exacerbated the problem of how to treat those who are dying, and who wish to hasten their deaths. This paper reviews a number of Canadian and international policies and key developments relating to the right to die debate. The right to die principle has been given some recognition by living will legislation, case law, and social movements committed to euthanasia. Nevertheless, little attention has been granted to the formulation of a policy proposal legalizing euthanasia, on which policy assessments can focus. In the absence of policy on euthanasia, the courts are placed in a position of forcing procedural change. This proposed policy, through the creation of Aid-in-Dying Boards, shifts the current focus on euthanasia from that of the judicial system and physician culpability, to that of Parliamentary and individual patient accountability. Model legislation is proposed regarding cessation of medical treatment, withholding of medical treatment, and active voluntary euthanasia.

I The Problem

Modern medicine has made significant progress in saving and extending lives. Nevertheless, medical advances have magnified a problem that has always existed: the problem of how to treat those who have decided their lives have no prospects for im-

provement and are no longer worth living.

Euthanasia is a consideration for some people who have conditions of terminal illness or incurable suffering. It is seen as a way to take control of one's death, taking it back from the hands of life sustaining technology, or as a means to stop incurable suffering.

Public attitudes concerning euthanasia have changed considerably in recent decades. In 1968, 45 per cent of Canadians supported legalized mercy killing; by 1992, 77 per cent of Canadians favoured physicians performing voluntary euthanasia on terminally ill patients (Bozinoff and Turcotte, 1992). In the United States, 65 per cent of the population favour voluntary euthanasia for incurable patients (Gallup, 1991). It is uncertain, however, if public opinion polls on euthanasia give a true measure of opinion on the issue, or if they are a reflection of the fear of losing control of oneself when one becomes incompetent, and of surrendering to excessive and invasive treatments. Additionally, it is possible that public opinion may be tempered by concerns for rising health care services that often prolong life, but do not necessarily contribute to improved quality of life. Responding to these fears are several Canadian societies dedicated to the right to die. For example, the Right to Die Society of Canada has 1835 members, and Dying with Dignity has 7000 members (Parton, 1993).

This commentary will examine the scope of the issues related to euthanasia from Canadian and international perspectives. It will review a number of euthanasia-related policies and propose a potential solution in the form of an aid-in-dying policy that permits both active and passive euthanasia. Currently, the emphasis on euthanasia is focused on the judicial system and physician culpability. The proposed policy shifts the emphasis to Aid-In-Dying Boards and patient autonomy.

Definitions

Euthanasia is defined in the *Medical Dictionary for Lawyers* (1960) as the 'act or practice ... of putting persons to death painlessly who are suffering from incurable or malignant diseases, as an act of mercy'. Euthanasia has been categorized as active, passive, voluntary and involuntary.

Active euthanasia involves the administration of a lethal substance. *Passive*

euthanasia is characterized by the withholding or cessation of life-sustaining treatment or nourishment. *Voluntary euthanasia* occurs when a patient makes the decision to terminate treatment or to end his/her life. *Rational suicide* is included in this category. It refers to a decision to commit suicide where a mentally competent individual has realistically assessed his/her situation, and whose motives to suicide are understood by his/her peer group (Siegal, 1986). *Involuntary euthanasia* is the merciful killing of someone without his/her consent.

II The Euthanasia Debate

Moral theorists, physicians, legal experts, academics and lay persons have contributed to an abundance of literature that discusses various aspects of euthanasia (Brock, 1992; Fenigsen, 1989; Fletcher, 1954; Gay-Williams, 1979; Gomez, 1991; Gaylin et al., 1988; Quill, 1991; Rachels 1975; Reichel and Dyck, 1989; Williams, 1958).

Supporters of Euthanasia

Supporters of active voluntary euthanasia argue that there is a moral duty to respect the wishes of a patient who desires death as a final treatment for terminal illness, uncontrollable pain, or incurable suffering. 'Heroic' or extraordinary medical treatments that prolong life and perpetuate suffering are considered dehumanizing and undignified - ignoring 'quality of life,' which is seen as a legitimate factor in decision-making, and should not yield to the quantitative preservation of life as an absolute value (Law Reform Commission, 1982).

Many proponents of euthanasia argue that the distinction between active and passive euthanasia is illusory since the passive form still requires an action of some sort. Specifically, an act of omission is equal to an act of commission since they have the same motive, and the same result (Browne, 1988; Fletcher, 1979; Rachels, 1975). Nevertheless, according to Rachels (1975),

in medical ethics the distinction is crucial. In some cases, it is considered permissible to withhold treatment and allow a patient to die, but it is never permissible to take direct action motivated to kill a patient. The problem is that the process of being 'allowed to die' can be slow and painful. Rachels (1975) argues that the withdrawal of a breathing tube will cause death by suffocation, a frightening experience: one that is less humane than a quick and painless lethal injection. According to Dutch physician Peter Admiraal, 'the only thing passive about passive euthanasia, is the physician' - there is no ethical difference between not initiating life support and a lethal injection' (Douglas, 1990).

Opponents of Euthanasia

Many who oppose euthanasia argue that killing is wrong in any context. Central to this view is a Judeo-Christian ethic; life is on loan to us from God, and 'one's passage from this life is subject to the will and power of God' (Coleman, 1987). Specifically, it is God's right to determine both the beginning and end of life - euthanasia is a violation of God's will. Under Roman Catholic doctrine, patients, as stewards of their bodies, are not required to use 'extraordinary' treatments that might be considered therapeutically useless, even though the result may be to hasten death (Coleman, 1987). In addition, the Guild of Catholic Doctors states: '[We] do not object to the giving of appropriate pain-relieving treatment, even in the knowledge that this may shorten the sufferer's life, nor to turning off the respirator when the patient is already dead. We should not regard either of these as euthanasia, and consider that their introduction into the discussion will only serve to blur the real issues' (British Medical Association, 1988).

In some situations, those who oppose euthanasia support killing in other contexts. For example, the British Medical Association (BMA) identifies three situations where killing may be justifiable - capital punishment; self defence; and mercy killing

(BMA, 1988). The BMA does not locate mercy killing in the context of terminal medical care. Rather, mercy killing is placed in a wartime context, such as that where a soldier might be killed as a means to prevent capture and torture by a cruel enemy (BMA, 1988).

Some argue that physicians should adhere to the distinction between cessation of treatment and active euthanasia - to otherwise hasten the death of a patient is to violate a sacred canon of medical ethics: 'doctors must not kill' (Gaylin et al., 1988). It is frequently suggested that in the doctor-patient relationship, which has an inherent power-imbalance, patient trust of the physician would be seriously compromised if doctors were to be seen as both 'healer' and 'killer' (Reichel and Dyck, 1989).

Other arguments against voluntary euthanasia focus on the implications of decriminalization of the practice. The 'slippery slope' argument suggests that legalization of voluntary euthanasia will lead to active involuntary euthanasia. Those who employ the 'slippery slope' argument often refer to the Nazi euthanasia program. Proponents of euthanasia argue that the 'slippery slope' argument is flawed. The Nazi euthanasia program had nothing whatsoever to do with merciful or compassionate killing (Fletcher, 1979). Ethicist Daniel Callahan (1988) observes that the Nazis did not start with voluntary euthanasia and then shift to involuntary euthanasia. They began with involuntary euthanasia and their rationale was unrelated to the concepts of self-determination or consent to treatment. Nonetheless, the 'slippery slope' argument is intuitively plausible, but 'rests upon a calculus of probabilities that has little grounding in history or experience' (Callahan, 1988).

Some opponents say legalization of euthanasia would have a negative impact on the motivation to research treatments for the terminally ill (Browne, 1988; Drain, 1990). It is suggested that there is always a risk of diagnostic error, or the potential that a new cure or treatment will be dis-

covered (Law Reform Commission of Canada, 1982). Proponents of euthanasia counter that the primary motivation behind medical research is the elimination or control of disease, not the avoidance of suffering, therefore euthanasia will never replace medical research (Browne, 1988; Fletcher, 1954).

The aged and the dying are frequently socially marginalized, hence approval of rational suicide or euthanasia for these groups risks becoming the obligation to suicide. It has been suggested that there exists the potential for a social climate where the aged, terminally ill, or otherwise dependent or infirm might experience subtle pressures to accept euthanasia (Law Reform Commission, 1982; Siegal and Tuckel, 1985; Tillock, 1991; Wanzer et al., 1984). Proponents of euthanasia argue that strict safeguards would protect vulnerable persons from abuse.

III Euthanasia in Canada

The following section delineates a number of Canadian euthanasia cases. The inconsistencies in the legal and political responses to the cases depict the complexities in attempting to address the problem in the absence of a clear euthanasia policy.

Dr. Natchum Gal

The extent to which euthanasia is practised in Canada is unknown; few cases ever come to the attention of the authorities. In 1983, the Canadian government showed it was prepared to take action in the case of Candace Taschuk. Approximately 16 hours after her birth, Taschuk, who was severely brain damaged, was removed from life support equipment. Under the direction of Dr. Natchum Gal, nurse Barbara Howell injected a lethal 15 milligram dose of morphine (Ferguson, 1988; McCarthy, 1983), causing Taschuk's death within 40 minutes (Sheppard, 1983). Dr. Gal, an Israeli, fled to his home country, and was subsequently charged with murder by the Alberta Attorney General; application for extradition of

Dr. Gal was unsuccessful (Ferguson, 1988; McCarthy, 1983). The Alberta Association of Registered Nurses issued suspensions of one year to Barbara Howell, and four months to her supervisor ('Two Nurses,' 1983).

Dr. Peter Graff

In 1991 the British Columbia College of Physicians and Surgeons (BCCPS) issued a statement against euthanasia after reviewing the deaths of two of Dr. Graff's patients (Wilson, 1991). The two elderly male patients, one with amyotrophic lateral sclerosis (ALS)¹ and the other with colon cancer, died of repeated doses of morphine and valium (Simpson, 1991). A provincial coroner's inquiry 'urged a review by the College of Physicians and Surgeons as to whether Dr. Graff's actions were acceptable' (Wilson, 1991). Despite the BCCPS ruling that Dr. Graff's method of treatment was unacceptable, and the coroner's conclusion that both patients died from morphine overdoses, no criminal charges were laid (Wilson, 1991).

Dr. Tom Perry

During an interview in 1990, Dr. Perry, an NDP MLA, admitted to giving morphine injections to his father, who was dying with cancer. 'If you asked me did it hasten the time of death, the answer is yes, it may have' ('B.C. Physicians Wary,' 1993). A media and political frenzy was quelled within days when the BCCPS stated that it believed Perry provided his father with quality palliative care - treatment that 'may coincidentally hasten death but is neither illegal or unethical' (Hunter, 1991).

The BCCPS claim that palliative, death-hastening treatment is not illegal is erroneous. Dr. Perry's conduct may have been consistent with the ethical practice of palliative care. Nevertheless, palliative care, if it serves to hasten death, is theoretically an act of murder. In 1987 the Law Reform Commission of Canada proposed that palliative treatment which shortens life be exempted from the *Criminal Code* provi-

sions pertaining to murder, negligent homicide, manslaughter, and furthering suicide:

Under present law, administration of palliative treatment likely to shorten life would in theory fall under subparagraph 212(a)(ii) [now 229(a)(ii)] and give rise to liability for murder. In practice, Canadian case-law has no record of conviction of a doctor for shortening a terminal patient's life by administering pain-relieving drugs. Moreover, most people, including religious leaders, see nothing wrong in giving treatment for the purpose of relieving pain in certain circumstances even though one result of such relief may be to shorten life. Clause 6(6) clarifies the law, reconciles it with present practice and brings the Code into line with current moral thinking (Law Reform Commission of Canada, 1987, p.60-61).

Nancy B.

The case of 'Nancy B.' is another well-known example of euthanasia. Suffering from Guillain-Barre syndrome,² 24 year-old Nancy B. was in control of her mental faculties, fully paralyzed from the neck down, and completely dependent upon a respirator (Deacon, 1991). In 1992, her request to have the respirator removed was granted by a Quebec Superior Court (*Nancy B. v. Hotel-Dieu de Quebec*, 1992). On February 13, 1992, Nancy's respirator was removed, and she died while under heavy sedation (Fennell, 1992; King, 1992).

In his decision, Justice Dufour determined that under Quebec civil law, Nancy B. had the right to demand the cessation of the respiratory treatment she had received. Furthermore, Dufour reasoned that the person who would perform the withdrawal of Nancy B.'s respirator would not 'in any manner' commit the crimes of murder, manslaughter or the aiding of suicide; there was no crime in removing Nancy B.'s respirator because it would not 'cause' her death (*Nancy B. v. Hotel-Dieu de Quebec*, 1992). It has been suggested that Mr. Justice Dufour's reasoning on Nancy B.'s causation of death was 'patently artificial' (Fish

and Singer, 1992). In order to avoid the *Criminal Code* provisions regarding manslaughter, murder, and aiding suicide, Dufour had 'no alternative but to hold that the withdrawal of Nancy B.'s respirator would not cause her death' (Fish and Singer, 1992). Nonetheless, it is clear that when the judge granted Nancy B.'s request for the withdrawal of her respirator, he, Nancy B., her physician, and all other involved parties were conscious that she would die without it (*Nancy B. v. Hotel-Dieu de Quebec*, 1992).

Consider a different scenario where a physician might have removed Nancy B.'s respirator against Nancy's wishes that treatment be continued. It is certain that the court would have found that the physician caused the patient's death. In the case of Nancy B., and others where life-sustaining treatment is withdrawn, the patient is committing a form of suicide, and the physician is assisting it.

Scott Mataya

In 1991, Scott Mataya, a nurse at Toronto's Wellesley Hospital, was charged with first degree murder for the mercy killing of 78 year-old Joseph Sauder. Mr. Sauder had fallen into an irreversible coma and his wife consented to the withdrawal of his ventilator so that death could occur. When Joseph Sauder began to convulse and vomit, Mataya panicked, and without doctor authorization, administered a lethal dose of potassium chloride; Sauder died minutes later (*R. v. Mataya*, 1992). Mataya was convicted on a lesser charge of administering a noxious substance, and received the maximum three-year probation period, a suspended sentence, and was prohibited from ever practising nursing again ('Nurse Spared,' 1992; *R. v. Mataya*, 1992).

In the case of *R. v. Mataya*, debate on euthanasia or mercy killing was avoided. Since the exact cause of Mr. Sauder's death could not be determined, the court was satisfied with addressing the issue in terms of the charge - administration of a noxious substance.

Sue Rodriguez

On September 30, 1993, the Supreme Court of Canada, in a 5-4 decision, turned down the petition of Sue Rodriguez for a physician-assisted suicide (*Rodriguez v. British Columbia*, 1993b). Rodriguez suffers from Amyotrophic Lateral Sclerosis and apparently has a physician who is willing to assist her death (Wilson, 1993). Rodriguez had argued that s.241(b) of the Criminal Code, which prohibits one from receiving assistance in committing suicide, was in violation of sections 7, 12 and 15(1) of the Charter (Constitution Act, 1982).

The Court stated that the prohibition on assisted suicide did not violate Rodriguez's Charter rights, and that the prohibition was grounded on a societal consensus against assisted suicide. In the majority decision, Justice Sopinka relied on the 'sanctity of life' principle which he argued is embodied in s.7 of the Charter: 'Even when death appears imminent, seeking to control the manner and timing of one's death constitutes a conscious choice over life' (*Rodriguez v. British Columbia*, 1993b, p.8).

Sopinka's reliance on the sanctity of life principle will present a strong argument for pro-lifers in future right-to-life cases. Even in the landmark abortion case of *R. v. Morgentaler* (1988), the Supreme Court did not include the sanctity of life in its decision.

In dissent, Justices L'Heureux-Dubé and McLachlin argued that s.241(b) denies control over one's body, which limits the s.7 right of 'security of the person'. For Justice Cory, 'dying is an integral part of living and, as a part of life, is entitled to the protection of s.7' (*Rodriguez v. British Columbia*, 1993b, p.11). Chief Justice Lamer determined that s.241(b) 'infringes the right to equality contained in s.15(1) of the Charter' (p.9). Lamer proposed a one year constitutional exemption to s.241(b) whereby a superior court could grant the right to an assisted suicide to individuals unable to commit suicide without assistance. Lamer suggested that Parliament should use this

'time to decide what, if any, legislation should replace s.241(b)' (p.10).

Earlier, in the BC Appeal Court, the three Supreme Court Justices were unanimous in stating that the euthanasia issue belongs in Parliament, not in the courts (*Rodriguez v. British Columbia*, 1993a). Only two weeks after that decision, parliament defeated a motion to *consider* decriminalizing euthanasia 140-25 (O'Neil, 1993).

AIDS-Related Euthanasia Cases

In recent years, there have been several well-publicized but non-adjudicated AIDS-related euthanasia cases in Canada. In June, 1992, the Corporation Professionnelle des Médecins du Québec (CPMQ) admitted that it had reprimanded a doctor after he had given a 38-year-old AIDS patient a lethal injection of potassium phosphate. Apparently the euthanasia was performed with the consent of the patient and his family, and in the presence of supportive friends (Charbonneau, 1992). The CPMQ disciplined the physician with three months probation; he was ordered to consult with another doctor within 72 hours of taking on a new patient, and to consult with a colleague before administering large daily doses of morphine (Charbonneau, 1992; King, 1992). No criminal charges were laid and the physician's name was not released by the CPMQ.

In British Columbia, AIDS counsellor David Lewis attracted international attention when he disclosed that he had assisted eight AIDS-afflicted friends to die over a nine-year period. Lewis said: 'I am hardly alone. I know of dozens of people here who responded to similar wishes. The only difference is I'm talking about it' (Taylor, 1990). An AIDS patient himself, Lewis later had an assisted death through an overdose of prescription drugs (Green, 1990).

In a 1991 issue of the *Vancouver PWA Newsletter*, an anonymously authored letter described the role played by a woman who assisted the death of a heterosexual male friend who, through intravenous drug use, had been infected with HIV ('Almost

Fearless,' 1991). The letter prompted a written reply from another person who claimed a similar experience (Nichols, 1992).

In 1991, Vancouver newspaper columnist Lyn Cockburn wrote an article describing the assisted suicide of a woman with AIDS. The death involved an overdose of Seconal and asphyxiation with a plastic bag (Cockburn, 1991). In 1993, Cockburn and two of her senior editors were found in contempt of court when they refused to identify their source – the man who allegedly asphyxiated the woman – at a coroner's inquest (Bellett, 1993). The coroner's decision has been referred to a judicial review by the BC Supreme Court.

IV Canadian Euthanasia-related Policies and Legal Initiatives

Current Canadian law permits one who wishes to die to commit suicide, or if competent, to refuse treatment that is life sustaining. Nevertheless, the ability and opportunity to commit suicide does not always exist, and the refusal of treatment does not necessarily bring about a painless or easy death for the patient. This raises the question of whether Canadian health policy should recognize assisted suicide and voluntary euthanasia as a choice for those who request it.

The Law Reform Commission of Canada (1982; 1983), hereinafter referred to as the LRCC, prepared both a working paper and a report on euthanasia, aiding suicide and cessation of treatment. The LRCC noted that the *Criminal Code* sections on homicide treat life in 'an exclusively quantitative, rather than qualitative, sense' (LRCC, 1982). This sanctity of life principle has given rise to 'vitalism' – a doctrine whereby human life is of absolute value and must be preserved at all costs (LRCC, 1982). Nevertheless, the evolution of medicine, science and technology, however, has called for reconsideration of the vitalist perspective (LRCC, 1982). The Commission identified 'quality of life' and 'death with dignity' as

increasingly becoming considerations for patients seeking greater participation in their health care decisions, and felt this concern was being reflected in the use of palliative care as an option to continuation or termination of treatment (LRCC, 1982).

In 1983 the LRCC recommended that euthanasia should remain a crime. Today, there is pressure to review the current legislation. For example, in refusing Sue Rodriguez the right to an assisted suicide, British Columbia Court of Appeal Justices McEachern, Proudfoot, and Hollinrake all argued that Parliament should represent public opinion on the issue (Wilson, 1993). The CMA recently announced that it will survey physicians to determine their views on euthanasia, and prepare a policy proposal for the General Council in 1994 (Sullivan, 1993). In Canada, the issue of euthanasia has reached the 'emerging policy' stage of development.

Physician Culpability and Patient Choice

In 1972, Parliament abolished the offences of suicide and attempted suicide, but retained the offence of counselling or aiding suicide (see appendix A). Although counselling or aiding suicide is punishable with a maximum sentence of 14 years imprisonment, there are no examples of this provision ever having been invoked.

Although Canada has no official euthanasia policy, the *Criminal Code* prohibits the act of homicide, prohibits a person from consenting to having death inflicted on him/her (s.14); places certain restrictions on the right to refuse treatment (s.45); prohibits aiding or abetting a suicide (s.241); and prohibits the acceleration of death, even if the victim is already dying (s.226). When the above mentioned sections of the *Criminal Code* were drafted, the type of problem being discussed here had not yet attained the critical threshold required to generate a need for policy; modern medical technology was not yet available and 'sophisticated and scientific palliative care was either unknown or in its infancy' (LRCC, 1983).

With respect to passive euthanasia, the Law Reform Commission of Canada (1992) notes physicians are caught in the dilemma of 'whether to abide by civil law and respect the wishes of lucid rational patients to terminate treatment or whether to respect the letter of the criminal law and continue to treat ... regardless of patient wishes'.

Canadian common law recognizes the right of competent adults to both consent to and refuse medical treatment (Rozovsky and Rozovsky, 1990). In 1990, an Ontario Court of Appeal upheld the right of a Jehovah's Witness to refuse a life-saving blood transfusion. The court ruled that 'the right of self determination which underlies the doctrine of informed consent also obviously encompasses the right to refuse medical treatment' (*Malette v. Shulman*, 1990).

Canadian criminal law makes a distinction between the action of killing and the inaction of allowing death to occur. Intent, not motive, is taken into account (LRCC, 1982). In its Working Paper *Euthanasia, Aiding Suicide, and Cessation of Treatment*, the LRCC (1982), noted that cessation of treatment may be included under a number of provisions of the *Criminal Code*, ranging from assault to homicide; failure to provide the necessities of life; or to use reasonable knowledge, skill and care; or aiding suicide. The LRCC found no record of a physician being convicted for ending the life of a terminally ill patient through the administration of pain-killing drugs, nor did it find any convictions for the termination of therapeutically useless treatment for a dying patient. The Commission also observed that Canadian courts have never directly blamed a doctor for refusing to prolong a patient's agony by not treating a secondary complication. The Commission concluded that the medical profession probably has little to fear in terms of the criminal law. It warned, however, that complacency was not warranted:

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 (LRCC, 1982:9).

In 1984, the Canadian Nurses Association developed the *Joint Statement on Terminal Illness* (CMA, 1987). The protocol has been adopted by the Canadian Medical Association (CMA), the Canadian Hospital Association, the Canadian Health Association, and the Canadian Bar Association, and is widely used as a basis for hospital policy development. The statement recognizes that there are conditions of 'ill health and inevitable death' where a physician may instruct that a patient should not be resuscitated (CMA, 1987). Such decisions involve a second medical opinion and consultation with the patient. Family consultation is deemed ethically acceptable in cases where the patient is incompetent. The CMA has continued to 'uphold the appropriateness of do-not-resuscitate orders for dying patients' despite legal advice to the contrary (Williams, Lowy and Sawyer, 1993).

The CMA also has a policy on informed decision making for consent to treatment. Physicians are required to disclose relevant information to patients prior to obtaining consent for medical treatment. Implicit in the policy is the recognition that a patient may refuse to consent to treatment (CMA, 1986).

It would appear that significant gains regarding patient choice have been made, and that these have been reflected in the civil law, and medical practice and policy. It is ironic that there is a distinct lack of corresponding legislation.

Parliamentary Initiatives

Several Canadian Members of Parliament have introduced legislation addressing various aspects of the right to die. In 1991, Robert Wenman's Bill C-203 which proposed *Criminal Code* amendments that

would free physicians from any legal obligation to administer treatment against the wishes of a patient, or when treatment becomes therapeutically useless. The Bill was defeated in a committee vote.

Bill C-261, proposed by Chris Axworthy, went considerably further than cessation or non-initiation of treatment. Its purpose was to legalize euthanasia, and to protect physicians in euthanasia-like situations where pain-killing treatment hastens death. The Bill, which was rejected, also intended to clarify concerns about physician liability for non-initiation or continuation of treatment at the request of the patient.

In 1992, Svend Robinson introduced Bill C-385, 'an Act to decriminalize physician-assisted suicide.' This Bill was never debated in parliament, and died on the order paper when an election was called.

BC Royal Commission Recommendations

The British Columbia Royal Commission on Health Care and Costs (1991) recently made four recommendations in support of euthanasia and assisted suicide. Each recommendation involved proposals that the provincial government lobby the federal government for amendments to the *Criminal Code*. The first recommendation dealt with the right to refuse treatment. The Commission felt that the *Criminal Code* should 'recognize the competent adult patient's absolute right to refuse medical treatment or demand its cessation,' and that such a right may be exercised by a duly appointed proxy in cases where the patient is not competent. The second recommendation pertained to requested mercy killing. The Commission suggested that terminally ill patients be allowed to request and receive fatal doses of pain medication. The third recommendation was that section 241(b) of the *Criminal Code* be amended so that aiding the suicide of a terminally ill patient would not be a criminal offence. The final recommendation dealt with the withdrawal or withholding of therapeutically useless treatment when consent cannot be obtained. In cases where the consent

of the patient or a proxy is unavailable, a physician would not be under legal obligation to provide such treatment, nor criminally liable for withdrawal of therapeutically useless treatment. To date, the recommendations have not been implemented.

V International Perspectives

Britain

In 1988 the British Medical Association (BMA) approved the Euthanasia Report. The Report made the traditional medical distinction between an active intervention by a doctor to terminate life and the decision not to prolong life, by not treating a patient. The BMA opposed any movement toward liberalizing the active termination of life which would alter the 'present ethos of medicine' (BMA, 1988). Nonetheless, the Report found it acceptable that patients may receive life threatening drug treatment provided that the sole intention is the relief of pain, illness, or suffering (BMA, 1988). The BMA recommended no change in the law, and advised that the 'deliberate taking of a human life should remain a crime' (BMA, 1988). The BMA concluded that its rejection of a change in the law was 'not just a subordination of individual well-being to social policy'; it is also 'an affirmation of the supreme value of the individual, no matter how worthless and hopeless that individual may feel' (BMA, 1988).

Since publication of the BMA report, there have been two significant euthanasia cases in Britain. The first involved Dr. Nigel Cox, who administered a lethal dose of potassium chloride to a 70 year old patient who was suffering from uncontrollable pain (Fleet, 1992a). Dr. Cox was convicted of attempted murder, and received a suspended 12 month prison sentence (Fleet, 1992b). The General Medical Council's Professional Conduct Committee allowed Dr. Cox to retain his medical licence and took no disciplinary action (Fletcher, 1992). The BMA refused comment on the disciplinary ruling, but added

'the deliberate taking of a human life is a crime and we do not believe that the law should change' (Fletcher, 1992).

The second euthanasia case involved Tony Bland, who had been in a persistent vegetative state for three years (Goodman, 1993). In Britain, the usual practice is to use minimum measures that will ensure the comfort of terminally ill patients and there is little concern if the dying process is hastened through the non-insertion of naso-gastric tubes (BMA, 1988). In Bland's case, however, feeding tubes had already been inserted, and he could breathe independently. Had Bland been 'brain dead and able to breathe only with the help of a ventilator, doctors would have no problem with switching off his supply of air' - in this case, failure to continue artificial feeding could be considered to be murder (Doyle, 1992). Bland's family and physician were granted House of Lords approval to have the feeding supply removed and in March, 1993, after the withdrawal of the feeding equipment, Bland died (Goodman, 1993).

There are serious implications for the Cox and Bland cases. The consequence of the Cox verdict is two-fold. First, the finding of guilt avoided the possibility that euthanasia could become, as in Holland, accepted in practice, if not in law. Second, the failure of the General Medical Council to discipline Dr. Cox could be interpreted as tolerance for his behaviour. In the case of Tony Bland, a precedent amounting to involuntary euthanasia may have been set. Keown (1993) sums up the Bland decision as 'a hard case which made bad law, largely by approving a consequentialist ethic radically inconsistent with the principle of the sanctity of human life. Apart from being sure to result in yet more hard cases, it may well serve to encourage the statutory legalisation of euthanasia.'

United States

The euthanasia debate in the United States has recently been influenced by a number of events. At the forefront is *Final Exit* (Humphry, 1991), a how-to manual for sui-

cide or 'self deliverance,' sold over 500,000 copies within its first year of publication (Fennell, 1992).

In 1991, Washington State held a referendum on the right to 'Aid in Dying'. The referendum, Initiative 119, failed by a vote of 54 per cent opposed and 46 per cent in favour (Carson, 1992). A similar proposal, California's Proposition 161, was also rejected by a 54-46 majority in 1992 (Capron, 1993). Had either Bill passed, it would have resulted in the world's first legalization of physician-assisted euthanasia.

A strong US lobby for patient choice in treatment decision-making is reflected by the 47 states which have passed 'living will' or 'natural death act' legislation (Downie, 1992). In 1990, the *Patient Self Determination Act* was passed, requiring Medicaid and Medicare health providers to advise patients about the right to refuse life-sustaining treatment and to complete living wills (Downie, 1992). Case law from *Quinlan* [1976] to *Cruzan* [1990] has also confirmed the right of competent individuals to refuse life-sustaining treatment on behalf of mentally incompetent patients.

In Michigan, Dr. Jack Kevorkian has gained considerable notoriety for assisting the suicides of 16 people since 1990 (Gibbs, 1993). He has been the subject of several criminal investigations regarding the deaths, and the Michigan State legislature recently passed a bill making the offence of assisted-suicide a felony ('Doctor assists,' 1993; Morganthau, Barrett and Washington, 1993). Kevorkian insists he will continue to assist patients who request his services, and states: 'I have never cared about anything but the welfare of the patient in front of me. I don't care about the law. I don't care about injunctions. I don't care about legislators' (Morganthau et al., 1993).

Switzerland

Contrary to the United States (Hirsch, 1990) and Canada (LRCC, 1982), where motive is immaterial in evaluating legal culpability for murder, the Swiss Penal Code

considers 'the actor's motive as the essential factor in determining the actor's culpability' (Hirsch, 1990). The likelihood that the offence will be repeated and the degree of criminal dangerousness is determined by motive (Hirsch, 1990; Silving, 1954). The philosophy of the Swiss law is that one who kills out of motivation to gain some sort of reward is at risk of repeating the act, whereas one who kills out of mercy is at much lesser risk of repeating the offence (Hirsch, 1990; Silving, 1954).

In addition to the consideration of motive, article 114 of the Swiss Penal Code, specifies 'homicide upon request,' as a separate crime with a lighter sentence than murder (Hirsch, 1990).

The Netherlands

In the Netherlands, physicians practise active euthanasia on patients suffering from terminal illness or conditions that involve unbearable suffering (Admiraal, 1988). Under the Dutch *Penal Code* euthanasia is illegal, but as a result of several court decisions dating from 1973, prosecution is not pursued provided that physicians follow certain prescribed guidelines (Gomez, 1991; Keown, 1992). According to van der Burg (1991), this tenuous legal relationship appears to be accepted by the majority of Dutch society and is more 'justifiable than it would have been had somewhere in the process a political compromise resulted in legislation'.

In February, 1993, the Dutch Parliament passed revisions to the guidelines that guarantee physicians immunity from prosecution. The regulations include: i) voluntary and persistent requests from the patient; ii) consideration of treatment alternatives; iii) 'perpetual, unbearable and hopeless suffering' experienced by the patient; iv) consultation with relatives and at least one other physician; and v) written documentation of patient history, and evidence of meeting the above criteria (Smit, 1993; 'Dutch soften,' 1993).

Despite the protective guidelines, there is still controversy regarding their applica-

tion. The actual number of cases reported to the Attorney General is considerably fewer than the estimated cases. Opponents of euthanasia argue that many physicians do not observe the guidelines, and most falsify the cause of death on patient's death certificates, for fear of being prosecuted (Bostrom, 1989; Fenigsen, 1990; Gomez, 1991; van der Sluis, 1989). In 1990, doctors reported 440 cases of voluntary euthanasia. In 1992, the number of reported cases rose to 1,318; an increase that experts attribute to a climate of more open discussion and greater consensus regarding the rules of conduct for euthanasia (Simons, 1993).

The journal, *Issues in Law and Medicine*, has published the work of several Dutch pro-life authors who are highly critical of euthanasia. In a seminal article regarding Dutch physicians' attitudes toward euthanasia, van der Sluis (1989), made allegations that doctors were developing the mentality that the killing of a sick person was the best service that could be offered. Van der Sluis (1989) also cited several accounts, of which he claimed direct knowledge, of gross abuses where doctors performed involuntary euthanasia on patients who had significant potential for continued life. Unfortunately, van der Sluis does not mention the ethical obligation he had in reporting his colleagues for their inappropriate actions. Nevertheless, his article does illustrate the magnitude of the emotional and philosophical conflict regarding the practice of euthanasia.

Prior to 1991, there was considerable speculation regarding the number of euthanasias being performed, with estimates ranging from 5,000 to 20,000 cases per year (van der Maas et al., 1991). In 1991, the Dutch Attorney General, Professor J. Rummelink released the comprehensive findings of the first nationwide study on euthanasia and end of life medical decisions. The Rummelink Commission concluded that 1.8 per cent (2,300) of all deaths are the result of voluntary euthanasia. Physician-assisted suicide accounted for 0.3 per cent (386) of all deaths. A further

0.8 per cent (1030) of all deaths were attributed to 'life-terminating acts without explicit and persistent request' – for example, palliative-type measures that shorten life (van der Maas et al., 1991).

Proponents of euthanasia applauded the Rummelink Report for what was interpreted as the first reliable evidence demonstrating that Dutch physicians are careful and responsible in carrying out euthanasia. Opponents, however, felt that the Report was far from reassuring. For example, the pro-life Dutch cardiologist Richard Fenigsen (1991), argues that within the Report's data, there are an additional 23,006 unaccounted euthanasia cases. To make his argument, Fenigsen employs a normative definition of euthanasia that includes passive euthanasia, palliative measures, and any other decision made by a physician that might hasten death (Fenigsen, 1991). It seems that Fenigsen's intent is not to demonstrate that there is little moral or ethical difference between active and passive euthanasia, assisted suicide, and treatment decisions that may shorten life; rather, Fenigsen wishes to create a sensationalistic statistic that suggests up to 56.5 per cent of all non-sudden deaths may be the product of physician decision-making (Fenigsen, 1991). Critics such as Dr. Fenigsen are in the minority; only 11 per cent of Dutch physicians say they would refuse to practice euthanasia (Simons, 1993).

VI The Policy Environment

Many euthanasia supporters base their arguments on the principles of liberty of choice, and the right to self-determination. Thus, an incurable or terminally ill patient should have the right to choose the time, place, and manner of his/her death. Legalization of active voluntary euthanasia would provide an *option* for such patients, provided they have the co-operation of another party to assist them.

The policy environment is formed from a general acceptance that death is inevitable and in some cases might be actively

facilitated. In particular, the policy environment involves social and legal attitudes toward death, suicide, homicide and euthanasia. The issues are normally differentiated, but when they are included in the 'right to die' context, the distinctions between suicide, homicide and euthanasia are less clear than they initially appear.

A reflection of this confused policy environment has been encountered in the court system, as judges attempt to define the issues. Court decisions in the absence of policy are cause for concern. Ekstedt (1991) notes that law is not policy, and therefore does not necessarily articulate any policy intent. In the absence of policy on euthanasia and right to die issues, the courts are placed in a position of forcing procedural change. The following policy proposal places the right to die issue in a formal environment – the Canadian Parliament.

Policy Alternatives

Medical procedures that sustain life may be juxtaposed with similar developments that allow for painless, non-violent death. Is it possible to arrive at an ethical and appropriate marriage between the technologies of sustaining life and those for compassionate killing? In the following sections, a number of options that deal with various aspects associated with the right to die, the right to refuse treatment, euthanasia and assisted suicide are presented.

1 No Policy

The absence of a policy implies support for the notion that killing is always wrong, no matter what the degree of suffering. It also implies a disregard for the principles of self-determination and individual autonomy, while simultaneously showing disrespect for the law as it currently stands in Canada. The unwritten policy of not charging individuals who hasten death is a contradiction; it fails to address the imbalance between current practice and criminal law. The consequence of this imbalance is that the courts are now being forced into the role

of interpreting law and creating policy. Since proclamation of the Charter, the courts have taken a proactive role in determining social policy with respect to issues such as abortion and gay rights. Nevertheless, social policy decisions, including euthanasia should be determined by Parliament.

2 Living Wills and Advance Directives

In essence, a living will specifies an individual's desire to control his or her dying process. It attempts to articulate ahead of time, the type and intensity of medical treatment one would like to receive, and the length of time such treatment should be continued. Some living wills also specify the types of care not desired, such as nasogastric feeding tubes or artificial respiration. It is a requisite of some living wills that a patient's condition be certified as terminally ill by two independent physicians,⁴ and that death be imminent (Smith, 1991). Such restrictions limit the utility of living wills.

Living wills are not legally recognized in Canada, and doctors are under no obligation to respect them. Some physicians argue that they cannot respect living will provisions because that would obligate them 'to perform extraordinary efforts on all those who have not signed a living will' (Clements, 1990).

Although living wills lack legal recognition, Canadians may prepare advance directives, which have the desired effect of living wills, and can be legally binding. Advance directives specify what procedures an individual desires, or does not desire, when he or she is unable to make that decision. Where an advance directive stipulates the kind of medical treatment, the kind or intensity of the undesired treatment, and the ethical values upon which the directive is based, then the document has legal validity (Kluge, 1992; see *Malette v. Shulman*, 1990).

The CMA recently distributed a policy summary that recommends physicians honour advance directives unless there are

'reasonable grounds for not doing so' (CMA, 1992). The policy also suggests that physicians assist their patients in the formulation of such directives (CMA, 1992).

Despite the apparently receptive climate to living wills and advance directives, they still play a limited role in decision making regarding the withholding or cessation of life-sustaining treatments (Brennan, 1988; Kelner et al., 1993; Smedira et al., 1990; Youngner et al., 1985). American research has shown that over 80 per cent of physicians have positive attitudes towards advance directives (Davidson et al., 1989), yet hospitals and other health care institutions do not regularly inquire whether patients have a living will (McCrary and Botkin, 1989). In Canada, a poll of over 2000 Ontario physicians indicated that only 64 per cent would respect patient wishes as expressed in a living will (Downie, 1992).

In addition to the problems associated with the relative novelty of living wills and advance directives, there are several other problems. First, they require regular updates to ensure consistency with changes in the individual's desires. Second, individuals confronted with death may actually change their minds about treatment and be unable to express themselves. This could lead to a situation in which a physician may respect an outdated will. Third, advance directives only deal with treatment issues, and cannot authorize active, voluntary euthanasia or assisted suicide. Fourth, a common problem with many living wills and advance directives is that they contain 'vague phrases, internal contradictions and loopholes' (Kluge, 1993a). For example, some refer to the administration of medication to alleviate suffering and allow death to occur should a person suffer from irreversible 'physical or mental disability'. Potentially, such disabilities could include minor brain damage, or loss of limbs. Presumably, those who possess such a directive, would not wish to be left to die simply because the *degree* of disability was not explicit. Finally, the most common problem with living wills and advance directives is

their lack of accessibility under emergency conditions. There is no central registry to determine whether a patient is in possession of a health care directive.

3 Enduring Powers of Attorney

The enduring power of attorney is an improvement on the living will concept. Whereas a power of attorney lapses if the grantor becomes incompetent, an enduring power of attorney comes into effect with the grantor's lapse into incompetence.

Recent developments in Ontario and British Columbia concerning substitute decision-making appear to confirm the trend toward patient autonomy and informed decision-making for consent to treatment. *Ontario's Consent to Treatment Act* (1992), *British Columbia's Representation Agreement Act* (1993), and *Nova Scotia's Medical Consent Act* (1988), all provide for some form of substitute consent whereby adults may delegate the authority to make personal treatment decisions, in the event that they become incapable of making such decisions.

Enduring powers of attorney help to legitimate the rights of patients to consent to or refuse treatment, and extend the power to another individual of the patient's choice. Nevertheless, such legislation should be coupled with parallel legislation protecting physicians and other decision-makers from criminal liability in the event that treatment or non-treatment hastens death. Furthermore, enduring powers of attorney do little to support the notion of active voluntary euthanasia.

4 Palliative Care

Since the 1960s, palliative or hospice care has gained acceptance in the mainstream of medical care for people with advanced illness (Stoddard, 1992). Palliative care is defined as 'active and compassionate care primarily directed toward improving the quality of life for people who are dying' (Latimer and Dawson, 1993). Palliative care involves a team approach that traditionally includes various medical and health care

professionals: doctors, nurses, social workers, psychiatrists, counsellors, art and music therapists, clergy, dietitians, and volunteers. In addition to patients who are dying, palliation may apply to persons who suffer from incurable illness. Relief of suffering is at the root of palliative care, and its intent is to 'neither hasten nor inappropriately prolong the dying process' (Latimer and Dawson, 1993). Despite this assertion, palliative care is sometimes referred to as 'double effect euthanasia' because the 'patient's death is a foreseeable potential effect of the treatment' (Council on Ethical and Judicial Affairs, 1992). Certainly, the complex treatment conditions that prevail in the end stages of terminal care, do not always allow a clear distinction between palliation and euthanasia (van der Sluis, 1989).

Nonetheless, palliative care is an option for many who seek alleviation from physical suffering, and may help to reduce requests for euthanasia and assisted suicide. Indeed, it is frequently argued that palliative care is 'the principal alternative to euthanasia' (Williams, 1991). Effective pain control, however, only deals with physical pain, and not mental pain. Palliative care is not an option for persons such as Nancy B., Sue Rodriguez, or others who are totally dependent upon technology for survival. It does nothing for their mental suffering, nor the reason for their suffering. Medical ethicist Eike Kluge (1993b), argues that in such cases, palliation merely renders persons insensitive to their suffering, and 'if that were ethically acceptable, we would never have to deal with the source of people's suffering. All we would have to do is drug them.'

5 Aid In Dying/Euthanasia Legislation

The most appropriate way to address the problem of euthanasia and the law is to implement legislation which, in certain cases, supports the active termination of life. Aid-in-dying legislation is grounded in an ethic that values the principles of equality of justice, self-determination, and individual au-

tonomy. It proposes that there are circumstances where morality calls upon society to allow termination of life through both active and passive means.

Aid in dying legislation would clarify issues for the courts that are distinct from those faced by ethicists and doctors. Courts use a foundation of current law and precedents to build new case law, thus facing a number of hurdles in deciding in favour of euthanasia. In the absence of law permitting euthanasia, the courts are forced to accommodate statutes pertaining to homicide to medical practice. As discussed earlier, homicide is generally considered to be conduct that involves the *intent* to cause death. Where intent is not shown, the consideration is on what was *known* to be likely to cause death. Furthermore, law treats omissions causing death as culpable provided that the actor owed a duty to the person who died (Smith, 1991; see Appendix A, s.215).

The duty of a doctor to provide care to a patient is mutually and societally understood, and the omission of such care if intentional (to produce death), or knowing (death is the likely result), constitutes homicide if the patient dies (LRCC, 1982).

The law of homicide may be accommodated to the societal preference for allowing a patient to die where the courts consider the duty to treat ceases when the patient will no longer benefit – that is, the withdrawal of non-beneficial treatment is deemed non-culpable. Such decisions are frequently made between doctors and their families. Nevertheless, restrictions on doctors' treatment obligations to patients is a cautious solution, with no principled basis for determining when the duty to provide treatment ends. Current medical practice suggests that the duty ends when doctors, patients, and their families say it should end.

Proposed Policy

The intent of this policy proposal is to bring the *Criminal Code* into balance with the common law, current euthanasia behav-

our, and to recognize the principles of individual autonomy, equality and justice, and self-determination. The aforementioned principles are consistent with the values articulated in the *Charter of Rights and Freedoms*. Section 7 of the *Charter* provides:

7. Everyone has the right to life, liberty and the security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

These values have been reaffirmed in several cases. In *R. v. Oaks* [1986], Chief Justice Dickson said that the essential values and principles for a free and democratic society include:

respect for the inherent dignity of the human person, commitment to social justice and equality, accommodation of a wide variety of beliefs, respect for cultural and group identity, and faith in social and political institutions which enhance the participation of individuals and groups in society.

The right to die has been afforded limited recognition in the form of living wills, and some case law. Since it has been established that the right to die exists, it follows that individuals who seek to exercise this right, and suffer from terminal illness or unbearable suffering, should have a remedy available to them. This policy proposal offers such a remedy.

In addition to its recognition of fundamental principles of justice, the policy has significant social benefits. First, it allows individuals to take control of their lives. How one dies is part of life itself, and one should be able to exercise choice regarding this aspect of life. Often, the knowledge that one has control of one's death leads to a greater feeling of control of one's life. A sense of control is essential to quality of life, especially when one is confronting death (P. Jepson-Young, personal communication, January 31, 1992).⁵

A second benefit is the ability for an in-

dividual to choose a less violent and therefore less tragic means of death. There are numerous examples of suicides that leave behind tremendous pain and guilt. For example, in the past decade, a significant number of suicides have been linked to AIDS. Amongst these suicides, many are violent (Marzuk et al., 1988; Kizer et al., 1988), others result in the grisly discovery of a decomposing body (Profili, 1992). Given that suicide is not a criminal offence in Canada, it seems rational that in certain circumstances, individuals should have the choice of a controlled, non-violent, assisted death.

The savings in health care costs is a third benefit. As medical costs skyrocket, and governments come under increasing pressure to control spending, the implications of euthanasia on the economy become increasingly apparent. Socio-economic factors play a critical role in health and death, and in some cases age alone is a criterion for who receives certain health care treatments (Tillock, 1991). Many governments are experiencing pressure to consider health care rationing in an effort to control spending (British Columbia Royal Commission, 1991; Callahan, 1987; Wigod, 1992).

In primitive societies, death-hastening behaviour of persons no longer able to contribute is considered normative (Freuchen, 1961; Glascock, 1990). Sociologist Harriet Tillock suggests that American society is moving in a similar direction: 'Once an individual's life is no longer of economic value to the society and may become an economic liability, we may emulate primitive societies and establish our own death-hastening pattern by refusing economic and other support to dependent elders' (Tillock 1991).

Tillock's suggestion that economics may become influential in decisions to support euthanasia may be generalized to the AIDS epidemic and associated escalation in health care costs. It is estimated that the first 10,000 AIDS cases in the US resulted in over \$1.4 billion in expenditures (Hardy et al., 1986). Such expense makes it easy to marry respect for euthanasia of the AIDS

patient who requests it, with the need for greater cost containment. It is unfortunate that if euthanasia does gain acceptance, it may be based on the argument of political economy, rather than a more principled one grounded in individual rights.

A fourth benefit is the savings in legal and court costs. Individuals should not have to go to court to obtain permission to die an assisted death. The expenses incurred in cases such as those of Nancy B. and Sue Rodriguez are prohibitive; the emotional cost and invasion of privacy immeasurable. A quasi-judicial board would be more cost effective, and offer greater privacy in decision-making.

Brock (1992) identifies another good consequence of legalizing euthanasia. Where death is expected and has been accepted, it is more humane that death occur 'quickly and peacefully, when that is what the patient wants'. We have concerns about the manner of our deaths, in part due to our desire that we will be remembered by others in times when we were happy, functioning, and contributing. Those who die suddenly, whether in their sleep or by accident, are often considered to have been fortunate to have died swiftly. For some people, euthanasia will be a more humane death than protracted dying in a suffering, drugged, or comatose state.

A final benefit is that the policy will allow individuals to make critical decisions regarding organ donation. The lives of up to five people can be saved with the harvested organs of a euthanasia recipient (Kevorkian, 1991), and up to 13 may be significantly improved (B.C. Registry for Organ Donors, 1993).

The following policy proposal recognizes that society and the law have made significant advances; acts and intents that once constituted homicide now fall within certain exceptions. To progress from the cessation of treatment sustaining life, to active aid-in-dying is a smaller, though crucial, advance.

The proposed policy is different from existing law proposals such as Initiative 119

and Proposition 161 in the US, and Bills C-203, C-261, and C-385 in Canada, in that it is not restricted to terminally ill patients for whom death is imminent. It allows non-terminally ill individuals to request euthanasia. This latter group is included because there are people who have dependencies on technology, or who have lost their reasons for existence and their will to live, while at the same time having a clear understanding of what a decision to die entails. Such individuals may experience even greater pain and suffering than persons with terminal illness.

The proposed policy treats life as something that is not unconditionally good. Rather, life is regarded as having value from the perspective of the individual who experiences it. If a person no longer has experiences, or no longer has wanted experiences, or if unwanted experiences outweigh wanted experiences, then that person may have a good reason to die (Browne, 1988). In other words, the individual is in a condition of unbearable suffering.

Circumstances which might fit into the category of unbearable suffering include those of persons suffering from the end stages of AIDS, terminal cancer, or uncontrolled pain; there is no known effective treatment, and the individual's quality of life has deteriorated to such an extent that there is little reason or motivation to continue living. Another appropriate circumstance might be that of an individual with Alzheimer's disease who wishes to die before suffering from a total loss of all mental faculties. Treatable depression would not typically be considered to be a condition of unbearable suffering. Presumably, there may be exceptional circumstances where untreatable depression could be considered sufficient to authorize voluntary euthanasia or assisted suicide.

VII Proposed Legislation

The proposed policy involves amendments

to the *Criminal Code*. The offences of aiding or abetting suicide, acceleration of death, and the restriction contained within section 14 on the right to refuse treatment would be deleted. An amendment to the law on homicide would allow individuals to administer euthanasia where permission is granted by an Aid-In-Dying Board. The following sample legislation is proposed as an introductory model for legislative development.

1. Preamble: AID-IN-DYING/EUTHANASIA ACT

This Act legalizes active aid-in-dying under certain conditions for competent patients who request it. This includes assisted suicide and active voluntary euthanasia. The Act recognizes the principles of equality of justice, self determination, and individual autonomy. The Act also permits physicians to withdraw or withhold therapeutically useless treatment, and permits competent patients or their proxy to make informed health care decisions that may cause death.

2. Definitions:

- a) Proxy, is a surrogate appointed by a patient to make treatment decisions, including euthanasia, in the event the patient becomes incompetent to make treatment decisions.
- b) Aid-in-Dying, is the withdrawal or withholding of life-sustaining treatment, or the administration of treatment intended to cause death.
- c) Aid-in-Dying Boards, are responsible for the review and approval or rejection of Aid-in-Dying Applications.
- d) Counsellor, is a professionally accredited person, trained to provide counselling to individuals who apply for aid-in-dying.
- e) Competence, means the ability to make informed health care decisions.
- f) Euthanasia License, is a license entitling the holder to receive aid-in-dying.

Commentary

Most aid-in-dying legislation deals specifically with terminal illness, cessation of treatment, and consent to treatment. This Act does not define these terms because its

principle intent is to allow for individual evaluation of all requests for assisted deaths. Membership of the Aid-in-Dying Board will come from a cross-section of professional backgrounds; the purpose being to encourage diversity of opinion and careful assessment of all applications. Board members would be appointed by the Minister of Health, and selection criteria should be based on principles of ethics, liberalism, and civil libertarianism.

Skilled, professionally-credentialed counsellors will discuss aid-in-dying and treatment options with applicants. Aid-in-Dying Counsellors would possess training in the evaluation of medical prognoses, experience with death and dying, knowledge of treatable depression, and skills in therapeutic counselling – including bereavement counselling. The counsellor's purpose is to educate aid-in-dying applicants and ensure that they fully understand the finality of an assisted death. Counsellors will also determine whether the request is made without coercion. The counsellor, in conjunction with the applicant's physician, will assess the competency of the applicant to make informed health care decisions, explore treatment alternatives, and make recommendations regarding the application to the Aid-in-Dying Board.

3. Application for Aid-in-Dying

A) Any person or designated proxy over the age of 18 may make application for aid-in-dying, with written reasons. The application shall be completed under the supervision of the Aid-in-Dying Counsellor. Applicants under the age of 18 must have the written consent of parents or legally appointed guardian.

B) Every applicant shall:

1. make application by form set out by the Ministry of Health.
2. sign the application before two witnesses in addition to the Aid-in-Dying Counsellor. The witnesses shall not be related to the applicant, nor be designated beneficiaries under a will of the applicant. Government, insurance companies, and health care pro-

essionals are prohibited from making application on behalf of persons.

3. provide all information deemed relevant by the applicant to the request for aid-in-dying. This may include, but is not limited to medical reports, psychiatric reports, evidence of technological dependency, and other personal history.

4. where the applicant is under age 18, provide the notarized consent of the parents or legally appointed guardian.

Commentary

Under the policy, only affected individuals, immediate family members, and designated surrogates (proxies) may request aid-in-dying on behalf of the patient. In order to limit the potential of economic motives from becoming involved, government, insurance companies and health care professionals may not request aid-in-dying on behalf of a patient. At all times the onus is on the applicant or proxy to provide reasons for the aid-in-dying request.

4. Aid-in-Dying Boards

1) the Minister of Health shall appoint the Aid-in-Dying Board members. The purpose of the Board is to assess, approve or refuse Aid-in-Dying applications.

2) Aid-in-Dying applications must be rendered a decision within 10 days of receipt.

3) Where the Board refuses an application, it shall provide reasons in writing.

4) Applicants may apply to the Minister of Health for review of refused applications.

5) Where the Aid-in-Dying Board approves an application, it shall issue a license authorizing aid-in-dying.

6) Aid-in-Dying Licenses shall be valid for three months from the date of issue.

7) Aid-in-Dying Licenses may be revoked at any time by the applicant.

Commentary

Section 4 provides for the creation of an Aid-in-Dying Board and a process for assessment and approval or refusal of Aid-in-Dying applications. The Board is responsible for, and mandated to timely evaluation of applications. If applications appear incomplete the Board may deny the

request, but the applicant may reapply with new information. Applicants may also request that the Minister of Health review a refused application. A formal appeal process is not outlined in the legislation, since this is considered a procedural exercise for the Health Ministry. Aid-in-Dying Licences are valid for up to three months in order to allow applicants time to make death preparations in a manner consistent with their emotional, personal, and spiritual needs. Liberty of choice is respected – applicants may revoke an Aid-in-Dying Licence at any time.

5. Administration of Aid-in-Dying

- a) Aid-in-dying is to be administered under the supervision of a qualified medical practitioner.
- b) The method of aid-in-dying shall be in any non-violent form that minimizes pain and suffering, and brings about a quick death.
- c) Persons administering aid-in-dying shall do so on a voluntary basis.
- d) Upon completion of an aid-in-dying procedure, a report shall be made to the Aid-in-Dying Board and the Coroner's office.

Commentary

Section 5 allows for voluntary administration of aid-in-dying. The administration of aid-in-dying is open to persons other than physicians because it is recognized that the administration of a fatal dose is not necessarily a medical procedure that must be directly performed by a physician. Under physician supervision, licensed aid-in-dying recipients or any other adult may administer aid-in-dying treatments. The intent is to allow the aid-in-dying recipient to maintain as much control as possible, in a format that brings about a reliable and quick death. Persons who object to euthanasia are under no obligation to provide aid-in-dying.

6. Exceptions to the *Criminal Code*

- A) Nothing in sections 14, 45, 216 and 217 shall be interpreted as:
 - 1) requiring a physician to provide or con-

tinue treatment where the patient or designated proxy refuses such treatment.

- 2) requiring a physician to provide or continue therapeutically useless treatment that is not in the best interests of the patient.

- 3) preventing a physician from providing palliative care that may shorten a patient's life.

B) No person is guilty of an offence pursuant to sections 215, 218, 226, and 246 where he/she:

- 1) fails to provide or continue treatment to persons who do not wish treatment, or where the treatment is therapeutically useless.

- 2) provides palliative care shortening life where the patient or proxy has provided informed consent.

Commentary

Section 6 is a modification of Bill C-261 and addresses *Criminal Code* amendments with respect to euthanasia situations involving the withholding and cessation of treatment, and palliative care. The amendments allow individuals to refuse medical treatment or consent to treatment causing death. Physicians and other individuals are protected in cases where they follow advance directives and living wills. The intent is to allow patients to die in a manner of their choosing, without subjecting their physician, family, or surrogates to legal sanction.

VIII Monitoring

There always exists the potential for abuse or error in any policy area. In the case of aid-in-dying and euthanasia policy, the risks are compelling because abuse can result in unsolicited deaths. Nevertheless, with strict control and monitoring the risks are minimized; violations can be addressed through criminal prosecution. Within the policy are a number of legislative safeguards which are summarized below:

- Voluntary participation for applicants and physicians.
- Aid-in-Dying boards.
- Counselling regarding decision-making and treatment alternatives.
- Assessment of ability to make informed

medical consent decisions.

-Time-limited Aid-in-Dying licences.

-Restrictions on who may request euthanasia on behalf of individuals.

-Medical supervision of Aid-in-Dying procedures.

-Independent third party witnessing of applications.

-Reviews by the Minister of Health.

IX Policy Evaluation

The policy should be evaluated by a joint committee consisting of public persons, representatives of Health and the Attorney General. It is suggested that the joint policy evaluation committee meet quarterly and publish an annual report containing statistics for all aid-in-dying applications and their outcomes. The identification of problems and recommendations for policy modification will be responsibilities of the committee. It is expected that with the articulated safeguards there will be minimal abuse, and that which occurs can be addressed through criminal prosecution.

X Conclusion

Fischhoff and Cox (1986) note that policy-making is a gamble where the policy-maker, in a state of incomplete knowledge, attempts to get the best possible deal for society. The right-to-die policy issue is no exception. This discussion has reviewed the nature of public and political attitudes regarding euthanasia and the right to die in several countries, of which only the Netherlands has accepted euthanasia under certain conditions. Recent court decisions in Canada, Britain, and the United States suggest that passive forms of physician-assisted suicide are legal. There is no reason why exceptions cannot be made in similar circumstances that involve more active measures.

In North America, there is a strong lobby for the legalization of various aspects relating to the right to die. So far, the movement has succeeded in placing the euthanasia

issue on the referendum ballot in a number of states. To date, Washington and California have held such referenda, each failing by an 8 per cent margin. In Canada, the right-to-die issue has been researched by the Law Reform Commission (1992), and its recommendations were avoided. Two private member's bills supporting the right-to-die have failed to get Parliamentary approval – a third was dropped when the 1993 federal election was called. The case of Sue Rodriguez has captured international attention, and stimulated considerable debate.

This paper has presented a policy proposal that aligns the *Criminal Code* with the current common law, and the *Charter*. Additionally, the policy permits active euthanasia and aid-in-dying in certain circumstances. It is a tragedy that the most important decisions of our lives are in a state of legal uncertainty. It is hoped that this proposal will provoke thoughtful discussion which will lead to an informed response to the complexities of euthanasia and aid-in-dying.

Notes

- * Graduate student, Department of Criminology, Simon Fraser University. I wish to thank the referees for their insightful critique and thoughtful suggestions regarding the content of the paper. I also wish to thank Margaret Jackson and Michael Young of the Simon Fraser University Department of Criminology for their discerning commentary and careful deliberation during the preparation of the paper.
- 1 Amyotrophic Lateral Sclerosis (ALS) or Lou Gehrig's disease, is an incurable condition which involves progressive degeneration of spinal, corticobulbar, and lower motor neurons, with subsequent spasticity and atrophy of cranial and spinal muscles (Miller, 1984).
- 2 Guillain-Barre syndrome is a neurological disorder causing 'acute febrile polyneuritis' (*Dorland's Illustrated Medical Dictionary*, 1981). Nancy's condition was diagnosed as incurable and irreversible, with an almost total denervation of the motor nerves.
- 3 B. Butters is Editor in Chief, *Vancouver Province* newspaper.
- 4 For example, see the 1993 version of the living will/advance health care directive of Goodbye, A

Right to Die Society.

- 5 Dr. Peter Jepson-Young, a physician with AIDS, was noted for the weekly CBC news segment 'AIDS Diary'.

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Appendix A

Related Criminal Code Sections*

Consent to death.

14. No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given. R.S.,c.C-34,s.14.

Surgical operations.

45. Every one is protected from criminal responsibility for performing a surgical operation on any person for the benefit of that person if

- the operation is performed with reasonable care and skill; and
- it is reasonable to perform the operation, having regard to the state of health of the person at the time the operation is performed and to all the circumstances of the case. R.S.,c.C-34,s.45.

Duty of persons to provide necessities - Offence - Punishment - Presumptions.

215. (1) Every one is under a legal duty

- as a parent, foster parent, guardian or head of a family, to provide necessities of life for a child under the age of sixteen years;
- as a married person, to provide necessities of life to his spouse; and
- to provide necessities of life to a person under his charge if that person
 - is unable, by reason of detention, age, illness, insanity or other cause, to withdraw himself from that charge, and

(ii) is unable to provide himself with necessities of life.

(2) Every one commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse, the proof of which lies on him, to perform that duty, if

(a) with respect to a duty imposed by paragraph (1)(a) or (b),

(i) the person to whom the duty is owed is in destitute or necessitous circumstances, or

(ii) the failure to perform the duty endangers the life of the person to whom the duty is owed, or causes or is likely to cause the health of that person to be endangered permanently; or

(b) with respect to a duty imposed by paragraph (1)(c), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.

(3) Every one who commits an offence under subsection (2) is guilty of

(a) an indictable offence and is liable to imprisonment for a term not exceeding two years; or

(b) an offence punishable on summary conviction. R.S., c.C-34, s.197; 1974-75-76, c.66, s.8; 1991, c.43, s.9.

Duty of persons undertaking act dangerous to life.

216. Every one who undertakes to administer surgical or medical treatment to another person or to do any other lawful act that may endanger the life of another person is, except in cases of necessity, under a legal duty to have and to use reasonable knowledge, skill and care in so doing. R.S., c.C-34, s.198.

Duty of persons undertaking acts.

217. Every one who undertakes to do an act is under a legal duty to do it if an omission to do the act is or may be dangerous to life. R.S., c.C-34, s.199.

Abandoning child.

218. Every one who unlawfully abandons or

exposes a child who is under the age of ten years, so that its life is likely to be endangered or its health is or is likely to be permanently injured, is guilty of an indictable offence and liable to imprisonment for a term not exceeding two years. R.S., c.C-34, s.200.

Acceleration of death

226. Where a person causes to a human being a bodily injury that results in death, he causes the death of that human being notwithstanding that the effect of the bodily injury is only to accelerate his death from a disease or disorder arising from some other cause. R.S., c. C-34, s.209.

Counselling or aiding suicide.

241. Every one who

(a) counsels a person to commit suicide, or
(b) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years. R.S., c.C-34, s.224; R.S. 1985, c. 27 (1st Supp.) s.7(3).

Overcoming resistance to commission of offence.

246. Every one who, with intent to enable or assist himself or another person to commit an indictable offence,

(a) attempts, by any other means, to choke, suffocate or strangle another person, or by any other means calculated to choke, suffocate or strangle, attempts to render another person insensible, unconscious or incapable of resistance, or

(b) administers, or causes to be administered to any person, or attempts to administer to any person, or causes or attempts to cause any person to take a stupefying or overpowering drug, matter or thing, is guilty of an indictable offence and liable to imprisonment for life. R.S., c.C-34, s.230; 1972, c.13, s.70.

Note

* *Criminal Code*, R.S.C. 1985, c.C-34.