The Right to Natural Death

Bernard M. Dickens*

I. Introduction

This article is designed to address the legal control individuals may exercise over the medical management of their own death. In particular, it considers legal powers to prevent the use of aggressive measures employing artificial means to postpone the natural death of persons in terminal conditions.[1] Resisting the patient's right to decline death-postponing treatment is the physician's power to attempt to prolong life. Regard is therefore paid to the tension between these competing interests.

Since the existence of individual human life is the precondition of enjoying individual human rights, the right to die may at first appear anomalous in inventories of recognized and asserted rights. A claim to act irrevocably to extinguish the potential for enjoying other rights appears incongruous, not least in a life-affirming culture where the preservation of human life is celebrated.[2] Where life is considered a divine gift or a communal responsibility, individuals may not be recognized to have rights of self-disposition, other than in acts of self-sacrifice dedicated to others. Historically, the common law, reflecting earlier feudal law, denied such claims of individual self-determination, since persons were locked into communal relations and duties incompatible with a right of unilateral withdrawal. This finds vestigial expression in section 14 of the *Criminal Code*,[3] which provides that:

> No person is entitled to consent to have death inflicted upon him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted upon the person by whom consent is given.

As against this, however, the claim to individual autonomy is the foundation upon which modern individual rights are built, so that rights to reach independent decisions about how to live may be

---

* LL.B., LL.M., Ph.D., LL.D., of the Faculty of Law, University of Toronto.

[1] From the perspective of general use of mechanical support of life, natural death may appear premature; see generally Fama, *Classification of Critically Ill Patients: A Legal Examination* (1980) 24 Saint Louis Univ. L.J. 541.

[2] This is recognized in the tendency to use the expression "heroic measures" synonymously with "aggressive measures" to describe medical attempts to resist death.

[3] R.S.C. 1970, c. C-34.

said to presuppose the right to decide whether or not to continue to live. With this evolving perception, historical criminal prohibitions against suicide were removed from the *Criminal Code* in 1972,[4] although counselling, procuring, aiding or abetting another's suicide remain punishable.[5] Where suicide may be tolerated as a regrettable private act, however, suicide as a public act of social or political protest may be resisted. Government is not necessarily required to remain passive before the prospect of demonstrative self-immolation by fire or hunger strike,[6] for instance, whether by commonly motivated groups or by individuals. Similarly, private rejection of reasonable life-saving measures on grounds of religious conviction, notably refusal of blood-transfusion by Jehovah's Witnesses, has resulted in judicial authorization of treatment.[7] Such refusal is not suicidally motivated, of course, since it is inspired by the hope and expectation of survival, perhaps by divine intervention.

Politically motivated death is, however, atypical in our society. The issue to be addressed in representative medical practice is whether and when a person may effectively decline medical treatment or means of hospital management, when refusal is believed to be likely to lead to a death which could be postponed by medical intervention. The longing for natural death draws much of its force from fears many people have of ending their lives being maintained by mechanical life-supporting equipment in a condition of helpless dependency and utter loss of personality and individuality.[8] People accustomed to exercising autonomy in life want to keep control of themselves in death, and to protect themselves against an abuse or misapplication of medical technology. The catchphrase or slogan "death with dignity" is often used, to contrast the feared indignity

---

[4] S. 225 was repealed by S.C. 1972, c. 13, s. 16.

[5] See s. 224, which applies whether suicide ensues or not.

[6] See Zellick, *The Forcible Feeding of Prisoners: An Examination of the Legality of Enforced Therapy* [1976] P.L. 153, considering the case of *Leigh* v. *Gladstone* (1909) 26 T.L.R. 139 (K.B.).

[7] See generally Kouri, *Blood Transfusions, Jehovah's Witnesses and the Rule of Inviolability of the Body* (1974) 5 R.D.U.S. 156. For cases where blood transfusions were ordered for Jehovah's Witnesses who were pregnant or had small children, see respectively *Raleigh-Fitkin Memorial Hospital* v. *Anderson* 201 A. 2d 537 (N.J. 1964) and *Application of President and Directors of Georgetown College* 331 F. 2d 1000 (D.C. 1964). In *Kennedy Hospital* v. *Heston* 279 A. 2d 670 (N.J. 1971) the Court denied a constitutional "right to die". A number of cases have, however, recognized the capacity of Jehovah's Witnesses to refuse blood even when death will probably result: see, *e.g.*, *In Re Brooks' Estate* 205 N.E. 2d 435 (Ill. 1965).

[8] See Keyserlingk, *Sanctity of Life or Quality of Life* (1979), 66-70.

of lacking self-control of body and mind in the closing stages of life. The right to seek an independent life has been extended to the claim to an independent death.

II. Non-consensual treatment[9]

The observation of Justice Cardozo in *Schloendorff* v. *Society of New York Hospital* that "every human being of adult years and sound mind has a right to determine what shall be done with his own body"[10] has become part of the rhetoric in modern common law jurisprudence.[11] Accordingly, individual power conclusively to decline life-prolonging medical care may appear to have been firmly established.[12] In fact, however, Justice Cardozo's proposition contains a passive precondition, namely soundness of mind, to which dynamic effect is now given so as to limit an individual's complete right to bodily autonomy.

It has been noted in a broader context that behaviour once assessed within doctrines of sin and heresy now may be assessed within classifications of disease, particularly psychopathology.[13] Suicidal acts have long been considered indications of mental imbalance, however, with the merciful effect of excusing the sin of suicide to permit burial in consecrated ground, and to relieve family stigma, since the mentally ill are morally blameless. Coroners' juries record verdicts of suicide while the balance of the mind was disturbed with little if any consideration given to the possibility that the choice of suicide may have been the act of a balanced mind; the fact of the deceased having reached that choice is presumed to indicate mental imbalance.

Operating prospectively, mental health legislation links homicidal and suicidal tendencies, and provides for a suspect's involuntary psychiatric assessment and subsequent detention and supervision, with or without other treatment, to prevent a destructive act. A

---

[9] See Somerville, *Consent to Medical Care* (1979).

[10] 105 N.E. 92 (N.Y. 1914).

[11] See, *e.g.*, *Marshall* v. *Curry* [1933] 3 D.L.R. 260 (N.S.S.C.) and the citation by Laskin C.J.C. in *Reibl* v. *Hughes* (1980) 114 D.L.R. (3d) 1, 10 (S.C.C.).

[12] In the "Brother Fox case", *Eichner* v. *Dillon* 426 N.Y.S. 2d 517 (App. Div. 1980), the right of a competent terminally ill patient in the United States to reject mechanical life supports was stated to be of constitutional dimension, embodied in the constitutional right of privacy, and not to depend on the mere common law "bodily right of self-determination".

[13] This theme underlines much of the writing of Thomas S. Szasz: see, *e.g.*, *The Myth of Mental Illness* (1961) and *Law, Liberty and Psychiatry* (1963).

number of provincial statutory formulae are employed to express the indication for involuntary assessment and detention,[14] but underlying them is the common recognition that persons deliberately placing themselves at risk of physical disabilities which may result in death, but which medical care may alleviate so as to render survival likely, are subject to preventive intervention.[15] They may pass under the legal guardianship of others, who may give legally effective consent to life-preserving treatment.[16]

The effect of cultural and professional psychiatric presumptions of the pathological nature of the loss of will to live is that individuals who reject life-prolonging medical care, and perhaps who decline what at best could be only death-postponing care, may be assessed as incapable to care for themselves due to unsoundness of mind. Medical literature includes records of patients who have survived to express gratitude to the physicians who ignored their refusals of treatment; records of those who eventually died in medically-imposed torment are more easily dismissed as only anecdotal, however, as derived from the distressed misunderstandings of the bereaved.[17] Disregard of patients' refusal of treatment is reinforced when they are elderly and affected by the conditions of mind associated with advanced age. Senility and confusion may be invoked to explain away decisions in which health care providers, and perhaps family members, cannot concur. Further, fears may exist that the refusal of treatment is not authentic, but is conditioned by a variety of psychological, sociological and, for instance, economic factors.

Accordingly, the right of physical and medical autonomy expressed in Justice Cardozo's observation may be subverted by denying the attribute of soundness of mind and authentic free-will necessary for its exercise. Further, such denial may be based upon

---

[14] Most refer generally to established danger to self or others. In Ontario, s. 8 of *The Mental Health Act*, R.S.O. 1970, c. 269 (as am. S.O. 1978, c. 50), refers to a person who "has threatened or attempted ... to cause bodily harm to himself" and who "is apparently suffering from mental disorder of a nature or quality that likely will result in ... serious bodily harm to the person ... or imminent and serious physical impairment of the person".

[15] See *Meyer* v. *Supreme Lodge K.P.* 70 N.E. 111 (N.Y. 1904), *aff'd* 198 U.S. 508 (1905), holding that administering an antidote to a would-be suicide was lawful.

[16] On the role of those under whose legal authority such incompetents fall, see Dickens, *The Role of the Family in Surrogate Medical Consent* (1980) 1 Health Law in Canada 49.

[17] See Jackson & Younger, *Patient Autonomy and 'Death With Dignity': Some Clinical Caveats* (1979) 301 New England J. Med. 404.

little more than medical or familial disagreement with the direction or exercise proposed. This leaves the right in a precarious state.

Disregard of the absence of patient consent to life-assisting treatment may be rationalized and defended by the conviction that the patient subscribes to the general life-affirming ethic and intends to survive. When the patient at risk of dying is unconscious and has expressed neither consent nor objection to care, such as when admitted to hospital in emergency following an accident, reasonable and even extraordinary measures to preserve life or health may be justifiable under the legal doctrine or presumption of implied consent. Withholding ordinary and reasonable treatment in these circumstances may, indeed, open the possibility of a malpractice or negligence allegation.

The limits of implied consent have not been comprehensively marked, of course,[18] and may not extend to non-essential, irreversible procedures. Most consent forms for surgical procedures contain a clause such as "I understand that during the course of surgery unforeseen conditions may be revealed and I authorize the additional surgical procedures that are indicated as being necessary for my condition in the best exercise of professional judgment, except these specific procedures, namely ...". In the absence of such a clause, due to its omission from the form, or the absence of any written consent because of patient unconsciousness or the emergency of the moment, the law nevertheless affords the physician the right which the clause declares. The purpose is to remove procedural barriers to life-saving and health-preserving medical care. The law presumes the patient's wish to survive in life and optimal health. The law may go further, however, and permit treatment to save life over the protests of the would-be suicide; it has been seen that such a patient's mental balance will be questioned, and any error in management will be legally justifiable if it favours life and preservation of the patient's future options.[19]

The conditioning of the legal approach to emergency and attempted suicide carries over to non-catastrophic cases where patients

---

[18] See Picard, *Legal Liability of Doctors and Hospitals in Canada* (1978), 66 *et seq.*

[19] S. 241 of the *Criminal Code* provides that:

> Every one who ... (b) without reasonable cause prevents or impedes or attempts to prevent or impede any person who is attempting to save the life of another person, is guilty of an indictable offence ... .

The prohibition may in theory include among "every one" the person whose life is attempted to be saved, so that a legal "right" to commit suicide cannot be unquestionably asserted.

simply want to remain medically untreated in the general or specific ways, such as by surgical means, by which their lives may be preserved. The patient's claim to be allowed to die may be resisted by health care providers' right to rescue.[20] It may at first seem doubtful in the light of developing dogma regarding free and informed consent of patients to medical treatment that non-consensual surgery or even less intrusive procedures would be undertaken, contrary to codes of medical ethics, but it is not obvious that Canadian law proscribes the imposition of life-saving surgery upon an adult, rational and resistent patient.[21]

Section 45 of the *Criminal Code*, sometimes described as the Good Samaritan provision, states that:

> Every one is protected from criminal responsibility for performing a surgical operation upon any person for the benefit of that person if
> (a) the operation is performed with reasonable care and skill, and
> (b) 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.

The provision leaves much to be desired as a positive guide to conduct. It is notable, however, that it makes no specific reference to individual consent of the person operated upon, but speaks only of what is reasonable in the circumstances, which introduces an objective and communal criterion of propriety. Coming in the general part[22] of the *Criminal Code*, moreover, the section governs later specific provisions, notably on assault, so that conduct falling

---

[20] This may appear an authentic right in view of the fact that, according to s. 241 (see note 19, *supra*) others have a duty not to obstruct its exercise. Absence of patient consent, or patient refusal, is not necessarily a "reasonable cause" for obstructing the attempt because of social interests in the preservation of life: see text between notes 38 and 40, *infra*.

[21] Ability to impose relief from danger to life upon a non-consenting patient may be reflected in Regulations under hospital legislation. Representative is Ontario Reg. 729, s. 49 (under *The Public Hospitals Act*, R.S.O. 1970, c. 378), which provides for written consent to surgery, but states that if "the surgeon believes that delay caused by obtaining the consent would endanger the life of the patient ... the consent is not necessary and the surgeon shall write and sign a statement that a delay would endanger the life ... of the patient". No distinction is recognized between clear refusal of consent and delay caused by obtaining consent. See also Sask. Reg. 285/74, s. 50, pursuant to *The Hospitals Standards Act*, R.S.S. 1978, c. H-10; N.B. Reg. 66-47, s. 40, pursuant to *Public Hospitals Act*, R.S.N.B. 1973, c. P-23; Reg. s. 3.2.1.8, pursuant to [*La*] *Loi sur les services de santé et les services sociaux*, L.R.Q., c. S-5.

[22] *I.e.*, Part I; the more specific category is given as "Protection of Persons in Authority".

within the assault prohibition may be defensible by virtue of section 45. It has been held that the section provides no defence to a charge of abortion, but that the common law defence of necessity, preserved by section 7(3) of the *Criminal Code*, may be relied upon.[23] The necessity defence is broader than that existing under section 45, since the latter is limited to "a surgical operation". Further, the leading common law necessity case of *R.* v. *Bourne*[24] confirms the legal availability of the defence to save not only life itself, but also physical and mental health.

While physicians may be understandably reluctant to rely upon the section 45 or necessity defences to undertake surgical or other procedures upon patients over their rationally presented objections, the availability in principle of these defences to criminal charges shows that patients have no clear legal rights to insist that they not be "rescued" from the effects of their own decisions. Patients may appear little better protected in their autonomy in civil law.

In principle, of course, non-consensual touching constitutes battery, and is actionable *per se* for recovery of nominal or token damages. If more than nominal damages are sought, however, such as substantive or exemplary damages, the legal question must be addressed of the loss sustained by patients kept alive against their wishes. A general reluctance of Canadian courts to consider human life a species of legal damage may be expected.[25] Courts in the United States have overcome their earlier refusal to regard wrongful conception and wrongful birth claims by adults regarding their children as actionable,[26] but very few steps have been taken to accept individuals' claims that they should not themselves have been conceived or born.[27] The language of *Gleitman* v. *Cosgrove*,[28] in which

---

[23] See *Morgentaler* v. *The Queen* [1976] 1 S.C.R. 616. S. 251(1) of the *Criminal Code*, which governs the crime of abortion, to which necessity may be a defence, makes no reference to the woman's consent. When the Code was amended in 1969 (S.C. 1968-69, c. 38, s. 18) to provide for lawful abortion by committee certification, s. 251(7) preserved consent provisions of the general law for certified procedures.

[24] [1939] 1 K.B. 687 (Cent. Crim. Ct).

[25] See *Doiron* v. *Orr* (1978) 20 O.R. (2d) 71, 74-5 (H.C.) *obiter*. For damages awarded for wrongful birth, however, see *Cataford* v. *Moreau* [1978] C.S. 933, 7 C.C.L.T. 250.

[26] See Ranous & Sherrin, *Busting the Blessing Balloon: Liability for Birth of an Unplanned Child* (1975) 39 Albany L. Rev. 221.

[27] But see *Curlender* v. *Bio-Science Laboratories* 106 Cal. App. 3d 811 (Ct App. 1980).

[28] 227 A. 2d 689 (N.J. 1967).

a child's wrongful life action was rejected, remains widely respected on this point.[29] The Court observed that:

> The infant plaintiff would have us measure the difference between his life with defects against the utter void of nonexistence, but it is impossible to make such a determination. This Court cannot weigh the value of life with impairments against the nonexistence of life itself .... [T]he infant plaintiff makes it logically impossible for a court to measure his alleged damages because of the impossibility of making the comparison required by compensatory remedies.[30]

The same reasoning may apply where an adult plaintiff sues a physician for having prolonged his life. The basis of compensatory damages is to put the plaintiff into the position in which he would have been had the wrong not occurred. Thus, a plaintiff claiming that a physician's battery or negligence resulted in his wrongful survival and resultant pain and suffering, would have the court measure the difference between his life as it endured and the void of death he was denied. Even if the court would recognize in principle that there may be conditions of life to which death is preferable, it is not easy to see how substantive damages might be calculated in this circumstance. Further, the patient's survival in a vegetative or unconscious state may appear to reduce or eliminate compensation for suffering.

The tragic preference an individual may have for his earlier death over his medically dependent enduring life is no doubt real, particularly in the United States, where medical costs may be borne individually rather than by a third party insurer, such as a government health plan. Anecdotes exist of elderly persons instructing their physicians that upon their death they want their money to go to their children, and not to their physicians' children, and that they therefore want no costly life-sustaining means to be employed when they fall gravely ill and are in danger of dying. Nevertheless, United States jurisprudence discloses no case in which litigation has resulted in an award of damages for wrongfully prolonging life. On the contrary, important cases have been compelled by hospitals sustaining patients' lives by artificial means, requiring family members or others concerned to obtain judicial support for their preference that such means be removed and the patients be allowed to die a natural death.[31]

---

[29] See *Becker* v. *Schwartz* 413 N.Y.S. 2d 895 (1978).

[30] *Supra,* note 28, 692.

[31] This was the origin of such celebrated cases as *In the Matter of Karen Quinlan* 355 A. 2d 647 (N.J. 1976); *In the Matter of Shirley Dinnerstein* 380 N.E. 2d 134 (Mass. App. 1978); *Eichner* v. *Dillon, supra,* note 12.

Beyond the conceptual difficulty in civil law of quantifying the damages caused by physical survival, as by medical battery over the patient's opposition, lies the doctrinal difficulty of showing the opposed life-preserving initiative to have been unlawful. The defence of necessity to save human life recognized in criminal law[32] may have a civil law counterpart in actions alleging trespass to the person. Trespass to property is defensible on this ground, as shown in such historic cases as *Mouse's Case*,[33] where property was held to have been justifiably thrown from a barge in danger of sinking, and in *Gregson* v. *Gilbert*,[34] where the Solicitor General of England contended that it was lawful to jettison cargo, namely one hundred and fifty negro slaves, from a ship running short of water on voyage if it were necessary to save other lives.[35] Since trespass to property may be lawfully undertaken where necessary to save human life, trespass to the person may be equally so, if reasonable and proportionate in all of the circumstances.[36] Where the individual subjected to the trespass is also the person whose life is intended to be saved, these conditions of the necessity defence may appear to have been met. Thus, a battery action brought by such a person may not only fail to secure more than nominal damages, but may fail on its merits due to the defendant's successful reliance upon the right of rescue, that is, the necessity to save human life.[37]

Courts in the United States may seem better guardians of the spirit of Justice Cardozo's autonomy postulate than those in Canada, particularly since the United States Supreme Court has emphasized the significance of the constitutional protection of individual pri-

---

[32] See s. 45 of the *Criminal Code*, and the common law defence preserved by s. 7(3) discussed in the *Morgentaler* case; see note 23, *supra*.

[33] (1609) 12 Co. Rep. 63; 77 E.R. 1341 (K.B.).

[34] (1783) 3 Dougl. 232; 99 E.R. 629 (K.B.).

[35] For a more recent application of the defence of necessity to save life serving to defeat a civil claim, see *Esso Petroleum Co. Ltd* v. *Southport Corporation* [1956] A.C. 218 (H.L.).

[36] Little case law exists directly on this point, but see *Humphries* v. *Connor* (1867) 17 Ir. C.L.R. 1 (Q.B.), holding that a constable may commit what would otherwise be an assault upon an innocent person if that is the only way of preserving the peace. The development of the necessity defence through such abortion cases as *Bourne*, *supra*, note 24, and *Morgentaler*, *supra*, note 23, demonstrates the legitimacy of sacrificing one life for another.

[37] This conclusion is offensive to principles of self-determination, and opens the way to superseding an individual's choice with objective and paternalistic preferences. The contention that individual refusal of life-saving treatment must be respected under legal sanction seems, however, to lack authority other than in doctrinal reasoning.

vacy.[38] Nevertheless, the respected Massachusetts Supreme Judicial Court found in 1977 that in principle such rights may be outweighed by countervailing state interests, namely, the preservation of life, the protection of interests of innocent third parties,[39] the prevention of suicide; and maintaining the ethical integrity of the medical profession and its right to take affirmative action to save life without fear of legal liability.[40]

Thus, an analysis of general principles of criminal and civil law discloses no general right of an individual to die, since others may not be bound to observe the limits upon intervention such a right would require. Modern analysis in the setting of contemporary medical and hospital practice may show a refinement of approach, however, distinguishing ordinary from extraordinary treatment, which may offer a patient more autonomy than is enjoyed under general principles. This may more fully serve the value of self-determination declared by Justice Cordozo.

III. Ordinary and extraordinary treatment

The body of traditional medical law emerged at a time when physicians visited the sick in their private homes, and treated them from the meagre contents of the black bags they carried. The relationship was contractual, based upon payment for services requested and rendered.[41] The patient could accordingly terminate the relationship and forbid future visits or maintain the relationship but control the choice of treatments. Hospitals were institutions of spiritual refuge, usually maintained as legal charities by religious denominations and staffed by women in religious orders, where the destitute sick and elderly went to die.[42] As recipients

---

[38] See *Roe* v. *Wade* 410 U.S. 113 (1972). For the impact of this case upon the right to resist artificial life maintenance, see *Eichner* v. *Dillon, supra,* note 12.

[39] See the *Raleigh-Fitkin Memorial Hospital* and *Georgetown College* cases, *supra,* note 7.

[40] *Superintendent of Belchertown State School* v. *Saikewicz* 370 N.E. 2d 417, 425 (Mass. 1977).

[41] Remuneration on the fee-for-service basis continues to play a strong emotional role in physicians' self-image as practitioners of an independent profession serving patients, even when payment for the service is made through a provincial health insurance plan at a collectively negotiated rate.

[42] The nature of the early "hospital" is shown in words sharing its origin, such as "hospitality", "hotel" and "host". The naming of the newly created centres where patients go to die a natural death in peace, dignity and understanding as "hospices" revives the inspiration of the early hospitals.

of charity, inhabitants of hospitals enjoyed few rights, but were required to conform to religious and secular discipline.

As medicine developed its scientific basis, especially in the eighteenth and nineteenth centuries, the needs of medical education and of medical research were increasingly recognized. Further, scientific developments created a technological growth in diagnostic, surgical and rehabilitative resources. Accordingly, hospitals grew in importance not only as centres where patients were available for teaching and study, but also as healing institutions where excellence in health service could be delivered to patients brought to the technological facilities they housed. Physicians, government departments and, for instance, municipalities came to run hospitals, and the modern diverse commercial and public-service hospital industry was created. With the advent of nation-wide health insurance in Canada, most hospitals have passed from rendering patients contractually purchased services, to rendering care to patients in collaboration with provincial health ministries and health insurance agencies. The law has been slow to note these developments, however, and is still struggling to see how hospital-patient relations intersect with physician-patient relations.[43]

The institutional and financial structure of health care delivery has an important bearing upon the distinction which has arisen in medicine in recent decades between ordinary and extraordinary treatment. In the days of care given from contents of physicians' black bags, no such distinction was drawn. Care was measured by a standard of the ordinary, both for the skills physicians were expected to be able to deploy and the materials they carried to their patients; other ordinary resources consisted in the nutrition, warmth, comfort and sanitation patients would be advised and instructed to maintain for themselves, and which the rudimentary hospitals could alone offer. It came to be accepted, however, that surgical means could be reliable, and basic surgery came to be considered part of ordinary care delivered in appropriate facilities. Particularly when public-service hospitals arose, and mechanical

[43] A significant case ended in an out-of-court payment by the successful defendant without recourse to the Supreme Court of Canada. The 3:2 division in the Ontario Court of Appeal in *Yepremian* v. *Scarborough General Hospital* (1980) 28 O.R. (2d) 494, *rev'g* (1978) 20 O.R. (2d) 510 (H.C.), reveals the depth of legal uncertainty. On the settlement out of court which precluded appeal to the Supreme Court of Canada, see The Globe and Mail (Jan. 17, 1981), 1. The American case of *Darling* v. *Charleston Community Memorial Hospital* 211 N.E. 2d 253 (Ill. App. Ct 1965), followed at trial in *Yepremian,* has clarified American law. See Picard, *supra,* note 18, ch. 10.

equipment became available to enhance caring skills, questions arose of competition between equally needful patients for scarce technological resources. The supply-and-demand pricing mechanism of a free enterprise health care market is alone inadequate to resolve the dilemma of allocating medical resources, since social expectations reflected in socially provided services entitle all to at least a common standard of health care.

Distinctions between, on the one hand, patients' moral duties to meet their responsibilities by accepting ordinary care to prolong life and the physicians' and hospitals' duties to offer such care, and, on the other hand, the discretionary offer and acceptance of extraordinary care, have been addressed in ethical discourse for several decades. The moral context and the medical context are not necessarily congruent, but considerable significance was given to the statement on prolongation of life made in 1957 to an international congress of anesthesiologists by Pope Pius XII, who emphasized obligations relevant to ordinary means of medical treatment. He observed that

> morally one is held to use only ordinary means — according to circumstances of persons, places, times, and culture — that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attachment of the higher, more important good too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends. On the other hand, one is not forbidden to take more than the strictly necessary steps to preserve life and health, as long as he does not fail in some more serious duty.[44]

In establishing the moral principle that, for prolongation of life, only ordinary treatment is obligatory for patients to receive, and for physicians and health facilities to offer, and that extraordinary treatment is permissible but not required, reference was helpfully made to the relative circumstances. The question of what treatment is ordinary in a specific case is answered by regard to place, time, culture and economy[45] ("means that do not involve any grave burden").[46]

---

[44] *The Pope Speaks: Prolongation of Life* (1957) 4 Osservatore Romano 393-8; see also the presentation in Horan & Mall, *Death, Dying and Euthanasia* (1977), 281-7.

[45] It may be offensive to consider the financial burden of preserving life, but see Fletcher, "Ethics and the Costs of Dying" in Milunsky & Annas, *Genetics and The Law II* (1980), 187.

[46] Interpretations, uncertainties and alternative formulations in the Papal pronouncement are reviewed in Veatch, *Death, Dying and the Biological Revolution: Our Last Quest for Responsibility* (1976), 106-14. A more recent papal statement preferred to speak of proportionate and disproportionate means: see *L'Eglise Canadienne* (21 August 1980), 678.

A distinction drawing upon these elements may appear realistic, since it takes account of differences in national, provincial and regional medical and life-sustaining resources. It also incorporates the sense of communal expectation, and the need to maintain a common basic or minimum standard of health care, without burdening hospitals and public funding agencies with impossible technological and financial obligations. A resource which is available, but which is in too limited supply to meet all the demands which could be made of it, such as an artificial or mechanical life-preserving device, will by definition be extraordinary. Accordingly, its withholding in any specific case will not be a breach of duty. On the other hand, everyone expects hospitals to be able to provide patients with nutrition, warmth, sanitary care and, for instance, an adequate range of basic drugs. Further, since these are ordinary care, patients may not be free to decline them while remaining in hospital.

The distinction drawn in 1957 by Pope Pius XII, which has animated subsequent bioethical debate, was given legal recognition in the celebrated case of Karen Quinlan in 1976.[47] Here, Chief Justice Hughes, of the New Jersey Supreme Court, observed that:

> We glean from the record here that physicians distinguish between curing the ill and comforting and easing the dying; that they refuse to treat the curable as if they were dying or ought to die, and that they have sometimes refused to treat the hopeless and dying as if they were curable. In this sense ... many of them have refused to inflict an undesired prolongation of the process of dying on a patient in irreversible condition when it is clear that such "therapy" offers neither human nor humane benefit. We think these attitudes represent a balanced implementation of a profoundly realistic perspective on the meaning of life and death and that they respect the whole Judeo-Christian tradition of regard for human life ... .
>
> Yet this balance, we feel, is particularly difficult to perceive and apply in the context of the development by advanced technology of sophisticated and artificial life-sustaining devices. For those possibly curable, such devices are of great value, and, as ordinary medical procedures, are essential. Consequently ... they are necessary because of the ethic of medical practice. But in light of the situation in the present case (while the record here is somewhat hazy in distinguishing between "ordinary" and "extraordinary" measures), one would have to think that the use of the same respirator or like support could be considered "ordinary" in the context of the possibly curable patient but "extraordinary" in the context of the forced sustaining by cardio-respiratory processes of an irreversibly doomed patient.[48]

This judicial observation achieves a number of helpful effects. It supports the refusal of physicians to treat curable patients as if

---

[47] *In the Matter of Karen Quinlan, supra,* note 31.
[48] *Ibid.,* 667-8.

they are dying, even when patients decline to accept treatment and invoke a right to die. It also supports physicians who decline to use or to continue to use aggressive or heroic measures on patients in terminal conditions, and thereby distinguishes between prolongation of life and mere prolongation of the process of dying.

The New Jersey court also amplified the 1957 papal statement that ordinary means are related, *inter alia,* to circumstances of persons. The ordinary/extraordinary distinction came to be drawn because of advances in medical hardware, such as artificial lungs, heart-lung machines and dialysis machines. It might have been believed that machines themselves could be identified as "ordinary", when they would have to be used to prolong life, and as "extraordinary" if they were in short supply relative to demand, when their initiation, and then their maintenance, would be discretionary. The 1957 reference to "persons" was amplified in the *Quinlan* case to show the significance of the individual patient's medical prognosis. If a medical means might effect a cure of a patient, it will be "ordinary" for that patient, while at the same time being only "extraordinary" for a patient whose prognosis, even with its employment, would remain unfavourable.

The Court in the *Quinlan* case also entered the troubled area of quality-of-life considerations.[49] It found that Karen Quinlan's medical prognosis was adverse, leading to the conclusion that her artificial life-supports could lawfully be removed, because she would never return to what the Court described as "cognitive or sapient life".[50] This neurological or intellectual criterion, consisting in awareness of self and others, even without capacity to communicate or to respond in any external way, may be sensitive to modern concepts that the brain is the repository of human personality and essence.[51] When the outer brain has irreversibly ceased to function, a capacity to experience human personality has left the body, even if the brain stem is alive and spontaneously maintains organic body functions; that is, even though criteria of "brain death" are not satisfied.[52] The patient, although alive, has an unfavourable prognosis, and accordingly is legally entitled only to ordinary treatment.[53]

---

[49] See Keyserlingk, *supra,* note 8, *passim.*

[50] *Supra,* note 31.

[51] For a discussion of brain function as a key factor in selecting the appropriate category for care of a patient, see Fama, *supra,* note 1, 517, n. 15.

[52] See Law Reform Commission of Canada, *Criteria for the Determination of Death* [Working Paper 23] (1979).

[53] Karen Quinlan remains alive at the time of writing, although her outer brain has liquefied and will never regain function. The brain stem is alive

Recognition of the role of individual prognosis assists in clarifying what treatment is ordinary. A terminal patient must be kept warm and comfortable, and be given nutrition as part of ordinary care. It is often found, however, that patients affected by malignancies or otherwise in terminal conditions die of such conditions as pneumonia. With the easy accessibility of antibiotic drugs in modern times in Canada, pneumonia is not in itself life-threatening, but is a relatively benign condition which is easily reversed. For the patient whose prognosis is favourable, drugs to treat pneumonia would be ordinary, and therefore obligatory. For the patient who, if cured of pneumonia, would face only death shortly thereafter, possibly in pain, severe discomfort or, perhaps at best, in unconsciousness or unawareness, antibiotics to treat pneumonia would be extraordinary. They might therefore be lawfully withheld, leaving the patient to a somewhat earlier, but natural and perhaps more comfortable, death.

The ordinary/extraordinary distinction pays no special regard to the wishes of patients or of their families. In the *Quinlan* case the Court did pay very particular attention to whether the applicant for permission to terminate the patient's life-supports, namely her father, was able to express to the Court and to hospital authorities Karen Quinlan's authentic preference regarding termination. This was indeed the point upon which the trial judge was reversed on appeal. The trial judge pursued her interests rather than her wishes, and doubted that an applicant seeming to opt for death could adequately represent her in the litigation. The appeal court, noting the depth of the father's knowledge of her personality, found him suitable to express the preferences Karen Quinlan would have wanted to prevail. The appeal court also proposed a tripartite decision-making method, involving a hospital ethics committee, the attending physicians, and the patient's family. Nevertheless, the distinction itself and its incidents are not dependent upon patient consent.

Accordingly, a patient may be given ordinary treatment over objections, or, if competent and fit to leave, be required to depart from the health facility. The rescue right of health professionals saves them from having to tolerate a patient's avoidable death while under their charge. Similarly, a patient cannot insist upon substandard medical and nursing care, although a compromise may

---

and supports spontaneous organic functions, such as heartbeat and respiration. She has contracted pneumonia on two occasions on each of which it was reversed by antibiotic drugs; had this occurred to another patient, death from pneumonia might have been allowed.

exist where a competent patient signs an assumption of liability statement, and forfeits legal claims for the incomplete nature of care the patient insists upon receiving, and for the incidents of such care.

Regarding extraordinary care, however, the patient and the patient's family cannot insist that it be given, since allocation of the perhaps scarce and costly resource is discretionary. The decision is governed by factors such as clinical assessment of individual prognosis, and the needs of other patients in the hospital and prospective patients in the community.[54] Further, where extraordinary means are initiated, they remain discretionary on the part of those bound by a legal duty of care.[55] They may thereafter be withdrawn at will and without consent,[56] unless the patient's prognosis has changed with the effect of making those medical means ordinary in the circumstances of the patient. Discretion on use of extraordinary means is mutual, however, and such means cannot be applied over the patient's refusal. If they are passively accepted when applied, this may serve as consent, and the patient's refusal need not be expressly invited. Where the patient with an adverse prognosis does object or refuse consent to extraordinary medical care, however, that rejection must be respected. The curable patient cannot resist prolongation of life, but the terminal patient is legally entitled to refuse prolongation of the process of dying, and to insist upon a natural death.

IV. Terminal conditions

There is an obvious sense in which human life itself is a terminal condition, but in the medical sense the concept requires refinement if it is to serve as a diagnostic or prognostic category. Definition

---

[54] It has been argued, however, that the decision to deny a scarce medical resource calls for legal procedural safeguards, based upon U.S. constitutional prohibitions of deprivation of life without due process of law: see *Due Process in the Allocation of Scarce Life-saving Medical Resources* (1975) 84 Yale L.J. 1734; *cf.* the *Canadian Bill of Rights*, R.S.C. 1970, Appendix III, s. 1(a).

[55] A person other than the attending physician who wilfully removes artificial life supports may fall under s. 209 of the *Criminal Code*: "Where a person causes bodily injury to a human being that results in death, he causes the death ... notwithstanding that the effect of the bodily injury is only to accelerate his death from a disease or disorder arising from some other cause". Liability may alternatively arise under s. 241(b): see note 19, *supra*, for impeding an attempt to save life; but see text at note 94, *infra*.

[56] But see the argument that administrative due process ought to be observed, at note 54, *supra*.

was included in the precedent-setting Californian legislation which gave terminal patients means by directive to express their refusal of life-sustaining procedures. *The Natural Death Act* of California[57] provides that:

> "Terminal condition" means an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serve [*sic*] only to postpone the moment of death of the patient.[58]

While patients in this rather narrowly-defined condition enjoy autonomy to decline life-sustaining (meaning death-postponing) procedures, such autonomy remains unavoidably dependent upon medical judgment, since patients cannot determine for themselves whether or not they have entered a terminal condition. The Act's definition expressly refers to "an incurable condition ... which ... would, within reasonable medical judgment, produce death". The definition of "life-sustaining procedure", which recognizes emergence of the call for natural death following technological developments capable of resisting death, is similarly tied to medical judgment. This is not based on an objective standard of "reasonable medical judgment", moreover, but is based upon the subjective clinical judgment of the attending physician. *The Natural Death Act* provides that:

> "Life-sustaining procedure" means any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which ... would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician, death is imminent whether or not such procedures are utilized. "Life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain.[59]

It is apparent, therefore, that under the scheme expressed in the law of California, the ambit and commencement of patient autonomy are defined by the judgment of physicians. The Californian law on refusal of treatment makes explicit what may be implicit in other common law jurisdictions, including those of Canada. It therefore becomes important to ask by what criteria or means a medical prognosis of a terminal condition and of imminent death may be made.

Caution derived from experience, and the uniqueness of each clinical case, may make physicians and hospitals hesitant to define

---

[57] Cal. Stats. 1976, c. 1439, constituting c. 3.9 of the *Health and Safety Code.*
[58] § 7187(f).
[59] § 7187(c).

a terminal condition in terms of time left to live. Imminence of death was measured, however, in a well-known statement proposed as policy for hospitals regarding the making and implementation of Orders Not to Resuscitate, produced within a group meeting under the auspices of the Center for the Analysis of Health Practices of the Harvard School of Public Health. The authors, associated with the Beth Israel Hospital in Boston, observe that:

> The specific issue of the appropriateness of cardio-pulmonary resuscitation arises frequently with the irreversibly, irreparably ill patient whose death is imminent. We refer to the medical circumstance in which the disease is "irreversible" in the sense that no known therapeutic measures can be effective in reversing the course of illness; the physiologic status of the patient is "irreparable" in the sense that the course of illness has progressed beyond the capacity of existing knowledge and technic to stem the process; and when death is "imminent" in the sense that in the ordinary course of events, death probably will occur within a period not exceeding two weeks.[60]

A patient may be in a terminal condition, of course, even when death is not imminent in this sense. Indeed, *The Natural Death Act* in California defines a "qualified patient" as one diagnosed and certified to be afflicted with a terminal condition,[61] and provides that if the person making a directive to withhold or withdraw life-sustaining procedures "is a qualified patient at least fourteen days prior to executing or reexecuting the directive, the directive shall be conclusively presumed ... to be the directions of the patient".[62] If the declarant becomes a qualified patient after executing the directive and has not subsequently re-executed it, the directive has less compelling force, and is influential but not conclusive.[63] Accordingly, a governing principle of the Californian Act is that a patient diagnosed to have a terminal condition must survive fourteen days before executing a directive in order for it to take full effect. This suggests that the Act affords only limited autonomy to a patient whose death is "imminent" under the Beth Israel Hospital test.[64]

---

[60] Rabkin, Gillerman & Rice, *Orders Not to Resuscitate* (1976) 295 New England J. Med. 364, 365.

[61] § 7187(e).

[62] § 7191(b).

[63] § 7191(c).

[64] For a discussion of treatment of patients whose death almost always occurs before the fourteen-day waiting period under *The Natural Death Act* of California has expired, see Imbus & Zawacki, *Autonomy for Burned Patients When Survival Is Unprecedented* (1977) 297 New England J. Med. 308, relating practice at the Los Angeles County-University of Southern California Medical Center.

Little clear guidance comes from judicial decisions. In the *Saikewicz* case,[65] the patient was treated as being in a terminal state when he appeared likely to die within a matter of weeks or months without treatment for leukemia. It was not predictable how long he might live with treatment by chemotherapy, but evidence suggested that life might be lengthened by up to thirteen months, and that it was likely that he would die sooner without treatment than with it.[66] The Massachusetts Supreme Judicial Court noted that:

> There is a substantial distinction in the State's insistence that human life be saved where the affliction is curable, as opposed to the State interests where, as here, the issue is not whether, but when, for how long, and at what cost to the individual that life may be briefly extended.[67]

The *Dinnerstein* case[68] concerned a sixty-seven-year-old patient with Alzheimer's disease, an incurable, degenerative brain disease. She was considered to be in a terminal condition when her life expectancy was no more than one year, and she was liable to suffer a cardiac or respiratory arrest at any time. The Massachusetts Appeals Court distinguished the case from *Saikewicz* on the ground that:

> This case does not offer a life-saving or life-prolonging treatment alternative within the meaning of the *Saikewicz* case. It presents a question peculiarly within the competence of the medical profession of what measures are appropriate to ease the imminent passing of an irreversibly, terminally ill patient in light of the patient's history and condition and the wishes of her family.[69]

A non-lawyer considering these cases has concluded that

> [w]e are left in utter chaos. Both courts seem to imply that the distinction between prolonging living and prolonging dying is crucial. Yet, Dinnerstein's court sees their patient as differing from Saikewicz in this regard, in spite of the fact that both had about a year to live.[70]

It may be, however, that the distinction can adequately be drawn between prolonging life and postponing death, not necessarily for purposes of philosophical consistency, but as a matter of legal process. Where an attending physician or the specialist to whom the attending physician refers the patient's case diagnoses a condi-

---

[65] *Supra,* note 40.

[66] A hearing on May 13, 1976 resulted in a decision not to treat Saikewicz, who died on September 4, 1976.

[67] *Supra,* note 40, 425.

[68] *Supra,* note 31.

[69] *Ibid.,* 139.

[70] Veatch, "Prolonging Living and Prolonging Dying: A Distinction That is Not Decisive" in Milunsky & Annas, *supra,* note 45, 182.

tion which the physician describes as terminal, notwithstanding the effects of treatment, that creates a *prima facie* presumption that it is terminal, and that treatment can at best postpone death. The patient may be considered to have an unfavourable treatment prognosis for purposes of distinguishing ordinary from extraordinary care.

A patient or family member on the patient's behalf wishing to contest the terminal diagnosis may do so by seeking a second or subsequent medical opinion, but this may be unrealistic where the patient is in a hospital or other institution, or lacks financial means. Although scientifically based, medical prognosis is not an exact science, however, or even a consensual art. Skilled physicians respectful of each other's opinions may reasonably differ. For the exercise of legal choice and autonomy, a patient must begin with the prognosis presented by the physician in charge of the case. Depending upon hospital staff structure, this may be made by an individual physician, or a physician in consultation with others.

The process of decision-reaching proposed in the case of Orders Not to Resuscitate reflects a reputable practice of consultative medical prognosis. It provides that:

> The initial medical judgment on such question should be made by the primarily responsible physician for the patient after discussion with an ad hoc committee consisting not only of the other physician attending the patient ... but at least one other senior staff physician not previously involved in the patient's care ... Although the unanimous opinion of the ad hoc committee in support of the decision of the responsible physician is not necessarily required (for some may be uncertain), a strongly held dissenting view not negated by other staff members should generally dissuade the responsible physician from his or her initial judgment.[71]

This approach was reinforced in the practice which evolved in New Jersey and beyond following the *Quinlan* judgment's reference to the role of hospital "ethics" committees. Where these committees have been constituted,[72] they are called "prognosis" committees.[73]

The conclusion of a terminal prognosis may thus aim at reflecting a medical consensus, but may also be influenced by elements of

---

[71] *Supra*, note 60, 365.

[72] Their spread was limited when the *Saikewicz* judgment of 1977 was interpreted to require judicial approval for decisions to withhold or withdraw extraordinary means, and to invalidate extrajudicial decisions reached according to the method indicated in the *Quinlan* case. The *Dinnerstein* judgment did not immediately restore the *Quinlan* principle in the confidence of medical professionals in the United States.

[73] See *e.g.*, Curran, *Law-Medicine Notes: The Saikewicz Decision* (1978) 298 New England J. Med. 499.

individual and institutional practice or style. Patterns of practice in defining conditions as terminal based upon life-expectancy may differ between regions, institutions within the same town or area, and even between departments and *ad hoc* committees within the same hospital. It may be hoped that exchanges of opinions and of information on practices will narrow disparities. Nevertheless, in an individual case a legally defensible, professionally based prognosis will be reached, which provides a legal basis for the decisions which follow from it.

It may be considered that disparities with effects which may determine life or death for an individual patient are intolerable, and that the subjective elements of prognosis should be reduced if not eliminated by taking such decisions out of the private realm and placing them in a public setting. In the United States, judicialization of medical decision-taking has been more widespread than in Canada, and was expressly advocated in the *Saikewicz* case, where the Court observed that:

> [S]uch questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created. Achieving this ideal is our responsibility and that of the lower court, and is not to be entrusted to any other group purporting to represent the "morality and conscience of our society", no matter how highly motivated or impressively constituted.[74]

This observation has been limited to relevant analogies of the *Saikewicz* case, which concerned a sixty-seven-year-old, profoundly mentally retarded, inarticulate chronic institutional resident with an I.Q. of ten and a mental age of approximately two years and eight months. Many respected commentators have interpreted the decision to leave sizeable areas of critical medical decision-making not requiring reference to the courts.[75] This is not necessarily inconsistent with the subsequent Massachusetts Supreme Judicial Court case *In the Matter of Earle Spring*,[76] where the Court stated that, "our opinions [in *Saikewicz* and *Spring*] should not be taken to establish any requirement of prior judicial approval that would not otherwise exist".[77] Further, the tradition of taking contentious issues to the courts, which is so deeply ingrained in the culture of

---

[74] *Supra*, note 40, 435.

[75] See for instance Annas, *Reconciling Quinlan and Saikewicz: Decision making for the terminally ill incompetent* (1979) 4 Am. J. of Legal Med. 367; Curran, *supra*, note 73; Schram *et al.*, *'No Code' Orders: Clarification in the Aftermath of Saikewicz* (1978) 299 New England J. Med. 875.

[76] 405 N.E. 2d 115 (Mass. 1980).

[77] *Ibid.*, 120.

the United States, is not a comparably significant part of Canadian culture. When one notes in addition that the judicial decisions in *Saikewicz* and the subsequent *Dinnerstein* case, both from Massachusetts, created a condition described as "utter chaos",[78] the present Canadian means of medical decision-making, notwithstanding its attendant risk of unevenness, may seem more tolerable.

V. Life-prolonging and the criminal law[79]

When it is recognized that physicians have duties to provide patients with ordinary care, and that patients cannot necessarily resist its administration, but that no comparable duty exists to offer or receive extraordinary care, notably artificial or mechanical life-supports, some uncertainties in the language of the *Criminal Code* may be resolved. An approach becomes apparent to problems faced in hospitals where decisions have to be made about whether to remove patients from life-supports, and whether to install patients upon supports from which they may be later removed when their prognosis has remained constant. Further, problems of hospital management may be better faced, and issues of legal liability may be clarified, when patients may become liable to removal from life-supports and intensive care units because patients with a more favourable prognosis have been admitted, and there are inadequate resources to give all patients optimum care.

It has been seen that section 14 of the *Criminal Code* provides that no person is entitled to consent to have death inflicted upon him, which prohibits a person's positive action intended to result in a collaborator's death, compatibly with section 224, which punishes counselling, procuring, aiding or abetting another's suicide. Not every administration of treatment known likely to result in death is homicide, however, or even what is sometimes called active euthanasia, whether voluntary or involuntary on the patient's part. Criminal law doctrine regarding both intent and causation may show that a physician prescribing treatment known likely to place a patient's life at risk, and even to be a probable eventual cause of death, may be acting properly.

This issue was faced in the sensationalized English case of *R.* v. *Bodkin Adams* in 1957.[80] A physician was charged with murder after

---

[78] Veatch, *supra*, note 70. The *Earle Spring* case, *supra*, note 76, may have reduced this to some extent.

[79] See Law Reform Commission of Canada, *Medical Treatment and Criminal Law* [Working Paper 26] (1980).

[80] The judge's summing up to the jury at the Lewes Assizes was unreported, but the case is considered in some detail, including recourse to a transcript

a patient who had left him a generous bequest in her will was found to have died of morphine overdose. The background of the case, developed through exhumations of other patients, disclosed a pattern of morphine-related deaths and generous bequests. The defence was that the patient had indeed died, as the defendant expected she might, with an intolerable excess of morphine, but that the medical cause of death was the condition morphine was administered to relieve, and that the intention of administering the drug was to relieve pain. Devlin J. (as he then was) instructed the jury that deliberately shortening life amounts to murder, and that there is no special legal defence of preventing severe pain. He then added, however:

> But that does not mean that a doctor who is aiding the sick and the dying has to calculate in minutes, or even in hours, and perhaps not in days or weeks, the effect upon a patient's life of the medicines which he administers or else be in peril of a charge of murder. If the first purpose of medicine, the restoration of health, can no longer be achieved there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten life.[81]

It may be implicit in this observation that a patient who consents to, or who actively seeks, a form of treatment which is intended to relieve suffering, but which will incidentally shorten life, is not having death inflicted upon him or her. Declining use of artificial life-supports and facing the prospect of natural death may be a legitimate means of relief from pain and suffering. On the issue of causation of death, Devlin J. told the jury that:

> Cause means nothing philosophical or technical or scientific. It means what you twelve men and women sitting as a jury in the jury box would regard in a common-sense way as the cause .... If, for example, because a doctor has done something or has omitted to do something death occurs ... at eleven o'clock instead of twelve o'clock, or even on Monday instead of Tuesday, no people of common sense would say, "Oh, the doctor caused her death." They would say the cause of her death was the illness or the injury, or whatever it was, which brought her into hospital, and the proper medical treatment that is administered and that has an incidental effect of determining the exact moment of death, or may have, is not the cause of death in any sensible use of the term.[82]

The jury acquitted, and no further homicide charges were brought against the defendant. Devlin, J. made reference to death coming an

---

of the summing up, in Williams, *Sanctity of Life and The Criminal Law* (1958), 289. See also Simpson, *Forty Years of Murder* (1978), 207.

[81] Transcript of instructions to the jury, from Williams, *supra*, note 80, 289.

[82] *Ibid.*

hour or a day sooner than it otherwise might. Although the judicial direction was given in the same year as the statement of Pope Pius XII, it did not consider mechanical means of life-prolongation, but confined itself to drug treatments. The use of machines opened the prospect, however, of death being postponed for far longer periods than hours or days. Nevertheless, the principle would seem to apply to the new context of machines no less than to the earlier context of drugs. A physician declining or discontinuing artificial means of postponing a patient's death in order to spare him or her pain and suffering does not cause the patient's death.[83] If giving intolerable amounts of drugs such as morphine may be legally defensible for this purpose, withholding or discontinuing extraordinary means, such as antibiotics to treat pneumonia, or artificial life-supports, for the same purpose would appear no less defensible. When this is done in conformity with the patient's request, it may appear as creditable service to the patient's autonomy in wishing to die a natural death.

This analysis casts a reflexion upon, and possibly a shadow over, section 45 of the *Criminal Code* and the necessity defence available under section 7(3).[84] While saving life may appear reasonable and necessary, employing surgical or other aggressive means to postpone death may not be, particularly when such postponement would leave a patient in pain or suffering, or aggravated by a sense of indignity. It has been seen that section 45 incorporates an objective and communal assessment of propriety, and it has been noted that the ranking of values founding the defence of necessity must also be undertaken according to objective and communal criteria.[85] Disillusionment with technology and its works, and evolving ethical awareness that not everything that can be done by technology should be done, may be conditioning a view that postpouing natural death may not necessarily be heroic or justified.

This conditioning may also affect the understanding of the duty binding parents, spouses and, for instance, those having charge of

---

[83] See the discussion of the blameless role of physicians who removed the kidneys of the two accused's victim and then shut off an artificial life support, in *R.* v. *Kitching & Adams* (1976) 32 C.C.C. (2d) 159, 175 (Man. C.A.); appeals against conviction were dismissed [1976] 2 S.C.R. ix.

[84] See the discussion in the text at notes 22-23, *supra.*

[85] See generally the discussion in Williams, *Criminal Law*, 2d ed. (1961), 746. In *R.* v. *Bourne, supra,* note 24, for instance, the judge directed the jury that ending the life of an unborn child is legally defensible when done to preserve the life or health (meaning physical or mental health) of the mother; the issue was not left to the subjective view of the jury.

others, to provide their children, spouses or dependents with "necessaries of life", as required by section 197 of the *Criminal Code*. It has been held that such necessaries may include medical aid,[86] as is consistent with the language of section 197(2) that an offence is committed when a person bound by a duty fails to perform it if:

> 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 [or injured] permanently.[87]

The duty of the section clearly applies to ordinary medical care, but it is not certain that it covers extraordinary means of care. The provision is older than provincial health insurance schemes, and applied when health care had to be provided from individuals' private funds.[88] There was clearly no duty then to supply costly technological means of care,[89] and it may be doubted that the duty has arisen subsequently, not least because hospitals have no duty to make them available. Where a patient may be eligible for extraordinary care and suffers permanent danger or injury to health in its absence, the cause of such danger or injury may be seen to lie in the predisposing condition, not in the failure to provide extraordinary means of care. This is reinforced by the evolving perception that death-postponing procedures are not necessarily preferable to natural death. Similarly, section 199, providing that

> 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

may be read restrictively, so that those rendering extraordinary treatment are seen to exercise a discretion rather than to discharge an undertaking, and the omission to continue such treatment may be understood not to endanger the patient's life, since this is threatened by the condition the extraordinary treatment may be taken to relieve.

The criminal negligence and homicide provisions of the Code may be explained in the same way. Section 202(1) provides that:

> Every one is criminally negligent who ... (b) in omitting to do anything that it is his duty to do, shows wanton or reckless disregard for the lives or safety of other persons.

---

[86] *R.* v. *Brooks* (1902) 5 C.C.C. 372 (B.C.S.C.).

[87] S. 197(2)(a)(ii) and (b); clause (b) refers to health being injured permanently.

[88] In *R.* v. *Yuman* (1910) 7 C.C.C. 474 (Ont. C.A.), it was held to be a lawful excuse for not providing necessaries of life that the accused was unable to support his wife.

[89] It may be recalled that the papal statement of 1957 defined ordinary means by reference to circumstances of person, and to means that do not involve any grave burden; see statement in the text at note 44, *supra*.

Section 202(2) makes it clear that "duty" means a duty imposed by law, which would appear to exclude provision of extraordinary care due to its discretionary status in law. Section 205(1) governing homicide provides that:

> A person commits homicide when, directly or indirectly, by any means, he causes the death of a human being.

It has been seen in the *Bodkin Adams* case,[90] however, that causation is not present where positive action which incidentally abbreviates life is taken in order to relieve pain, and the argument is more compelling that withholding extraordinary, death-postponing measures cannot be said to "cause" natural death. Withholding ordinary care, however, such as nutrition, nursing and warmth, may be a cause of death constituting manslaughter,[91] when the presence of a contributing or predisposing natural cause of death is no defence, since there may be more than a single cause of death.[92]

Section 241, prohibiting obstruction of a person "who is attempting to save the life of another person" governs only those who act "without reasonable cause".[93] It may be insufficient cause that the patient does not consent to or positively opposes such a life-saving attempt, due to the limited licence given to suicide and to the extent of public interests in saving human life. It may be a reasonable cause, however, that the attempt is misconceived or will very likely be futile, when it may only postpone a terminal patient's death at the cost of inflicting pain and suffering. If the person "who is attempting to save the life of another person" is only briefly postponing the natural death the patient desires, by recourse to extraordinary measures, it may be lawful for a person with an appropriate interest, such as another physician or a family member,[94] to obstruct the discretionary and uninvited effort on behalf of its intended but unlikely beneficiary. Devlin J., in *R.* v. *Bodkin Adams*, approved action to relieve pain and suffering "even if the measures

---

[90] See note 80, *supra*. The facts in *Bodkin Adams* may escape s. 209 of the *Criminal Code*. Administering a drug to provide relief from pain cannot be described as causing bodily injury, any more than may surgery which a patient does not survive, for instance due to respiratory failure while under anesthetic.

[91] See *The Queen* v. *Instan* [1893] 1 Q.B. 450 (C.C.C.R.).

[92] See *R.* v. *Kitching & Adams, supra*, note 83.

[93] See note 19, *supra*.

[94] It has been seen (*supra*, note 19) that s. 241(b) governs "[e]very one" who obstructs "any person who is attempting to save the life of another person", so that in theory it governs the person whose life is attempted to be saved.

... may incidentally shorten life",[95] which indicates approval of such action which permits life to run to its natural termination.

VI. Natural death legislation

Since *The Natural Death Act* took effect in California at the beginning of 1977,[96] almost every state legislature in the United States has received proposals for comparable legislation, and many Acts have been passed. Most states have used the Californian model with some modifications, and several have adopted somewhat different approaches, such as Idaho and Arkansas.[97] Discussions, analyses and comparisons of state laws have now generated a sizeable literature on the subject in law journals and elsewhere. This tends on occasions to be related, however, to the issues of suicide and euthanasia, which may distort the appearance of the legislation. Suicide and natural death stand in contrast rather than comparison to each other, and, similarly, euthanasia in the sense of active steps to end life before its natural termination would appear distinguishable.

In March, 1977 a Private Member's Bill was presented to the Ontario Legislature derived from the Californian experience (see Appendix). The issue was apolitical, and on a free vote on Second Reading, the legislature approved the measure by a sizeable majority, sending it to Committee for consideration in detail. A provincial election intervened to terminate consideration, and the matter has not been taken up subsequently. Space does not allow a critical discussion of the proposal. The one question which must be addressed, however, in light of the analysis above, is whether such legislation would achieve any legal effects which could not be achieved without it. It is acknowledged that non-legal effects of enactment would have been probable, since an Act which does nothing more than declare present law would at least bring it more visibly to the attention of the public and especially of the medical and hospital communities.

The proposed legislation was given a long title, *An Act respecting the Withholding or Withdrawal of Treatment where Death is Inevitable.* It defined "terminal condition" as "an incurable condi-

---

[95] See note 81, *supra.*

[96] See note 57, *supra.*

[97] For one of the earlier summaries of United States practice, see Raible, *The Right to Refuse Treatment and Natural Death Legislation* (1977) 5 Medicolegal News (No. 4, Fall) 6. See also Relman, *Michigan's Sensible 'Living Will'* (1979) 300 New England J. Med. 1270.

tion ... by reason of which, in reasonable medical opinion, death is imminent and only postponed without improvement of the condition during the application of life-sustaining procedures."[98] It therefore made clear its application only to death-prolonging or death-postponing procedures. The legislation's effect was intended to be triggered by a medical diagnosis, and it provided a means to resolve medical uncertainty about whether a terminal condition existed, in the event of doubt.[99] "Life-sustaining procedure" was the expression used for a death-postponing procedure, defined as "a medical procedure or intervention that utilizes mechanical or artificial means to sustain, restore or supplant a vital function to postpone the moment of death, but does not include a medical procedure or intervention for the purpose of alleviating pain".[100] This covered extraordinary treatment, apparently requiring hardware as opposed, for instance, to drugs, although many modern pharmaceutical products are artificial.

The proposal permitted competent adults alone to make a written, signed and witnessed declaration limiting their express or implied consent to treatment to exclude "life-sustaining procedures" during their terminal condition. A declaration would be valid for five years unless revoked,[101] revocation occurring upon the signatory indicating in any manner an intention to revoke, without regard to mental competence, or automatically upon the signatory becoming pregnant.[102] A declaration would have taken effect upon being given to the signatory's attending physician or to a medical staff member or employee of the health facility where the signatory was a patient.[103]

When the proposed legislation's definitions of terms are read into the language of the written declaration,[104] it may appear that the statement would have clear legal significance in the absence of the legislation under which it claimed its authority. The legislation would have created no right to an avoidable death, but would simply have made formal an informal practice, to which patients may have current recourse, of giving tangible expression to their refusal (in advance or upon its proposal) of discretionary artificial means of postponing death beyond the time of its natural occur-

98 Clause 1(d).
99 Clause 4.
100 Clause 1(b).
101 Clause 2.
102 Clause 3(3).
103 Clause 3(1).
104 Form 1.

rence. The provincial proposal did not attempt to affect rights and duties under the *Criminal Code,* of course, nor did it contain civil remedies where a patient's direction was disregarded. Sanctions may have been implicit, however, both in liability to professional discipline for misconduct, and in civil remedies for interfering with the patient without consent and in defiance of a clear refusal of discretionary treatment. These sanctions exist, of course, under present law.

Much of what the proposal aimed to achieve, therefore, can be achieved under existing law.[105] In that sense, the legislation was unneccesary for purely legal purposes. It was a very limited proposal, designed to secure rather less than a number of its supporters in the community appeared to believe, since it would have opened no door to active voluntary euthanasia; equally, it would have secured less than a number of its opponents feared, since it would have afforded physicians no power to end a life capable of natural continuation. It might have opened the way, however, to psychological, social, family or other pressure upon sick or elderly persons to make declarations they would not spontaneously have made.

One of the proposal's advantages would have been to provide a means to resist the rescue fantasies of physicians, by patients' written declarations that natural death was not to be obstructed. Another benefit would have been to require physicians to satisfy themselves definitively whether their patients who had registered declarations were actually in a terminal condition. At present, physicians intending to exercise their discretion in favour of employing extraordinary means may be able to avoid identifying the patient's point of entry to such a condition, and rely for patient consent to treatment upon implication, or the hospital's form of consent for general treatment or surgery. Since informed and free consent is a continuing condition of treatment, it may be useful to have a means to require physicians expressly to renew consent, and therefore to give an opportunity for consent to be refused, at the point of introducing extraordinary means.[106]

---

[105] It may be noted, for instance, that in the "Brother Fox case", *supra,* note 12, effect was given to an informal spoken expression of a wish to decline extraordinary care, although recourse might have been made in theory to a written form.

[106] If a patient were unconscious or otherwise unable to give or decline effective consent at that time, extraordinary means might be initiated pending receipt or refusal of consent from the appropriate person acting on the patient's behalf.

Conclusion

There is no clear legal right to die an avoidable death. When death is irresistible and imminent, however, mechanical and other extraordinary means to postpone its incidence may be rejected by patients or, where they are not competent to exercise choice, by appropriate others on their behalf. Where extraordinary means of treatment are rejected, patients will be left to ordinary treatment and the resources of their own bodies, minds and personalities. Where those are not sufficient to sustain life, they will achieve their right to a natural death.

Appendix

Ontario's Proposed Natural Death Act

Explanatory Note

The purpose of this Bill is to provide a means whereby an individual may limit the effect of a general or implied consent to medical treatment to prevent the use of life-sustaining procedures while in a terminal condition.

The Bill is designed to achieve this purpose by permitting an individual to execute a direction limiting his consent. Once a physician or hospital employee has notice of this direction, there is no defence of consent as a basis to avoid civil liability if the patient is treated with life-sustaining procedures during a period of terminal condition.

An Act respecting the Withholding or Withdrawal of Treatment where Death is Inevitable

1. In this Act,

   (a) "attending physician" means physician selected by or assigned to a patient and who has responsibility for the treatment and care of the patient;

   (b) "life-sustaining procedure" means a medical procedure or intervention that utilizes mechanical or artificial means to sustain, restore or supplant a vital function to postpone the moment of death, but does not include a medical procedure or intervention for the purpose of alleviating pain;

   (c) "physician" means a person licensed under Part III of *The Health Disciplines Act*, 1974;

   (d) "terminal condition" means an incurable condition caused by injury or disease by reason of which, in reasonable medical opinion, death is imminent and only postponed without improvement of the condi-

tion during the application of life-sustaining procedures.

Direction limiting consent

2. (1) Any person who has attained the age of majority, is mentally competent to consent, is able to make a free and informed decision and has, or is deemed to have, consented to medical treatment may, in writing in Form 1 signed by him, direct that the consent does not extend to the application of life-sustaining procedures during a terminal condition.

Witnesses of direction

(2) A direction under subsection 1 is not valid unless the signature is witnessed by two persons neither of whom is a relative or an attending physician or other person engaged in the health care of the person giving the direction.

Beneficiary of estate as witness

(3) No person who witnesses a direction under subsection 2 is entitled to any benefit from the estate of the person who gives the direction, except charges or directions for payments of debts.

Duration

(4) A direction is valid for five years from the date of its signing unless revoked under section 3.

When direction effective

3. (1) A direction under section 2 does not take effect unless it is given to the attending physician of the person giving the direction or, where the person is a patient in a health facility, is given to the attending physician or a person on the medical staff of or employed by the health facility.

Direction included in medical records

(2) Upon a direction being given to one of the persons mentioned in subsection 1, the direction or a copy of it shall be included in the medical records of the person giving the direction.

Revocation

(3) Where the person signing a direction in any manner and without regard to mental competency indicates to one of the persons mentioned in subsection 1 an intention to revoke the direction or is pregnant, the direction is revoked and shall be removed immediately from the medical records and destroyed.

Direction deemed valid

(4) Notwithstanding subsection 1, a direction given thereunder by a person who had not attained the age of majority, was not mentally competent to consent, or was not able to make a free and informed decision, is valid for the purposes of this Act if the person who acted upon it had no reason to believe that the person who gave it had not attained the age of majority, was not mentally competent to consent, or was not able to make a free and informed decision, as the case may be.

Terminal condition

4. Where doubt exists as to whether or not a terminal condition exists for the purpose of a direction,

(a) a terminal condition shall be deemed to exist where in the opinion of two physicians, each of whom has made a separate diagnosis in respect of the person giving the direction and neither of whom has any medical responsibility for that person, the terminal condition exists; and

(b) a terminal condition shall be deemed not to exist where in the opinion of one physician whose opinion is sought for the purposes of clause (a) a terminal condition does not exist.

Civil liability

5. No action or other proceeding for damages lies against any person for any act or omission made in good faith and without negligence in the observance or intended observance of a direction purporting to be given under this Act.

Other obligations not affected

6. Nothing in this Act shall be construed to impose an obligation to provide or perform a life-sustaining procedure where the obligation does not otherwise exist at law.

Insurance

7. (1) A death that occurs subsequent to the withholding or withdrawal of life-sustaining procedures pursuant to a direction signed under this Act shall not be deemed to be a suicide or self-induced death under any policy of insurance.

Idem

(2) A requirement that a person sign a direction as a condition for being insured for or receiving health care services is void.

Offence

8. Subject to subsection 3 of section 3, every person who wilfully conceals, cancels, defaces or destroys the direction of another without that person's consent is guilty of an offence and on summary conviction is liable to a fine of not more than $1,000 or to imprisonment for not more than thirty days, or to both.

Commencement

9. This act comes into force on the day it receives Royal Assent.

Short title

10. This Act may be cited as *The Natural Death Act*, 19??.

Form 1

DIRECTION TO ATTENDING PHYSICIAN AND MEDICAL STAFF

I, ..., being of sound mind, wilfully and voluntarily, direct that all life-sustaining procedures be withheld or withdrawn if at any time I should be in a terminal condition and where the application of life-sustaining procedures would serve only to artificially prolong the moment of death.

It is my intention that this direction be honoured by my family, physicians and medical staff as the final expression of my legal right to refuse medical or surgical treatment and to die naturally.

Made this ..... day of ..... (month, year)

.....
(signature)

The person signing this directive is personally known to me and I believe him/her to be of sound mind.

.....
(Witness)

.....
(Witness)