EUTHANASIA AND THE LAW

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In considering the controversial issue of euthanasia, the author looks at the problems involved in legalizing certain forms of euthanasia, the advantages and disadvantages of "living wills" legislation, and possible civil or criminal liability of doctors who refrain from using extraordinary measures to prolong the life of dying patients. Alternatives to euthanasia and consequent legal developments are also discussed.

I. INTRODUCTION

The medical advances of the last few decades have given the medical profession a two-edged sword; the extension of human life by artificial means and the painless termination of life by drugs. "The ability of man to wield this sword has moral and ethical as well as practical considerations that are mind-boggling."[1] It is because of these medical advances that euthanasia and related subjects have become so important in the eyes of so many. Unfortunately, while medicine has been surging ahead, the development of our law has been lagging behind, to the point that it is more correct to call it "non-development". "Where the issues are ones of life and death, the law must strive for the greatest certainty that can be had."[2]

II. THE DEMAND FOR LEGALIZED EUTHANASIA

The medical revolution of the last twenty-five years has increased longevity to the point where ". . . death may be desired long before medicine lets it occur."[3] Medical advances have enabled physicians to achieve not only cures, but half cures, prolonging the lives of the terminally ill in situations where death would be a welcome blessing. In addition, technical advances have enabled the medical profession to prevent, in many cases, the full appearances of all the conditions enabling a doctor to certify death. As a result, there has been an increasing number of writers calling for the legalization or voluntary euthanasia, or mercy-killing.[4]

The proponents of euthanasia argue that it is cruel to prolong intense suffering of one who is mortally ill and desires to die. In a response no doubt dictated by compassion and humane motives, the demand for mercy-killing legislation reflects a change in social attitudes which demands less government control over what is seen as

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1. C. Everett Koop, "A Right To Die (II)" (1976) 2:2 *Human Life Rev.* 39.
2. M. George Parker, "You Are A Child Of The Universe: You Have A Right To Be Here" (1977) 7 *Manitoba L.J.* 174.
3. Daniel C. Maquire, "The Ethical And Technological Basis For The Right To Choose Death" *Euthanasia Symposium* (1974) 60.
4. *For e.g.*, see Arval A. Morris, "Voluntary Euthanasia" (1970) 45 *Washington L. Rev.* 239.

unwarranted intervention in matters of personal and private choice. "The underlying principle is that the choice of life or death should always be with the individual concerned, and that the choice of what happens to him should be in accordance with his values and not the values of others."[5] It is then asserted that it is a logical extension of the "right to die" argument that it is not wrong for the person to ask another to help him carry out his desire, nor is the other wrong in doing so.

The term "right to die" is in fact a misnomer. People do die, and will continue to do so whether the "right" is given or not. It hardly seems necessary to enact legal measures to enforce the right to bring about one's death, since anyone who wants to commit suicide is not likely to be prevented. What is really sought when the phrase "right to die" is used, is that it be made respectable to commit suicide and to involve others in that decision. "It is asked of us that we 'integrate' suicide into the fabric of our lives, participate in the decision, provide ritually sanctifying means."[6]

III. PROBLEMS WITH "LEGALIZED EUTHANASIA"

The claim to a "right to die" demands more than a right to one's own death. It means a right to be put to death, which necessarily involves a duty on others to partake in the active inducement of death. If there were indeed a "right" to kill oneself, a fireman who prevented a would-be suicide from splattering himself on the pavement might find himself susceptible to a tort action. It may even be looked upon as morally presumptuous to try to persuade a man not kill himself.

To make death a matter of choice may be more a source of complication than of liberation in our lives. In the minds of many, what is made legal is thereby made morally or ethically justifiable. Once suicide is institutionalized, it is not only permitted but encouraged. "As soon as it is legitimized as an option it becomes incumbent on the subject to explain why he has not chosen it rather than another course."[7] Such a choice, offered to a gravely ill person could and would ". . . sweep up in the process, some who are not really tired of life, but think others are tired of them; some who do not really want to die, but who feel they should not live on, because to do so when there looms the legal alternative of euthanasia is to do a selfish or cowardly act,"[8] To allow people to kill themselves, or have others perform the deed for them, without social disgrace, is to put pressure on them to do it. While the pressure in most cases will be slight, in others, especially those of conscientious and charitable people who have become a burden on their families, it may be intense, even irresistable. Elderly people would be continually agonizing as to whether they should relieve families and friends of the burden they impose. Undoubtedly, some will feel obligated to choose death.

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5. M.G. Parker, *supra* n. 2 at 152.
6. M.J. Sobran, "The Right To Die(I)" (1976) 2:2 *Human Life Rev.* 29.
7. *Id.* at 31.
8. *See* Yale Kamisar, "Some Non-Religious Views Against Proposed 'Mercy Killing' Legislation" (1958) 42 *Minnesota L. Rev.* 990.

If doctors and nurses were ever to endorse the idea that in some circumstances euthanasia is the best course of action to take in the "treatment" of the patient, inevitably there would be times when it would be felt that particular patients ought to ask for euthanasia. This would colour their attitudes towards and treatment of that patient, leading the patient to feel rejected and unwanted. Similarly, while proponents of euthanasia may suggest that patients would be comforted with the knowledge that their doctor will relieve them from unnecessary suffering should they become terminally ill, some patients may fear that their doctor would presume consent when they are in agony, even if they wanted to live.

There is the possibility that mercy-killing, even if humanely applied, would radically alter the sucess of medical treatment. Often, even the treatment of a non-fatal illness requires the physician to strengthen the will of the patient to endure a certain amount of suffering. "How could will be summoned if the patient knew euthanasia was a legally and medically acceptable option for him?"[9] There is also the problem that the physician himself would more readily adopt a defeatist attitude in instances where, but for the euthanasia option, a more positive attitude would prevail.

> I suggest to you that ninety percent of the cures which occur are a combination of the physician's treatment and the patient's will to live largely as a result of the faith he has in the man who looks after him and attends upon him as his doctor. . . it is of the utmost importance. . that the physician's role as a healer and preserver of life be in no way impaired. He ought never to be made an instrument of death. . . his effectiveness as a healer would steadily decline.[10]

Doctors, whose total purpose is to cure, now have the confidence of their patients. However, should doctors be given the authority to kill, for whatever reason, then that absolutely essential factor in the doctor-patient relationship, complete confidence, will be destroyed.

Many of those advocating euthanasia believe that it is a very cruel law which prevents sufferers from achieving a quick death, or that forces other people who care for them to helplessly watch their pointless pain.[11] However, there are certain deceptive elements that one must be cautious of in this approach. The first is our emotional response to a situation. A visitor entering an intensive care unit may feel revulsion at the sight of all the equipment assembled to keep the patient alive. The natural desire to be rid of such ugliness can lead to the desire for the death of the afflicted. Conversely, the onlooker may be motivated by feelings of sympathy and pity which manifest themselves in a desire for the death of the patient. However, the emotional reaction of the patient may be quite different.

The desire in the observer may be quite unrelated to any actual suffering the patient is undergoing. "Too often, talk of death with dignity comes from the relatives of the dying or from social scientists

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9. Stanley Joel Reiser, "The Dilemma Of Euthanasia In Modern Medical History: The English And American Experience" *The Dilemma of Euthanasia* (1971) 39.

10. Dr. Morris Shumiatcher Q.C., "Potential Risk, Abuse And Misuse of Legislation Governing Euthanasia" *Euthanasia Symposium, supra* n. 3 at 77.

11. *See* Anthony Flew, "The Principle of Euthanasia" *Euthanasia And The Right To Death* (1970) 33.

and philosophers who consider the sight of the dying somewhat undignified."[12] However, there is nothing inherently undignified about being fed intravenously or having one's respiration aided by a mechanical device.

> Dignity is something one either does or does not possess. It is an inherent, personal, indefinable concept. If a person lives with dignity, a person dies with dignity. If a person does not live with dignity, a person will not die with dignity. A dying patient in a hospital may be sustained by the steady drip from a glucose bottle, but still feel as dignified as she felt when she was healthy. Her relatives, on the other hand, may consider the scene distasteful and unseemly, and thereby rob the patient of her sense of self-worth.[13]

A second element at work is our tendency to project our own feelings on others. Given my present wishes, aspirations and tastes, it might seem unbearable to be old and senile, with a body racked by disease. I may even think I would prefer death to such a life. However, my thinking that death is preferable for such a person is a judgment that misses the real issue: the choice for that person is not between being old and sick and being young and healthy. The choice is between being old and sick and not being at all.

A third factor to consider is the actual pain involved in the dying process and the treatment of the terminally ill. There are misconceptions as to the amount of pain that surrounds death. Evidence suggests that the natural dying process is not the ordeal that it is thought to be.[14] "Nature itself usually effects a gracious transition from time to eternity, dulling the consciousness as the bodily processes ebb. When nature is negligent, drugs will eliminate unbearable pain."[15] Current work being done at the Cook County Hospital pain clinic reveals that there is now no such thing as intractable pain.[16] Any pain can be controlled if it is the desire of the physician to do so. In fact, now no one under medical care need die in agony.[17]

Much of the appeal surrounding the move to legalize euthanasia centres on the belief that it would be voluntary. Since "voluntary" implies that it would be available only to those who freely and knowingly request it, there arises the issue of mental competence. If the test of competence is as intangible and uncertain as it is with respect to capacity to execute a will, there is cause for concern, especially in light of the irreversibility of mistakes. The effect of drugs and disease, or violent reactions to surgical procedures may undermine the capacity for rational and independent thought.[18] Too often the case for euthanasia is built around carefully constructed abstract and hypothetical presentations.

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12. B.D. Colen, *Karen Ann Quinlan: Dying in the Age of Eternal Life* (1976) at 61.
13. *Id.*
14. *See* S.J. Reiser, *supra* n. 9 at 40; Neil Elliott, *The Gods of Life* (1974) at 76.
15. Paul Marx *Death Without Dignity* (1975) at 11.
16. Dennis Horan, "Introduction" *Death, Dying and Euthanasia* (1977) 302.
17. Jonathan Gould and Lord Craigmyle, *Your Death Warrant?* (1971) at 132. Dr. Cicely Saunders, O.B.E. and Medical Director, St. Christopher's Hospice, London, argues that pain need not accompany dying and will not if the proper drugs are administered, and administered as only a part of a whole treatment of the patient which is physical, psychological and philosophical in nature and extent.
18. *See* Frohman, "Vexing Problems in Forensic Medicine: A Physician's View" (1956) 31 *New York University L. Rev.* 1222. David W. Louisell, "Euthanasia and Biothanasia: On Dying and Killing" *Death, Dying and Euthanasia, supra* n. 16, at 387.

> It does not take into account the experience of clinicians who know that severely ill patients often show distorted judgment and decreased capacity for rational thinking, and that decisions by such patients can vary a great deal whether they are in a state of severe depression and suffering, or during a period of remission and greater mental clarity.[19]

Dr. Kubler-Ross has made a significant contribution to a better appreciation of death by the medical profession. Through a careful clinical study she had been able to identify five stages through which a typical dying person travels: denial, anger, bargaining, depression, and acceptance.[20] A patient's ordinary response to a query about euthanasia would likely be markedly different if that patient were in the depression state or in the denial stage. It would appear that the members of the very segment of the population for whom euthanasia is most urged would be the ones least likely to be able to give free consent. "The so-called independent decision to die is more romance than reality."[21]

A further consideration is that the legalization of euthanasia necessarily implies that death is in some circumstances an objective good, not only for the subject who finds his existence unendurable, but also for the observers.

> ... [I]t will be possible, and very likely socially permissible, for others to regard the subject critically and decide for themselves that he would be better off dead. All that will be lacking then for them to sentence him to die will be a decision-making apparatus. And once the attitude has taken root that we may reasonably *suggest* death for others, I cannot see why we should not proceed to prescribe it.[22]

Once death is defined as a good in itself, the elimination of others for their own good is inevitable. Therefore, it has been suggested that if euthanasia is legalized in the name of humanism, we cannot, in the name of humanism, deny death to those who lack the physical and mental capacity to ask for it.[23] This would include the retarded, infant handicapped, senile senior citizen and comatose accident victim. Such a view gives rise to the fear that the rules may be misapplied, the distinctions blurred, and practices may extend beyond those who comply with the strict requirements. It is believed that to legalize euthanasia would open the door to a greater relaxation of our present prohibition against killing.[24] This is the "thin edge of the wedge" theory.[25] It has been forcefully argued that to pass off fears about legalized euthanasia as so much nonsense is not only to ignore history but to sweep away much of the ground on which the notion of civil liberties rests — the

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19. Jacques Genest, "Bioethics and the Leadership of the Medical Profession" *Annals*, April 1977 133.
20. *See* Elizabeth Kubler-Ross, On Death and Dying *(1969)*.
21. Denyse Handler, *Mercy Killing* (1977) at 11.
22. M.J. Sobran, *supra* n. 6 at 31.
23. Walter W. Steeles Jr. and Bill M. Hill, "A Plea for a Legal Right To Die" (1976) 29 *Oklahoma L. Rev.* 328.
24. *See* Sissela Bok, "Euthanasia and the Care of the Dying" *Dilemma of Euthanasia supra* n. 9 at 8.
25. For a very detailed discussion of this theory, see Yale Kamisar, *supra* n. 8.

inviolability of human life.[26]

The present controversy surrounding euthanasia is part of a more general cultural phenomenon, an outlook that devalues life by reference to such secular terms as "quality of life". Man can be made to abandon his longing for freedom, his belief that the individual is an end and a achievenment in itself. The retarded, the aged, and the deformed are put out of sight, in homes and in hospitals, to get them off our hands where we don't have to respond to them personally. Studies have shown that not only nurses and physicians, but also relatives, tend to avoid dying patients.[27] There is a growing tendency for physicians to look at the disease rather than the person.[28] This can all be seen as part of a dehumanizing process similar to that which George Orwell predicted would overtake us by 1984.

IV. ALTERNATIVES TO EUTHANASIA

A. *Improve the "Conditions of Dying"*

A better alternative to the legalization of euthanasia is the promotion of practices other than euthanasia to ease the suffering of the sick or dying (*e.g.*, — the use of pain relieving drugs and the blocking or cutting of nerves) as well to relieve the unpleasant conditions surrounding them. This approach has been adopted by St. Christopher's Hospice in London.[29] "The conditions under which people die are often horrible not because better conditions *cannot* be provided, but because health-care personnel and society at large fail to do what *could* and *should* be done."[30] When these conditions are improved, the cry for euthanasia will disappear because it will be irrelevant.

B. *Withdrawal of Treatment*

Unfortunately, in recent years needless semantic distinctions have been developed which only confuse the issue. Terms such as "active" and "passive" euthanasia, or "positive and "negative" euthanasia are

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26. *Id.* at 1038. While references to Nazi Germany should not be made in order to make an *in terroram* argument, it must be remembered that the German euthanasia program was a creation of a small group of physicians, not Hitler, and both a society and the medicine practiced in that society voluntarily opted for the involuntary destruction of the mentally ill, the unfit, and the socially outcast. For a detailed examination of the development of euthanasia in German, from 1920, to 1945, see Leo Alexander, "Medical Science Under Dictatorship" *The New England Journal of Medicine* 241: 39-47, 1949 (reprinted in *Death, Dying and Euthanasia, supra* n. 16, at 571-592); Fredric Westham, "The Geranium In The Window: The Euthanasia Murders" *Death, Dying and Euthanasia supra* n. 16, at 602-614.

27. S. Bok, *supra* n. 24 at 11.

28. *Id.* at 12.

29. The establishment in 1967 of St. Christopher's Hospice in London has been an innovation in the treatment of the dying. In St. Christopher's, the schedule and regimen are established to fit the needs of the individual patient, who is seen as a person who happens to be dying, and not an object for revulsion and neglect. The function of the institution's staff is to make the final days of those near death as fulfilling as possible. Families, friends and even pets are encouraged to visit patients at will. Such a centre has now been opened in New Haven, Connecticut.

30. Germain Grisez, "Suicide and Euthanasia" *Death, Dying and Euthanasia, supra*, n. 16, at 782.

not uncommon today.[31] Confusion is increased by the fact that *voluntary* euthanasia may be seen as active or passive, positive or negative, and so may *involuntary* euthanasia.

Active or positive euthanasia is merely euthanasia as it should be properly understood, that is the direct killing of a person, with or without his knowledge or consent. An example of such would be the administration of a lethal dose of medication.

On the other hand, passive or negative euthanasia is *not* euthanasia at all. Rather, it is merely the avoidance or discontinuation of extraordinary means of preserving life. "It usually refers to removing supportive equipment or drug treatment when the patient has irrevocably entered the process of dying. . . It is, in fact, a necessary part of every good doctor's concern for his patient's welfare and is standard procedure in every good hospital."[32]

Deciding whether treatment is preserving life or simply prolonging death is an often difficult process, but where treatment has been determined by medical science to be only death prolonging, the physician should be allowed to terminate it. It is a ". . . necessary correlative to the excessive intrusion of life-prolonging technology which prohibits death from having its appropriate place in our life."[33] Death must be recognized as the natural end of life. Once the process of dying has begun, the concern should not be to extend that process as long as possible, but to make it as good and fitting as possible.[34] "What one is doing is allowing a natural irreversible process, namely death, to continue its course."[35] Letting someone die is not acceptable merely because it is "passive", but also because it recognizes that the patient is beyond all reasonable hope of recovery; it does not constitute an attack upon life. The President of the Swedish Society of Surgery has stated: "We refrain from treatment because it does not serve any purpose, because it is not in the patient's interest. I cannot regard this as killing by medical means: *death has already won*, despite the fight we have put up, and we must accept the fact"[36] [italics mine]. Therefore, the physician ceases to do what is really useless so as not to stand in the way of what is now the better treatment of the patient.

C. *Criminal and Civil Liability of Doctors*

(1) Criminal Liability

The extent of a physician's responsibility in preserving a patient's life is an unsettled area of the law. Under section 178 of the *Criminal Code*, individuals undertaking to administer medical treatment are

31. *See for e.g.*, O. Ruth Russell, *Freedom To Die* (1977); Douglas Becker *et.al.*, "The Legal Aspects of the Right to Die: Before and After the *Quinlan* Decision" (1976-77) 65 *Kentucky L.J.* 823; Norman L. Cantor, "Law and the Termination of an Incompetent Patient's Life-Preserving Care" *The Dilemma of Euthanasia* (1975).

32. Paul Marx, *Death Without Dignity* (1975) at 8.

33. Kenneth Vaux, "The Social Acceptance of Euthanasia: Prospects and Problems" *Euthanasia Symposium*, *supra* n. 3 at 13.

34. *See* John Gallagher, "Euthanasia" (1975) 3 *The Chelsea Journal* 121; Your Death Warrant?, supra n. 17 at 131.

35. B.D. Colen, *supra* n. 12 at 56.

36. As reported in *The Times*, London, Dec. 7, 1966. Also, *see* A.B. Downing, "Euthanasia: The Human Context" *Euthanasia And The Right To Death*, *supra* n. 11 at 15.

under a legal duty to use reasonable knowledge, skill and care in so doing. It has been suggested by one English commentator that a doctor would not be liable for omissions if he could justify the failure to give treatment on the grounds that such was useless.[37]

Section 199 of the *Code* states that everyone who undertakes to do an act is under a legal duty to do it, if an omission to do the act is or may be dangerous to life. It is open to debate whether a physician or hospital could be prosecuted under section 199 if the physician left instructions not to provide medical treatment to his terminally ill patient.[38] In all likelihood, whether or not criminal liability will attach will depend to a large extent upon the nature of the services which the doctor is seen to have contracted to perform.[39] Whether the duty of care requires the physician or hospital to exhaust every available means to preserve life remains unsettled. "Courts could limit a doctor's duty to prolong life either upon the theory that patients implicity consent to only general medical treatment or by setting a standard of care based on prevailing professional practices."[40] This latter view is interesting in light of a resolution approved by the General Council of the Canadian Medical Association in 1974 that "The CMA recognize that there are conditions of ill health and impending inevitable death where an order on the order sheet by the attending physician of 'no resuscitation' is appropriate and ethically acceptable."[41] This resolution was carried notwithstanding the advice of the CMA's own Canadian Medical Protective Association who cited the *Criminal Code* as being in disagreement with the intent of the resolution.[42]

Under section 202 of the *Code*, a person is criminally negligent who, in doing anything or in omitting to do anything that is his duty to do, shows a wanton or reckless disregard for the lives or safety of others. The potential for a charge should be obvious, although it is arguable that the physician is not showing a "wanton or reckless disregard" for his patient if he should feel that no treatment is the best treatment under the circumstances.

The question of criminal liability is further complicated by the omission-commission dichotomy. Withholding insulin from a diabetic patient dying of terminal cancer is clearly an omission. However, withdrawing life support systems (*e.g.* turning off a respirator or kidney machine) may be perceived as an omission by merely refraining from the provision of further treatment, or as a commission because it involves an act by the physician. If the latter view is adopted, a physician could well find himself charged under the *Criminal Code*,

37. Elliott (1974) 4 *Medical Science Law* 78.

38. *See* Gilbert Sharpe, "Euthanasia: The Consequences of Turning Off the Respirator" (Dec. 1977) *The Canadian Lawyer*. 9.

39. American commentators appear to adopt this approach. For example, see Jeffrey Alan Smyth, "Antidysthanasia Contracts: A Proposal For Legalizing Death With Dignity" (1974) 5 *Pacific Law Journal* at 738-763.

40. Stephen R. Akers, "The Living Will: Already A Practical Alternative" (1977) 55 *Texas Law Review* 673.

41. Dr. E.J. Moriarty, "The Canadian Medical Association Position on Euthanasia" *Euthanasia Symposium, supra* n. 3 at 87.

42. *Id.*

section 205 which provides that a person commits homicide when, directly or indirectly, by any means, he causes the death of a human being. Section 212 states that culpable homicide is murder when the person who causes the death of a human being means to cause his death. Finally, section 209 states that where anyone causes bodily injury to a human being that results in death, he causes the death notwithstanding that the bodily injury has only accelerated his death from a disease or disorder arising from some other cause. Though it has been suggested that the *Criminal Code* does not envisage the hospital as the chief site of commission for these offences,[43] the physician's liability is nonetheless unclear.

To help clarify the issue of whether certain procedures are acts or omissions, a suggested test could be that an action is an act if it *causes* something to occur, while an omission would merely *permit* it.[44] Under such a test, the unplugging of a respirator would be an omission, because the doctor is permitting the patient to expire, but is not himself the *cause* of death.

Liability for an omission is based on a duty to act, and consequent failure to carry out that duty. Therefore, should a patient refuse certain medical treatment, the doctor cannot be held criminally or civilly liable for the failure to act because no duty is present. It is trite law that the patient has a legal right to refuse medical treatment.[45] There are some American cases which suggest that a patient does not have such a right where refusal would likely result in the patient's death and where the state may have a compelling state interest in keeping the patient alive.[46] However, such a doctrine has not found its way into Canadian courts.

(2) Civil Liability

A physician ordinarily cannot treat a patient without exposing himself to civil liability unless he has given a fair and reasonable explanation of the proposed treatment, including full disclosure of the benefits and risks involved, and the patient has consented with a full understanding of what the treatment involved.[47] This "doctrine of informed consent" makes no sense without a right to an informed refusal and so the right to refuse treatment or withdraw consent at any time is a necessary corollary to it.

The crux of the problem is: how far does the doctor have to go before it can be said that he has carried out his duty to the patient? This question becomes of great importance when dealing with a terminally ill patient who is comatose, semi-conscious, or so under the

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43. G. Sharpe, *supra* n. 38.

44. *See* George Fletcher, "Prolonging Life" (1967) 42 *Washington L. Rev.* 1006.

45. *See Mulloy* v. *Hop Sang* [1935] 1 W.W.R. 714 (Alta. C.A.).

46. *See Raleigh Fitkin — Paul Morgan Memorial Hospital* v. *Anderson* 201 A. 2d 537, where the court held that the state's interest in protecting the life of the fetus justified overriding the pregnant patient's refusal of a blood transfusion. *See also Application of President and Directors of Georgetown College* (1964) 331 F.(2d)1000. However, where a compelling interest is not found, the patient is permitted to refuse the treatment: *In re Estate of Brooks* (1965) 205 N.E.(2d)435.

47. *Halushka* v. *University of Saskatchewan* (1965) 53 D.L.R. (2d) 436.

influence of drugs and/or disease that the consent to or refusal of life-prolonging measures could not be seen as that of a competent person.

The physician-patient relationship is essentially contractual. The doctor's duty to prolong life must be seen as a function of this relationship. As the patient is likely unaware of the usual medical treatments employed, there must be seen in the relationship with the physician an implied agreement that the physician may perform such services as he thinks fit, and for as long as the case requires, which would be until his services are no longer needed, or no longer of any use. The patient's expectations must in turn be a function of prevailing standards of practice in the profession.[48] Therefore, the physician's decision to withhold or withdraw life-sustaining measures must ". . . accord with the standard of care expected of a reasonable physician in similar circumstances".[49]

Usually, a good defence to a negligence suit is the "defence of approved practice", where it is shown that the treatment was in accordance with the accepted and approved practice of the day in the circumstances.[50] Where there is a difference of opinion as to what is approved practice, the practice of a "respectable minority" of the members of the profession will be taken as approved practice.[51]

There is no doubt that antidysthanasia (the failure to take positive action to prolong the life of an incurable patient)[52] is widespread. Doctors, theologians, and others conclude that a majority of physicians now practice and support it.[53] Several surveys of physicians confirm the wide extent of the practice.[54] One survey revealed that 80% of physicians questioned favoured and had practiced it.[55] Though another survey showed that the vast majority of physicians did not consider themselves hampered by the law,[56] there is a good argument that the withdrawal of treatment, as opposed to the withholding of it, is an intentional tort — a battery — for which the defence of approved practice would be inapplicable. Also, the courts have not dealt with the extent of the duty a doctor has to his patient. Though in *In re Quinlan*,[57] the Supreme Court of New Jersey held that a respirator could be withdrawn from a patient in an irreversibly comatose condition without civil or criminal liability attaching, this case was decided on constitutional grounds that have no applicability in Canada.

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48. *See* George P. Fletcher, "Prolonging Life: Some Legal Considerations" *Euthanasia And The Right To Death*, *supra* n. 11 at 84.
49. G. Sharpe, *supra* n. 38 at 8. Also, *see Crits* v. *Sylester* [1956] 1 D.L.R. (2d) 502 (Ont. C.A.) *affd.* [1956] S.C.R. 991.
50. Lorne E. Rozovsky *Canadian Hospital Law; A Practical Guide* (1974) at 49-50.
51. *Id.* at 50. Also, *see Bolam* v. *Frier Hospital Committee* [1957] 2 All E.R. 118.
52. *See* John Strand, "The Living Will: A Right To Death With Dignity" (1976) 26 *Case Western Reserve L. Rev.* 487.
53. *For e.g., see* S.R. Akers, *supra* n. 40 at 689.
54. *Id.* at 690-693 for a review of over 10 surveys and polls.
55. R.H. Williams, "Propagation, Modification and Termination of Life: Contraception, Abortion, Suicide, Euthanasia" *To Live and to Die: When, Why and How* (1973) at 90-91.
56. J. Gould, *supra* n. 17 at 117-121.
57. (1976) 355 A. (2d) 647 (N.J.) cert. denied, 97 S. Ct. 319 (1976).

And further it must be remembered that "custom" is not a defence to a charge under the *Criminal Code*.[58]

(3) Ordinary and Extraordinary Measures

It has been suggested by numerous legal commentators that the physician's duty demands that "ordinary" measures be taken to preserve the life of the patient, but that "extraordinary" measures need not be taken.[59] Ordinary measures have been defined as ". . . all medicines, treatments, and operations which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain or other inconveniences."[60]

Extraordinary measures would be ". . .all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit."[61]

While a precise line cannot be drawn between the two, there is a spectrum running from very ordinary means, such as air, to very extraordinary means, such as a heart transplant for a comatose patient. Means which at one time were extraordinary may become ordinary (*e.g.*, the use of insulin to treat sugar diabetes). The condition of the patient and his chances of survival will also affect the perception of what is ordinary care. Thus, in the *Quinlan* case, it was stated that: "The use of the same respirator or life support could be considered ordinary in the context of possibly curable patients, but extraordinary in the context of forced sustaining of an irreversibly doomed patient."[62]

The ordinary-extraordinary approach reflects a profound respect for life. It does not accept actual killing, even for the best motives. Nor does it allow arbitrary decisions based on the worth of a particular type of life. While it does recognize that there are times when it is best not to prolong the dying process, there is no abandoning of the patient. The obligation to provide ordinary treatment is still present, and what is to be considered ordinary will vary with the individual, the circumstances, and the state of medical technology.

At the present time there is no legislation or case law defining the parameters of medical procedures. However, in 1957, Pope Pius XII told an assembly of physicians that there is no moral obligation to use such modern devices as respirators to maintain life when there is no hope of recovery.[63] When death becomes inevitable, a physician may ". . .permit the patient, already virtually dead, to pass on in peace."[64] Lord Lang, a former Archbishop of Canterbury, expressed similar

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58. *R.* v. *England* [1925] 43 C.C.C. 11. The classic English decision concerning custom is *R.* v. *Reed* (1871) 12 Cox. C.C.1.

59. *See for e.g.:* S.R. Akers, *supra* n. 40; Dennis J. Horn, "Euthanasia As A Form Of Medical Management" *Death, Dying and Euthanasia, supra* n. 16; Ellen J. Flannery "Statutory Recognition of the Right to Die: The California Natural Death Act" (1977) 57 *Boston University L. Rev.* 148.

60. Gerald Kelly, "The Duty to Preserve Life" (1951) 12 *Theological Studies* 550.

61. *Id.*

62. (1976) 355 A. (2d) 668.

63. *See B.D. Colen, supra* n. 12 at 58; Neil Elliott, *supra* n. 14 at 98.

64. *New York Times*, Nov. 25, 1957, 1.

views.[65] Jewish law, which opposes euthanasia, also sanctions the withdrawal of artificial factors which merely delay the death of an individual who is obviously dying.[66] Lord Justice Coleridge, in speaking of omissions and legal duty, stated: "It is not correct to say that every moral obligation is a legal duty; but every legal duty is founded upon a moral obligation."[67]

Therefore, because the use of extraordinary treatment is not considered a moral duty by religious groups that do condemn euthanasia, it is submitted that there is some authority for the proposition that it is not a legal duty as well.

In the United States, the "substituted judgment doctrine" has arisen. This allows the court ". . .to act as the incompetent's supreme guardian by exercising its equitable powers."[68] Where the doctrine has been applied, it has only been after the courts have found it to be in the patient's "best interest".[69] As well, all the cases dealing with the "substituted judgment doctrine" have dealt with the issue of whether or not to allow organ transplants from incompetent donors. Arguably this doctrine can be applied to cases where a doctor seeks confirmation of a right to refuse what he believes to be extraordinary life-sustaining procedures. Alternatively, a hospital "ethics committee" could be set up to review such practices. Thus in the *Quinlan* case, the court found that where the attending physician concluded that the patient would never emerge from her comatose condition and that life-support apparatus should be discontinued, such could be done if the hospital ethics committee and the guardian or family of the patient agreed.[70] Judicial opinion to confirm such decisions was felt to be unnecessary and inappropriate, not only because it would be a gratuitous encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome.[71]

D. *Living Wills*

Recently, the concept of a "living will" has evolved, whereby a patient executes a written directive, duly witnessed, that his consent to medical treatment does not extend to the application of life sustaining procedures during a terminal condition.[72] The idea of a living will is the result of ". . .the growing fear of many elderly that they will not be permitted to die in God's and nature's good time because of the enthusiasm of our bio-medical apparatus."[73] It is a mistake to refer to

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65. Joseph Fletcher, "The Patient's Right To Die" *Euthanasia And The Right To Death, supra* n. 11. at 67.

66. Neil Elliott, *supra* n. 14.

67. Quoted in *People* v. *Beardsly* (1907) 113 N.W. 1128 at 1130.

68. *See* Douglas Becker *et.al.*, "The Legal Aspects of the Right to Die: Before and After the *Quinlan* Decision" (1976-77) 65 *Kentucky Law Journal* 839.

69. *Strunk* v. *Strunk* 445 S.W. 2d 145 (Ky. 1969); *Howard* v. *Fulton — De Kalb Hospital Association* 42 U.S.L.W. 2322 (Ga. 1973); In *In re Richardson*, the court refused to permit a transplant from an incompetent donor when it was felt not to be the donor's benefit. See also *In re Guardianship of Pescinski* 226 N.W. 2d 180 (Wis. 1975).

70. *In Re Quinlan, supra* n. 62 at 671-672.

71. *Id.* at 669.

72. *See* proposed *Act respecting the Withdrawal of Treatment where Death is Inevitable*, s 2(1) *Appendix.*

73. Kenneth Vaux, "The Social Acceptance of Euthanasia: Prospects and Problems" *Euthanasia Symposium supra* n. 3 at 16.

"living wills" as authorizing the practice of euthanasia, as some so readily do.[74] The application of the living will is limited to permitting the patient to determine the *types* of medical treatment he may receive. It may not be used as a means for directing a doctor or another individual to act affirmatively to terminate his life.

Living wills have been the subject of much praise and criticism.[75] The California *Natural Death Act* gives legal status to a living will.[76] In March 30, 1977, a bill called the *Natural Death Act*, modelled after the California act, was introduced in the Ontario Legislature.[77] Essentially the bill would permit any competent person over eighteen years of age to sign a directive to instruct physicians that consent to medical treatment does not extend to the application of life-sustaining procedures during the terminal condition.[78] The separate diagnosis and opinion of two physicians, neither of whom has any medical responsibility for that person, is needed before a terminal condition is deemed to exist.[79] The directive is not valid unless signed by two witnesses, neither of whom is a relative, attending physician or other person engaged in the health care of the person giving the direction.[80] The directive is valid for five years from the date of signing, but does not take effect until given to the attending physician of the patient, or where the person is a patient in a health facility, to a person on the medical staff of or employed by the health facility.[81] The directive may be revoked in any manner and without regard to mental competency by indicating to the attending physician or member of the health facility such an intention.[82] Any person acting under the proposed bill in good faith would be protected from civil liability.[83]

The bill was designed to accommodate the unconscious patient. According to the Government whip Lorne Maech, who introduced the bill: "Under this bill, I can sign a directive now when I am in good health so as to relieve my family, if I am unconscious, of having to make the decision. My wishes about what should happen would be on paper. It would also relieve the doctor of the responsibility to advise. He need only diagnose."[84]

The Ontario bill expired when the minority Progressive Conservative government went down to defeat in April, 1977. As of the time of

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74. For example, *see B.D. Colen*, *supra* n. 12 at 161; Neil Elliott, *supra* n. 14 at 139.

75. *See* Luis Kutner, "The Living Will: Coping With The Historical Event Of Death" (1975) 27 *Baylor L. Rev.* at 39-53; J. Strand, *supra* n. 52 at 485-526; S.R. Akers, *supra* n. 40 at 696; Ellen J. Flannery, *supra* n. 59 at 148-177 g.

76. *California Health and Safety Code* s. 7185095 (West 1976). For a detailed examination of the California Act, see Douglas Becker *et.al.*, *supra*, n. 31 at 823-879; Ellen J. Flannery, *supra* n. 59 at 148-177g.

77. Bill 3, Private Members Bill, 4th Session, 30th Leg. The proposed Act has been reproduced in full in the Appendix. *Editor's Note: A similar bill was introduced in the Fall Session of the Alberta Legislature 1978, but allowed to die on the order paper.*

78. *Id.* s. 2(1).

79. *Id.* s. 4(a).

80. *Id.* s. 2(2).

81. *Id.* s. 2(4) and 3(1).

82. *Id.* s. 3(3).

83. *Id.* s. 5.

84. Denyse Handler, "A Right to Die Bill in Ontario" 4:12 (1977) *The Uncertain Human* 3.

this writing the bill has not been reintroduced. It has been the only attempt to give legislative authority to "living wills" in Canada. Although modelled after the California act it was revised to avoid deficiencies that act. As it is also similar to a bill introduced in the British Parliament (and defeated by a large majority on the first reading),[85] this writer feels the bill is worthy of some analysis.

Some have argued that living will legislation is the opening wedge toward the ultimate legalization of euthanasia.[86] However, if one accepts the view that withholding life-prolonging treatments from patients who have entered the process of dying is not euthanasia, but rather a proper and ethical medical procedure which is currently practiced in our society on a large scale, such an argument does not appear to have any basis in logic.

The Ontario bill has also been criticised because it is felt to be unnecessary legislation.[87] Thus one doctor stated: "Only a very few doctors use extraordinary means to prolong life when all reasonable hope of recovery is gone."[88] While there is no reason to doubt the correctness of this statement, the act is designed to protect those patients who would otherwise be at the mercy of overzealous doctors. Therefore, it could lessen the possibility of useless, painful and expensive medical treatment as death approaches.

Though the bill would relieve the physician of all civil liability, there is some doubt, as previously mentioned, whether a doctor who refrains from the use of life-prolonging measures could escape liability under the *Criminal Code*. Without the co-operation of the Federal Government in amending that *Code*, the provincial exercise is futile.[89]

The bill defines a "life-sustaining procedure" as ". . .a medical procedure or intervention that utilizes mechanical or artificial means to sustain, restore, or supplant a vital function to postpone the moment of death, but does not include a medical procedure or intervention for the purpose of alleviating pain."[90] The definition does not make it clear whether the phrase "life-sustaining procedure" is to be taken to include normal care, such as the feeding of the terminal patient by intervenous. And as practically any medical procedure can be said to "postpone the moment of death", (such as giving insulin to a diabetic patient who is otherwise healthy), this writer suggests the phrase should be worded "to prolong the death of a patient who has entered the process of dying".

A terminal condition is defined as an ". . .incurable condition caused by injury or disease by reason of which, in reasonable medical opinion, death is imminent and only postponed without improvement of the

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* *Editor's note: This was true when Mr. Campbell wrote this paper, but a similar bill was introduced in the Alberta Legislature by Dr. W. Buck (Sc. - Clover Bar) during the 4th session of the 18th legislature. The bill number was 244 and its short title was The Natural Death Act. It died on the order paper.*

85. *Times of London*, February 13, 1976.

86. Y. Kamisar, *supra* n. 8.

87. Heather Morris M.D., "A Doctor Replies" *The Uncertified Human*, *supra* n. 84 at 7.

88. *Id.*

89. Bill 3, *supra* n. 77.

90. *Id.* s. 1(b).

condition during the application of life-sustaining procedures."[91] Such a definition could include a stroke victim who has suffered severe brain damage. Such a condition is "incurable", yet some people improve markedly from strokes while others do not. Also, death must be seen as "imminent", but what does this mean? A day, a week, a month or a year? Is each physician to provide his own definition?

If a living will were to become law, then in the absence of such a document, the patient could risk being overtreated, as the physician would be unwilling to be left open to legal action for the alleged "failure" to apply the possible life-sustaining procedures to the dying patient. In other words, in the living will's absence, the physician may feel obligated to use extraordinary means. He may feel compelled to use life-prolonging procedures against his better judgment. "A document that was originally initiated as a matter of free choice may become compulsory for anyone who wants to die in peace."[92]

A living will offers no relief to persons under the age of majority or to comatose patients, those critically injured patients who are brought into the emergency room unconscious, or those patients suffering from a terminal illness who are so heavily drugged or in such great pain as to be incompetent to make such a decision, and have not had the foresight to make out a directive beforehand. "Paradoxically, since it is likely that large numbers, through neglect or ignorance, will never write a will, it is not unlikely that the legislation will lead to an increase in excessive treatment rather than a decrease."[93] Though the Ontario bill states that the act shall not be construed to impose an obligation to provide life-sustaining procedures where the obligation does not otherwise exist at law,[94] this possibility is the very crux of the whole issue. While it is unclear at this time, if a doctor is under no legal obligation to provide extraordinary treatment, then any living will is superfluous. If there is a legal obligation to provide extraordinary treatment, then a living will offers no assistance to those who are unable to or have neglected to sign one.

In some respects the concept of a living will resembles that of the testamentary will, since both express the signer's wishes before he or she becomes unable to express them, either by death or incapacity. Therefore, just as requirements for testamentary wills serve ritual, evidentiary, and protective functions, these same policies arguably apply to the execution of living wills to insure that the signer realizes the precise significance of his or her actions.[95] Thus it is not inconceivable that a living will would be found invalid due to non-compliance with certain formalities, and should the signer become incapacitated in the meantime, he could be relegated to the position of a person who had never signed one, with all of the above implications flowing from it.

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91. *Id.* s. 1(d).

92. G. Sharpe *supra* n. 38 at 18.

93. Richard McCormick, "Legislation and the Living Will" (March 12, 1977) *America* 213.

94. Bill 3, *supra* n. 77, s. 6.

95. *See S.R. Akers, supra* n. 40 at 696.

E. *Legislation to Protect Doctors from Liability*

It has been suggested that living will legislation is not designed to protect patients against the excessive zeal of physicians, but rather to protect physicians against existing laws that hamper their freedom to omit extraordinary medical treatment.[96] Therefore, this writer feels that it is best to face the issue of physician protection directly. Though living wills are an attempt to clarify an uncertain area of our law, this writer believes that they would not only be a half-way measure of reform, but would cause more problems than they would solve. This may be one reason the Canadian Medical Association is on record as opposing the "living will".[97] It is suggested that legislation can be written without creating the problems alluded to above. A better approach would be for the federal and provincial governments to enact legislation stating that no physician will be subject to criminal or civil liability should that physician cease or refrain from using extraordinary measures to prolong the life of a patient who has, in his opinion, entered the dying process. A suggested definition of what is "ordinary" and what is "extraordinary" treatment could be that given above. In order to prevent abuse, there could be an added stipulation that the opinion of the attending physician must be supported by the opinions of two independent physicians, and authorization from a hospital "ethics committee". "There is no way that particularized medical practice can be legislated. Will we pass statutes saying when and under what circumstances an appendix may or must be removed? The physician's judgment must be relied upon by society in these matters."[98] As a matter of public policy, such legislation should make it perfectly clear that a physician is not obligated to withhold or withdraw such extraordinary measures, particularly if he is asked not to do so by his patient.

F. *Reduced Penalties for Those Guilty of Euthanasia*

Though suicide is no longer illegal, for obvious reasons, everyone who counsels or procures a person to commit suicide or aids and abets a person to commit suicide is guilty of an indictable offence.[99] As well, no person is entitled to consent to have death inflicted upon him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted.[100] The element of motive has been rejected as a defence to a criminal proceeding.[101]

While it is felt that one should be adamant in the belief that euthanasia should not be legalized, at the same time one has to recognize the difference between one who kills on request or with consent for some altruistic motive and a cold blooded killer or one who kills for self interest. There are some countries that recognize that mercy-killing

96. R. McCormick, *supra* n. 93.

97. Toronto *Globe and Mail* July 2, 1974.

98. Dennis Horon, "Editor's Comment On the Living Will" *Death, Dying and Euthanasia supra*, n. 16 at 371.

99. Criminal Code, Section 224.

100. Criminal Code, Section 14.

101. *R.* v. *Lewis* (1903), 7 C.C.C. 261. (Ont. C.A.).

is worthy of special status *vis à vis* other types of murder. For example, in Germany, while mercy-killing is still classed as homicide, the punishment is limited to a maximum of two years.[102] In Norway, the punishment may be reduced below the minimum provided for a homicide under certain specified conditions.[103] The Penal Codes of Switzerland,[104] Italy,[105] the Netherlands,[106] Spain,[107] Poland,[108] and Japan,[109] all allow mitigation in penalty if the killing was carried out at the request of the victim.

This writer has been unable to find a single Canadian case dealing with mercy-killing. However, a comparison of English and American cases has shown that without exception, the defendants involved have been acquitted by the juries, or convicted by subsequently had the sentence reduced drastically or suspended.[110] The cases show that the criminal law as written and the criminal law as administered in practice can be quite different.

> The leniency shown in all the cases is persuasive evidence that the present law of homicide in these countries is sufficiently flexible to allow a judge and jury convinced of a slayer's merciful and humanitarian motives to treat him accordingly. Hypocritical as such results may be to many, few would find them unfair or ill-advised, even among those most opposed to any affirmative legalization of euthanasia. Most of those in the latter category find such verdicts most desirable, for they reach a just result in the particular case, but leave the thrust of the criminal law on the side of preserving all life, regardless of its 'quality' to the individual concerned or to society.[111]

V. CONCLUSION

The legalization of euthanasia must be seen as undesireable for our society. Though no one can deny the humanitarian intentions of those who seek the elimination of restrictions against euthanasia, this writer believes that state's undeniable compelling interest in the sanctity of life would be unduly compromised. However, the medical profession and their patients need to be protected by legislation that would allow people to die a "natural" death with dignity. A more humanistic attitude then, is that: ". . .directly killing an innocent person is a violation of the goodness of life; failure to use ordinary means of preserving life is an attack upon the goodness of life; the decision not to use extraordinary means, even if the patient dies as a result, is acceptable."[112] Though the legal recognition of "living wills" is a valid attempt at correcting the problem, this writer believes that legislation defining the parameters of a physician's duty is a better approach.

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102. *German Penal Code* s. 216.
103. *The Norwegian Penal Code* 1961 s. 235.
104. S. 114.
105. Art. 579.
106. Art. 29304.
107. Art. 409.
108. Art. 227 (1932).
109. Art. 269.
110. David W. Meyers, *The Human Body and the Law* (1970) at 144-155.
111. *Id.* at 151.
112. Leonard J. Weber, *Who Shall Live?* (1976) at 87.

APPENDIX

BILL 3 1977

Her Majesty, by and with the advice and consent of the Legislative Assembly of the Provice of Ontario, enacts as follows:

1. In this act,

Interpretation

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

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

(c) "physician" means a person licensed under Part III of The Health Disciplines Act, 1974: 1974, c. 47

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

Direction limiting consent

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

Witnesses of direction

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

Beneficiary of estate as witness

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

Duration

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

When direction effective

3. (1) A direction under section 2 does not take effect unless it is given to the attending physician of the person giving the direction or, where the person is a

patient in a health facility, is given to the attending physician or a person on the medical staff of or employed by the health facility.

Direction included in medical records

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

Revocation

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

Direction deemed valid

(4) Notwithstanding subsection 1, a direction given thereunder by a person who had not attained the age of majority, was not mentally competent to consent, or was not able to make a free and informed decision, is valid for the purposes of this Act if the person who gave it had not attained the age of majority, was not mentally competent to consent, or was not able to make a free and informed decision, as the case may be.

Terminal condition

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

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

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

Civil liability

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

Other obligations not affected

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

Insurance

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

Idem

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

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

9. This Act comes into force on the day it receives Assent. Commencement

10. This Act may be cited as The Natural Death Act, 1977. Short title

FORM 1
(The Natural Death Act, 1977)
DIRECTION TO ATTENDING PHYSICIAN
AND MEDICAL STAFF

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

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

Made this _____day of _____(month, year)

_____
(signature)

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

_____
(Witness)

_____
(Witness)

EXPLANATORY NOTE

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

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