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I. *Introduction*

Advances in medical technology, discoveries in pharmacology, and developments in bio-engineering have made it possible for the modern physician to save and/or sustain the lives of individuals who but a few decades ago would have died. These developments have proved a mixed blessing. While on the one hand they have allowed the physician to exercise his profession more successfully, on the other they have opened up before him a domain of decision problems that few of his predecessors have had to face. The thrust of these problems may be focussed into a single question: Ought he to employ the techniques, drugs and devices thus at his disposal in all cases, or ought he to proceed selectively?

In many instances this question is resolvable by an appeal to the wishes of the patient himself. Whatever the legalities of the matter, physicians have generally operated and continue to operate on the principle that the expressed desire on part of an otherwise competent patient not to receive resuscitative, sustaining or heroic measures is not *eo ipso* indicative of diminished capacity and therefore should be honoured.[1] In other cases, the economics of the situation produce a triage context in which universal allocation is ruled out in any case and the only question that arises is whom to select, and on what basis.[2] However, there is a third array of cases where no triage

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1. *Cf.* Lance Tibbles, "Is He Dead? Should He be Allowed to Die? Who decides?" Conn. Med. 39:11 (1975) at p. 734. Charles H. Montange, "Informed Consent and the Dying Patient", *The Yale Law Journal* 83 (July 1, 1971) 1632, at 1634, 1648, 1649 f. etc., esp. 1656 f.; Michael T. Sullivan, "The Dying Person: His Plight and his Right" *NELR* 8 at 197; W. H. Baugham *et al.*, "Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations" *Notre Dame Lawyer*, 48: 5 (June, 1973) at 1219. Aranson, *The Right to Die: Decisions and Decision Makers* (New York, 1974) at 59.

2. *Cf.* F. J. Ayd, Jr. "The Hopeless Case: Medical and Moral Considerations", *Journal of the American Medical Association* 181 (1962) at 1099; Diana Crane, *The Sanctity of Social Life: Physicians' Treatment of Critically Ill Patients* (New York: Russell Sage Foundation, 1975); Marvin Kohl, *Beneficent Euthanasia* (Buffalo: Prometheus Books, 1975); Charles Fried, "Terminating Life Support: Out of the Closet", *New England Journal of Medicine* 295 (August 12, 1976) at

pressures obtain[3] but where informed consent is not possible either. The cases in question range from those of infants who are so physiologically aberrant and defective that they might well be called monsters[4], to those of irremedially brain-damaged and comatose adult human beings at the other end of life.[5]

The present article, although wider in its implications, focusses on only one part of this spectrum: On the array of cases that involves radically defective and cerebrally at best only rudimentarily developed (or severely damaged) neonates who require prompt surgical and/or medical intervention in order to survive but who, even with such intervention, will not survive their first year. The questions that the article will address are the following: Does the attending physician, and do the associated medical personnel, have an obligation to intervene constructively in such cases? Alternatively, may they allow the infant to die without active interference

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390; "Optimum Care for Hopelessly Ill Patients. A Report of the Critical Care Committee of the Massachusetts General Hospital", *New England Journal of Medicine* 295 (August 12, 1976) at 362; Jery B. Wilson, *Death By Decision: The Medical, Moral, and Legal Dimensions of Euthanasia* (Philadephia: The Westminster Press, 1975); S.C. Stein *et al.*, "Selection for Early Treatment in Myelomeningocele: A Retrospective Analysis of Various Selection Procedures", *Pediatrics* 54:5 (November 1974) at 553; A. R. Jonsen, *et al.*, "Critical Issues in Newborn Intensive Care: A Conference Report and Policy Proposal", *Pediatrics*, 55:6 (June, 1975) at 756; K. Vaux, *Who Shall Live?* (Philadelphia, Fortress Press, 1970); R. H. Williams, *To Live and To Die: When, Why and How*, (New York: Springer, 1973); R. S. Duff and A. G. M. Campbell, "Moral and Ethical Dimensions in the Special Care Nursery", (1973) *New England Journal of Medicine* 289 at 890; J. Lorber, "Criteria of Selection of Patients for Treatment", *Fourth International Conference on Birth Defects*, (Vienna, 1973); G. K. Smith and E. D. Smith, "Selection for Treatment in Spina Bifida Cystica", (1973) *British Medical Journal* 4, at 189; David J. Roy, *Medical Wisdom and Ethics in the Treatment of Severely Defective Newborn and Young Children* (Montreal: Eden Press, 1978); H. T. Englehardt, Jr., "Euthanasia and Children: The Injury of Continued Existence", (1973) *Journal of Pediatrics* 83, at 170; T. J. O'Donnell, "The Morality of Triage", *Georgetown Medical Bulletin* 14 (August, 1960) at 68; W. P. Williams, "Should the Patient be Kept Alive?" *Medical Economics* 44 (January 9, 1967) at 60.

3. Or at least where these are not of decisive importance. To a certain degree, no medical facility is free of such pressures, since neither human nor material resources are unlimited.

4. *Cf.* Bracton, cited in G. Williams, *The Sanctity of Life and the Criminal Law* (1957) at 20 f.; Blackstone talks of the "shape of mankind" and Luther, in his *Table Talks*, refers to "monsters".

5. For a good bibliography on the subject, see *A Selected and Partially Annotated Bibliography of Society, Ethics and the Life Sciences*, compiled by S. Sollitto and R. M. Veatch, revised by I. D. Singer (Hastings-on-Hudson, New York: The Hastings Centre, 1978).

on their part to hasten its demise? Or, finally, may they directly procure its death or engage in such overt measures as are known to lead to or to accelerate its death?

This series of questions may be approached from two distinct theoretical points of view: the legal, and the moral. Is there a legal obligation in such cases? Is there a moral one?[6] The discussion that follows will consider both of these issues; that is to say, it will address both the question of what the legalities of the matter are and the question of what they ought to be. There is no explicit Canadian case law on the subject. Consequently the discussion will concern itself mainly with statutory considerations. More specifically, it will argue that current statutes touching the subject are unworkable, that they incorporate a crucial ambiguity centering around the use of "human being" and "person", and that nothing short of a fundamental redrafting of the relevant sections of the Criminal Code will resolve the issue. It will also be argued that even aside from this, the Code fails to reflect both popular and medical ethical opinion, and that therefore any redrafting should be such as to bring it into step with current understanding of the ethics of the matter. This, so it will be suggested, can only be effected by a statutory acceptance of the distinction between human being and person respectively, and by a provision for the mandatory euthanatizing of radically defective neonates in certain cases.

Euthanasia of radically defective neonates is a matter of medical reality in other countries.[7] There is no reason to suppose that Canada is a medical enclave in this matter, differing from all the rest. In fact, as we shall see in a moment, quite the reverse is the case. Nevertheless, as was mentioned above, there is an essential

6. I shall ignore the pragmatic imperatives except insofar as they impinge on the ethics and legalities at stake.

7. *Cf.* John A. Robertson, "Involuntary Euthanasia of Defective Newborns: A Legal Analysis," (1975), 27 *Stanford Law Review* 213, at 214; R. S. Duff and A. G. M. Campbell, "Moral and Ethical Dilemnas in the Special-Care Nursery", (1973), *New England Journal of Medicine* 289, at 890, where 43 cases over a 2½ year period are discussed; and, "On Deciding the Care of Severely Handicapped or Dying Persons: With Particular Reference to Infants", *Pediatrics* 57 (April, 1976) at 487; John Lorber, "Selective Treatment of Myelomeningocele: To Treat or Not to Treat", *Pediatrics* 53 (March 1974) at 307; Michael J. Garland, "Care of the Newborn: The Decision Not to Treat" *Perinatology/Neonatology* 1 (September/October, 1977) at 14; W. L. Langer, "Infanticide: A Historical Survey" *History of Childhood Quarterly* 1 (Winter 1974), at 353; A. R. Jonsen, R. H. Phibbs, W. W. Tooley, M. J. Garlan, "Critical Issues in New born Intensive Care: A Conference Report and Policy Proposal", *Pediatrics,* 55:6 (June, 1975) 756, at 761, etc.

lack of Canadian case law on the subject. Therefore it can only be surmised that this lack is a function of the exercise of judicial discretionary power, not of the absence of medical actions.

If the analysis that follows is correct, then this judicial situation is in part a result of the terminological ambiguity indicated, in part a result of the judiciary's attempt to compensate for the failure of the relevant statutes to reflect current ethical standards. The revisions suggested in the course of the analysis, therefore, will not only have the advantage of removing statutory unclarity, but also of allowing the law to approach more closely its ideal of reflecting the ethical standards of society.

II. *The Medical Context*

The sort of situation that typically falls under the present rubric may be exemplified by the following case: A male infant, B, was born alive but suffering from severe physiological abnormalities, rudimentary development of the cerebrum, and esophageal atresia. Both the abnormalities and the atresia required corrective surgery and/or treatment. Without correction of the atresia, infant B would have died of dehydration and/or starvation, the former probably occurring first; but even with such surgery the prognosis was that infant B would not survive beyond his first year because the other abnormalities and defects, considered *in toto,* were simply too great.[8]

In this sort of case, it is common medical practice not to intervene surgically or otherwise, to refrain from intravenous feeding and similar supportive measures, and simply to leave the infant alone to die.[9] That course of action was followed in the present case. The infant died of dehydration and starvation after 17 days. After an intensive investigation, no charges were laid. The reasoning offered in support of this involved several parameters:[10] *First,* it was argued that since the prognosis for the infant was negative even with

8. The defects included severe hydrocephalus with increased intracranial pressure and herniation of the cerebellar tonsils; polymicrogyri; severe dysraphism with deformities of the base of the orbit and nasal structure; multiple limb defects due to amniotic band syndrome.

9. For a notorious instance of this but without the fatal prognosis if the atresia had been removed, see the 1971 Johns Hopkins case, discussed in J. M. Gustafson, "Mongolism, Parental Desire, and the Right to Life", (1973), 16 *Perspectives in Biology and Medicine* 529.

10. The following is based on an interview with the responsible judicial authorities.

surgical intervention, to enter upon a process of corrective surgery or even life-sustaining action would merely have had the effect of prolonging if not of increasing the terminal suffering of the neonate. *Second,* it was suggested that the severity and extent of the infant's incapacitation was so great that even if he had lived he would have been a continuous burden to his family, and would have constituted a drain on the medical resources of society as a whole, syphoning off already scarce medical resources that could have been employed more usefully elsewhere. *Third,* it was maintained that a duty to intervene in any capacity, and *a fortiori* in a medical one, can exist only where there is a possibility of success. In this situation, however, the very nature of the case ruled out any possibility of saving the infant's life. Therefore no duty of medical intervention obtained. *Fourth,* it was said that non-interference — the abstaining from the use of extra-ordinary or heroic measures — was justified not only in itself, since such measures are never obligatory, but also did not constitute an *act* and therefore could not be adjudged culpable. *Fifth,* it was contended that in virtue of the nature and extent of the infant's cerebral incapacitation he was not in fact a person and that therefore, all things being considered, there was no duty to attempt to save and/or sustain him in any case.[11]

Approaching the above from a moral standpoint, the reasoning involved could be challenged on several accounts. Vis-à-vis the *first,* it could be argued that there is an absolute moral duty to preserve human life,[12] that this duty supersedes any consideration of comfort or even of expected outcome for the recipient of the relevant action,[13] and that in any case no human prognosis is certain. Unexpected, not to say miraculous turns of events have occurred, and in light of the absolute duty to preserve human life

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11. A version of this was proposed in Jonsen, *et al.,* at 758. For a contrary position, see John A. Robertson, *Supra* at 216.

12. *Cf.* A. Schweitzer, *Kultur and Ethik* (München: Beck) 1960, esp., chap. XVIII; W.M. Abbott, "Sacredness of Life", (1963), 108 *America* 326, and "The Sanctity of Life", (1959), 101 *America* 667; G. Boas, "The Sanctity of Life", *Maryland State Medical Journal* 2:3 (March, 1953) 128; Karl Barth, *Church Dogmatics* (Edinburgh, 1961) III/4 426 f.

13. This argument could find its basis in Kant's position that "humanity and . . . every rational creature [is] an end in itself". *Foundations of the Metaphysics of Morals* transl. L. W. Beck (New York: Bobbs Merrill, 1959) 49. See also J. V. Sullivan, *The Morality of Mercy Killing* (Newman Press, 1950), 73 *et pass.;* G. Boas, *Supra;* W. M. Abbott, *Supra;* Karl Barth, *Supra* at 161; Edward Shils, "The Sanctity of Life" in D. H. Labby, ed., *Life or Death: Ethics and Options* (University of Washington Press, 1968) 29.

every effort must be made to allow them to take place.[14]

To the *second* consideration it may be responded that it involves a utilitarian train of reasoning whose acceptance would mark the beginning of a slide down a slippery slope: from the killing or allowing to die[15] of radically defective neonates to the euthanatizing of those who, on the strictly utilitarian calculus, constitute an unacceptable (disproportionately large) drain on social facilities and resources.[16] Furthermore, echoing John Stuart Mill's distinction between the qualitative and the quantitative parameters of utility, it could be pointed out that utilitarian considerations like the preceding would be unacceptably restrictive since they would ignore the qualitative parameter. More specifically, they would ignore the benefits that, were the other course of action adopted, would accrue to the moral side of man. For, "it must never be forgotten that among the capacities and values to be realized, the most important are the moral potentialities and values, and these include the virtues of compassion and devotion to the welfare of others. Consequently those who devote themselves to the care of [these individuals] may by so doing be realizing in themselves greater values than they would if they applied these [resources] to more selfish pursuits".[17]

The *third* consideration may be countered by the suggestion that it radically misconstrues the nature of the physician's obligation. It is not, as this consideration would have it, to effect a cure. If it were, every death, every failure to effect any cure whatever, would constitute a failure to fulfil a duty — and that is absurd. Instead, as one physician recently put it, "it is the doctor's duty to sustain [the patient's life] as long as possible;"[18] and as Muir, J. commented, "A patient is placed, or places himself, into the care of a physician

14. It should be noted that this argument does not consider the degree of likelihood of the cure (or revision) as a relevant parameter. *Cf.* Richard Trubo, *An Act of Mercy* (Nash, 1973) 59.

15. See Yale Kamisar "Some Non-religious Reasons Against Proposed Mercy-Killing Legislation", (1958), 42 *Minnesota Law Review* 969.

16. *Cf.* R. H. Williams, *Supra,* at 88; Joseph Fletcher, "Technological Decisions in Medical Care" In K. Vaux, ed. *Who Shall Live? Medicine, Technology, Ethics* (Philadephia, 1970) 130; R. B. Reeves, "When is it Time to Die? Prologue to Voluntary Euthanasia", (1973), 8 N.E.L.R. 183, at 190; Eliot Slater, "Health Service or Sickness Service" in S. Gorovitz *et al., Moral Problems in Medicine* (Englewood Cliffs: Prentice Hall 1976) at 354.

17. Errol E. Harris, "Respect for Persons," in Richard T. de George, ed., *Ethics and Society* (Garden City, New York 1966) at 128.

18. K.A. Karnofsky, "Why Prolong the Life of a Patient with Advanced Cancer?" (1960), 101 *C.A. Bulletin of Cancer Progress* 9.

with the expectation that he (the physician) will do everything in his power, everything that is known to modern medicine, to protect the patient's life".[19] In other words, the reply to this consideration could focus on the distinction between an act-oriented and an outcome-oriented appraisal of professions, and could argue that medicine belongs to the former sort, and could then maintain that therefore the failure or inability to provide a cure or save a life does not abrogate its act-oriented obligation: to continue to intervene as long as possible.[20]

The *fourth* reason could be countered in various ways: e.g. by pointing to the inherent ambiguity of the ordinary-extraordinary (normal-heroic) distinction,[21] or by arguing that in theory as well as in practice, the failure to act may itself be tantamount to an act and that therefore the failure to intervene cannot be adjudged non-culpable simply because it does not involve any action.[22]

Nor is the *fifth* reason immune for critique. It could be challenged by denying the alleged distinction between "human being" and "person";[23] or by admitting it but questioning its moral relevance;[24] or simply by challenging anyone who advances this

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19. Muir, J., quoted in Hilda Regier, "Judge Rules for Respirator Use and Traditional Medical Standards", *Journal of Legal Medicine* (November/December 1975) 10.

20. *Cf. Johnston* v. *Wellesley Hospital* [1971] 2 O.R. 103, at 111; Addy, J.: "A Physician gives no guarantee of success", but guarantees the performance of a certain kind of action. See also *Town* v. *Archer* (1902), 4 O.L.R. 383, at 388, where it is stated that success may be looked for only on the basis of express prior agreement. R.E. Cooke, "Whose Suffering?" in Gorovitz, *et al.* at 357.

21. *Cf.* Robert M. Veatch, *Death, Dying and the Biological Revolution* (New Haven: Yale University Press 1976) at 105-115; Paul Ramsey, *The Patient as Person* (New Haven: Yale University Press 1970) at 120 f. *et pass.*; John A. Robertson, "Involuntary Euthanasia", at 235.

22. *Cf.* Otto Kirchheimer, "Criminal Ommissions" (1942), 55 H.L.R. 615 at 618 f., 623; T.P. Barbetta *et al.*, "Euthanasia: A Survey of Medical Decisions" *University of Toronto Medical Journal*, 44: 4 (February 1976), pp. 66-69 at p. 69; Joseph Fletcher, *Euthanasia and the Right to Die*, at 68; P.J. Fitzgerald, "Acting and Refraining" *Analysis* 27: 4 (1973) at 133. But see R.M. Sade and A.B. Redfern, "Euthanasia" *New England Journal of Medicine* 292: 16 (April 17, 1975) at 864. See also below.

23. This seems to occur in *Maine Medical Center* v. *Houle*, NO. 74-145, at 4 (Super. Ct., Cumberland Cty, February 14, 1974). See also S. Bok, "Ethical Problems in Abortion", *Hastings Center Studies* January 1974 33, at 41; D. Bonhoeffer, *Ethik*, ed. by E. Bethge (Munich, 1976) at 110; H. Thielicke, "The Doctor", at 162 f. etc. But see E.-H.W. Kluge, *The Practice of Death* (New Haven: Yale University Press 1975) at 93-95 and "Infanticide as the Murder of Persons" in M. Kohl, ed. *Infanticide and the Value of Life*

24. Kluge, *Supra*

form of reasoning to come up with definitions that are acceptable to all concerned.[25]

III. *Section 197 of the Code*

But whatever the outcome of these moral considerations, the statutory facts of the matter are as follows: Section 197 of the Code, in its relevant parts, states

> 197 (1) Every one is under a legal duty
> (c) to provide the necessaries of life to a person under his charge if that person
> (i) is unable, by reason of detention, age, illness, insanity or other causes, to withdraw himself from that charge, and
> (ii) is unable to provide himself with the necessaries of life.
>
> (2) Every one commits an offense who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse, the proof of which is upon him, to perform that duty, if
> (b) with respect to a duty imposed by paragraph (1) (c), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.

By this section, the failure to fulfil one's duty of providing the necessaries of life for the person under one's charge is an offense if the circumstances are as specified. Consequently, since food and drink are necessaries of life,[26] the failure in the present instance to provide them, in full knowledge of the consequences of such a failure, constitutes a *prima facie* dereliction of duty within the meaning of this section.

Once again, there are several ways in which one might try to invalidate such an inference: by arguing that the infant was not under the charge of the physician; by claiming that food and drink, in the sense in which they would have had to be supplied in the present instance, do not fall within the statutory meaning of

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25. *Cf.* John A. Robertson, *supra,* pp. 246 ff.

26. This is not only obvious in itself, but also follows from Walkem, J.'s statement in *R.* v. *Brooks*, 9 Brit. Col. L.R. 13 at 18 that "necessaries of life" mean "such necessaries as tend to preserve life, and not necessaries in their ordinary legal sense." It is interesting to note that oxygen and other chemical elements necessary for human metabolic processes are hereby also included. See also *R.* v. *Lewis* (1903), 6 O.L.R. 132, 2 O.W.R. 566, 7 C. C.C. 261 (C.A.)

"necessaries of life"; by arguing that the failure to intervene medically was not likely to impair the health of the infant permanently nor that it in fact did so, but that such impairment was due to other causes; or, finally, by contending that infant *B* was not a person and therefore was not entitled to the protection of this section. Let us consider these seriatim.

(a) *Duty of Care*

The claim that the infant was not under the charge of the physician could be supported by the contention that it is the parents that constitute the proper authority, and that therefore the onus of care falls upon them. It could also be maintained that even if the duty of care had lain with the physician or the hospital, *Barnett* v. *Chelsea and Kensington Hospital Management Committee*[27] clearly shows that both would have been absolved from any onus by the fact that the cause of the infant's debility was irremediable and that he would have died anyway.

This reasoning, however, is negated by the following considerations: the attending physician, in accepting the task of delivering the infant, also accepted the infant as being under his care[28], and could not consequently rid himself of that onus simply because the nature of the infant was different from what he had expected and the execution of his task of care had become more difficult. The means for discharging his duty of care were available to him: he could have performed the operation or initiated intravenous feeding. He chose not to do so. Consequently *Regina* v. *Instan,*[29] although not directly on the case, nevertheless indicates the line that must here be followed. In taking upon himself the "moral obligation" of delivering and caring for the infant, the physician incurred a "clear duty at common law to supply [food and drink] to the deceased".[30] As to the case of *Barnett* v. *Chelsea and Kensington Hospital,* it must be distinguished from the one at hand. There, death would have occurred from causes other than the lack of medical attention even if that attention had been forthcoming;[31] here, death would not have occurred because of dehydration and starvation if care had

27. *Barnett* v. *Chelsea and Kensington Hospital Management Committee* (1969) 1 Q.B. 428, at 435.
28. *Cf. Ybarra* v. *Spangard,* (1944), 25 Cal. (2d) 486, 154 P.2d 687; John A. Robertson *supra* at 225 ff. See also O. Holmes, *The Common Law* (1881) at 278.
29. *R.* v. *Instan* (1893), 17 Cox Crim. Cas. 602
30. *Id.*, at 604.
31. See note 27 *supra*

been extended. It would (probably) have occurred within a year from the multiple birth defects — but that is not the point at issue here and now. Therefore, to follow *Barnett* in this particular instance would constitute an unwarranted extension that would license the abandonment of all those who, with reasonable certitude, are known to die within the year.

(b) *Necessaries of Life*

In the common law, both food and drink are adjudged necessaries of life.[32] However — so it might be argued — neither surgical procedures nor intravenous feeding fall under this rubric.[33] Consequently, so one might continue, even if infant B was under the charge of the attending physician, the latter's failure to employ these measures was not an offense under the meaning of this section.

The claim that intervenous feeding and surgical intervention *per se* are not necessaries of life may certainly be admitted. However, to argue on that basis that therefore the failure to employ either measure did not fall under the meaning of this section is to misconstrue the issue. It is not these means that are taken to be the necessaries in question but the food and drink deliverable by means of them. Food and drink are necessaries of life, and the means for delivering them were available to the physician. In fact, it was this very availability that created the decision-problem in the first place. Therefore, there did occur a deliberate failure to use the available means to supply the necessaries of life, and consequently the applicability of section 197 (2) remains.

(c) *Causation*

In ordinary life as well as before the law, the fact that two successive states are causally unrelated suffices to exonerate the agent of the first from any gravamen attaching to the second.[34] Therefore in cases like that of infant B it is sound strategy to attempt

32. See note 26 *supra*. See also *R.* v. *Senior* (1899), 1 Q.B. 283

33. This line of reasoning would be supported by the claim that such measures would constitute extraordinary means and therefore are not obligatory.

34. It should be noted that this differs from the notion of indirect causality which will be discussed below. On the topic of responsibility *cf.* H. L. A. Hart, *Punishment and Responsibility* (Oxford: The Clarendon Press 1968). For a somewhat wider-ranging philosophical discussion of various factors associated with the notion of responsibility see Richard B. Brandt, *Ethical Theory* (Englewood Cliffs: Prentice Hall 1959) Chap. 18.

to evade the onus of responsibility by maintaining that the death of the infant was causally independent of any failure to intervene: that it was due to the neonate's physiological defects which, when nature was allowed to run its course unaided, predictably took their toll.

However successful such a defense may be in other cases, it is not clear that in the present instance it is cogent. Abstracting from the question of whether the infant died from his multiple defects or other causes — the issue was already touched upon in (a) above — the defense itself consists of two strands: one, that the failure to act was not itself a causal determinant of the ultimate outcome, and that therefore it ought not to be subject to the same evaluation; the other, that even if this failure to intervene was a causal determinant, it was so only indirectly, and that it was the whole spectrum of birth defects and their natural consequences that really and directly brought about the death.

Both strands of reasoning have been advanced in recent discussions; but both are untenable.[35] Vis-à-vis the first, the following considerations should make this clear. The sequences of events that constitute the history of the world may properly be described as consisting of series of causal chains that impinge upon and causally effect one another.[36] Each point in time, therefore, can

35. For a discussion of the status of a failure to act, see Kirchheimer, *supra,* who espouses a position somewhat analogous to that of St. Thomas Aquinas, *Summa Theologica* II:II:79:3. See also J. R. Connery, "The Moral Dilemna of the Quinlan Case" *Hospital Progress* 56 (16): 18 (December 1975) at 18 f. The notion of failure to act not having the status of an act is fundamental to the active-passive euthanasia distinction. On the latter see Marya Mannes, *Last Rights* (New York, 1974) at 31, who characterizes it as "conveniently tenuous"; W. H. Baugham *et al.,* "Euthanasia: Criminal Tort, Constitutional and Legislative Considerations", (1973) N.D.L. 48 1202, at 1207; Sade and Redfern, *loc. cit.;* Veatch, *supra,* chap. 3; Paul Ramsey, *The Patient as Person* (New Haven: Yale University Press 1970) chap. 3 at 151, "In omission no human agent causes the patient's death, directly or indirectly". But see J. Fletcher, "The Patient's Right to Die" — Downing *supra,* at 68; Kluge, *supra,* at 156 n. 20. On the notion of indirect euthanasia, see Daniel C. Maguire, *Death by Choice* (Garden City: Double Day 1974) at 120 ff.; Veatch, *supra,* at 101 ff.; Jonathan Bennett, "Whatever the Consequences" *Analysis* 26 (1966) at 83. In this context, the whole issue of the status of the doctrine of the double effect is also relevant. For a brief critical discussion of the latter, see Foot, *Supra;* E.-H. W. Kluge, "The Allocation of Scarce Medical Resources in Crisis Contexts and the Principle of Double Effect", in *Proceedings of the Thirteenth Conference on Value Inquiry* (Geneseo, 1979) at 94 and *The Practice* at 62-4; J. T. Mangan, S. J. "An Historical Analysis of the Principle of Dougle Effect: *Theological Studies* 10 (1949) at 40.

36. *Cf.* Richard A. Trammel "The Presumption against Taking Life", *Journal of Medicine and Philosophy* 3: 1 (1978) at 64 f, esp. 65.

be represented as a situation involving several possible outcomes, where which one of these possibilities is actualized is a function of the nature of the preceding casual series, the structure of the extant situation, and the nature of the casual impetus operative at that point in time. Such a description, however, would be a description of the physical events only. It would be deontologically completely neutral. A description involving moral and legal responsibility, however, must incorporate an analysis of the physical events in terms of *acts:* in terms of the deliberate determination of the flow of events by a moral agent to one of the several alternatives open at that point in the causal chain. Such a determination, in turn, may occur in one of two ways: by means of an interference by the agent in the established causal sequence, or by means of non-interference and thereby an allowing or making sure that the established sequence will proceed to its expected denoument.

The notion of an act, therefore, is neutral with respect to the question of whether or not any physical activity, any intervention in the established sequence of causal events, took place. The only important factor is, whether or not the putative agent was in a position to determine the eventual outcome. Whether this determination took place through causal interference or by non-interference and thus ensuring (allowing) the continuation of the extant causal sequence is irrelevant. It is this understanding of the matter that underlies Otto Kirchheimer's statement that

> A man who caused another to be drowned by refusing to hold out his hand would in common language be said to have killed him . . . . We ask . . . whether the drowning could have been prevented if the expected action had taken place. When we answer this question in the affirmative, we confirm the relevance of the omission as a cause. Under this hypothesis, there is no difference between the causality of omission and of positive action, and the same rules, or absence of rules, which govern commission apply to omission.[37]

The preceding analysis shows why both in theory and in practice, the failure to intervene may itself be considered an act, and why the same evaluation is appropriate even though no physical activity took place.[38] The relevance of this for the case at hand is clear. The physician's failure to intervene, whether surgically or through intravenous feeding, eventuated, as it was known it would, in the

37. Kirchheimer, *supra,* at 618 f

38. See also Trammel, *loc. cit. Regina* v. *Instan* would seem to confirm this.

infant's death. Therefore the failure to intervene, even though not a physical activity, nevertheless was a causal determinant of the death. And what is more, the decision not to intervene was adopted precisely because it was known beforehand that if this course was followed, death would ensue. Therefore it was a deliberate determination of the death. Whence it follows that the absence of causal activity cannot be adduced as a relevant parameter, and to adapt the words of Otto Kirchheimer, "the same rules, or absence of rules, which govern commission apply to [this] omission".

Nor can this conclusion be avoided by taking into account the second strand of the argument: the claim that the infant directly died of the natural consequences of his multiple defects and that the omissive causal determination was merely indirect. For in the first instance, section 205(1) states clearly

> 205(1) A person commits homicide when, *directly or indirectly, by any means,* he causes the death of a human being. [emphasis added][39]

For statutory purposes, therefore, the physician's plea of the indirect nature of his involvement cannot free him from susceptibility to the charge of homicide. Nor, in the second instance, can the complexity of the causal context be adduced as an exculpating moment. For, so it must be replied, few causal situations are simple. Usually, several causal elements interact to produce a given effect. However, no matter how complex the causal situation, the following rule holds true: *if* it is known or reasonably foreseeable that a given causal determination with respect to one of the causal elements will result in a certain outcome when the other causal elements are present, and *if* these other causal elements are known to be present, *then,* all other things being equal,[40] the individual responsible for the particular determination of that causal element will incur the onus for the final outcome.[41]

In the present instance, all of these conditions are met. The complex of causal parameters in the form of physiological defects was known, the result of the failure to intervene in the case of the atresia was also known, and the possibility of determining the causal nexus otherwise, by interfering, did exist. Therefore the responsibility for the ultimate outcome must be ascribed to the

39. *Martin's Annual Criminal Code* (1976).
40. *I.e.,* there being no other determining agents — in which case the responsibility would be shared.
41. If he could have determined it otherwise.

determining agent in question, the complexity of the causal situation notwithstanding. That is to say, it must be ascribed to the physician and the attending medical personnel.

For statutory purposes, therefore, neither the physician's plea of the causal complexity of the situation nor of the indirect nature of his involvement can free him from incurring a charge of homicide.

(d) *Culpable Homicide*

However, the following consideration obtrudes itself. It might be argued that since Section 205 distinguishes between culpable and non-culpable homicide, i.e.,

> 205(5) A person commits culpable homicide when he causes the death of a human being,
> (a) by means of an unlawful act,
> (b) by criminal negligence

there are two ways in which it is possible to exculpate the responsible physician even if the preceding analysis were to be accepted: by showing that the act in question[42] was not in fact one of homicide, or by showing that even though it was one of homicide it was not culpable.

To establish the first as an exculpating moment in the present instance requires that it be shown that infant *B* was not a human being. That move, however, is clearly blocked; for, section 206 states

> 206(1) A child becomes a human being within the meaning of this Act when it has completely proceeded, in a living state, from the body of its mother whether or not
> (a) it has breathed,
> (b) it has an independent circulation, or
> (c) the navel string is severed.

Undeniably, this section is out of date. For instance, it would be inapplicable to genetically, morphologically and psychologically human beings who were gestated in an artificial placenta[43] or in the intestinal cavity of a non-female person.[44] It would also not apply to

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42. For the act-omission distinction, see *supra*.
43. See G. Chamberlain, "An Artificial Placenta", *American Journal of Obstetrics and Gynecology*, 100 (March 1968) at 615. Paul Ramsey, *Fabricated Man* (New Haven: Yale University Press 1970) at 107.
44. At the present time this remains a theoretical possibility, but given techniques of *in vitro* fertilization and artificial plancenta (see note 43 *supra*), it must be taken into account.

fetuses in the third trimester as long as they were not born, even though they were fully developed;[45] etc. These shortcomings, however, are irrelevant to the point at issue: There is no question but that infant *B* was a human being within the meaning of the term as defined by this section. The charge of culpable homicide, therefore, is not avoidable by reason of the non-humanity of the infant.

That leaves the second alternative. Although an act of homicide had been committed, it was excusable by the fact that it fell neither under clause (a) nor clause (b) of section 205(5). This could be argued in the following way: Clause (a) does not apply on the facts alone. Nothing was *done* in any relevant sense. As to clause (b), here section 202 is relevant.

> 202(1) 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.
> (2) For the purposes of this section, "duty" means a duty imposed by law.

Section 197, of course, also applies. However — so the reasoning could continue — both these sections deal with *persons,* not human beings. Therefore, unless the locutions "human being" and "person" are to be construed as synonymous, neither section can apply to the present case. Infant *B*, although unquestionably a human being, was not a person. Consequently clause (b) does not apply either; wherefore the homicide in question was not culpable.

These last remarks really go to the heart of the present issue. They focus on the lack of adequate statutory guidelines for interpreting the locution "human being" vis-à-vis that of "person", highlight the consequent ambiguity of the interconnection between the two locutions, and show up the resultant failure of sections, that *prima facie* are intended to be complementary, actually to mesh. For the alternatives are clear: either the two terms are synonymous, and then a charge of culpable homicide would appear justified even though this might conflict with common ethical sentiment, prosecutorial discretion and medical practice; or

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45. One of the ironic consequences of this would be that whereas suit could be brought on part of an infant for damage sustained *in utero,* and in that sense for purposes of the action the infant must have had the status of a person at the time of the intra-uterin damage (*cf. Montreal Tramways Co.* v. *Léveillé,* [1973] S.C.R. 456), that status disappears for purposes of actions under section 206. For a discussion of problems associated with this, see E.-H.W. Kluge, "The Right to Life of Potential Persons", (1977), 3 *Dalhousie Law Journal* 837.

they are not synonymous, and then the statutes dealing with the necessaries of life apply only to persons whereas those dealing with homicide apply to human beings, wherefore there exists a serious incompleteness and disjunction in the law.

IV. *"Human being" and "Person"*

Are "human being" and "person" to be construed as synonymous? The import of this question extends far beyond the limits of the present issue. However, confining the discussion within the context of what has gone before there appear to be at least two reasons why their synonymity must be rejected. *First,* any such synonymity would entail a problem of internal consistency for the Code as a whole. That is to say, it is a rule of logic that any two terms that are synonymous may be substituted for one another in extensional contexts *salva veritate.*[46] In the present instance, however, this is not possible. The Code considers corporations, societies and the like to be persons,[47] but it would clearly be the height of absurdity to declare them human beings on that basis and to accuse of homicide anyone who brought about the unlawful termination of their existence.

A *second,* as it were, external reason why their synonymity cannot be accepted lies in the nature of the terms themselves. Whatever its history, the term "human being" currently has an essentially biological import and denotes membership in the species *homo sapiens.* As such, it is associated with certain more or less delimited and more or less arbitrary criteria for membership in that species. In that sense, the term is normative in nature; and as our biological sophistication grows, the limits of the concept as well as its criteria of application are adjusted accordingly. So, for example, the term's initial historical focus on the presence of certain overt physical characteristics has been successively modified[48] until today it centres around the presence of a specific genetic code irrespective of whether or not that code is fully expressed.[49]

46. *Cf.* Leibniz. "Non inelegans specimen demonstrandi in abstractis" *Oper. Philos.* ed. J. E. Erdman I at 94; Gottlob Frege, *Grundlagen der Arithmetik* (Breslau: Koebner 1884) at 65. Arthur Pap, *Semantics and Necessary Truth* (New Haven: Yale University Press 1958) at 277 ff.

47. *Cf.* section 2

48. For a discussion of some aspects of this, see Daniel Callahan, *Abortion: Law, Choice and Morality* (New York: Macmillan 1972) chapter 10, esp. at 356-64; Kluge, *The Practice* at 88 f.

49. For a discussion of this, see Callahan, *supra,* esp. at 360 ff.

However, precisely because the term has essentially biological import, its normative parameters are without deontological significance. Any such significance that may be associated with it is an extraneous and accidental accretion resulting from the close connection between the truth-conditions of the use of the term and those of the term "person". For, apart from purely legal contexts, the only persons with whom we are familiar in ordinary life are also members of the species *homo sapiens,* and by far the largest proportion of human beings that we encounter are also persons. Therefore it is easy to conflate the two: to move from talk about the one to talk about the other and vice versa, without realizing that a slide has occurred.

Nevertheless, such a move is conceptually illegitimate, its facility notwithstanding. For, in contradistinction to the term "human being", "person" *is* deontologically normative. It too is a category term, but one that delimits its domain of application not on the basis of biological characteristics but on the basis of deontologically significant attributes such as obligations, volitions, choice or right. To be sure, what falls within the domain of persons thus delimited will also have certain publicly observable physical characteristics; and in light of what was said above, it is not surprising that by and large these parallel or complement those of "human being". However, the core meaning of the term lies elsewhere, and is not subject to the vagaries of biological sophistication. Instead, it resides in the concept of a being with conscious awareness: of a morally responsible agent.[50]

The two locutions, therefore, are logically and conceptually distinct. Whence it follows that the second of the two alternative conclusions indicated above in fact obtains. That, however, is an unsatisfactory state of affairs. In effect, it requires that prosecutorial discretion determine the interrelationship between the two most fundamental locutions of this part of the Code on the basis of the facts as they are apprehended, rather than the classification of the facts being determined on the basis of the meanings of the terms in question. Consequently, prosecutorial discretion is exercised on the basis of what amounts to an *a priori* judgment of the case. This

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50. *Cf.* Karl Rahner, "Gedanken über das Sterben" *Arzt u. Christ* 15 (196) at 25 f; Trubo, *supra* at 152; Joseph Fletcher, "Ethics and Euthanasia" in R. H. Williams, *To Live*, at 115; J. M. Gustafson, "Mongolism" at 544; H. Thielicke, "The Doctor", at 162 (although Thielicke seems to be ambivalent); H. T. Engelhardt, Jr., "On the Bounds of Freedom" *Conn. Med.* 40:1 (January 1976) at 51.

situation entails a complete reversal of the proper order of things, and thereby runs the danger of judiciary inconsistency and politically motivated prejudgment.

What follows is a proposal to rectify this situation by means of a revision of the Code itself. The focus of this revision will be the fundamental difference between the two locutions noted above. Among other things, that difference allows for the possibility that something may be a human being without being a person.[51] Once this is incorporated into the statutes, it allows them to reflect the current distinction between biological life on the one hand and personal life on the other,[52] which, in turn, makes it possible to express as a matter of statute what currently, as in the case of infant *B*, is a matter of *ad hoc* discretion, and moreover makes it possible to deal with situations like this in a manner consistent with the current moral ethos and with actual medical practice. It also has the not inconsiderable advantage of being sufficiently general in scope as to allow for an extension to situations of euthanasia in general.

V. *The Harvard Criteria*

A fruitful way of approaching the task of revision is by considering the concept of death as adumbrated in the Report of the Ad Hoc Committee of the Harvard Medical School, entitled "A Definition of Irreversible Coma".[53] Reduced to its bare essentials, that Report recommends the adoption of the following criteria for the determination of death:

(1) unreceptivity and unresponsivity to noxious stimulation,
(2) apnea,
(3) absence of all cerebral reflexes, and
(4) isoelectric electroencephalogramme in the absence of central nervous system depressants and hypothermia, this being verified at least 24 hours after the initial determination.

51. *Cf.* Kluge, *The Practice* at 88-95. *Cf.* Karl Rahner, *supra* at 25 f.; D. Arnold, "Neomorts", *University of Toronto Medical Journal,* LIV:2 (January, 1977) at 37; Trubo, *supra* at 152, 166 *et pass.;* Joseph Fletcher, "Ethics" at 115, and "Technological Devices" at 126. But see Bonhoeffer, *supra* at 110; H. Thielicke, "The Doctor" at 162 ff.; Gustofson, *Supra* at 554; Robertson, *supra* at 247 f.

52. See *supra* note 51. See also Paul Ramsey, *The Patient,* chapter 2 *pass.;* H. T. Engelhardt, Jr., "On the Bounds of Freedom" at 51 ff.; Peter M. Black, "Brain Death" I & II, *New England Journal of Medicine* 299:7 (August 17, 1978) at 338 and 299:8 (August 24, 1978) at 393, which gives a very good discussion of recent developments from a medical point of view.

53. "A Definition of Irreversible Coma: Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death" *JAMA* 205:6 (August 5, 1968) at 85.

Although not explicitly stated as such, these criteria amount to a definition of death in terms of the complete cessation of all brain function, and in that sense have provided the impetus for a great deal of medico-legal[54] and philosophical debate.[55] They have even come to function as the basis of death-related legislation in various states of the United States,[56] and in a slightly modified version are fundamental to the 23rd Working Paper of the Law Reform Commission of Canada.[57]

For present purposes, the important point to notice in connection with the Harvard Criteria is that a patient who meets them may well be alive according to the traditional criteria that centre around the presence of a heart beat, respiration and the other vital functions.[58] Therefore it may happen that a given patient may be dead according to the Harvard Criteria while being alive from the traditional point of view.[59] The important thing about this, in turn, is that this is

54. For a bibliography on the subject, see E. Jaksetic, "Bioethics and the Law: A Bibliography", (1976) 2 *Am. J. Law and Medicine* 263; and Committee on Evolving Trends in Society Affecting Life, *Death and Dying: Determining and Defining Death — A compilation of Definitions, Selected Readings and Bibliography* (San Francisco California Medical Association 1975). See also "In the matter of Petition of Louis Mari," Commonwealth of Massachusetts, Plymouth Superior Court No. CA 77-5062, May 16, 1977; W. J. Curran, "The Brain-Death Concept: Judicial Acceptance in Massachusetts", (1978) *New England Journal of Medicine* 298 1008.

55. L. C. Becker, "Human Being: The Boundaries of the Concept", (1975) 4 *Philosophy and Public Affairs* 334; Hans Jonas, "Against the Stream" *Philosophical Essays: From Ancient Creed to Technological Man* (Englewood Cliffs: Prentice-Hall, 1974); Paul Ramsey, *The Patient,* Chap. 2; Robert Veatch, *supra* chaps. 1 and 2, Englehardt, *supra,* at 51 f.; Kluge, *The Practice, loc. cit. The Journal of Medicine and Philosophy* 3:1 (March 1978) is entirely devoted to the issue and the articles in it contain good bibliographies.

56. The Kansas statute KSA 77-202 (Suppl. 1974) was the first. Since then Maryland (1972), New Mexico (1973), Virginia (1973, Alaska (1974), California (1974) and Oregon (1975) have added similar statutes as have Michigan (1975), West Virginia (1975), Lousiana (1976) Iowa (1976), Montana (1977), Illinois (1975), Georgia (1975), Tennessee (1976), Idaho (1977). *Cf.* F. J. Veith, *et al.,* "Brain Death", *JAMA* 238 (1977) at 1651 and 1744 for summary and discussion of the legislation until 1977.

57. *Working Paper 23: Criteria for the Determination of Death,* Law Reform Commission of Canada (1979) (F. C. Muldoon, J. -L. Baudouin, G. V. La Forest, E. J. Houston).

58. However, it should be noted that clinical investigation has shown that patients who meet the Harvard Criteria will not survive as functioning biological organisms beyond three months, even given the best and most sophisticated medical support currently available. See Black, *supra,* at 338 ff, and A. W. Walker and G. F. Molinari, "Criteria of Cerebral Death". *Trans. Am. Neurol. Assoc.* 100 (1975) at 29.

59. The Kansas Statute is notorious for difficulties arising in this respect. For a

possible only because the Harvard Criteria are in fact based on the distinction between "human being" and "person" discussed above. In a sense, therefore, the above anomaly is merely a reflection of that fact. To be sure, neither the Committee itself nor later commentators have appreciated this, but there is evidence to show that in fact this is the case. So for example, the Committee itself said that "responsible medical opinion is ready to adopt new criteria for pronouncing death to have occurred in an individual sustaining irreversible coma as a result of permanent brain damage,"[60] and went on to explain that

> From ancient times down to the recent past it was clear that, when the respiration and heart stopped, the brain would die in a few minutes; so the obvious criterion of no heart beat as synonymous with death was sufficiently accurate . . . . This is no longer valid when modern resuscitative and supportive measures are used. These improved activities can now *restore "life" as judged by the ancient standards of persistent respiration and continous heart beat. This can be the case even when there is not the remotest possibility of an individual recovering consciousness following massive brain damage.*[61]

The passage as a whole, and particularly the italicized segment, makes sense if and only if the Committee intended to differentiate between a patient who is alive in a biological sense only, and one who is alive *qua* person; and if, further, the Committee was of the opinion that it was only the death of an individual *qua* person that was of consequence. On that understanding, it becomes apparent that the Committee in fact tacitly defined personhood in terms of the present capability of an individual for conscious awareness, and that it considered the permanent destruction or loss of that capability to be the destruction or loss of personhood itself: as the death of the individual *qua* person. Since it is the brain that functions as the physiological (neurological) basis of this capability, it is not

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discussion, see W. J. Curran, "Legal and Medical Death: Kansas Takes the First Step" *New England Journal of Medicine* 284 (1971) at 260; I. M. Kennedy, "The Kansas Statute on Death — An Appraisal" *New England Journal of Medicine* 285 (1971) at 946; D. H. Mills, "The Kansas Statute — Bold and Innovative", *New England Journal of Medicine* 285 (1971) at 968; R. M. Veatch, *supra* at 62; L. F. Taylor, "A Statutory Definition of Death in Kansas" *JAMA* 215 (1971) at 296; A.M. Capron and L. R. Kass, "A Statutory Definition of the Standards for Determining Human Death: An Appraisal and a Proposal", (1972) 121 *University of Pennsylvania Law Review* 87.

60. See *supra* note 53 at 87

61. *Id. loc. cit.*

surprising that therefore the Committee singled out its incapacitation beyond functional recovery as indicative of personal death.

To reiterate, therefore, the Harvard Criteria are definitive of the death of a person, not of that of a human being. However, understood in that way the notion of death involved amounts to nothing more nor less than that of the loss of personhood by an entity who previously was a person. Therefore the Criteria may also be seen as definitive of the loss of personhood. Loss of personhood, however, trivially involves the absence of personhood — and herewith the relevance of all this to the preceding discussion becomes apparent: if the brain damage (incapacitation) of a defective neonate is such as to fall under the provisions of the Harvard Criteria, and apnea obtains, then the neonate cannot be considered a person in the sense of those Criteria.

VI. *Difficulties and Alternatives*

This last proposal, however, is still insufficient: it still will not allow the attending physician to deal with radically defective neonates of the type of infant *B* in anything like the manner that current medico-ethical standards seem to sanction. That is to say, although the preceding is indeed a logical extension of the Criteria, it points to a fundamental shortcoming of the Criteria as they stand: they express the fundamental insight of the distinction between a person and a human being insufficiently clearly, and are still too much bound to the traditional conception of death.

A brief reflection on the facts will make this clear. As they stand, the Harvard Criteria will not allow individuals who are irretrievably brain damaged and irreversibly comatose with no capacity for higher brain activities whatever to be declared dead *qua* persons. The case of Karen Ann Quinlan and of Elaine Esposito illustrate this only too well.[62] These individuals still evince medullar reflexes and primitive, purely biological functions like that of independent respiration. That fact rules out any declaration of death on the basis of the Criteria. However, this itself makes it clear that in this respect the Criteria are reverting to the old conception of human (biological)

62. On the case of Karen Ann Quinlan, see *In the Matter of Karen Ann Quinlan: The Complete Legal Briefs, Court Proceedings and Decisions in the Superior Court of New Jersey* (Arlington, Va.: University Publications of America, 1975), and for a bibliography, *The Hastings Center Bibliography* at 25; on Elaine Esposito, see AP release of November 27, 1978 (Victoria Daily Times, November 27, 1978 at 21).

life as definitive of personal life, and thereby are blurring once again the distinction between human being and person that provided the impetus for the Criteria themselves.

The same point may be stated somewhat differently in terms of the whole brain — higher brain centres distinction. As they stand, the Criteria, insisting on the absence of all brain reflexes,[63] operate with a whole-brain conception of personhood:[64] personhood is grounded in the present functional capability of the whole brain. However, as several commentators have pointed out[65] and as was the underlying motivation for the formulation of the Criteria themselves,[66] what makes an individual a person is his present capability for conscious awareness and its attendant ramifications, such as moral decision capability, perceptual awareness and the like. These, however, are not functions of the brain as a whole. The lower brain centres have no part in them. It is only the higher centres of the brain, the cerebrum, that plays any role. The lower centres merely govern the organic functioning associated with the biological life of the body. Therefore by insisting that there must be no brain reflexes *at all,* the Criteria, which supposedly distinguish between personal and merely biological life, in fact present merely biological life as a sufficient condition for personal life, and by that fact contradict their own *raison d'être*.

This situation can, of course, be remedied quite easily: simply by bringing the Criteria themselves into line with their underlying motivation. Death, i.e., the death of a person, need merely be defined in terms of the permanent destruction or functional incapacitation of the higher brain centres. Furthermore, there are several ways in which such destruction or incapacitation can be established: by angiography,[67] by ultra-sound techniques,[68] by

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63. See clause (3) *supra*
64. On the notion of a whole-brain approach, see Capron and Cass, *supra,* at 104 ff.; Veatch, *supra* at 68 ff. and "The Whole-Brain Oriented Concept of Death: An Outmoded Philosophical Formulation", (1975) *Journal of Thanatology* 13.
65. *Cf.* Veatch, *supra* at 71. S. I. Benn, "Abortion, Infanticide and Respect for Persons" in J. Feinberg, ed., *The Problem of Abortion* (Belmont: Wadesworth 1973) at 92; Michael Tooley, "A Defense of Abortion and Infanticide", *Philosophy and Public Affairs* 2:1 (1972); Kluge, *The Practice* at 88 ff. and "Infanticide as the Murder of Persons" in M. Kohl, ed., *Infanticide and the Value of Life* (Prometheus Books 1978); Robertson, *supra* at 246 ff.
66. See *supra*
67. J. Korein *et al.*, "Radioisotopic Bolus Technique as a Test to Detect Circulatory Deficit Associated with Cerebral Death", (1975) 51 *Circulation* 924.
68. J. K. Campbell *et al.*, "Pulsatile Echoencephalography" *Acta Neurol Scand.:*

computer tomography,[69] by electroencephalography,[70] etc. But which ever of these is used — and ideally, several should in used in combination[71] — if there is found to be a permanent destruction or incapacitation of the higher brain centres which form the organic basis of the capability for conscious awareness, then the necessary condition for personal death will have been met, the continued presence of reflexes in or function of the lower centres notwithstanding. At the same time, this will also be a sufficient condition, since someone whose cerebrum has been rendered permanently disfunctional can never again attain conscious awareness.

This notion of present functional capability for conscious awareness, therefore, by itself allows for a formal definition of personal death that avoids the shortcomings of the Harvard Criteria. For, if we distinguish between a natural person on the one hand, and a constructive person (a legal fiction) on the other, then all of the preceding can be incorporated into the following definition:

D1: A natural person is dead if and only if his higher brain centres (cerebrum) no longer have the present functional capability for conscious awareness.

Three things should be noted about this definition. *First,* it expresses clearly the prevalent medical attitude towards the interrelationship between brain-function, conscious awareness and personal death, and captures the thrust of the motive underlying the Harvard Criteria themselves. *Second,* as opposed to some other recent proposals,[72] it does not tie the determination of the presence or absence of this functional capability to the use of sophisticated diagnostic machinery. Since the cerebrum deteriorates beyond functional recovery within 30 minutes of the cessation of

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45 (1970) at 1; S. Uematsu and A. E. Walker, "A Method for Recording the Pulsation of the Midline Echo in Clinical Brain Death", (1974) 135 *Johns Hopkins Medical Journal* 383

69. C. Radberg and S. Söderlundh, "Computer Tomography in Cerebral Death" *Acta Radiol* Suppl. 346 (1975) at 119

70. D. Silverman *et al.*, "Cerebral Death and the Electroencephalogram", (1969) 209 JAMA 1505; Silverman *et al.*, "Irreversible Coma Associated with Electrocerebral Silence", (1970) 20 *Neurology* 525; Robertson, *supra pass.*

71. Robertson, *supra* at 399 f

72. Techniques involving angiography, tomography, etc. (see notes 68-70, *supra)* suffer from this shortcoming. On the other hand, the proposal of the Law Reform Commission in its Working Paper 23 (at 59) suffers from the shortcoming that it would rule out the use of sophisticated technological techniques except where resuscitative machinery is being used.

circulation, traditional cardiographic techniques and/or criteria for determining death will remain fully acceptable. Not, of course, because they establish the absence of independent cardiac action, but because after 30 minutes of oxygen deprivation brought about by cardiac arrest or whatever, the cerebrum has in fact deteriorated. The traditional criteria, therefore, will remain as sufficient for determining personal death, *but not as necessary*. The more sophisticated electroencephalographic, etc. techniques allow an earlier determination of personal death because they can detect such irreversible deterioration prior to the onset of the acute physiological breakdown detectable by the old criteria. Therefore, instead of involving two distinct definitions of death, such as in the Kansas statute,[73] the proposal above is a single definition that allows for several types of mutually compatible criteria.

Third, and for present purposes perhaps most importantly, the proposed definition allows for a clear and unequivocal formulation of the person-human being distinction as an addition to section 2 of the Code:

> "Person" means any entity capable of acts that fall within the provisions of this Act. A person may be either a "natural person" or a "constitutive person". A natural person is any biological entity of the species homo sapiens that possesses the present functional capability for conscious awareness, or any human being whose cerebrum is structurally sufficiently like that of a normal adult human being that, if it were fully operational without structural change, it would evince neurological activity of the same nature as that of a normal adult human being.
> A "constructive person" is any association of persons constituted in such a way as to be able to act as a social agent in the manner of a natural person.
> A "human being" is any living biological entity that is a member of the species homo sapiens.

VII. *Some Proposals*

Admittedly, the preceding definition is complex, but nothing less will be sufficiently precise. Furthermore, it has several points in its favour. Not only does it provide for conceptual clarity where currently none exists, but it also allows for a systematic approach to the whole array of person-oriented problems, beginning with that of the status of the human embryo and ending with that of the irreparably comatose and moribund senescent. It provides for an

73. See note 56 *supra*

answer to the question whether a biological organism is *already* a person, is *still* a person, or is a person *no longer*. And in doing so, it makes possible a uniform and consistent procedural determination of the gamut of cases ranging from abortion to euthanasia, and does so in a way that captures an essential part of what in recent literature has gone under the heading of quality of life.

More importantly for the present context, however, is the fact that it also makes possible a redrafting of those sections of the Code whose problematical import was the topic of the initial discussion. The relevant clauses of section 205, for example, could now be stated like this:

205(1)A person commits homicide when, directly or indirectly, by any means, he causes the death of a natural person.

(5)A person commits culpable homicide when he causes the death of a natural person,

(a) by means of an unlawful act,
(b) by means of criminal negligence,
(c) by causing that person, by threats or fear of violence or by deception, to do anything that causes his death, or
(d) by wilfully frightening that person, in the case of a child or a sick person.

With the addition of the amendment to section 2 above, section 205 would rule out any prosecution for culpable homicide in situations where the being in question is (still or already) a human being but is not a person. Cases like that of Karen Ann Quinlan or of infant *B* could therefore be terminated without the threat of legal action for culpable homicide. In fact, the whole range of brain damage cases, which otherwise would be (and currently are) problematic, would herewith be resolvable in a uniform manner and any conflict between legal statute and medical ethos and practice would be avoided.[74]

Furthermore, section 206, which also was relevant to the case of infant *B*, could, in its relevant clauses, be rewritten in the following manner:

206(1)A human being becomes a natural person within the meaning of this Act when it has acquired the present

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74. It is important to note that this would not be the case if the definition of death proposed in Working Paper 23 of the Law Reform Commission were to be adopted. It is significant that the proposal of the Commission represents the majority view and was not accepted unanimously.

functional capability for conscious awareness, whether or not
(a) it has proceded from its place of gestation, or
(b) it has actually realized this capability in any observable manner.

(2) A human being ceases to be a natural person when the neurological basis of his present functional capability for conscious awareness is irreparably destroyed or damaged beyond functional recovery within the limits of personhood as set out in section 2 above.

Clause 206(2) would fulfil the role of a definition of death. As to 206(1) (a), there are two reasons for its particular formulation. One is, that current techniques of *in vitro* fertilization together with the present capability for constructing an artificial placenta[75] make it extremely likely that within the foreseeable future gestation will no longer take place *in utero* in all cases. However, it would clearly be unacceptable to deny personhood to a human being who in all other respects met the criteria for being a person, except that he did not proceed *ex utero*. Similar considerations, *mutatis mutandis,* apply to individuals gestated in the specially prepared abdominal cavity of a non-female person: a medical possibility that also obtains. The second reason for 206(1) (a) is that given the meaning of "natural person" as set out above, a fetus will generally become a person at the end of the first trimester of the gestation period. Consistency, however, demands that the locality in or at which a person finds himself is irrelevant to his status *as a person*. Consequently, if a fetus attains the status of person prior to leaving the locality of his place of gestation, that should not provide a bar to his being accorded the rights to which otherwise he would be entitled.[76]

Other alterations in the remainder of the sections identified above as being problematic will be apparent. In some cases, such as those of ss. 197 and 202, few if any changes are required because the notion of person involved in them is already in accord with the preceding. In other cases, such as that of ss. 212, 213, and so on, wholesale redrafting will be necessary, involving at least the substitution of "person" for "human being" in the majority of cases. To pursue this matter further, however, transcends the parameters of the present discussion.

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75. See note 43 *supra*
76. For a consideration of some difficulties surrounding the present legal position on this issue, see Kluge, "The Right of Life", *pass.*

VIII. *The Case of Infant B and a Further Proposal*

The implications of these suggested revisions for the case of infant *B* are apparent. The threat of criminal liability facing both medical practitioner and support personnel under the present statutes would disappear. By section 206 (1), infant *B* would not be a person, and therefore by section 205 (1) no charge of homicide could be laid. Furthermore, prosecutorial discretion would no longer have to be relied upon to bring about an agreement between what is current medical practice and what is law, nor would the decision as to the meaning of "human being" and "person" have to await appraisal of the facts at hand. The proper order of determination would thereby be restored.

Nevertheless, despite these advantages, the proposed statutory revisions are insufficient. They lead to a moral anomaly. While the proposed revision will allow the death of neonates like infant *B* who do not meet the criteria for personhood, they require that infants who do meet the criteria be kept alive even though they should face a life of unmitigated, unbearable agony and suffering. In other words, the proposed revisions permit neonate non-persons to be freed compassionately from their suffering, whereas they require neonate persons to be made to suffer even though they may be moribund and for the short duration of their life face unmitigated suffering.

Some contemporary moralists, noteably those of theological inclinations, would suggest that this is morally quite acceptable. J. V. Sullivan, for instance, has stated that "suffering is almost the greatest gift of God's law";[77] and Helmut Thielicke has argued that "pain exercises not only a negative function in our life but also a creative function whereby it helps us to become what we are supposed to be",[78] and has gone on to say that "suffering could be part and parcel of our very destiny. What would humanity be if suffering were to be totally eliminated and we knew nothing but the absurd happiness of dull lemurs?"[79] However, most contemporary theologians seem to differ in their opinion[80] and their position is

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77. Sullivan, *supra,* at 73. See also *On Dying Well* Anglican Church Information Office (1975) at 21.
78. Thielicke, "The Doctor", at 166
79. *Id.* at 165
80. Even Thielicke himself seems to vacillate. See *id.,* at 165. "It is surely part of man's nature to combat suffering, and in this respect to protest against the natural processes which impose this suffering upon us". For a clearer statement, however,

reflected more accurately by Dean Inge's confession, "I do not think that God willed the prolongation of torture for the benefit of the soul of the sufferer";[81] an assertion, incidentally, that is in clear accord with Pope Pius XII pronouncement on the use of extra-ordinary means.[82] As to the medical position, its sympathies also lie in the other direction, and are more appropriately expressed by the following suggestion:[83]

> Life preserving intervention should be understood as doing harm to an infant who cannot survive infancy, or will live in intolerable pain, or cannot participate even minimally in human experience.[84]

A morally acceptable redrafting of the Code would therefore have to avoid this anomaly. One way of doing so is to suggest that the physician (or individual in charge)[85] may make use of analgesics and the like in whatever dosages are deemed necessary to alleviate the pain and suffering even though such ministration should entail, and should be known to entail, a shortening of the life-expectancy of the infant concerned.[86] However, while in theory such an act would be distinguishable from one where the medication was given in order to procure "a fair and easy passage",[87] the distinction would prove impossible to demonstrate in actual practice.[88] Therefore, in order to avoid profitless legalistic entanglements, the

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see L. Weatherhead, *The Christian Agnostic* (Hodder and Stoughton, 1965) at 187; Peter Green, *The Problem of Right Conduct* at 283; Karl Barth, *supra,* at 425 ff (who talks of medical "fanatics" in this context); Ramsey, *The Patient* chap. 2 *pass.* The admission that extra-ordinary means need not be used also falls here. *Cf.* Pope Pius XII, "Prolongation of Life", (1957) 4 *Osservatore Romano* 393; Gerald Kelly, "The Duty of Using Artificial Means of Preserving Life", (1950) 11 *Theological Studies* 204 and *Medico-Moral Problems* (St. Louis: Catholic Hospital Association 1958); Edwin Healy, S. J., *Medical Ethics* (Chicago, 1956) at 70.

81. W. R. Inge, *Christian Ethics and Moral Problems* at 373

82. Pope Pius XII, "Prolongation of Life" at 393

83. Jonsen *et al,* supra at 760

84. *Cf.* John Lorber, "Selective Treatment of Myelomeningocele: To Treat or Not to Treat" *Pediatrics* 53: 3 (March, 1974) at 307, and "The Doctor's Duty to Patients and Parents in Profoundly Handicapped Conditions", in D. J. Roy, *supra;* but see J. M. Freeman, "Ethics and Decision Making Processes for Defective Children" in Roy, *supra;* Kluge, "Infanticide", *supra;* Engelhardt, "Euthanasia and Children: The Injury of Continued Existence", (1973) 83 *Journal of Pediatrics,* 170.

85. After all, there is no guarantee that such decisions will always have to be made in a medical setting.

86. *Cf.* T. Lohmann, *Euthansie i.d. Diskussion* (Patmos, 1975) at 97 f

87. Bacon, *A New Atlantis*

88. *Cf.* Kluge, "The Allocation", at 97 f

statutes should simply accept the fact that from a contemporary ethical point of view the termination of irremediable suffering is acceptable and that in such cases considerations of the quality of life outweigh considerations of the fact of life itself. In statutory terms, this may be expressed as follows:

S.197(4) (a) No one is under a legal duty to provide the necessaries of life for an infant under his charge if the exercise of that duty would result in the existence or continuation of a state of irremediable pain and/or suffering beyond a reasonable level.

(b) In all cases that fall under the preceding paragraph, the attending physician or person in charge shall employ such measures as are deemed, upon due consideration, to be suitable and appropriate for terminating the life of the infant under his charge as quickly and as painlessly as possible.

The implications of this proposal do, of course, extend beyond the context of defective neonates, moribund or otherwise. With due alteration of detail, the proposal could be extended to cases involving adult persons as well as adult human beings. In that way, it could become the means for enacting general euthanasia legislation that would be more reflective of the current medical ethos. However, desirable as such an extension might be, to address this topic would transcend the limits of the present discussion.

In conclusion, a note of warning: unless the distinction between a human being and a person is formally accepted in statute, and unless some provision for the termination of hopelessly suffering infant life is enacted, physicians will continue to find themselves in conflict with the law while in agreement with public ethics. Such a conflict, however, not only casts serious doubt on the moral responsiveness of the law but also presents a danger: in leaving to individual prosecutorial discretion what should be a matter of statutory law, it raises the spectre of the politics of medico-legal confrontation.