EUTHANASIA BY CONFUSION

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> 'There's glory for you!' 'I don't know what you mean by "glory",' Alice said. 'I meant, "there's a nice knock-down argument for you!"' 'But "glory" doesn't mean "a nice knock-down argument",' Alice objected. 'When I use a word', Humpty Dumpty said in a rather scornful tone, 'it means just what I choose it to mean - neither more nor less.'
>
> Lewis Carroll, *Through the Looking-Glass*, Ch 6.

The euthanasia debate is beset by confusion. This has been caused by both accident and design. One important way to promote the legalisation of euthanasia is through various types of confusion. These confusions span, first, the domain of semantics - confusion in definition; confusion created through choice of language; and confusion of association and analogy. Second, they span important areas of ethical and legal analysis - confusion of means and ends; confusion in the use of the legal concepts of intent and causation; and confusion in interpreting common law precedents. We need to examine, understand and, where possible, dispel these confusions.

I. CONFUSION IN SEMANTICS

A. Confusion in Definition

The definition of euthanasia - as is also true of physician-assisted suicide - is highly confused. For the sake of clarity, euthanasia should be defined as *a deliberate act or omission that causes death undertaken by one person with the primary intention of ending the life of another person, in order to relieve that*

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person's suffering.[1] The paradigm case of euthanasia is the giving of a lethal injection[2] to a suffering, terminally ill person who requests and gives informed consent to this. Neither a requirement for informed consent nor that the person be terminally ill is, however, an element of the definition of euthanasia given above. This definition, therefore comprehends non-voluntary euthanasia - the patient is incompetent to give or withhold consent - and involuntary euthanasia - the patient is competent, but euthanasia is administered without asking for the patient's consent to this. In contrast, in The Netherlands the guidelines governing that country's *de facto* legalisation of euthanasia define this as requiring "explicit consent".[3] This means that non-voluntary and involuntary interventions aimed at ending a person's life are not regarded as euthanasia, although in practice some Dutch doctors do not seem to be aware of this.[4]

Another way in which confusion arises in the definition of euthanasia is that many people who support euthanasia lump together under the global category of 'medical decisions at the end of life', decisions concerning palliative care, pain relief treatment, refusals of treatment - including life support treatment and especially artificial hydration and nutrition - and physician-assisted suicide and euthanasia. They argue that all of these decisions that are aimed at trying to ensure that the patient experiences a 'good death' and that could or will shorten the patient's life, are decisions that involve euthanasia. While this is true in a broad sense - the term euthanasia comes from 'eu' (good) 'thanatos' (death) - this very broad definition of euthanasia can give rise to serious confusion.

First, physicians and nurses who accept such a broad definition and are asked in survey research whether they have ever been involved in euthanasia, are likely to state that they have been. This, in turn, can be used as evidence that many physicians and nurses are secretly carrying out euthanasia and that it would be safer for individuals and society to legalise euthanasia, in order to bring it out into the open and ensure that it is not used abusively.

This line of reasoning is sometimes taken further, to imply that persons opposed to the legalisation of euthanasia should consider withdrawing their opposition on the grounds that this will result in fewer cases of euthanasia being performed, than if euthanasia were to remain prohibited. Quite apart from the fact that there is, of course, no evidence that such a reduction would occur, indeed the results of the *de facto* legalisation of euthanasia in The Netherlands would suggest the contrary,[5]

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1 MA Somerville, "The Song of Death. The Lyrics of Euthanasia" (1993) 13 *Journal Contemporary Law & Health Policy* 9, 1-76.

2 Unless otherwise indicated, the term 'lethal injection' is used throughout this text to mean an injection given with the primary intention of killing the person to whom it is administered

3 State Committee on Euthanasia, *Report on Euthanasia*, Government Printing Office, The Hague (1985) The definition was also used in the 1991 *Remmelink Report* and in the summary brochure, *Medical Practice with Regard to Euthanasia and Related Medical Decisions in The Netherlands*, Ministerie van Justitie (1991), p 3 Despite the requirement for 'explicit consent', recent research has shown a large number of cases of non-voluntary and involuntary 'euthanasia' occurring in The Netherlands. See notes 4, 16 and 17 *infra*.

4 H Hendin, C Rutenfrans, Z Zylicz, "Physician-Assisted Suicide and Euthanasia in the Netherlands" JAMA 1997, 227(21): 1720-22

5 *Ibid.*

this argument entirely misses the point. The primary objection of many people who are anti-euthanasia is that to kill another person is *inherently wrong*. The fear of abuse of euthanasia, were it to be legalised, is a secondary, although important, objection. If, as those who are anti-euthanasia argue, the basic objection to physician-assisted suicide and euthanasia is that they are different in *kind* not just *degree* from other decisions about medical treatment at the end of life, then to lump together all of these is to assume what needs to be proven, namely, that physician-assisted suicide and euthanasia are morally the same as the other forms of end-of-life medical care that could or will shorten life.[6] If physician-assisted suicide and euthanasia are to be justified it must be on their own merits and not by false association[7] with other interventions that are viewed as ethically and legally acceptable.

Definitional confusion is also generated by describing all decision-making relating to medical care and treatment at the end of life, as 'medical decisions at the end of life'. 'Medical decisions' is a misnomer; many of these decisions are not medical decisions properly so-called. They have foundations, aspects and effects far beyond medicine and are better referred to as 'decisions at the end of life in a medical context'. Such characterisations are important because they alert us to the wide range of considerations beyond medicine that must be taken into account, and persons other than health care professionals who need to be involved, in making these decisions.

Within a narrower context, the term 'physician-assisted suicide' is also confusingly used. Often it refers to euthanasia - the physician intervenes on the patient with a primary intention of killing him or her, most often by giving a lethal injection - which is homicide not suicide. This term is sometimes changed to 'physician-assisted death', which can mean euthanasia or physician-assisted suicide, but also connotes a very broad range of procedures that physicians undertake - indeed have ethical and legal obligations to undertake - to help dying people. We all want physician assistance of the latter kind,[8] but do not mean, in stating this, that we necessarily agree with physician-assisted suicide and euthanasia.

The euthanasia debate is too important to risk carrying it out on the basis of confusion as to what does and does not constitute euthanasia. The most honest and clear approach would be first to debate the question of whether or not we agree that the law should be changed to allow physicians to give lethal injections to terminally ill, competent adults who request and give their free and informed consent to this. This is not the only question that we need to answer about euthanasia. Among the many others are, for example, if we reject euthanasia should we allow physician-assisted suicide? Or, if we allow euthanasia, should this be available in the case of some incompetent people? But we need to deal first with a situation in which we all agree that euthanasia is involved, and we should start with the most straightforward one, that of physicians giving lethal injections

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6 See *infra* pp 557-9, for further discussion.

7 See *infra* pp 555-7, for a discussion of other cases of false association

8 AM Capron, "Euthanasia in the Netherlands. American Observations" (1992) 22 *Hastings Center Report* 30.

to competent, suffering, terminally ill people who request and consent to this. This should help us to eliminate both the current confusion surrounding the definition of euthanasia, and the further confusion which flows from this, which is bad for all of us whether we are for or against euthanasia.

B. Confusion in Language

A matter related to confusion in definition, is the confusion that can occur from our choice of language to describe euthanasia. For instance, a vastly different impression is made, emotional reaction evoked, and behaviour elicited by describing euthanasia as "a merciful act of clinical care"[9] as compared with describing it as killing.[10] In this respect, an interview that I recently conducted with Doctor Roger Hunt, an Australian palliative care physician, who was influential in the legalisation of euthanasia in the Northern Territory of Australia, is of interest.

When I said to Doctor Hunt, "[t]ell me why you think doctors should be allowed to kill dying patients who want this", he objected to my use of the word kill. He said that he "prefer[red] to be specific about terms that we use in medicine" and that we should talk of "voluntary euthanasia, rather than ... killing. Kill is a broad word which includes murder, manslaughter, and various other types of killing. We're [people who are pro-euthanasia are] talking specifically about VAE [Voluntary Active Euthanasia]. Now if doctors are involved in VAE, *I think most people expect it of doctors* not to turn their back on someone who is dying and suffering, and walk away".[11] Not only most people, as Doctor Hunt states, but probably everyone expects doctors not to walk away from suffering, dying patients. But do they also expect most doctors to provide euthanasia as Doctor Hunt believes? Moreover, is this approach likely to cause confusion concerning people's views on euthanasia, in that something with which we all agree - namely, the primary obligation of personal care that physicians owe to their patients - is inextricably linked to euthanasia through the language and sentence structure used? This link is created through the word "it" in Doctor Hunt's statement, in that it refers both to doctors not walking away and to voluntary active euthanasia.

The fact that the term *voluntary active euthanasia* has been reduced to an acronym - VAE - and the term, itself, are also noteworthy. Does the use of an acronym make euthanasia less threatening, more familiar and ordinary? The term *passive euthanasia*, or less often *voluntary passive euthanasia*, is used by people who are pro-euthanasia to describe withdrawals or refusals of treatment that result in death. They argue that if these are morally and legally acceptable - as most people agree that they are provided certain conditions are fulfilled - this means that people *agree that euthanasia is acceptable* and, therefore, they contend, it should make no ethical or legal difference whether this is effectuated through passive or

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9 Report of the Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death, "Assisted Death" *The Lancet* 1990; ii 610-613.

10 Somerville, note 1 *supra*.

11 Transcript of Pilot Segment, *Searching for Ethics 2001*, video taped, Uluru, Australia, April 1997 (emphasis added)

active means.[12] To the contrary, those who are anti-euthanasia base their case on the proposition that there are long established, well understood, profound and important differences between allowing a person to die and making that person die, that is, putting that person to death.[13] Consistent with this position, and to avoid confusion as to what is and what is not euthanasia, they oppose the use of the term passive euthanasia to describe justified withdrawals of treatment that will result in death.

There can also be confusion about what a dying person means to communicate in using certain language. For instance, many people, at a certain stage of terminal illness, express the wish to die; indeed, to come to an acceptance of death may be an important part of our human dying process. This is very different from wanting to be killed. We need to keep such distinctions in mind in assessing whether people are really asking for euthanasia. Moreover, even if they are, we need to take care that this is not a way of asking some other question or seeking reassurance and comfort, for example, that the person is not seen as an unbearable burden by caregivers or that he or she will not be abandoned.[14]

A striking example of different interpretations of what patients mean by a certain communication is right now the focus of considerable controversy. In an article in the Journal of the American Medical Association, Hendin et al[15] comment on a Dutch study of euthanasia carried out by van der Wal et al,[16] of which a summary account is published in the New England Journal of Medicine.[17] Doctor Hendin and his co-authors point out that in 1995 in The Netherlands, there were over 1500 cases of doctors administering lethal doses of opiates to patients with the intention of killing the patient. In the vast majority of these cases, "no request for death was made by the patient", although a substantial number of the patients were mentally competent and could have made known their desires. In a press interview,[18] Doctor van der Wal confirmed that "no request for death was made by the patient in these cases", but said that "doctors had received previous approval to administer opiates". A request to do whatever was necessary to ease pain had been made by the patients at some point. In short, the best reading of this situation, from the point of view of the physicians involved, was that they interpreted a request for pain relief treatment as a consent to being killed. The

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12 See *infra* pp 557-9, for discussion

13 This distinction was articulated in this way by Chief Justice Renquist, speaking for the United States Supreme Court in the landmark judgment *Vacco v Quill*, US Supreme Court Docket No 95-1858, 26 June 1997. (United States Law Week, 65 LW 4695, June 24, 1997).

14 MA Somerville, "Unpacking the Concept of Human Dignity in Human(e) Death Comments on 'Human Dignity and Disease, Disability and Suffering' by Sylvia D Stolberg" (1995) 11 *Humane Medicine* 148-51.

15 Note 4 *supra*.

16 G van der Wal, PJ van der Maas, *Euthanasia en Andere Medische Beslissingen rond het Levenseinde* (1996) The Hague, The Netherlands, Staatsuitgeverij.

17 PJ van der Mas, G van der Wal, I Haverkate et al, "Physician-Assisted Suicide and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995" *New England Journal of Medicine* 1996, 335 1609-1705; G van der Wal, PJ van der Maas, JM Bosma et al, "Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands" *New England Journal of Medicine* 1996; 335. 1706-1711

18 L Lagnado, "Top Journals Divide Over Assisted Suicide" *Wall Street Journal*, 4 June 1997, B1

alternative is that these physicians simply decided that the patient's consent to euthanasia was irrelevant.

Interpreting patients' requests for pain relief treatment as requests for euthanasia has a very worrying flip-side. This could augment one effect of the legalisation of euthanasia, namely that this can cause patients to refuse opiates which they desperately need for pain relief treatment, because they are frightened of being killed.[19] This reportedly happened[20] subsequent to the legalisation of euthanasia in the Northern Territory of Australia.[21] It could also raise similar concerns for people who live in jurisdictions where euthanasia is still prohibited. Consequently, even those who are pro-euthanasia should oppose the use of pain relief medication as a means of carrying out euthanasia, because to do so can deliver a message that results in terminally ill people, who are frightened of being subjected to euthanasia or morally opposed to it, depriving themselves of essential pain relief treatment.

C. Confusion in Association

Describing euthanasia as simply the "final stage of good palliative care"[22] and thereby associating it with such care, can affect our impression of euthanasia and reaction to it. Although not everyone agrees on all aspects of what constitutes the best palliative care, it would be very surprising to find disagreement with its underlying objectives of relief of pain and suffering and the provision of humane and compassionate care for dying persons. If then, as the pro-euthanasia argument goes, euthanasia is simply another example of good palliative care, why would anyone be opposed to it?

Proposing that euthanasia is just one part of good palliative care is an example of putting a 'medical cloak' on euthanasia. Doing this makes euthanasia a medical issue concerning primarily individual patients, their families and physicians. We ignore or bury the fact that euthanasia is an equally important philosophical and societal issue. One way to identify the effects of the confusion caused by viewing euthanasia only under a 'medical cloak', is to ask, as has recently been proposed, whether we should have a specially trained group of lawyers, rather than physicians, carry out euthanasia.[23] Considering persons other than physicians undertaking euthanasia makes us disconnect our assumptions about euthanasia from our assumptions about physicians and the medical context - which are that, generally, physicians seek to do no harm; medical treatment is involved when physicians intervene on people; and the medical context is an ethical and safe forum. In this respect, I have noted, anecdotally, that some of the same persons

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19 Pilot sequence, note 11 *supra*, per Professor Norelle Lickiss, Sydney, Australia and Professor Aranda Sanchez, Melbourne, Australia

20 The Parliament of the Commonwealth of Australia, Senate Legal and Constitutional Legislation Committee, *Consideration of Legislation Referred to the Committee Euthanasia Laws Bill 1996*, Senate Printing Unit, Department of the Senate, Parliament House, Canberra, pp 39-55.

21 *The Rights of the Terminally Ill Act*, 1995 (NT). Subsequently, the Commonwealth Parliament passed *The Euthanasia Laws Act* 1997 (Cth) overriding the Territory legislation

22 T Quill, "The Case for Euthanasia", Symposium, *Searching for the "Soul" of Euthanasia*, 11th International Congress on Care of the Terminally Ill, Montreal, Canada, 1996.

23 RM Sade and MF Marshall, "Legistrothanatry: A New Specialty for Assisting in Death" (1996) 39(4) *Perspectives in Biology and Medicine* 547-549.

who strongly object to describing euthanasia as killing, respond to the suggestion that lawyers should be authorised to administer euthanasia to the effect that it would be unacceptable to permit lawyers to kill people. It may be that what we decide about euthanasia will be the same when we decide about it outside the medical context, as when that decision-making occurs under the cloak of medicine. The point is, however, that we cannot afford simply to assume that this will be the case.

Another confusion of association in relation to euthanasia arises in some survey instruments in which the questions asked inextricably link euthanasia and the provision of adequate pain relief treatment. For example, people are asked whether or not they agree that a terminally ill person in great pain and suffering should be allowed to request a lethal injection. There are at least three problems here. First, respondents' emotional response to the thought of leaving people in pain can colour their response to euthanasia and make them more favourable to this than they would otherwise be. Second, sometimes the only response provided for in questionnaires is either to agree or disagree with both euthanasia and pain relief treatment that will shorten life; that is, there is no way to record agreement with such pain relief treatment and rejection of euthanasia, one must accept or reject 'the package'. Third, at the least, this approach confuses euthanasia and pain relief treatment that will shorten life and it can be an example of the latter being defined as euthanasia.[24]

Yet another confusion of association is that between religion and an anti-euthanasia position. An argument, frequently articulated by those who are pro-euthanasia, is that those who are opposed to euthanasia hold this position essentially on religious grounds. While it is true that some people do oppose euthanasia because of their religious beliefs, there seems to be a reluctance to accept that there are good secular-based reasons to oppose euthanasia and that the anti-euthanasia stance of many people is founded on these. There can also, although much less often, be confusion caused through automatically associating being pro-euthanasia with being anti-religion. Even some members of the clergy in some religious denominations are pro-euthanasia.[25] I do not intend here, to deny that one's religious stance can influence one's views on euthanasia, rather we need to be careful about making automatic assumptions in this regard. Even more importantly, we need to avoid devaluing or dismissing certain views just because they are associated with religious beliefs. We are usually sensitive, today, to religious bigotry, but we may not be as sensitive to anti-religious bigotry.

Still another confusion of association that might be relevant to the euthanasia debate is that between individualism and a sense of personal identity. We could most need a sense of personal identity when we are dying. This might be necessary to give us a sense that our life has had meaning, which we probably need to die peacefully. Currently, we may be seeking a sense of personal identity

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24 See *infra* p 558 for an example of just this approach.

25 H Shepherd, "Unity council sets new direction" *The [Montreal] Gazette*, 21 June 1997, J-7. "[L]ate last year . a group of churches including the Catholics, some evangelical churches and some in between, publicly criticised a trend toward acceptance of *euthanasia* - a statement that the United Church of Canada and the Quakers did not support "

through 'intense individualism', in particular, through its dominant feature of providing a sense of being in control. Euthanasia shares this feature with 'intense individualism': it is a very powerful expression of seeking control. Most people, however, probably cannot find a sense of personal identity in 'intense individualism'. Rather, they need to find this in a structure of complex human relationships which include those that can only be created through feeling that one is a member of a community. As Isaiah Berlin says, "I am [at least in some important respects] what I see of myself reflected in the eyes of other people".[26] In short, paradoxically, we might only be able to find full individual identity through participation in community, that is, through the immersion of our individuality in the greater whole. This brings us face to face with a major problem in many contemporary Western societies, that of the loss of a sense of community.

Loss of community may also be a causal factor in the emergence of the euthanasia debate in these same societies. In them, death does not occur in community and surrounded by tradition, ritual and ceremony. Dying persons are often isolated, even to the extent that they can suffer intense, "pre-mortem loneliness",[27] and death is often sterilised, deritualised, dehumanised. Euthanasia might be a complex response to this loss of collective ways to deal with death in that it accommodates an approach to death that is highly individualistic, but at the same time euthanasia deaths are often also surrounded by ritual explicitly associated with this way of dying.[28]

II. CONFUSION IN ETHICAL AND LEGAL ANALYSIS

A. Confusion of Means and Ends

There is also confusion in the euthanasia debate between the ethical and legal acceptability of certain outcomes and the ethical and legal acceptability of the means used to achieve those outcomes. The strongest version of the pro-euthanasia argument in this respect, is that if death is inevitably imminent for a person who wants and consents to euthanasia, then to provide this is no different from withdrawing life-support treatment from a person who refuses this and dies as a result. In both cases, the argument goes, death is the outcome and the means used to achieve this are not morally distinguishable and should not be legally distinguished; it is inconsistent to support the ethical and legal acceptability of certain withdrawals of treatment that result in death and not likewise to support euthanasia by lethal injection. To summarise, the proposition is one that has already been referred to, namely that there is *no ethical or moral difference* between death resulting from a refusal of treatment and death resulting from a lethal injection and there ought to be *no legal difference*. Applied to physician-assisted suicide, properly so-called, this argument becomes that, in refusing treatment that results in death, a person commits suicide and there is no moral or

26 I Berlin, *Four Essays on Liberty* (1969) London, Oxford University Press

27 J Katz, *Silent World of Doctor and Patient* (1984) New York, Free Press

28 See M Seguin, *A Gentle Death* (1991) Toronto, Key Porter Books.

ethical reason to distinguish this from physician-assisted suicide and, therefore, these two situations should be treated in the same way by the law.[29]

In contrast, those who are anti-euthanasia argue that there *is a moral and an ethical difference* between accepting a patient's refusal of treatment, even if this results in death, and giving the person a lethal injection, or assisting the person to commit suicide, and, therefore, the *legal difference* between these situations *should be maintained.*[30] In other words, they argue that the means through which death occurs is a morally relevant issue and the law should continue to reflect that some of these means are morally and ethically acceptable and others, namely, euthanasia and physician-assisted suicide, are not.

One example of the confusion of means and ends being used in support of euthanasia, can be found in a recent article, *Slow Euthanasia*, by Billings and Block.[31] They state that physicians frequently "hasten death slowly with a morphine drip", which they describe as 'slow euthanasia'. They argue that it would be better for everyone - patients, families and physicians - and more honest to accept 'rapid euthanasia'. To reach this conclusion, they downplay the relevance of the physician's intention in giving treatment that could, or even would, shorten life. For instance, they equate pain relief treatment that could have this effect, which is given with the primary intention of relieving pain, and an injection given with the primary intention of killing the person. They do this by characterising the means in both situations as humane, ethical treatment of dying patients, that is, in such a way that they are the same, and point out that in both situations the same end - the death of the patient - results. As part of this approach, they define euthanasia to include necessary pain relief treatment that will shorten life and reject the doctrine of "double effect as an unconvincing justification for [such] euthanasia".[32]

Billings' and Block's article elicited a series of responses,[33] which point out that the authors have failed to appreciate the important ethical and legal distinctions that inform not only the law concerning euthanasia, but also, the law in general, especially the criminal law. For instance, if a doctor hangs a morphine drip with the primary intention of killing the patient and not with the primary intention of relieving the patient's pain, this would be euthanasia and prohibited as such. If, on the other hand, such a drip is needed to relieve pain and the primary intention is "to kill the pain not the patient",[34] the law would not regard this as euthanasia.

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29 For an example of this approach, see DPT Price, "Assisted Suicide and Refusing Medical Treatment: Linguistics, Morals and Legal Contortions" (1996) 4 *Medical Law Review*, 270-299

30 Somerville, note 1 *supra*.

31 JA Billings and SD Block, "Slow Euthanasia" *Journal of Palliative Care* 1996; 12: 21-30

32 *Ibid.*

33 B Mount, "Morphine Drips, Terminal Sedation, and Slow Euthanasia: Definitions and Facts, Not Anecdotes" *Journal of Palliative Care* 1996, 12 31-37; B Dickens, "Commentary on 'Slow Euthanasia'" *Journal of Palliative Care* 1996; 12: 42-43, R Portenoy, "Morphine Infusions at the End of Life: The Pitfalls in Reasoning from Anecdote" *Journal of Palliative of Care* 1996, 12: 44-46; H Brodie, "Commentary on Billings and Block's 'Slow Euthanasia'" *Journal of Palliative Care* 1996; 12: 38-41.

34 MA Somerville, "Death of Pain: Pain Suffering and Ethics" in GF Gebhart, DL Hammond, and TS Jensen (eds), *Progress in Pain Research and Management*, Volume 2, Proceedings of the 7th World

Necessary pain relief treatment that shortens life would be justified under the *doctrine of double effect*. This requires, first, that the act which results in the bad consequence, the shortening of the patient's life, is morally neutral. Providing pain relief treatment is such. Second, the pain relief must not be achieved by shortening the patient's life, that is, through the bad consequence. Third, the bad consequence, the shortening of the patient's life, must not be primarily intended as either an end or a means, rather, the primary intent must be the legitimate aim of relieving the patient's pain. And, fourth, there must be no other reasonable way of achieving the pain relief that does not involve the undesired effect of shortening the patient's life; that is, the proportionality of the good and bad consequences required to justify the bad consequence must be present.[35] As Dickens says, Billings and Block:

> apply an outcome oriented test that simply links a physician's use of medications with their inevitable effect regardless of immediate intent. However, intent is at the centre of ethical and legal judgments in this area, not a secondary or marginal concern unworthy of regard in ethical [or legal] analysis as the authors mildly acknowledge.[36]

To summarise, some of the confusion between, on the one hand, pain relief treatment and refusals of treatment that could or will shorten life and, on the other hand, euthanasia, is caused by focusing on the outcome, namely death, and arguing that if a person is terminally ill, it is morally and ethically irrelevant and should be legally irrelevant how this outcome occurs. The central issue in the euthanasia debate is not, however, the outcome of death; that is, the issue is not *if* we will die, because we all eventually die. The issue is *how* we die and whether some means of dying, namely physician-assisted suicide and euthanasia, ought to continue to be legally prohibited. To respond to this question, we need to examine, in greater detail, the role that physicians' intentions play in drawing the line between acceptable and unacceptable medical interventions that will or could shorten life.

B. Confusion of Intent

A fundamental principle of the criminal law is that a crime requires both a criminal act, an *actus reus* - conduct which the definition of the crime in question requires to have occurred[37] - and an accompanying criminal mind, a *mens rea*. In general, *mens rea* is constituted by having an intention to cause the prohibited outcome. Classically, a person will be held to have intended an outcome that results from his or her conduct, if either that outcome is a certain or almost certain result of the conduct in question and the person knows this, or the outcome is less certain than this, but the person desires that outcome to result. In general, a person's motive is not relevant to determining whether or not *mens rea*

Congress on Pain, International Association for the Study of Pain, IASP Press, Seattle, Washington, 1994, pp 41-58

35 See J Keown, "Restoring Moral and Intellectual Shape to the Law after Bland" (1997) 113 *Law Quarterly Review*, 481-503 at 484, note 10, citing the House of Lords Select Committee on Medical Ethics, *Report of the Select Committee on Medical Ethics* HL Paper 21-I of 1993-1994, at [242]. It is noteworthy that many criminal law texts, for example, Colvin, note 37 *infra*, and Stuart, note 52 *infra*, do not contain any discussion of this doctrine or even reference to it.

36 Dickens, note 33 *supra* at 43.

37 E Colvin, *Principles of Criminal Law* (1991, 2nd ed) Carswell, Toronto, at 48

is present. There are exceptions to this rule however, when motive can be drawn into the assessment of *mens rea*.[38] Relatively recently, some courts have taken a more straightforward approach and held that, in criminal law, intention bears its ordinary meaning of aim or purpose, and that foresight of even certain consequences of the conduct in question is, at best, merely evidence from which purpose may - or may not - be inferred by the jury.[39]

But even taking the more stringent, classical approach to intent, when the motive *is* to relieve pain and *is not* to kill the person, a *mens rea* of intention to kill that would otherwise be present in giving necessary pain relief treatment that will shorten life,[40] will not be taken into account by the criminal law. These cases fall within the exception, referred to above, to the classical rule that motive is irrelevant to intent. In other words, because there is no motive to kill the patient, there is no criminal *mens rea*. Moreover, the giving of such pain relief treatment is not the *actus reus* of a culpable homicide, because it is not an *unlawful* act causing death, as required for that crime.[41] Likewise, one way in which the law justifies the legality of withdrawal of treatment that results in death, as compared with the illegality of physician-assisted suicide or euthanasia, is through a distinction with respect to intention. In physician-assisted suicide and euthanasia the *primary intent* is to cause death. In withdrawing life support treatment that patients have refused, the *primary intent*[42] is not to cause death but to *respect patients' rights to inviolability*, their right not to be touched without their consent, which includes the right not to have treatment applied to them without their informed consent. Indeed, there would be a criminal assault in continuing treatment which the patient had refused.

In contrast, if life support treatment were withdrawn from an incompetent patient who had not previously refused the treatment (or whose substitute decision maker had not validly refused this), there is a potential for criminal liability. Once again, intent would be relevant to determining whether or not this would be imposed. If the treatment were withdrawn because it was medically futile[43] there would be no criminal liability; if it were not medically futile and withdrawn with the primary intent of killing the person this would constitute the crime of homicide, which, depending on the circumstances and the definition of euthanasia used, might or might not also be classified as euthanasia.[44] In short, a primary *intent to kill* is never legally acceptable. An *intent of allowing to die* may or may not be

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38 *Ibid* at 200

39 *R v Maloney* [1985] AC 905 (UK)

40 It should be noted that medically appropriate pain relief treatment, that is properly titrated to the patient's pain, is unlikely to kill the patient, indeed it can prolong life I have taken here, however, the strongest pro-euthanasia argument against the anti-euthanasia case, which is that those who agree with pain relief treatment that will shorten life, but not with euthanasia, are inconsistent at best, and, more realistically, hypocritical.

41 See for example the Canadian *Criminal Code* RSC 1985 [Revised Statutes of Canada] cC-46 (as amended), section 222(5)(9).

42 See Somerville, note 1 *supra* at 4, note 7, for a discussion of the concept of primary intent, which is a synonym for motive

43 For discussion of medical futility see *infra* pp 569-70.

44 See *infra* p 570 and note 76

legally acceptable depending on all the circumstances.

Legal immunity for administering necessary pain relief treatment given with the primary intention of relieving pain, but that will shorten life, is implemented through the doctrine of double effect.[45] One way of viewing this doctrine is that it allows motive or primary intent to negate a *mens rea* of intention to kill which would otherwise be present. The doctrine of double effect could also be regarded as functioning through its building into the requirements of the *actus reus* the absence of elements that, alternatively, could function as a defense of necessity. In the context of providing necessary pain relief treatment that will shorten life, this defence can be articulated as follows: the necessity to use certain means to relieve pain justifies the use of these means even though the undesired result of doing so will be the shortening of life. Transferred into the context of *actus reus*, the elements of this defence become: the *actus reus* of a culpable homicide will not be present, if the act causing death was the administration of treatment necessary to relieve the patient's pain. This is a strained analysis and we can ask why, in relevant situations, the law would not just, as it usually does where appropriate, apply necessity as a defence.

At least two reasons can be postulated. First, there could be an important aim of not raising even the spectre of criminal liability in the context of providing fully adequate pain relief treatment, because this could make physicians concerned about giving such treatment and reluctant to do so out of fear of attracting criminal liability. As a true defence, necessity operates by way of 'confession and avoidance', which means that it raises the possibility of criminal liability. The actor confesses to an act that attracts criminal liability and then avoids liability for it by proving all the essential elements for a defence of necessity. Second, there is probably concern not to open up the defence of necessity in the context of medical treatment at the end of life, which using the *absence of 'necessity'* as a necessary element of the *actus reus* of any crime associated with the giving of pain relief treatment,[46] rather than using necessity as a defence in these circumstances, can achieve. Indeed, those who are pro-euthanasia do argue that a defence of necessity should apply to the provision of euthanasia, as the courts in The Netherlands have held.[47] Responses to this proposition by those opposed to euthanasia are of two kinds. First, they argue that a defence of necessity has never been applied to allow the taking of human life except where this is justified on the basis that it was necessary to save one's own life (that is, as self-defence) or to protect the lives of others. Second, they point out that, difficult as it can be to accept, there is some suffering that we cannot eliminate and we should not seek to do this through inflicting death and that euthanasia is not necessary for the relief of persons' pain. In extreme cases, pain relief can be achieved through means that do not involve

45 For discussion of this test, see *supra* p 559.

46 The one exception to this statement is that the analyses and arguments presented in relation to pain relief treatment that will or could shorten life apply *mutatis mutandi* to similar treatment for the relief of symptoms of serious physical distress, such as acute breathlessness or intractable vomiting, experienced by some dying persons

47 B Sneiderman and M Verhoef. "Patient Autonomy and the Defence of Medical Necessity Five Dutch Euthanasia Cases" (1996) 34(2) *Alberta Law Review* 374-415

killing a patient, for instance, through total sedation, which makes it very unlikely that a court would hold that a defence of necessity would apply to justify euthanasia as a means of relieving pain.

The use of total sedation in the case of dying patients is yet another issue that raises complex ethical and legal concerns. These cannot be explored here, but, as the Canadian Parliament's *Special Senate Committee on Euthanasia and Assisted Suicide*[48] recommended in their report, they need in-depth research. On the one hand, in a few rare cases where a person is receiving good palliative care, but all other measures to relieve pain or other symptoms of unbearable physical suffering have failed, total sedation could be the treatment of choice and ethically and legally acceptable as such. On the other hand, there should be serious concern if the number of these cases in a given unit were more than a very few. This would be a strong indication that such treatment was, in fact, being used as a form of 'slow euthanasia', properly so-called.[49] Moreover, as in other areas of the euthanasia debate, our choice of language can profoundly affect how we view total sedation. Some people who are pro-euthanasia have decried the willingness of those who are anti-euthanasia to approve of people dying in a state of 'pharmacological stupor', while being unwilling to permit lethal injections. Although we may not agree with the substance of the arguments that such criticisms reflect, they do contain valid warnings of the need for all of us, including those who are anti-euthanasia, to question constantly the essential nature, ethical integrity and consistency of our actions, values and beliefs concerning end-of-life decision-making.

To return to the issue of intent, when pain relief treatment that only *might* shorten life is given, there is probably no *mens rea* of intention because the outcome may not be certain enough to be intended and death is not a desired outcome. Alternatively, a *mens rea* of recklessness - conscious, unjustified risk-taking - which would support a charge of manslaughter and even, in some circumstances in some jurisdictions, murder, could arguably be present. However, when the risk-taking with respect to shortening life is the only way to relieve pain, it is most unlikely that it would be held to be *unjustified* and, therefore, a *mens rea* of recklessness would not be present.

Those who are pro-euthanasia argue that in many cases it is not possible to determine whether a physician's primary intent is to relieve pain or to kill the patient or, indeed, that both aims could be concurrently present.[50] In some cases this determination might not seem possible, although we should keep in mind that juries in criminal cases are asked to make such determinations with respect to intent every day. Moreover, even if the task proves difficult in certain cases, this does not lessen the importance of making a distinction between these different primary intents, and of recognising the impact beyond individual cases that changing this approach would have. The criminal law is an important value-forming, value-upholding institution for society. Changing the criminal law,

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48 Parliament of Canada, *Report of the Special Senate Committee on Euthanasia and Assisted Suicide*, Minister of Supply and Services Canada, Ottawa, 1995.

49 See the discussion, *supra* pp 558-9, in which necessary pain relief treatment is wrongly characterised as 'slow euthanasia'

50 See for example, Lagnado, note 18 *supra*

therefore, has important effects on societal values. The present legal approach to giving treatment that is necessary to relieve pain, but that could or will shorten life, which distinguishes a primary intent to relieve pain from a primary intent to kill and only imposes criminal liability when the latter is present, means that society can maintain its most important fundamental norm, that we do not kill each other, while still allowing physicians to administer such pain relief treatment. It is essential that we can *both* give such treatment and uphold this norm, which we cannot do if we legalise euthanasia.

C. Confusion of Causation

Physicians often describe themselves as being deeply confused by the law's approach to finding the presence or absence of causation with respect to the death of a person that results from, for example, a withdrawal of life support treatment, as compared with that which results from the administration of a lethal injection. This is not surprising as causation is a complex, technical and nuanced area of legal theory, that can be confusing even for lawyers. The legal concept of causation and its application to decision-making at the end of life in a medical context, is explored in this section.

Some of the confusion in understanding the law's approach to causation with respect to death when this occurs as a result of a refusal of treatment, as compared with as a result of a lethal injection, has been introduced by those in favour of euthanasia who argue that the causation distinctions made between these two situations are artificial. They contend that in both cases the 'but for' test[51] - the law's test for causation-in-fact - shows that the action of the physician was responsible for the death of the patient: 'but for' the withdrawal of treatment the patient would not have died, therefore, the withdrawal of treatment is the cause of the patient's death; 'but for' the lethal injection the patient would not have died, therefore, likewise, the lethal injection is the cause of the patient's death. This approach, however, contains confusion of at least two kinds.

First, a causation analysis only becomes relevant in the criminal law when there is conduct that could constitute a crime accompanied by the required *mens rea*, and the question is whether that conduct caused the prohibited outcome. In the case of a patient's refusal of treatment and the withdrawal of treatment subsequent to that refusal, there is no illegal act of which a causal link to a relevant outcome needs to be determined. In contrast, when a physician gives a lethal injection - which *prima facie* constitutes the *actus reus* of a crime - and the physician agrees that this was accompanied by an intention to kill - the required *mens rea* - it is relevant to ask whether this lethal injection was the cause of the patient's death: 'But for' the lethal injection, would the patient have died at that time? It is only if it is proven beyond a reasonable doubt that the injection was the cause of death, that the physician is criminally liable. In other words, causation is an essential requirement that must be established as part of the *actus reus* and in addition to *mens rea*, to find criminal liability. *It is not a factor which, standing alone, gives rise to liability.* Hence the argument that a

51 See, *infra* p 564.

physician 'caused' a patient's death in either turning off a respirator pursuant to the patient's refusal of treatment, or in giving a lethal injection and, therefore, both cases should be treated alike in terms of criminal responsibility, fails to understand or to apply some of the most basic tenets of the criminal law.

The second confusion in relation to the legal doctrine of causation is that persons who are pro-euthanasia seem to assume that the 'but for' test must always be applied. The law, however, sometimes recognises causal connections without this test being satisfied and it ignores some connections which would be established under that test.[52] Moreover, in the case of a refusal of treatment that results in death, the 'but for' test is complicated because there is not a sole cause of death present. Rather, there are two causes, the patient's underlying condition and the removal of life support. If the question were framed simply as 'but for' the patient's underlying condition, would the patient have died when taken off the life support and the answer to this is *no*, as it is when people are dependent on life support, then it is the patient's underlying condition - natural causes - that for *the purposes of the law* caused the person's death, not the removal of the respirator. The issue is, *when* should the question be framed in this way?

When multiple causes are present, there is a value judgement involved in choosing which formulation of the 'but for' test predominates in establishing causation-in-fact,[53] and whether none of the causal factors, one, more than one, or all of them, each of which could attract legal liability, count as relevant in establishing criminal liability. In a situation where one has a duty not to continue to treat the patient with artificial life support because the patient has refused this or because it is medically futile, then it is inappropriate to formulate the test of causation (even if it were relevant to assess causation, itself, which it is not if the act of withdrawing treatment is legal) in terms of whether the cause of death was the withdrawal of the treatment. The physician cannot have a legal obligation both to withdraw the treatment and not to withdraw it and we must choose which of these duties predominates in a given situation. If the former, then the relevant test of the cause of the patient's death is 'but for' the patient's underlying condition would the patient have died; if the latter, 'but for' turning off the respirator would the patient have died.

Yet another approach is to recognise that the withdrawal of life support treatment involves a situation of multiple causation in which one of the causes (respiratory failure) is, in itself, sufficient to cause death, while the other cause (turning off the respirator) is not sufficient in the absence of respiratory failure. While the courts could still hold the latter to be a cause for the purposes of the law (a contributing cause) - and will do so when turning off the respirator

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52 Colvin, note 37 *supra* at 80-82

53 The criminal law tends not to use, overtly, the distinction between causation-in-fact and causation-in-law, which is well developed in tort law (See J Fleming, *The Law of Torts* (1992) The Law Book Company Ltd, at 192-204) Rather, in deciding criminal cases courts speak simply of causation. Their reason for doing this is probably to avoid the appearance of using judicial discretion or arbitrariness in relation to their decisions on causation (see *infra* p 555, pp 568-9) The result is, however, greater confusion in the theory and sometimes the application of the law governing causation in the criminal law than in tort law. See Colvin, note 37 *supra* at 78-95, D Stuart, *Canadian Criminal Law* (2nd ed) Carswell, Toronto, at 102-116.

constitutes an illegal act[54] - they do not do so when the act of turning off the respirator is legal. Although a determination of causation is not relevant in the latter circumstances, at first glance somewhat paradoxically, the courts have often taken pains to justify their decisions not to impose criminal liability in such cases, *from the point of view of causation*: they hold that, from the law's perspective, turning off the respirator was not the cause of death. We could speculate whether there are psychological reasons that make judges feel compelled to do this. Most probably, however, the courts have felt it necessary to make a finding that death resulted from natural causes in the 'turning off the respirator' cases, in order to distinguish these cases from the giving of a lethal injection and to avoid any possibility that they could be seen as setting a precedent to the effect that lethal injections would be legally acceptable.

It is clear in tort cases that cause-in-fact, the test for which in single cause cases is most often the 'but for' approach, does not, however, by itself, establish causation for the purposes of legal liability. Cause-in-law, *causa causans*, is also required.[55] This is sometimes referred to as the essential cause or causes, if any, among the causes-in-fact, that will be regarded as the cause by the law. Although this second aspect of causation, 'causation as a question of law',[56] is relevant to the criminal law, it is not frequently openly discussed in that context, or, when it is, the courts and commentators recognise the hesitancy and uncertainty that surround its definition and application.[57] Probably these difficulties are associated with concerns that open use of the doctrine could give the impression that a finding of causation, and hence of criminal liability, was discretionary on the part of the judge. The same concerns are not present, at least to the same degree, in imposing civil liability in tort cases where the concept is constantly identified and used. Indeed, on occasion criminal law judges have turned to tort law cases to clarify and explain the operation of the concept of cause-in-law.[58] Consequently, it is worth examining how this concept functions in that area.

In the law of civil responsibility - tort law - the tests for causation-in-law are of varying degrees of stringency. The test which most favours liability is that causation-in-law will be present for those consequences the risk of which would not be unforeseeable to the reasonable person in the same circumstances. The Privy Council described what constituted such a foreseeable risk as "one which would occur to the mind of a reasonable man in the [same] position...which he would not brush aside as far-fetched".[59] A test which favours liability less is that causation-in-law will be present only for those consequences the risk of which a reasonable person in the same circumstances would have reasonably foreseen.[60]

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54 See *infra*, p 570.

55 Fleming, note 53 *supra* at 192-3, 202-204.

56 Stuart, note 53 *supra*

57 *Ibid* at 110-16; Colvin, note 37 *supra* at 84-90.

58 *R v Knutsen* [1963] Qd R 157 (CCA) as cited in Colvin, *ibid* at 87-8

59 *Overseas Tankship (UK) Ltd v The Miller Steamship Co Pty Ltd (The Wagon Mound) (No 2)* [1966] 2 All ER 709 (PC)

60 *Overseas Tankship (UK) Ltd v Morts Dock and Engineering Co Ltd (The Wagon Mound) (No 1)* [1961] AC 388; 1 All ER 404 (PC).

A causal test of directness - how directly the harm that results is linked to the wrongful conduct - although no longer a sufficient test of causation-in-law, can also play a role in assessing this.[61] In the context of criminal law, the most accused favouring test of causation would be used, as there is a presumption in the law against imposing criminal liability.[62] This would mean that an accused person must have subjectively foreseen the outcome of the conduct that gives rise to criminal liability, or the risk of this occurring, although not the exact way in which this outcome results, in order to be held causally responsible for that outcome. Subjective foreseeability of the consequences for which one seeks to hold an accused criminally liable, rather than objective foreseeability as in the civil law, is necessary because *mens rea* is an essential element in imposing criminal liability. Moreover, when the prohibited outcome results from crystallisation of a risk, in practice, although not in theory, the likelihood of occurrence of that risk will probably need to be higher in criminal law than in civil law, for it to be characterised as reasonably foreseeable for the purposes of making a finding that causation is present. Again, this is because there is a presumption of innocence in favour of the accused, which means that all doubt must be resolved in favour of the accused.

In the context of criminal law, Colvin summarises the situation relating to causation as follows:

> At common law, two different general tests have been used in handling questions of causal responsibility. They will here be called the 'substantial cause' test and the 'reasonable foreseeability' test. The 'substantial cause' test is a *retrospective test*. It involves looking backwards from a result in order to determine whether, in the light of all that happened, a particular causal factor has played a substantial role in bringing about that result. In contrast the 'reasonable foreseeability' test is a *prospective test*. It involves adopting the position of the person who was alleged to have caused the result and then looking forward from the conduct towards the result. The question is asked whether or not the conduct made the result a reasonably foreseeable consequence, in the sense that it was within the normal range of expected outcomes ... Each of these tests carries a good deal of judicial support. In most instances they yield the same outcomes but divergences are possible. Unfortunately the courts have avoided confronting the differences between the tests. Cases are handled by reference to one or the other, with the alternative usually being ignored. If the alternative is recognised at all, the choice which has been made is usually not defended.[63]

We can apply these tests of causal responsibility to death resulting either from the withdrawal of life support treatment which the patient has refused, or from the administration of a lethal injection. Death is a *reasonably foreseeable* result of withdrawing the life support treatment, but the courts have consistently held that such withdrawals are not the *substantial cause* of death. Death is also a *reasonably foreseeable*, in fact, certain, result of a lethal injection, but, in contrast to the previous situation, one could not imagine a court holding, when there is proof beyond a reasonable doubt that death resulted from the injection, that the lethal injection was not the *substantial cause* of death.

In tort cases, in deciding whether or not causation-in-law is present, judges sometimes refer to their needing to determine the *proximity* or *remoteness* of the

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61 *Ibid.*

62 One expression of this is the presumption of innocence

63 Colvin, note 37 *supra* at 84-85.

damage from the cause. This can be regarded as simply another way of expressing the foreseeability-of-consequences test of causation, or as an additional test which must be fulfilled in order to establish causation-in-law. The words proximity or remoteness accurately connote that, to a greater or lesser extent, this test involves an exercise of judicial discretion in making a finding as to causation. The test can be regarded as a device which allows a judge to factor into the decision-making a determination as to moral blameworthiness. It allows a judge to find that, even though causation-in-fact is established, causation is not present in a particular case if blameworthiness is low or absent. The terms proximity and remoteness are not used often by courts in determining causation in the criminal law,[64] this is probably, again, because they raise a strong implication of there being a discretionary component in a judgment as to causation, and the identified exercise of such a discretion is much more carefully constrained in a criminal culpability context than a civil liability one.

It is important to note how the tests of remoteness or proximity interact with the 'but for' or causation-in-fact test. "[W]hat is meant by 'proximate' is that because of convenience, of public policy, or a rough sense of justice, the law arbitrarily declines to trace a series of events beyond a certain point. This is not logic. It is practical politics."[65] In summary, even if 'but for' the act in question the outcome in question would not have occurred, the court can still find that, in the eyes of the law, there is no causal link between that act and that outcome. We can speculate whether the concepts of remoteness and proximity could help to explain the different findings with respect to causation in relation to death resulting from the refusal of life support treatment and that resulting from a lethal injection. What role does the absence of moral blameworthiness play in finding that the withdrawal of life support does not cause death? Or does the presence of 'natural causes' and the fact that death would not result in the absence of these, make death from a refusal of treatment remote from, not proximate enough to, the withdrawal of that treatment? The same analysis would not apply to death from a lethal injection.

Public policy, another test that involves an exercise of discretion, may also be used in tort law to justify a finding that causation is not present, although judges have classically been very reluctant to use it because of its perceived nature of being 'an unruly horse'.[66] This test is sometimes articulated as an element in assessing cause-in-law, or as a part of the test for proximity or remoteness, but it is best viewed as being an additional test. It is used to find that, for reasons of public policy, causation is absent. But it is not used to find the contrary, that is, that for reasons of public policy, causation is present. In other words, when

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64 In comparison, the American Model Penal Code's definition of causation [Section 203] requires that the consequence for which one seeks to hold the accused liable must not be "too remote or accidental in its occurrence to have a just bearing on the actor's liability or on the gravity of his offence".

65 J Fleming, note 53 *supra* at 203, citing *Palsgraf v Long Island RR* 248 NY 339 (1928) at 352, per Andrews J Cf Lord Wright: "The law must abstract some consequences as relevant, not perhaps on the grounds of pure logic but simply for practical reasons" (*Liesbosch v The Edison* [1933] AC 449 at 460)

66 *Richardson v Mellish* (1824) 2 Bingham 229 at 252, Burrough J.

called into play as an element of the doctrine of causation, public policy operates only to provide immunity from legal liability, not to impose it. Once again we can speculate whether there is an element of public policy at play in finding that causation is absent when death results from withdrawal of treatment pursuant to a patient's request, but this same element is not operative when death results from a lethal injection.

It is worth noting here, that outside the context of causation, the notion of public policy plays a special role in the criminal law in characterising acts to which the consent of the person affected by those acts may function as a defence. For instance, the intentional infliction of bodily harm, beyond a certain very limited degree, will be held to be contrary to public policy and, therefore, at common law the consent of the person suffering that harm will not be a defence to such an act.[67] In contrast, consent to an act of minimal harm that is not deemed to be contrary to public policy will function to protect the person inflicting the harm from a charge of criminal assault.

In this respect, we can compare an act of turning off a respirator on which a person depends for life-support and the giving of a lethal injection. Turning off a respirator is not, in itself, contrary to public policy and, therefore, one way in which this can be justified is with the consent of the person at that time or in advance (or, if the person is incompetent and has not left 'advance directives', the consent of the person's legally valid substitute decision-maker). In contrast, giving a lethal injection to a person is, in itself, contrary to public policy and hence the consent of the person to this is irrelevant to criminal liability for giving it. This raises the issue of how necessary pain relief treatment given with the primary intention of relieving pain that could or will shorten life should be *prima facie* characterised from a public policy perspective. Just as the intent to relieve pain and not to kill justifies, through the doctrine of double effect, the administration of such treatment, likewise this same intent legitimates this treatment from a public policy perspective and, therefore, it can be given with the consent of the patient. Indeed, it should be considered to be contrary to public policy to fail to offer fully adequate pain relief treatment to persons who need this.

The above discussion, as a whole, raises the sometimes vexed issue of the exercise of judicial discretion and the role that this should play in determining legal liability. One's view in this respect may differ depending on how the exercise of that discretion is characterised. For instance, there is a major difference between, on the one hand, identifying this as an example of purely arbitrary decision making on the part of the judge and, on the other hand, characterising it as the use by the judge of human 'ways of knowing' other than pure reason. For example, the judges in both the Supreme Court of Canada and United States Supreme Court, in finding that a legislative ban on assisted suicide, which includes physician-assisted suicide, was not unconstitutional, looked to the history of their respective countries, including their legal and

67 See for example, *R v Donovan* [1934] 2 KB 498, 25 Cr App R 1 (CCA). See also *R v Jobidon* (1991) 66 CCC (3d) 454 (Supreme Court of Canada).

legislative histories - that is, to human memory as a 'way of knowing'. Thus memory was used to balance a strictly reasoned argument that there was no moral and ought to be no legal difference "between letting a patient die and making that patient die",[68] to find that there were important, profound and well-established differences between these.

D. Confusion of Case Law

I turn now to an article recently published in *The Lancet*, which is yet another example of an argument for the legalisation of euthanasia based on confusion. Mason and Mulligan propose that euthanasia should be introduced by stages, that is, it should first be made available for persons suffering from certain conditions.[69] The two conditions they suggest are permanent vegetative state and progressive neurological disease.[70] In making this proposal, the two authors decry the fact that "the rhetoric of euthanasia is blurred", and then proceed to add to the confusion. In this instance, the confusion resides in their interpretation of the judgments in two Canadian cases, to the effect that the courts in these cases were moving towards support for euthanasia. One of these cases, *Nancy B*,[71] involved a refusal of treatment that resulted in death. In the other, the *Rodgriguez* case,[72] the Supreme Court of Canada was faced with a claim that the prohibition of physician-assisted suicide in the Canadian *Criminal Code*[73] contravenes persons' constitutional rights to liberty and security of their person. In other words, this latter case involved the court adjudicating a claim that terminally ill people have a constitutionally protected 'right' to physician assistance in committing suicide.

Mason and Mulligan first recognise that medically futile treatment can be withheld or withdrawn from persons in a permanent vegetative state. The term 'medically futile treatment' has already been mentioned in passing.[74] Although, as is well known, medical futility is difficult to define and its determination involves value judgements, it is necessary to use this concept. There is no ethical or legal obligation to continue to give medically useless treatment - indeed, at least in publicly funded health care systems, there is an ethical obligation not to waste scarce health care resources, which giving such treatment would constitute. Therefore, we cannot avoid the need to make decisions as to when certain medical treatment has become futile.[75] Provided that care is taken

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68 *Quill v Vacco* note 13 *supra*, per Renquist CJ.

69 JK Mason and D Mulligan, "Euthanasia by Stages" *The Lancet* 1996; 347. 810-811.

70 Mason's and Mulligan's proposal moves the focus from the right to self-determination and autonomy of the patient, to the disease from which the patient suffers, as a primary justification for euthanasia. This raises important issues about the impact that legalising euthanasia would have on disabled people, who suffer from the same or equally debilitating conditions.

71 *Nancy B v Hôtel-Dieu de Québec* [1992] RJQ 361; 86 DLR (4th) 385 (Sup Ct) (translation from French).

72 *Rodriguez v Canada (AG)* [1993] 3 SCR 519; 107 DLR (4th) 342.

73 Note 41 *supra*

74 See *supra* p 561.

75 This raises an interesting issue, which cannot be discussed in detail here; the basic presumption from which we should assess obligations to give medical treatment In brief, it can make a difference, especially in difficult cases where, for instance, we are unsure whether or not treatment should be

to limit strictly the definition of what constitutes medically futile treatment in any given case, most people who are anti-euthanasia would agree that such treatment can be withdrawn. They would not agree however, that this constitutes either euthanasia or, as Mason and Mulligan propose, a basis for its approval.

Yet another way in which confusion between the withholding or withdrawal of treatment and euthanasia can arise, is that there are cases in which the withholding or withdrawal of treatment would constitute euthanasia. For instance, to withhold or withdraw life-support treatment from a person who had always been mentally incompetent with the primary intention of inflicting death on the person, rather than on the basis that any reasonable physician would agree that the treatment was medically futile, would be at best euthanasia.[76] As this example demonstrates, and as discussed already, it is not only what we do, but the reasons for which we do it that are important in defining whether or not certain conduct constitutes euthanasia.[77] Moreover, it is these reasons, and not simply the outcome of any given decision, that will set the precedents for what is legally allowed or prohibited in decision-making in a medical context at the end of life.

Mason and Mulligan base their case for introducing 'euthanasia by stages' on their finding that "there are strong indications that courts and law enforcement authorities outside the United Kingdom are coming to accept the practice [of euthanasia and physician-assisted suicide]".[78] As mentioned previously, they cite as authority for this proposition two relatively recent Canadian cases, the decisions of the Superior Court of Quebec in *Nancy B*[79] and the Supreme Court of Canada in *Rodriguez*.[80] The *Nancy B* case involved withdrawal of life support treatment. It is, therefore, important to understand the basis on which the law in Canada allows withdrawal of medical treatment in order to determine whether the court in this case was, as Mason and Mulligan assert, in fact, tending towards support for euthanasia. The *Rodriguez case* involved a claim that prohibiting physician-assisted suicide contravened individual rights protected under the Canadian *Constitution*. Again, it is important to understand the law on which this claim is based, and that on which the judgments handed down in the Supreme Court of Canada were founded, to determine whether Mason and

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withdrawn, if we start from a basic presumption that a treatment should be continued unless it can be shown that it is useless, or a presumption that only a treatment that might be useful (or, even more stringently, is reasonably likely to be useful) must continue to be given to the patient In cases of equal doubt about usefulness or futility the basic presumption governs. Therefore, *in the same circumstances*, the first presumption would mean that the treatment must be continued; the second presumption would mean that it could be withdrawn. See Somerville, note 1 *supra* at 63-67.

76 It merits noting that if a similar situation arose with respect to a competent person who refused to consent to the withdrawal of the treatment, but this was withdrawn anyway, we would unhesitatingly call this murder not euthanasia Moreover, the issue of withdrawing medically futile treatment from a competent patient against that patient's will (or in the case of incompetent patients, contrary to the will of their substitute decision-makers) raises complex legal issues that are likely to be faced by courts in the near future, as we experience severe restrictions on health care budgets in many jurisdictions

77 See *supra* pp 559-63

78 Note 69 *supra*

79 Note 71 *supra*.

80 Note 72 *supra*.

Mulligan are correct that this case shows the courts moving towards recognising the legality of euthanasia - or, more accurately, physician-assisted suicide.

The *Nancy B* case required the court to apply the *Civil Code* of Quebec (private law in Quebec is governed under a civilian juridical regime, as in France). The *Civil Code* provides that "the human person is inviolable", that is, not allowed to be touched without the person's consent.[81] The *Code* also expressly provides that medical care or treatment must not be given to a competent person without that person's free and informed consent.[82] Nancy B had suffered irreversible respiratory paralysis as a result of *Guillain-Barré* syndrome and was dependent on a respirator. She asked for this life-support treatment to be discontinued. The court affirmed Nancy B's right to refuse such treatment, even though this would result in her death.

The court held that the duty to respect the person's refusal of treatment is almost absolute in the case of a competent adult person.[83] It found that Nancy B wanted "the respiratory support treatment being given to her to cease so that nature can take its course..."[84] It ruled that this "may not properly be viewed as an attempt to commit suicide ...[because] death ... would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury".[85] In particular, the court found that turning off the respirator would not offend any of the provisions of the Canadian *Criminal Code*[86] (which is based on the common law), because no act that would constitute homicide or assistance with suicide would be present. The judge concluded "that homicide and suicide are not natural deaths whereas in the present case, if the plaintiff's [Nancy B's] death take place after the respiratory support treatment is stopped at her request, it would be the result of nature taking its course."[87]

In the *Rodriguez* case, all judges of the Supreme Court of Canada strongly upheld the right to refuse treatment - including on the basis of the person's right to inviolability - but, just as strongly, a majority differentiated this from any right to have assistance in committing suicide or access to euthanasia. The technical legal basis of the majority's judgment was that the prohibition on assisting in suicide in subsection 241(b) of the *Criminal Code*, was constitutionally valid, that is, such assistance could be interdicted by Parliament through the criminal law. In coming to this conclusion, the majority analysed the relevant sections of the *Canadian Charter of Rights and Freedoms*,[88] that part of Canadian constitutional law that allows individuals to challenge the validity of legislation on the grounds that it contravenes the individual's constitutionally protected rights. However, they also extensively explored the history of prohibitions on assisting in suicide, the approach of other jurisdictions to this issue, and the

81 Civil Code of Quebec, Article 19.
82 *Ibid*, Article 19 1
83 *Nancy B*, note 71 *supra* at 390-1 (DLR).
84 *Ibid* at 392 (DLR).
85 *Ibid*, citing *Re Conroy* 486 A 2d 1209 (NJJ 1985) at 1224.
86 Note 41 *supra*
87 *Nancy B*, note 71 *supra*, at 934 (DLR)
88 Part 1 of the *Constitution Act* 1982, being Schedule B to the *Canada Act* 1982 (UK) 1982, c 11

common law governing medical decisions at the end of life, and used their findings in these respects as further support for their decision.[89]

Of the four judges in dissent in the *Rodriguez* case, who held that the prohibition on physician-assisted suicide was constitutionally invalid, the judgment of the Chief Justice of Canada was the most unprecedented. Chief Justice Lamer ruled that there is a "right to choose suicide"[90] enshrined within Canadian constitutional law, and that a failure to provide assistance in committing suicide to persons who are physically unable to carry this out themselves, contravenes constitutional rights against discrimination on the basis of physical handicap legislated in section 15 of the *Canadian Charter of Rights and Freedoms*. It was essential to the Chief Justice's ruling that the prohibition of assisted suicide in the *Criminal Code* was unconstitutional, that he find, first, a right of the plaintiff, Sue Rodriguez, with respect to having assistance to commit suicide; second, that this right was infringed as a result of discrimination; and, third, that this discrimination flowed from the prohibition on assisting a person to commit suicide. The Chief Justice found that, both under the *Charter* and at common law, the rights of the individual to self-determination and autonomy gave rise to *a right to choose, in accordance with the law,*[91] *how to conduct one's own life.*[92] Moreover, in view of the fact that Parliament had repealed the legislation making suicide a crime and, therefore, suicide was legal, he ruled that this right to choose extended to a right to choose suicide. There is no necessary reason to suppose that the "right to choose suicide" which the Chief Justice articulated would be limited to terminally ill people, as the Chief Justice himself recognises,[93] or even to people who were ill. In fact, the contrary could be argued, as the Chief Justice based this right to choose suicide on the general rights of all individuals to self-determination and autonomy. This raises the issue of whether emergency treatment of persons who have attempted suicide and refuse medical treatment could also contravene this right.

This brief mention of just some of the complex issues raised in the very long judgment of the Supreme Court of Canada in the *Rodriguez* case can be contrasted with Mason and Mulligan's use of this case to support their proposal for the legalisation of physician-assisted suicide. They state that:

> [t]he arguments [by which they seem to mean the reasons of the majority of the Supreme Court of Canada, in upholding the constitutional validity of the crime of assisted suicide] were ... based very largely on Canadian constitutional law and the dissenting opinions [which would have allowed physician-assisted suicide and included the judgment of the Chief Justice] were of more general application.[94]

If anything, the contrary is the case. A 'right to choose suicide' has never been articulated in the common law, and it seems highly unlikely that such a right could be established except on a constitutional law foundation. Indeed, it was

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89 See MA Somerville, "Death Talk in Canada. The Rodriguez Case" (1994) 39 *McGill Law Journal*. 602-617

90 *Rodriguez* note 72 *supra* at 365

91 *Ibid* at 363.

92 *Ibid* at 365

93 *Ibid* at 384

94 Note 69 *supra* at 811.

because the prohibition on assisted suicide in the *Criminal Code* breached Sue Rodriguez's rights to autonomy and self-determination and these rights were protected under her *right to security of the person* in section 7 of the *Charter*, that the Chief Justice held that the prohibition was unconstitutional and, therefore, ruled that it should be struck down. Interestingly, the Chief Justice did not rely on the section 7 *right to liberty* to support his judgment, nor did he discuss the interaction of the section 7 *right to life* with the section 7 rights to self determination and autonomy, when these latter are used to choose suicide. Moreover, the *ratio* of the Chief Justice's judgment is that the prohibition on assisted suicide in the *Canadian Criminal Code* constitutes prohibited discrimination within the anti-discrimination provisions of section 15(1) of the *Charter*. In other words, the use of constitutional law was essential and central to the Chief Justice's finding that Sue Rodriguez had a right to physician assistance in committing suicide, in fact, that she had a right to euthanasia.

One of the main arguments in the *Rodriguez case* in support of physician-assisted suicide, was one outlined previously,[95] namely, that Canadian law recognises patients' rights to refuse treatment, even when this will result in death; that this is to recognise a right to die; and that it should make no difference legally whether this right is exercised through passive means (refusal of treatment) or active means (physician assistance in committing suicide or euthanasia). It is important to understand the juridical basis of the right to refuse treatment, because the extent to which this right can be used to ground an argument for the legalisation of euthanasia varies depending on the nature of this basis. This basis can differ, as can be seen by comparing Canada and the United States.

In Canada, the right to refuse treatment has been consistently interpreted by the courts, with the exception of some of the dissenting judges in the *Rodriguez* case who articulated a broader base for this right, as founded on the person's right to *inviolability* - that is, the right not to be touched without one's consent. Such a right is of only negative content and cannot be used to found a positive content right to have assistance in committing suicide or access to euthanasia. In contrast, in the United States the courts have interpreted the penumbra right of privacy which the United States Supreme Court has found surrounds that country's *Constitution*,[96] as including a right to personal *autonomy*. This right has been held to have both negative and positive content limbs, that is, to encompass not only a right to refuse treatment,[97] but also, a positive content right to determine what happens to oneself. The latter includes rights to be free from state interference in the form of law, in deciding what should happen to one's body.[98] Recently this right was interpreted by the United States Ninth Circuit Court of Appeals[99] and Second Circuit Court of Appeals,[100] as giving rise to a

95 *Supra* at pp 554, 557-8
96 *Roe v Wade* 410 US 113 (1973) (USSC)
97 *Cruzan v Director, Missouri Department of Health* 497 US 261 (1990) (USSC).
98 *Roe v Wade* note 96 *supra*
99 *Compassion in Dying v Washington* 79 F 3rd 790 (9th Cir 1996)
100 *Quill v Vacco* 80 F 3rd 716 (2nd Cir 1996)

constitutional right not to be prevented from seeking physician assistance in committing suicide. These cases were appealed to the United States Supreme Court which has just ruled that state laws prohibiting assistance in suicide are constitutionally valid.[101] But the constitutional validity of state laws that would allow euthanasia or physician-assisted suicide, in countries such as the United States and Australia which have a federal constitution that gives jurisdiction over criminal law to the states, remains an open question.[102] This is very likely to be tested in the near future.

III. CONCLUSION

The euthanasia debate is a momentous one. It involves our *past* - the norms and values we have inherited; our *present* - whether we will change these; and our *future* - the impact that a decision, now, either for or against euthanasia, will have on our descendants both as individuals and a society.[103] The outcome of this debate will set the 'death tone' of the society in which they will live and die, and will have a major impact on the societal paradigm - the 'shared story' - on which their society will be based.[104] Consequently, we need to engage in this debate, not only, with great honesty, integrity and courage, but also with clarity, not confusion. This clarity must extend to recognising that there are many important points relating to decision making at the end of life on which we all agree, whether we are for or against euthanasia. We then must start our debate from this agreement, rather than from our disagreement. This will change the 'tone' of the debate, which, in turn, can change its outcome.

Almost everyone agrees that competent persons should be able to refuse treatment including through 'advance directives' (living wills or durable powers of attorney) and that when it is impossible to determine a person's wishes there is no legal or moral obligation to continue to administer medically futile treatment. Likewise, almost everyone agrees that people have the right to adequate pain relief treatment, even that which could or will shorten life, if this is necessary to relieve pain. Where we disagree is whether physician-assisted suicide and euthanasia should be legalised. This issue must be faced head-on and not dealt with by confusing it, whether accidentally or intentionally, with rights to refuse treatment or the provision of adequate pain relief treatment. To do so is to pre-empt the question that needs to be addressed - whether there ought to continue to be a legal difference between refusals of treatment and the

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101 *Vacco v Quill* note 13 *supra*, *Washington v Glucksberg* US Supreme Court Docket No 96-110, 26 June 1997 (United States Law Week, 65 LW 4669, June 24, 1997).

102 In Australia *The Rights of the Terminally Ill Act 1995* of the Northern Territory, which authorised euthanasia and physician-assisted suicide, was overridden by legislation (The *Andrews Bill* 1997) passed by the Federal Parliament. The power of the Parliament to override Territory legislation could, however, well be different from its power with respect to state legislation This could be tested if any of the pro-euthanasia bills currently before Australian state legislatures are passed into law.

103 MA Somerville, "Legalizing Euthanasia Why Now?" (1996) 68(3) *Australian Quarterly* 1-14

104 MA Somerville, "Genetics, Reproductive Technologies, Euthanasia and the Search for a New Societal Paradigm" (Editorial) (1996) 42(12) *Soc Sci Med*, IX-XII.

provision of adequate pain relief treatment, on the one hand, and physician-assisted suicide and euthanasia, on the other hand.

In addressing these issues, we need to recognise the harm that can be done to the law, in general, by the facile use of legal concepts - whether those of intention, causation, or 'precedent' in the form of case analysis. It should be a matter of serious concern, especially to lawyers, when those using these concepts to promote the legalisation of euthanasia distort them, whether intentionally or because they have only a poor understanding of them from a legal point of view. Moreover, the question is not only a matter of our rightful, profound sympathy for persons experiencing serious suffering, or whether, as Mason and Mulligan suggest, there are certain dreadful diseases or conditions for which we believe euthanasia is appropriate, but also, and at least of equal importance, whether allowing physicians to intervene on patients with a primary intention of inflicting death is inherently acceptable as a foundational principle and basic value in our societies. We cannot answer this question through confusion or 'in stages'. Rather, we must answer it openly, honestly, directly and, it is to be hoped, wisely.