

1990

## Rejecting Criminal Liability for Life-Shortening Palliative Care

Donald G. Casswell

Follow this and additional works at: <https://scholarship.law.edu/jchlp>

---

### Recommended Citation

Donald G. Casswell, *Rejecting Criminal Liability for Life-Shortening Palliative Care*, 6 J. Contemp. Health L. & Pol'y 127 (1990).

Available at: <https://scholarship.law.edu/jchlp/vol6/iss1/10>

This Article is brought to you for free and open access by CUA Law Scholarship Repository. It has been accepted for inclusion in Journal of Contemporary Health Law & Policy (1985-2015) by an authorized editor of CUA Law Scholarship Repository. For more information, please contact [edinger@law.edu](mailto:edinger@law.edu).

## REJECTING CRIMINAL LIABILITY FOR LIFE-SHORTENING PALLIATIVE CARE

*Donald G. Casswell\**

*It is possible that a physician who administers life-shortening palliative care, even to a terminally ill patient with the patient's consent, commits murder. The Law Reform Commission of Canada, as part of its proposals on recodifying criminal law, has recommended that criminal liability not attach to the administration of life-shortening palliative care "appropriate in the circumstances." The author submits that while the aim of the Commission's recommendation is good, the phrase "appropriate in the circumstances" should be replaced with more specific criteria for determining when life-shortening palliative care may be administered. Failure to do so would leave physicians in almost as uncertain a situation as is presently the case, preventing them from administering such care without fear of criminal liability.*

---

\* Associate Professor of Law, University of Victoria, Victoria, British Columbia, Canada. I would like to thank Joan Young and Roberta Reader (both of Third Year Law, University of Victoria, 1989-90) for their research assistance; my colleague, Professor Robert G. Howell, Dr. Ranald R. Donaldson, physician and surgeon, Victoria, and Dr. Neil MacDonald, Professor of Palliative Care, Department of Medicine, University of Alberta, for their helpful comments on various drafts of this article; and Marilynne Seguin, Executive Director, Dying with Dignity, Dr. David Roy, Center for Bioethics, Clinical Research Institute of Montreal, and Noreen Teoh, World Health Organization, Geneva, Switzerland, for providing me with information. Of course, any shortcomings are my responsibility. Parts of this article were originally presented as a paper at the Third Indo-Pacific Congress on Legal Medicine and Forensic Sciences, Madras, India, September 1989.

Vex not his ghost. O let him pass! He hates him  
That would upon the rack of this tough world  
Stretch him out longer.

SHAKESPEARE: *King Lear*, Act V, Scene iii, Kent speaking.

## I. INTRODUCTION

A physician working as a hospital resident is asked to see a 20-year old woman dying of ovarian cancer. She has not eaten or slept in two days and is vomiting unrelentlessly. The physician determines that she is suffering from severe air hunger. She says, "Let's get this over with." The physician injects the patient with enough morphine "to do the job." Within seconds, the patient is restful. Within four minutes, she is dead.<sup>1</sup> Is the physician a murderer? Maybe.<sup>2</sup> Should he be?<sup>3</sup> If his primary motive was to relieve the patient's suffering, most Canadians would say "no."<sup>4</sup>

This Article considers the potential criminal liability of a physician who, with his or her patient's consent, acts to alleviate pain, suffering or other symptom and thereby shortens the patient's life. After reviewing the present uncertain state of the law, this Article reviews a recommendation by the Law Reform Commission of Canada rejecting such criminal liability and suggests amendments to the proposal.

Defining words used to discuss contentious issues is not easy and writers sometimes assign markedly different, even completely inconsistent, meanings

---

\*\* The citations in this article do not necessarily conform to the Harvard Uniform System of Citation. Some citations follow the author's instructions as to the Canadian form.

1. Based on an actual incident related in *It's Over, Debbie*, 259 J. A.M.A. 272 (1988), author's name withheld by request.

2. See *infra* text accompanying notes 12-58.

3. "He" is used in this sentence and "his" in the next rather than the "he or she" and "his or her" format used elsewhere in this article since the physician in the case recounted was male.

4. Law Reform Commission of Canada, REPORT 30: RECODIFYING CRIMINAL LAW (revised and enlarged edition) 60-61 (1987) [hereinafter REPORT 30]. "[M]ost 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." *Id.* In a recent Gallup poll commissioned by the *Toronto Star*, 77% of adult Canadians surveyed believed "that when a person has an incurable disease that causes great suffering, then a doctor should be allowed by law to end the patient's life through mercy killing, if the person has made a formal request in writing." Gallup Canada, Inc., *Dramatic Increase in Support for Euthanasia*, CANADIAN DOCTOR 15 (July 24, 1989). In the particular case considered in the text, the Chief Judge of the Cook County Court, Chicago, ruled that no crime had been proven. See Smith, *All's Well That Ends Well: Towards a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?*, 22 U.C. DAVIS L. REV. 275, 339 n.459 (1989). The distinction between relieving suffering and causing death is considered *infra* at text accompanying note 6.

to the same word.<sup>5</sup> In this article, "palliative care" refers to any medical intervention in which the physician's primary purpose is the alleviation of a patient's pain, suffering or other symptom.<sup>6</sup> Palliative care is distinguished from treatment directed toward a cure or interventions primarily intended to cause death. Interventions intended primarily to cause death to the patient are acts of euthanasia ("mercy killing"). In cases where the physician is only able to alleviate the patient's pain, suffering or other symptom by administering treatment which will cause death but intervenes with the primary motive of alleviating pain, suffering or other symptom rather than causing death, the physician has administered palliative care rather than committed an act of euthanasia.<sup>7</sup> In particular, while the time between the physician's intervention and the patient's death is a relevant circumstance in assessing the physician's motive, it cannot be determinative. For example, even if the physician's intervention causes the patient's death almost immediately and he or she foresaw death as a likely consequence of the intervention, an act of euthanasia has not been committed, provided that his or her motive was alleviation of the patient's pain, suffering or other symptom. The distinction

---

5. For example, Smith, *supra* note 4, at 337 indicates that "euthanasia" has been variously defined so as to mean both "any good death" and "morally outrageous death" (footnotes omitted). A typical definition of "euthanasia" is "a deliberate life-shortening act (including abstaining) by or with the help of someone other than the person concerned and performed in the patient's interest and in a gentle way." Van der Meer, *Euthanasia: A Definition and Ethical Conditions*, 4 J. PALLIATIVE CARE 103 (1988).

6. In this article, it is not necessary to distinguish among "pain," "suffering" and "other symptom." However, in some situations it may be analytically helpful to distinguish "pain" and "suffering." See Somerville, *Pain and Suffering at Interfaces of Medicine and Law*, 36 U. TORONTO L.J. 286, 287-88 (1986). It is similarly unnecessary in this Article to define palliative care other than in terms sufficient to distinguish such care from euthanasia. However, it should be noted that "palliative care" in medical usage normally includes relief of the patient's emotional, spiritual and social problems as well as pain, suffering or other symptom.

7. This matter requires consideration of the relationship between euthanasia and pain relief treatment given to terminally ill patients. In both cases there is a desire to relieve suffering. The difference is that in euthanasia the primary aim is to do this by inflicting death, whereas in pain relief treatment the primary aim is simply to relieve pain, not to shorten life or to cause death, although this may be a secondary effect. One can envisage a continuum that has at one end the giving of pain relief treatment that will certainly not shorten life, a middle position where there is a possible double effect flowing — that of relieving pain (which is the primary intention) and that of possibly shortening life (which is not desired) — and at the other end a situation of a certain double effect because pain relief treatment will necessarily shorten life. This last case has some of the characteristics of active euthanasia, but it differs from it in that the desire is not to shorten life. However, motive or desire is not usually relevant as a differentiating factor to allow criminal liability to be imposed in one case but not in the other with respect to conduct which is otherwise identical and which is carried out by a person who has subjective knowledge of the consequences and risks of that conduct.

*Id.* at 307.

is between intended consequences and unintended but foreseeable consequences.<sup>8</sup> Finally, the expression "pain, suffering or other symptom" refers collectively to any condition which results in loss of dignity for the patient. The term "other symptom" includes such conditions as disintegration of bodily functions, incontinence, continuous saliva flow, extreme fatigue and shortness of breath, which may result in loss of dignity but which might not be considered to be "pain" or "suffering."

"Terminal illness" is used to refer to an incurable condition which in reasonable medical opinion will produce death. The sophist might argue that life itself is an incurable condition which, in reasonable medical opinion and certain lay knowledge, will produce death. At the other extreme, definitions of "terminal illness" typically require or seem to require that death be imminent.<sup>9</sup> In this Article, the scope of terminal illness is not limited to situations in which death is imminent or reasonably expected within a predetermined length of time. An arbitrarily chosen time period, within which death is expected, should not be given legal significance: the severity of different patients' suffering is not necessarily different simply because they are expected to suffer for different periods of time. Further, while "palliative care" is sometimes associated only with the treatment of terminally ill patients,<sup>10</sup> non-terminally ill patients may also require such care in order to control or

---

8. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 77-82 (Washington, D.C. 1983) [hereinafter PRESIDENT'S COMMISSION STUDY]. The difficult question of "intent" in criminal law is considered *infra* at text accompanying note 37.

9. For example, one definition indicates that "terminal" is "applied to a morbid condition forming the *final* stage of a fatal disease." THE COMPACT EDITION OF THE OXFORD ENGLISH DICTIONARY 204 (1971) (emphasis added). Similarly, while no Canadian legislation defines terminal illness, a Private Member's Bill presented to the Ontario Legislature defined "terminal condition" as "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 condition during the application of life-sustaining procedures." The Bill was never enacted. See Dickens, *The Right to Natural Death*, 26 MCGILL L.J. 847, 873-79 (1981) (emphasis added). This definition was based, in part, on California law which defines "terminal condition" as "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." CAL. HEALTH AND SAFETY CODE § 7187(f) (West Supp. 1990). Notably, despite referring to the "moment of death" which perhaps suggests some requirement of imminency, the statute contains no such explicit requirement.

10. For example, a typical definition of "palliative care" is "the alleviation of pain and symptoms *once cure of the underlying diseases is no longer perceived as possible.*" PARLIAMENT OF VICTORIA, SOCIAL DEVELOPMENT COMMITTEE: INQUIRY INTO OPTIONS FOR DYING WITH DIGNITY (SECOND AND FINAL REPORT) 201 (1987) (citing HEALTH DEPARTMENT VICTORIA, *Palliative Care Policy and Program Discussion Paper 7* (Melbourne 1986) [hereinafter PARLIAMENT OF VICTORIA]).

eliminate pain, suffering or other symptom. Therefore, "palliative care" is not restricted to the terminally ill.

Four possible situations involving the administration of palliative care, generated by the principal variables, may be represented schematically as [life-shortening palliative care, non-life-shortening palliative care] X [terminally ill patient, non-terminally ill patient].<sup>11</sup> Two of these situations are non-contentious since if palliative care is non-life-shortening, criminal liability for murder is irrelevant. Thus, the two situations which must be considered are administering life-shortening palliative care to a non-terminally ill patient and administering such care to a terminally ill patient.

## II. POSSIBILITY OF CRIMINAL LIABILITY FOR ADMINISTERING LIFE-SHORTENING PALLIATIVE CARE

In prolonging a patient's life, a physician may also be prolonging pain, suffering or other symptom. On the other hand, a physician who administers life-shortening palliative care by definition shortens the patient's life. Either course may be characterized as harming the patient and, therefore, unethical.<sup>12</sup> Opinion in the medical profession is divided on whether administration of life-shortening palliative care is ethical.<sup>13</sup> The ethical dilemma

---

11. In those situations where shortening life is a risk associated with palliative care, that risk is normally not completely predictable. However, for the purposes of this article, "life-shortening palliative care" may be defined as including any care which the physician subjectively knows is likely to cause death. See *infra* text accompanying note 15. Other variables associated with administering palliative care include whether the patient is competent and the severity and expected duration of his or her pain, suffering or other symptom. With respect to the latter, see Somerville, *supra* note 6, at 299-309. The former is considered *infra* at text accompanying notes 77-81.

12. Various versions of the Hippocratic Oath exist, but the following is included in a representative version: "I will prescribe regimen for the good of my patients according to my ability and my judgement and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death." *DICTIONARY OF MEDICAL ETHICS* 210 (A. Duncan, G. Dunstan & R. Welbourn eds. 1981). On the historical underpinnings of the possibly conflicting goals of alleviation of suffering and prolongation of life, see Smith, *supra* note 4, at 343.

13. It is difficult to distinguish viewpoints in the literature dealing with euthanasia and those dealing with life-shortening palliative care. See *supra* text accompanying note 6. See also *BRITISH MEDICAL ASSOCIATION, EUTHANASIA* 45-56 (1988) (reviewing the prevailing medical practices in Europe, Australasia and North America in the context of treatment of the terminally ill) [hereinafter *EUTHANASIA*]. Referring to British practice, the Association states: "Palliative rather than invasive care is the rule for general and surgical management in terminal disease and reflects the intent to opt for comfort and a gentle death rather than the technological prolongation of life." *Id.* at 47. The Association goes further: "In contrast to the tendency in U.K. and European practice, American doctors tend to use all available treatments to prolong life." *Id.* at 54. This generalization concerning American practice is not reflected in the conflicting opinions represented in *It's Over Debbie*, *supra* note 1, at 272. See Green, *What's Wrong with Trying to Make the Patient Comfortable?*, 138 *CANADIAN MED.*

facing the physician is complicated by the possibility that a physician who administers life-shortening palliative care commits murder. The *Criminal Code of Canada* provides that a person commits homicide when he or she directly or indirectly causes the death of a human being by any means.<sup>14</sup> Murder includes causing the death of a human being by means of an unlawful act where the person causing death means to cause bodily harm that he or she knows is likely to cause death and is reckless whether death ensues or not.<sup>15</sup> Further, no person may consent to have death inflicted on him or her and consent does not affect the criminal liability of a person who causes death.<sup>16</sup> Therefore, the patient's consent to the administration of life-shortening palliative care would not afford the physician a defence to a charge of murder.

### III. ADMINISTERING LIFE-SHORTENING PALLIATIVE CARE TO A NON-TERMINALLY ILL PATIENT

A non-terminally ill patient may experience pain, suffering or other symptom which may only be alleviated by life-shortening palliative care. There appears to be no Canadian or English case which has considered the criminal liability of a physician who administers life-shortening palliative care to a non-terminally ill patient and, therefore, no guidance whatsoever as to the law in such a case.

In the course of a comprehensive consideration of pain and suffering, Margaret Somerville has suggested that "[a] blanket rule covering all situa-

---

A.J. 959 (1988); Singer, *Should Doctors Kill Patients?*, 138 CANADIAN MED. A.J. 1000 (1988); Pellegrino, *Ethics*, 261 J. A.M.A. 2843 (1989); Wanzer, Federman, Abelstein, Cassel, Cassem, Cranford, Hook, Lo, Moertel, Safar, Stone, & Van Eys, *The Physician's Responsibility Toward Hopelessly Ill Patients*, 320 NEW ENG. J. MED. 844 (1989). The article states:

In the patient whose dying process is irreversible, the balance between minimizing pain and suffering and potentially hastening death should be struck clearly in favor of pain relief. Narcotics or other pain medications should be given in whatever dose and by whatever route is necessary for relief. It is morally correct to increase the dose of narcotics to whatever dose is needed, even though the medication may contribute to the depression of respiration or blood pressure, the dulling of consciousness, or even death, provided the primary goal of the physician is to relieve suffering. The proper dose of pain medication is the dose that is sufficient to relieve pain and suffering, even to the point of unconsciousness.

*Id.* at 847.

14. *Criminal Code*, R.S.C. 1985, c. C-46, s. 222(1).

15. *Criminal Code*, R.S.C. 1985, c. C-46, ss. 222(5)(a), 229(a)(ii). Only those parts of the definitions of "culpable homicide" and "murder" directly relevant to the present discussion have been included.

16. *Criminal Code*, R.S.C. 1985, c. C-46, s. 14. However, a prior characterization of the conduct in question as criminal or non-criminal affects the relevance of consent. See Somerville, *supra* note 6, at 108-09.

tions is totally inappropriate as it would fail to take due account of different degrees of pain and suffering occurring in different circumstances, where the differences should be legally significant."<sup>17</sup> In particular, "a person at serious risk of committing suicide because of intractable, chronic, severe pain should be allowed the option of choosing a pain relief treatment, even if it may shorten life, if there is no other reasonable alternative to such treatment."<sup>18</sup> In other words, the non-terminal nature of the patient's condition must be balanced against the severity and expected duration of his or her pain, suffering or other symptom. The important point is that life-shortening palliative care should not be denied to non-terminally ill patients in all cases.

Where courts have been required to give directions concerning the future treatment of children, a test for assessing the severity of pain, suffering or other symptom has been developed: is the person's life so "demonstrably awful" that it would be in his or her best interest to be allowed to die?<sup>19</sup> This test could be used to determine whether the circumstances of a non-terminally ill patient justify the administration of life-shortening palliative care.

#### IV. ADMINISTERING LIFE-SHORTENING PALLIATIVE CARE TO A TERMINALLY ILL PATIENT

Lord Donaldson, M.R. recently said, "the problem of how to treat the terminally ill is as old as life itself. Doctors and nurses have to confront it frequently, but it is never easy."<sup>20</sup> As old as the ethical and legal problems associated with treating the terminally ill may be, they have been exacerbated by modern medical technology which permits physicians to prolong life virtually indefinitely.<sup>21</sup>

There appears to be no Canadian case and only one English case which has considered the criminal liability of a physician who administers life-shortening palliative care to a terminally ill patient.<sup>22</sup> One other English

---

17. See Somerville, *supra* note 6, at 300-01.

18. *Id.* at 299-300.

19. See, e.g., *In re B. (a Minor)*, [1981] 1 W.L.R. 1421 (C.A.) at 1424; *Re Superintendent of Family and Child Service and Dawson* [1983], 145 D.L.R.(3d) 610 (B.C.S.C.) at 623; *In re C. (a Minor)*, [1989] 3 W.L.R. 240 (C.A.), considered *infra* at text accompanying notes 40-51.

20. *In re C. (a Minor)*, [1989] 3 W.L.R. 240 (C.A.) at 242. For a related decision considering prohibiting the publication of information about the case, see *In re C. (a Minor)*, [1989] 3 W.L.R. 252 (C.A.). This case is considered *infra* at text accompanying notes 40-51.

21. See *supra* text accompanying notes 12-13.

22. It appears that only two American cases have specifically considered the criminal liability of a physician who administers life-shortening palliative care to a patient. The cases share a number of similarities. In each, the physician was charged with murdering a patient

decision, while not specifically dealing with the criminal liability issue, did confront the conflict between prolonging life and administering life-shortening palliative care.

In *R. v. Adams*,<sup>23</sup> the accused physician was tried for the alleged murder of an eighty-one year old patient, Edith Alice Morrell. Mrs. Morrell was suffering from cerebral arteriosclerosis and the effects of a stroke. There was conflicting evidence whether she was experiencing pain and it is not apparent whether the medical evidence explicitly indicated that she was terminally ill, although the case seems to have proceeded on the basis that she was.<sup>24</sup> The prosecution's theory was that Dr. Adams, wishing to acquire under Mrs. Morrell's will an oak chest containing silver and valued at 276 pounds,<sup>25</sup> administered drugs<sup>26</sup> to her with the intent to kill her. The defence maintained that Dr. Adams intended to relieve Mrs. Morrell's pain and that her illness, not the drugs, caused her death.<sup>27</sup>

Mr. Justice Devlin charged the jury that the humanitarian motive of a physician who shortens a patient's life is irrelevant. However, his Lordship went on to instruct the jury that:

If the first purpose of medicine, the restoration of health, could no longer be achieved, there was still much for the doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally

---

who was dying of cancer, the defence argued that the patient might already have been dead when the physician acted (in one case injecting the patient with potassium chloride and in the other giving him air intravenously), and there was expert medical evidence indicating that the patient might have died of causes other than the physician's act. Both physicians were acquitted. See R. VEATCH, DEATH, DYING, AND THE BIOLOGICAL REVOLUTION: OUR LAST QUEST FOR RESPONSIBILITY 78-80 (1976); Smith, *supra* note 4, at 354. Two additional American cases have considered the liability of a physician who administered life-shortening palliative care to a relative. See B. Sneiderman, J. Irvine & P. Osborne, CANADIAN MEDICAL LAW 238-40 (1989) [hereinafter CANADIAN MEDICAL LAW].

23. Central Criminal Court, London, 1957, unreported, but discussed in Palmer, *Dr. Adams' Trial for Murder*, [1957] CRIM. L. REV. 365; G. WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW 288-90 (1958); Dickens, *supra* note 9, at 868-70, 872; D. MEYERS, MEDICO-LEGAL IMPLICATIONS OF DEATH AND DYING 127-28 (1981).

24. See excerpts from Mr. Justice Devlin's charge to the jury, *infra* at text accompanying notes 28-29, which refer to situations in which "the restoration of health could no longer be achieved" and "the case of the dying."

25. To put the prosecution's argument concerning motive into perspective, the night nurse received 300 pounds and the chauffeur 1000 pounds under Mrs. Morrell's will. Palmer, *supra* note 23, at 376.

26. Morphine, heroin and paraldehyde. *Id.* at 365, 369-71.

27. One of the prosecution's expert medical witnesses admitted in cross-examination that it was impossible to rule out natural causes, such as further cerebral hemorrhage, as the immediate cause of death. *Id.* at 373.

shorten life.<sup>28</sup>

Mr. Justice Devlin stated that in such a situation the patient's illness and not the administration of palliative care would cause the patient's death. However, his Lordship added words of caution:

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. But it remains the fact, and it remains the law, that no doctor, nor any man, no more in the case of the dying than of the healthy, has the right deliberately to cut the thread of life.<sup>29</sup>

After deliberating for forty-four minutes, the jury found Dr. Adams not guilty.<sup>30</sup>

Since the medical evidence was not certain that the administration of drugs had in fact been a cause of Mrs. Morrell's death,<sup>31</sup> Mr. Justice Devlin's instruction to the jury on causation was entirely appropriate. It is difficult, however, to support as a generalized proposition his Lordship's reasoning that palliative care which has the "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."<sup>32</sup> If a factual causal connection between the administration of palliative care and the patient's death is proved and if the physician subjectively knew that the palliative care he or she was about to administer would likely be life-shortening, it would seem that causation would be established.<sup>33</sup> Further, two causes may operate together, with each legally being a cause of an event.<sup>34</sup> In the present context, both the patient's illness and the physician's administration of life-shortening palliative care would be causes of the patient's death.

As alternatives to Mr. Justice Devlin's absence of causation analysis, writ-

28. G. WILLIAMS, *supra* note 23, at 289.

29. *Id.*

30. Dr. Adams was charged with a second count of murder but the prosecution elected not to proceed. Palmer, *supra* note 23, at 377.

31. *See supra* note 27.

32. G. WILLIAMS, *supra* note 23, at 289.

33. With respect to factual causation, note carefully the use of "directly or indirectly" in the *Criminal Code's* definition of "homicide." *See supra* note 14 and accompanying text.

For an act or omission to be a cause of an event it must cause the event in the sense that the event would not have occurred but for the act or omission. However, two sufficient causes may operate together, whether independently or complementarily. . . . In addition, the conduct in question must be an imputable cause of the event. Intended consequences are nearly always imputed; the problems relate to unintended consequences.

G. WILLIAMS, *TEXTBOOK OF CRIMINAL LAW* 400 (2d ed. 1983) [hereinafter *TEXTBOOK OF CRIMINAL LAW*].

34. *TEXTBOOK OF CRIMINAL LAW, supra* note 33, at 400.

ers have justified his Lordship's instructions either by reasoning that there was an absence of intent (the physician did not have the required criminal intent to murder but rather intended to alleviate suffering)<sup>35</sup> or by saying that the act was justified by necessity.<sup>36</sup> However, there are also difficulties with each of these alternatives. In the case of the former, the finding that a physician was acting to relieve pain rather than to cause death is relevant to his or her motive, with the requisite intent nevertheless established if he or she subjectively apprehended that the palliative care would likely be life-threatening.<sup>37</sup> While reasoning focused on necessity does require a balancing of competing values,<sup>38</sup> such reasoning necessarily remains as the mere explanation of an isolated case and cannot afford clear guidance.

In *In re C. (a Minor)*,<sup>39</sup> the English Court of Appeal considered the future treatment of a terminally-ill 16-week old child. Baby C., who had been born prematurely, was suffering from congenital hydrocephalus and the effects of a poorly formed brain structure.<sup>40</sup> She was blind, either deaf or suffering from very poor hearing, had generalized spasticity in all her limbs, and was unable to absorb nutrition from food.<sup>41</sup> She was described as having become terminally ill even before her birth and her ultimate prognosis as hopeless.<sup>42</sup> As the Master of the Rolls put it, "the sad but fundamental truth [was] that C. was dying and the only question was how soon this would happen."<sup>43</sup> Since C. had been made a ward of the Court for reasons unconnected with her medical condition, an application was brought for directions concerning C.'s treatment.<sup>44</sup>

The Judge at first instance ordered that the continued treatment of C. be

---

35. D. MEYERS, *supra* note 23, at 126-27.

36. G. WILLIAMS, *supra* note 23, at 286-88.

37. "Intent" and "motive" are used interchangeably in ordinary speech, making it difficult to distinguish these terms for legal analysis. Essentially, "intent" refers to a person's immediate intent to cause something to happen by means of acting or omitting to act whereas "motive" refers to the person's ultimate intent. ("Intent" is repeated deliberately.) For examples illustrating attempts at distinguishing "intent" and "motive," see *TEXTBOOK OF CRIMINAL LAW*, *supra* note 33, at 75-76. See also *supra* text accompanying note 6.

38. G. WILLIAMS, *supra* note 23, at 286-87. In order to benefit from the defence of necessity, the accused must have been faced with an urgent situation or imminent peril, there was no legal alternative and the harm inflicted was less than the harm avoided. See *Morgentaler v. The Queen* [1975], 20 C.C.C.(2d) 449 (S.C.C.); *Perka v. The Queen* [1984], 14 C.C.C.(3d) 385 (S.C.C.); *R. v. Morgentaler* [1985], 22 C.C.C.(3d) 353 (Ont.C.A.), *rev'd in part on other grounds* [1988] 1 S.C.R. 30.

39. [1989] 3 W.L.R. 240 (C.A.).

40. *Id.* at 242.

41. *Id.* at 245.

42. *Id.* at 242, 246.

43. *Id.* at 244.

44. *Id.* at 242-43.

in accordance with the opinion expressed by a physician described as "one of the nation's foremost paediatricians."<sup>45</sup> Lord Donaldson, M.R. summarized the direction of that opinion by saying that it "took the view that the goal should be to ease the suffering of C. rather than to achieve a short prolongation of her life."<sup>46</sup> In particular, antibiotics, intravenous infusions and nasogastric feedings were to be undertaken only if, in the opinion of the doctors and nurses treating C., these treatments would reduce her suffering.<sup>47</sup> Distinguishing previous decisions<sup>48</sup> which had concluded that the lives of seriously handicapped children could not be described as so demonstrably awful to warrant permitting them to die, the Court of Appeal unanimously agreed that the Judge's order was in the best interests of C.<sup>49</sup> Balcombe, L.J. succinctly described the Court's order as having the effect of "authoris[ing] the hospital to withhold life-prolonging treatment for Baby C."<sup>50</sup>

While *Adams* and *In re C.* seem to indicate that under English common law, and perhaps Canadian law as well, it is not murder for a physician to administer life-shortening palliative care to a terminally ill patient,<sup>51</sup> there is no certainty in this conclusion. Beyond the difficulties already mentioned,<sup>52</sup> legal analyses of intent and causation fail to confront the underlying value conflicts,<sup>53</sup> leaving the possibility that decisions may be arrived at through the mechanical application of doctrine.<sup>54</sup> While necessity analysis does require consideration of such values, clear guidance is nevertheless still not provided.<sup>55</sup>

In summary, the law provides no clear guidance to physicians concerning possible criminal liability for administering life-shortening palliative care to

45. *Id.* at 244.

46. *Id.* at 245.

47. *Id.*

48. *In re B. (a Minor)*, [1981] 1 W.L.R. 1421 (C.A.); *Re Superintendent of Family and Child Service and Dawson* [1983], 145 D.L.R.(3d) 610 (B.C.S.C.).

49. *In re C. (A Minor)*, [1989] 3 W.L.R. 240 (C.A.).

50. *In re C. (a Minor)*, [1989] 3 W.L.R. 252 (C.A.) at 259.

51. It must be realized that even under the existing law the physician is not required to treat life as an absolute value. . . . [W]hen a patient is suffering from a painful illness the doctor may lawfully administer a narcotic to relieve pain even though he knows that the drug, used in quantity as it sooner or later has to be, is likely to prove fatal if not anticipated by the disease. The immediate relief of pain counterbalances the risk of accelerated death.

G. WILLIAMS, *supra* note 23, at 287-88. *See also* Dickens, *supra* note 9, at 868-70, 872; Somerville, *supra* note 6, at 308 n.56.

52. *See supra* text accompanying notes 33-38.

53. N. CANTOR, *LEGAL FRONTIERS OF DEATH AND DYING* 31 (1987) (referring to the "myths" involved in such analysis).

54. *See* G. WILLIAMS, *supra* note 23, at 290 (illustrating an example of the pitfalls of causation analysis).

55. *See supra* text accompanying note 38.

a terminally ill patient and no guidance whatsoever in the case of a non-terminally ill patient.<sup>56</sup> A physician who believes that administering life-shortening palliative care is murder will be prevented from giving such care.<sup>57</sup> The result is that patients requiring and requesting such care may not receive it. Legislation is required to remove the spectre of criminal liability looming over physicians who consider administering life-shortening palliative care.<sup>58</sup>

## V. THE LAW REFORM COMMISSION'S RECOMMENDATION

The Law Reform Commission of Canada has recommended that the offences of helping, advising or inciting a person to commit suicide, negligent homicide, manslaughter and murder, as defined in its proposed new *Criminal Code*,<sup>59</sup> not be applicable:

[I]n respect of the administration of palliative care that is appropriate in the circumstances to control or eliminate the pain and suffering of a person regardless of whether or not the palliative care reduces the life expectancy of that person, unless that person refuses to consent to that care.<sup>60</sup>

---

56. See J. Baudouin, *Euthanasia and Cessation of Treatment for Terminally Ill Patients* 4 (paper presented at the Annual Meeting of the Canadian Association of Law Teachers, Vancouver, June 1983).

57. The other potentially relevant legal liability of the physician is civil liability for failure to administer palliative care. The possible civil and criminal liabilities are related.

[S]hould failure to provide adequate, reasonably available pain relief treatment constitute medical negligence or malpractice? . . . [O]ne cannot create a duty to give pain relief treatment and impose private law liability in tort for unreasonable failure to fulfill this and at the same time threaten criminal liability for administering the pain relief treatment which is required. . . . [I]f pain relief treatment which may shorten life were not able to be given without attracting potential criminal liability, it not only need not or may not, but must not be given. Consequently, the criminal law is important in establishing the scope of private law duties to provide pain relief treatment.

Somerville, *supra* at note 6, at 296-97.

It is submitted that it is highly unlikely that a physician would be held civilly liable in respect of a failure to administer life-shortening palliative care. In this regard, it is necessary to distinguish between the patient enjoying the right to request and consent to such care and being able to demand that a particular physician administer such care. Balancing patient autonomy and professional autonomy is considered *infra* at text accompanying note 83.

58. It is difficult to imagine that even a decision of the Supreme Court of Canada could be generally determinative on this matter, since any decision would be dependent upon its particular facts.

59. REPORT 30, *supra* note 4, at 185-86.

60. *Id.* at 186. This statement repeats the Law Reform Commission's previous recommendation of such an amendment. See LAW REFORM COMMISSION OF CANADA, WORKING PAPER 28: EUTHANASIA, AIDING SUICIDE AND CESSATION OF TREATMENT 70-71 (1982) [hereinafter WORKING PAPER 28]; LAW REFORM COMMISSION OF CANADA, REPORT 20: EU-

The essential thrust of this recommendation is to make motive relevant in certain cases. If the physician's primary motive was the relief of pain and suffering, no criminal liability attaches even if he or she subjectively knew that administering palliative care would be life-shortening. On the other hand, if the primary motive was to cause death, criminal liability would attach. Distinguishing between non-criminal life-shortening palliative care and criminal euthanasia has been the Commission's consistent position.<sup>61</sup>

Two additional points concerning the recommendation should be noted. First, it is not limited to situations involving terminally ill patients. However, in commenting on its recommendation, the Commission did note that "Canadian case-law has no record of conviction of a doctor for shortening a *terminal* patient's life by administering pain-relieving drugs."<sup>62</sup> Second, using the limitation "unless [the patient] refuses to consent to that care"<sup>63</sup> puts the onus on the prosecution to establish that there was a refusal. That is, the provision contains a presumption in favour of a patient's desire to receive life-shortening palliative care in the limited circumstances encompassed by it. This presumption is analogous to emergency medical interventions, where the patient's consent to treatment is assumed in the absence of his or her refusal.<sup>64</sup>

No legal rule can eliminate the ethical dilemma facing a physician who is considering administering life-shortening palliative care.<sup>65</sup> A patient, however, who seeks such care should enjoy access to it. Recognizing such a right should follow upon acceptance of the principle of self-determination.<sup>66</sup>

---

THANASIA, AIDING SUICIDE AND CESSATION OF TREATMENT 22-23 (1983) [hereinafter REPORT 20]; LAW REFORM COMMISSION OF CANADA, REPORT 28: SOME ASPECTS OF MEDICAL TREATMENT AND CRIMINAL LAW 8 (1986).

61. WORKING PAPER 28, *supra* note 60, at 68; REPORT 20, *supra* note 60, at 17-20; REPORT 28, *supra* note 60, at 12-13. See also *supra* text accompanying note 6.

62. REPORT 30, *supra* note 4, at 60 (emphasis added). However, at least one physician was charged with first degree murder in such a case. The case was never tried since the physician left Canada and the Canadian government could not obtain his extradition. See CANADIAN MEDICAL LAW, *supra* note 22, at 242.

63. REPORT 30, *supra* note 4, at 186.

64. *Marshall v. Curry*, [1933] 3 D.L.R. 260, 60 C.C.C. 136 (N.S.S.C.) (action of trespass did not lie where surgeon, who without the patient's consent, reasonably believed that the patient's organ should be removed to save that patient's life); *Malette v. Shulman* [1987], 63 O.R.(2d) 243 (H.C.) (physician held liable when he administered blood to Jehovah's witness carrying a card stating "refusal to consent" to blood transfusions).

65. See *supra* text accompanying notes 12-13.

66. In *Reibl v. Hughes*, [1980] 2 S.C.R. 880 at 890, Laskin, C.J.C., for the Court, quoted the following statement by Judge Cardozo in *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914): "Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . ." Under Canadian law, attempting to commit suicide is not a crime, although counseling, aiding or abetting another to commit suicide is, whether suicide ensues or not. *Criminal Code*, R.S.C. 1985, c. C-

Empirical studies indicate that patients frequently do not receive adequate pain relief despite the availability of analgesic drug therapy.<sup>67</sup> Failure legally to facilitate access to palliative care may force a patient to endure, against his or her will, "an intrusive and futile battery of medical interventions"<sup>68</sup> involving "cruel and unnecessary practices."<sup>69</sup> As the Law Reform Commission noted, statutorily rejecting criminal liability for the administration of life-shortening palliative care would clarify the law and bring it "into line with current moral thinking."<sup>70</sup> Further, the Commission's recommendation is consistent with recent opinion in other countries.<sup>71</sup> For these reasons the aim of the Law Reform Commission's recommendation is good.<sup>72</sup> However, it is submitted that the recommendation could be improved.

## VI. IMPROVING THE LAW REFORM COMMISSION'S RECOMMENDATION

The expression "appropriate in the circumstances" is vague and would leave physicians in almost as uncertain a position as is presently the case. It should be replaced by criteria which would, first, provide a degree of certainty sufficient to permit physicians to administer life-shortening palliative care without fear of criminal liability. Second, the criteria should explicitly recognize the possibility of lawfully administering such care to both terminally and non-terminally ill patients. In addition, "other symptom" should be added to "pain" and "suffering" to include conditions which might not be characterized as "pain" or "suffering." Therefore, it is submitted that the

---

46, s. 241. For a comprehensive consideration of the position of someone who assists another to commit suicide, see Smith, *supra* note 4.

67. Shapiro, *The Right of Privacy and Heroin Use for Painkilling Purposes by the Terminally Ill Cancer Patient*, 21 ARIZ. L. REV. 41, 42 (1980); Angell, *The Quality of Mercy*, 306 NEW ENG. J. MED. 98 (1982); WORLD HEALTH ORGANIZATION, CANCER PAIN RELIEF 7-8 (1986).

68. EUTHANASIA, *supra* note 13, at 55.

69. *Id.*

70. REPORT 30, *supra* note 4, at 61.

71. See PRESIDENT'S COMMISSION STUDY, *supra* note 8, at 77-82; PARLIAMENT OF VICTORIA, *supra* note 10, at 217-18, 220-21, 224; Roy, *Ethical Issues in the Treatment of Cancer Patients*, 67 BULLETIN OF THE WORLD HEALTH ORGANIZATION 341 (1989). The article by Roy refers to accepted acts of euthanasia in the Netherlands and Japan. *Id.* at 343-44. It also addresses the recommendation of the World Health Organization's Ethics Working Group: "Since patients have a right to receive, and health care professionals have a duty to provide, adequate relief of pain, countries should review their laws to eliminate legal impediments to the achievement of adequate pain relief." *Id.* at 346.

72. One author expresses the opinion that "its implementation would probably have a positive impact on medical practice, eliminate continuation of useless medical treatment, promote the responsibility of the medical profession and the development of palliative care." Baudouin, *supra* note 56, at 27.

Law Reform Commission's recommendation should be amended to provide that criminal liability is not incurred:

[I]n respect of the administration of palliative care to control or eliminate the *pain, suffering or other symptom* of a person regardless of whether or not the palliative care reduces the life expectancy of that person, *if in the opinion of a medical practitioner*

(a) *that person is terminally ill, or*

(b) *that person's life is demonstrably awful because of pain, suffering, or other symptom, unless that person refuses to consent to that care.*

Reliance upon the opinion of a medical practitioner is drawn from the example of other legislation<sup>73</sup> and "demonstrably awful life" is derived from precedent.<sup>74</sup> The latter presents a very difficult standard to apply. In the present context, however, it is intended to refer to those situations in which a physician agrees with the patient that the quality of his or her life is so unacceptable as to warrant the administration of life-shortening palliative care even though he or she is not terminally ill. In assessing a patient's circumstances, factors to be considered include (1) the nature and severity of the patient's pain, suffering or other symptom; (2) whether the patient is sentient, capable of experiencing relationships with others<sup>75</sup> and able to maintain personal dignity; and (3) how well the patient is able to bear his or her pain, suffering or other symptom and, in particular, whether he or she is at risk of attempting suicide. It must be emphasized that the physician would not be imposing his or her assessment of the patient's life against the patient's will: the presupposition throughout is that the patient consents to, and indeed probably initiates a request for, palliative care even though such care will be life-shortening.

Further, "palliative care" and "terminally ill" should be defined. A probably non-contentious definition of "palliative care" would be "any medical intervention in which the physician's primary motive is the alleviation of pain, suffering or other symptom rather than attaining a cure." Defining

---

73. Such legislation may deal with matters of competence. See, e.g., *The (British Columbia) Infants Act*, R.S.B.C. 1979, c. 196, s. 16; *The (British Columbia) Mental Health Act*, R.S.B.C. 1979, c. 256, s. 20. Other legislation deals with the ability to engage in an activity such as driving a motor vehicle. See, e.g., *The (British Columbia) Motor Vehicle Act*, R.S.B.C. 1979, c. 288, s. 221. Most recently, Bill C-43, *An Act respecting abortion*, 2nd Session, 34th Parliament, Nov. 3, 1989, specifically employs the criterion of "a medical practitioner who is of the opinion . . .".

74. For example, *In re B. (a Minor)*, [1981] 1 W.L.R. 1421 (C.A.) at 1424; *Re Superintendent of Family and Child Service and Dawson* (1983), 145 D.L.R.(3d) 610 (B.C.S.C.) at 623; *In re C. (a Minor)*, considered *supra* at text accompanying notes 39-50.

75. For example, in *In re C. (a Minor)*, considered *supra* at text accompanying notes 39-50, the medical evidence suggested that Baby C. likely was unable to "experience very much."

“terminally ill” is contentious. As indicated, “terminal illness” is often associated with imminent death.<sup>76</sup> It is submitted that such a limitation should not be included. Rather, “terminally ill” should be defined as “suffering from an incurable condition which in reasonable medical opinion will produce death.” While these definitions provide some structure, hopefully they remain flexible enough to permit a situational analysis of individual patients’ circumstances.<sup>77</sup>

## VII. LIFE-SHORTENING PALLIATIVE CARE, PATIENT AUTONOMY AND PROFESSIONAL AUTONOMY: THE NEED FOR A TOLERANT LAW

### A. *The Requirement of Patient Consent*

Life-shortening palliative care would only be recognized as lawful if administered with the patient’s consent.<sup>78</sup> The law of informed consent is applicable to administering life-shortening palliative care in the same way as to any other medical intervention. If the patient is a competent adult, the patient may consent to or refuse the administration of life-shortening palliative care.<sup>79</sup> In the case of an incompetent adult patient, the principle of self-determination should be respected by first asking whether the wishes of the patient, expressed at a time when he or she was competent, are known.<sup>80</sup> In the case of a child, the child may be competent to decide for himself or herself whether to consent to life-shortening palliative care.<sup>81</sup> If not, the child’s parent or legal guardian will be able to give or withhold consent on the child’s behalf, subject to the constraint that if the parent or guardian is not acting in the child’s best interest, the court will be able to substitute its

76. See *supra* note 9 and accompanying text.

77. The Law Reform Commission did not define “palliative care” and did not use “terminal illness.” Ensuring flexibility is essential. “Each clinical case, particularly those involving life-death decisions, . . . [raises] the one governing question of the moment: how can we help *this person* live or die in a fashion that honours his or her dignity and ours as well?” Roy, *Ethics in Palliative Care*, 3 J. PALLIATIVE CARE 3, 5 (1987).

78. See *supra* text accompanying note 63.

79. *Reibl v. Hughes*, [1980] 2 S.C.R. 880.

80. Several American cases have considered this type of situation, the principal context having been the incompetent patient’s right to have treatment discontinued. See Annas, *Reconciling Quinlan and Saikewicz: Decision Making for the Terminally Ill Incompetent*, in E. DOUDERA, LEGAL AND ETHICAL ASPECTS OF TREATING CRITICALLY AND TERMINALLY ILL PATIENTS 28-62 (1982); Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375 (1988); Smith, *supra* note 4, at 384-408.

81. If the child has the ability to understand the proposed medical intervention, he or she is competent at common law. *Johnston v. Wellesley Hospital* [1970], 17 D.L.R.(3d) 139 (Ont.H.C.); *Re L.D.K.*, C.A.S. Metro Toronto v. K. [1985], 48 R.F.L.(2d) 164 (Ont.Prov.Ct.). Alternatively, the child may be competent by statute. See, e.g., *The (British Columbia) Infants Act*, R.S.B.C. 1979, c. 196, s. 16.

judgment.<sup>82</sup> In short, as Lord Donaldson, M.R. said in a slightly different context, "no new principle is involved"<sup>83</sup> with respect to the informed consent aspect of administering life-shortening palliative care.

### B. Reconciling Patient Autonomy and Professional Autonomy

By rejecting the possibility that a physician may be criminally liable for administering life-shortening palliative care, Canadian law would take a large step towards recognizing that a patient enjoys a right not to suffer. Certainly, rejection of criminal liability for administering life-shortening palliative care would allow decisions about such care to be made by individual patients, according to their personal beliefs, in consultation with their loved ones and physicians.

The question remaining is whether a patient may require a particular physician to administer life-shortening palliative care. The Commission's proposal does not encompass this question, and rightly so. If a patient were able to require a particular physician to administer life-shortening palliative care, he or she would be able to force his or her moral opinion upon a physician who might not share that opinion. This outcome would be as objectionable as denying life-shortening palliative care to a patient who wishes it on the grounds that someone else found such care morally unacceptable. The patient who wishes life-shortening palliative care may seek treatment by a physician who does not find such care morally offensive. A tolerant law which permits, but does not require, the administration of life-shortening palliative care balances patient autonomy and professional autonomy, and respects different ethical, moral, and professional opinions.<sup>84</sup>

## VIII. CONCLUSION

The thrust of the Law Reform Commission's recommendation rejecting

---

82. Either pursuant to the court's common law *parens patriae* jurisdiction or, more typically, under child welfare legislation. See, e.g., *The (British Columbia) Family and Child Service Act*, R.S.B.C. 1979, c. 119.1, s. 10(1)(b); *Re Superintendent of Family and Child Service and Dawson* [1983], 145 D.L.R.(3d) 610 (B.C.S.C.).

83. *In re C (a Minor)*, [1989] 3 W.L.R. 240 (C.A.) at 249.

84. Patient autonomy is a crucial aspect of informed patient care. This is achieved most successfully where a trusting and open relationship between the doctor and the patient allows participation in decisions about illness and its treatment. Doctors should regard patients as authorising treatment, and should respect those authorisations and any decision to withdraw consent. But autonomy works both ways. Patients have the right to decline treatment but do not have the right to demand treatment which the doctor cannot, in conscience, provide.

EUTHANASIA, *supra* note 13, at 67. See also N. CANTOR, *supra* note 53, at 5; Smith, *supra* note 4, at 359-60.

criminal liability for administering life-shortening palliative care is good. However, it does not explicitly recognize the possibility that non-terminally ill patients may require such care nor would it provide adequate guidance to physicians as to when such care may lawfully be administered, either to terminally or non-terminally ill patients. This Article suggests that the Commission's recommendation be amended along the lines proposed. Otherwise, patients may still be denied the right to choose not to suffer because of physicians' uncertainty as to the lawfulness of administering life-shortening palliative care.

It is not unreasonable to suppose that most of us hope to die peacefully and with dignity.<sup>85</sup> Rejecting the possibility of criminal liability for administering life-shortening palliative care would increase the chances that we will enjoy the option of death with dignity.<sup>86</sup>

---

85. In a poll of 509 lawyers, 49% believed that the physician referred to in the situation considered in *It's Over Debbie*, *supra* note 1 and accompanying text, should be prosecuted criminally, whereas 34% thought not. Interestingly, however, 56.8% of the same group answered "yes" to the question "Should active euthanasia — the administration of a lethal injection to a terminally ill patient who wants to die — be legal?" and 51.3% indicated that they would ask their physician for relief similar to that given to "Debbie" if they were "hopelessly ill and in great pain." See Reidinger, *Lawpoll: Should Active Euthanasia Be Legal?*, 74 A.B.A. J. 20 (June 1988). As indicated, the poll's questions were expressed in terms of active euthanasia rather than life-shortening palliative care. *Quaere* whether more respondents would have approved of the same acts if they had been characterized as life-shortening palliative care rather than as active euthanasia? See *supra* text accompanying note 6.

86. "There is no necessity that any person die in misery, deprived of human dignity." G. GRISEZ & J. BOYLE, *LIFE AND DEATH WITH LIBERTY AND JUSTICE* 183 (1979).