

A Winnipeg Inquest: A Case of Natural Death or Physician-Assisted Suicide?

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I. INTRODUCTION

ON OCTOBER 8, 1993, the *Winnipeg Free Press* carried a front page story under the headline, "Coroner probes MD's role in death at King George."¹ According to its first sentence: "A Winnipeg doctor who allegedly helped a man die by disconnecting his respirator and injecting him twice with morphine has raised questions about laws governing assisted suicide." The article noted that the patient had died six months earlier and that the respirator had been removed at his request. It also stated that the Chief Medical Examiner had said that he "will be reviewing the records concerning the patient to determine whether the doctor had acted inappropriately."

Front page articles on the case were featured in the *Free Press* on the following two days. In all three articles, the first sentence used the phrase, "allegedly helped." (The adverb "allegedly" has the ring of criminal law about it, as a suspect is invariably referred to as the alleged offender until such time as he is convicted.) In the third article, it was reported that the Chief Medical Examiner had commented that: "I don't believe it's a natural death. The issue is where palliative care ends and euthanasia begins."² Later in October, the Chief Medical Examiner concluded his investigation of the case. His findings led him to the view that the patient's death was in fact a suicide, and he accordingly amended the death certificate to that effect. (As completed by the doctor who had "allegedly helped" the patient die, the document stated that death was the result of natural causes.)

That same month, the Chief Medical Examiner submitted a report on the case to the Department of Justice, in which he reviewed the patient's medical history

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¹ Since the name of the King George Municipal Hospital has been changed to the Riverview Health Centre, the name Riverview will be henceforth used.

² "Hospital hushes incident." *Winnipeg Free Press* (10 October 1993) A1.

and explained his decision to amend the death certificate.³ In March 1994, the Deputy Attorney General announced at a news conference that no criminal charges would be laid because “there is no basis for criminal prosecution against anyone in this case.”⁴ However, the Chief Medical Examiner announced at that time that he was calling for an inquest to “clear the air and ... to determine who did what and when and by what means.”⁵ A four-day inquest was accordingly held in August 1994, and Collerman, P.C.J. released his findings in January 1995.⁶

The Chief Medical Examiner’s report and the inquest findings will be considered in due course. At this juncture, however, we turn to the medical history of the patient whose doctor “allegedly helped” him die by disconnecting his respirator.

II. THE PATIENT’S MEDICAL HISTORY

MR. L DIED on April 8, 1993, within 30 minutes after his respirator was disconnected at his request by his physician, Dr. B. He died at the age of 49, six years after a diagnosis of amyotrophic lateral sclerosis (ALS).⁷ ALS is a devastating neurological disease that attacks the motor neurons responsible for transmitting electrical impulses from the brain to the body’s muscles. Its inexorable course has been likened to being buried alive; although its deadly onslaught on the body is unremitting, it leaves the mind intact. ALS first entered public consciousness in 1939, when it forced baseball superstar Lou Gehrig to retire from the game. Gehrig died two years later at the age of 37, and since his death ALS has been called Lou Gehrig’s disease. ALS was also the disease that afflicted Sue Rodriguez, whose constitutional challenge of s.241 of the *Criminal Code* (the offence of aiding suicide) was rejected by a 5-4 margin by the Supreme Court in 1993.⁸

³ *Investigation into the Death of ___*. Office of the Chief Medical Examiner, October 1993 [hereinafter cited as *Investigation*]. At the inquest that was later held (see note 6), a publication ban on the names of the patient and his family was issued. For that reason, the patient will be referred to as Mr. L. Although the name of the physician later appeared in the media, I have chosen to refer to him as Dr. B.

⁴ “Patient’s death probed; police won’t lay charges” *Winnipeg Free Press* (2 March 1994) A1.

⁵ *Ibid.*

⁶ *In the Matter of: The Fatal Inquiries Act. And, in the Matter of _____, Deceased. Findings of the Fatal Inquiry*, Presided Over by The Honorable Judge Howard Collerman, January 6, 1995 [hereinafter cited as *Inquest*].

⁷ *Inquest* at 24.

⁸ *Rodriguez v. Attorney General of Canada et al.*, [1993] 3 S.C.R. 519.

From the time of diagnosis in 1987, Mr. L's health gradually deteriorated. However, in the four month period beginning in December 1990 his overall condition rapidly worsened. By April 1991 he was wheelchair-bound, not only unable to feed himself but also finding it increasingly difficult to ingest food. He had become completely dependent upon his devoted family (his wife and three children). At that time he was advised of the need for a tracheostomy (the surgical insertion of a tube in his throat to provide permanent ventilator support). He agreed to that procedure and also to a transfer to Riverview. Around that time he signed a document stating in part:

I am fully aware of my disease and feel that when I no longer wish to have medical support or the use of a ventilator to prolong my life, I will communicate this to my wife who will notify the doctor. At this point in time, I do not know when this will occur, but I will consult with my family and we will decide. If the time comes when I can no longer communicate my wishes in any way, I request that my ventilator and life support be discontinued.⁹

It is true that this document was signed two years before the Manitoba Health Care Directives Act was proclaimed, under which its last sentence would qualify as a so-called living will or advance directive. Even so, there is no reason why it could not have been regarded at that time as a legally binding direction. In 1990 the Ontario Court of Appeal had ruled in the case of *Malette v. Shulman*¹⁰ that a Jehovah's Witness Medical Alert Card — refusing blood under any circumstances — was a binding legal direction that precluded the defendant-physician from transfusing the patient when she arrived unconscious in hospital following an automobile accident. The abovementioned statement by Mr. L was likewise an advance directive, and it could just as easily have been regarded as a binding legal direction if the patient's physician had refused compliance and the family had legally challenged his refusal.

In any event, Riverview agreed to accept Mr. L as a patient and to adhere to that document. He accordingly underwent the tracheostomy at the Health Sciences Centre, was ventilated, and transferred to Riverview on April 26, 1991.

Over the next 16 months, the patient's condition slowly but inexorably moved downhill toward its inevitable end. By August 1992, he was experiencing paralysis of both legs and very limited use of his arms and hands. He was unable to bathe or carry out his natural functions without assistance. As summarized by Collerman, P.C.J. in his "Findings of the Fatality Inquiry":

⁹ *Inquest* at 11.

¹⁰ (1990) 72 O.R. (2d) 417.

The nurses' daily notes from this point forward describe a courageous struggle by a gentle man to try to deal with an illness which slowly but constantly robbed him of his energy and independence. These notes portrayed, as well, a family whose support was substantial, caring, and unwavering.¹¹

In December 1992, a stomach tube was implanted because he could no longer swallow food. By this time he could communicate only by using a computer with a breath-activated attachment, albeit it would take him three or four minutes to communicate three or four words. In that month, his ventilator had a mechanical problem, and he began to gasp because he could not breathe on his own. This happened on other occasions as well. It was thus clear to his care-givers that he could not breathe on the slightest without ventilator support. According to the nurses' notes in January 1993, he was having problems with incontinence and an inability to clear secretions from his throat, which made his breathing all that more difficult.¹² By March, as reported in the Inquest Findings:

[T]he nursing notes indicate clearly that various of the medications offered to him during this period of time would resolve one problem and create another. These notes, as well, indicate interrupted and tiring sleep patterns caused by a constant need to be repositioned while in his bed. During this entire period of time, however, true to the description of the disease provided in the *Rodriguez* case, while his body was failing, his mind remained ever alert.¹³

On 17 March 1993, he was visited by Dr. B, a longtime critical/intensive care specialist. Mr. L's Riverview physician had indicated a reluctance to disconnect his respirator if and when asked to do so, and the patient had then connected to Dr. B because of the latter's involvement with the local ALS patient support group. Dr. B was not opposed in principle to disconnecting a consenting patient's respirator, and he accordingly agreed to attend at Mr. L's bedside. During that meeting, Mr. L painstakingly spelled out on his computer:

I am getting weaker and my face muscles are affected. I don't want to face what is next. I don't want to be paralysed with a brain that functions. I want to die. No good time. It's getting harder. I have been thinking about this for the last two years. It's my body. This isn't a life. It's hard on my family.¹⁴

As Dr. B later noted in the patient's file on that date:

¹¹ *Inquest* at 12.

¹² *Ibid.* at 13.

¹³ *Ibid.* at 15.

¹⁴ *Ibid.* at 17.

Long visit. Wants to die. Paralysis now in face. Can't eat. Soon unable to control suck/blow to computer. Quality of life is obviously deteriorating. He is becoming increasingly insistent that ventilator be disconnected.¹⁵

On 21 March, the nursing notes reported that he had to be suctioned five times over a four hour period, an indication that his breathing was becoming progressively more laboured. And it only got worse. On the morning of 28 March, he was "suctioned at least 15 times for small to moderate green, foul-smelling secretions."¹⁶

On 31 March, the Riverview medical director made the following entry in the patient's chart:

On his board, he spelled out, "I've had enough. I have a right to stop treatment." Mrs. L. supports her husband, as do the children & extended family. When Dr. B. returns, process, time & date to disconnect ventilator will be decided.¹⁷

By the beginning of April, the patient had lost virtually all control of his body and was losing control of his lips. The impending loss of his puffing ability would of course mean the loss of his only means of communication¹⁸ (recall that two years earlier he had signed a document that under such circumstances he would no longer wish to live). There was also increasing need to suction secretions from his airways.

The patient was now determined to die, and it was arranged that Dr. B would disconnect his ventilator on the evening of 8 April. Dr. B was accordingly granted temporary privileges at Riverview. That date was not chosen by the patient but was simply a time at which Dr. B, the medical director, and the family's pastor could all be available.¹⁹ The significance of the date selection will be noted in due course. At 3:15 p.m. on 8 April, the following nursing notes were entered in his chart:

Patient a bit weepy this morning. Asked him if he was scared, & he replied "no." Just a little sad. Otherwise in fairly good spirits, even laughing a bit. Appears he is at peace with his decision as his wife said that he was making out his obituary this afternoon. His family were all in this afternoon and appear to be coping reasonably well.²⁰

¹⁵ *Ibid.* at 16.

¹⁶ *Ibid.* at 20.

¹⁷ *Ibid.* at 21.

¹⁸ *Ibid.*

¹⁹ *Ibid.* at 22.

²⁰ *Ibid.* at 23.

That evening, the physicians, the pastor, and the family gathered at the patient's bedside. At 10:05 Dr. B administered an injection of morphine (17 milligrams) and then disconnected the respirator. There then followed two additional doses of 17 milligrams each, and then one final dose of 25 milligrams. The patient was pronounced dead at 10:35.²¹ In his October 1993 report to the Department of Justice, the Chief Medical Examiner expressed concern about the quantity of morphine given the patient:

A dose of 76 milligrams over 15 (sic) minutes is considered fatal in the literature. The effect of the morphine, of course, is enhanced by the co-existing disease process which, in itself, made it difficult for the patient to breathe.²²

What, then, was the role played by the morphine in the patient's death? It is to that question that we now turn.

Dr. B had promised Mr. L that he would not let him suffer when it came time to disconnect his respirator. He was of course aware of the incidents in which the patient, unable to breathe, had gasped for air when his respirator had malfunctioned. When asked during the inquest about the patient's inability to breathe on his own, Dr. B responded:

You can really never be absolutely certain until you take somebody off...but I thought that in view of the length of time ... since he'd had ALS, the progression of the disease ... through the respiratory muscles and involving the lower part of his face, the fact that he'd lost laryngeal function, so he couldn't talk anymore and he couldn't swallow, and that, coupled with the incidents that were reported when he was disconnected, meant that it was unlikely, very unlikely, that he would be able to breathe.²³

Appreciating that Mr. L would most likely be unable to breathe once the respirator was withdrawn, Dr. B had resolved to give him morphine to ease his passage. He selected morphine because of its two-fold properties: as an analgesic (painkiller) and as a sedative, which together would combat his air hunger. When morphine kills, it does so by suppressing the patient's breathing. In other words, when a patient dies from a lethal dose of morphine, the cause of death is respiratory arrest. Thus, when a patient (such as Mr. L) cannot breathe on his own, the morphine cannot cause his death. The reason for its administration in such cases is to suppress the patient's drive to breathe, thus eliminating the distress and discomfort that would be caused by his futile gasping for breath.²⁴ It is surely trite

²¹ *Ibid.* at 42.

²² *Investigation* at 14.

²³ *Inquest* at 30.

²⁴ *Ibid.* at 34.

to comment that to die by suffocation is a horrible death: to gasp for air when one cannot breathe on one's own.²⁵ Dr. B had promised Mr. L that he would not let him suffer, and the way to do that was to do what Dr. B did in fact do — administer morphine.

In fact, it is to state the obvious that, if Dr. B had not sedated his patient before disconnecting his respirator, his failure to do so would have been morally unconscionable. And beyond that, leaving aside civil liability for negligence, allowing the patient to suffocate would have been grounds for prosecution under section 221 of the *Criminal Code* for *causing bodily harm by criminal negligence*. The offence is committed when the accused shows “reckless and wanton disregard” for human life in the course of breaching a legal duty.²⁶ It is beyond question that Dr. B was under a legal duty to mitigate the suffering caused by the termination of his patient's artificial life-support; and his failure to do so would no doubt have constituted a “reckless and wanton disregard” for his patient's life during the final moments of an agonizing death.

As noted, the respirator was disconnected when the patient received the first injection. He appeared quite alert as he turned his eyes toward Dr. B. He was exhibiting some flaring of his nostrils and upper facial grimacing, but there was no chest movement to suggest any breathing whatsoever. However, the nasal flaring indicated that the patient was attempting to breathe. The second dosage was then administered, but it did not suppress the breathing drive; the third dosage quickly followed, but still the patient tried to breathe and still grimaced. Dr. B then administered the final dosage of 25 milligrams, and there was no further movement. As he testified at the inquest:

Because he had not breathed, I really did not feel that there were any restrictions on me as to the amount of morphine that I could administer, because I knew the moment that I saw his alae nasi — his nostrils — were flaring, and that there was no movement of his chest, and there was no air moving in and out of his tracheostomy, that he could not breathe and therefore that the morphine would have no effect on his demise; that...he would die as a result of the disconnect.²⁷

After pronouncing the patient dead, Dr. B completed a Medical Certificate of Death, in which he described the immediate cause of death as respiratory failure due to amyotrophic lateral sclerosis.²⁸ Since he and the hospital considered the

²⁵ On a personal note, I was a childhood asthmatic at a time when there was no treatment for the disease. I thus experienced time after time the frightfulness of gasping for air. A half century later I still remember what it was like.

²⁶ *Criminal Code* of Canada, R.S.C., 1985, Chap. c-46, s. 219.

²⁷ *Inquest* at 41.

²⁸ *Ibid.* at 42.

death as due to natural causes, it was not reported to the Medical Examiner's Office as an unnatural death. (It is only unnatural deaths that must be reported pursuant to the *Fatal Inquiries Act*.²⁹)

Six months after the patient's death the Chief Medical Examiner amended the death certificate to note suicide as the cause of death. His reason was that, if a patient picks the time at which he will die, then the death is not attributable to the underlying disease process but is rather categorizable as suicide. (When he amended the death certificate, he was under the impression that the time of death had been specifically chosen by the patient. However, as explained, the date was selected because it was a time at which Dr. B, the Riverview Medical Director, and the family's pastor could all be in attendance.) In his October 1993 report to the Deputy Attorney General, the Chief Medical Examiner stated that the patient "had formed the intent to die and made specific arrangements in respect to this intention."³⁰ He then concluded:

Due to the expressed and implied intent of the patient to choose his time of death, Mr. [L]'s death has been classified by the Chief Medical Examiner as a suicide... . Suicide is defined as "the intentional taking of one's own life."³¹

After acknowledging in that report that a patient has the right to discontinue treatment, he submitted that whether such manner of dying is suicide depends upon the intent. In his opinion:

Whereas a person may be aware that death may follow, he or she may, until the very end, wish that this not be so, however inevitable the outcome. This is not the case here. There was a specific act at a specific time made with clear intention for death to follow --- a death which would not have taken place at *that date and time* without the discontinuation of the respirator and the administration of morphine.³²

In that report he also expressed the opinion that 76 milligrams of morphine (the amount given Mr. L) is considered a "fatal" dose. However, according to the medical literature, patients with advanced cancer have received as much as 140 milligrams of morphine in an hour without causing decreased consciousness or respiratory depression.³³ (Aside from which is that, as noted, the morphine given

²⁹ *The Fatal Inquiries Act*, L.M. 1989-90, c. 30 - Chap. F52, ss. 6(1) and 7(9).

³⁰ *Investigation* at 9.

³¹ *Ibid.*

³² *Ibid.* at 11.

³³ G. Fraser, "Intravenous Morphine Infusions for Chronic Pain", letter (1980) 93 *Annals of Internal Medicine* 781 at 781-82.

Mr. L could not have depressed his respiration because he had no respiration to suppress.)

In any event, the Chief Medical Examiner called for an inquest, which was held over four days in August 1994. An expert medical witness, Dr. Robert Hudson, an anaesthetist at St. Boniface Hospital, did not fault the dosages and amounts of morphine given the patient. In his view, it was entirely appropriate to administer whatever amount of morphine was required to extinguish the patient's drive to breathe and to alleviate his suffering and distress. Furthermore, he stated that, because of Mr. L's inability to breathe, the morphine could not have caused his death. As he explained, morphine does not interfere with a patient's ability to breathe but rather depresses his drive to breathe by virtue of its effects upon the central nervous system. If, as was the case with Mr. L, the patient cannot breathe on his own, then the effect of the morphine is solely to prevent suffering and to provide comfort as the patient dies.³⁴ A second expert witness, a University of Minnesota professor of pharmacy, testified to the same effect as Dr. Hudson.³⁵

Aside from the morphine issue was the question whether the Chief Medical Examiner had correctly labelled the patient's death as a suicide. In his evidence at the inquest, he testified that he had so amended the death certificate because he considered himself bound by a provision in the *Fatality Inquiries Act* that defines "cause of death" as:

The medical cause of death, according to the International Statistical Classification of Diseases, Injuries, and Causes of Death, as published and from time to time revised by the World Health Organization of the United Nations Organization.³⁶

However, it is pertinent to note that in its five-fold classification scheme of the medical causes of death — natural, homicidal, suicidal, accidental or undetermined — the W.H.O. does not define the various terms. One is thus led to conclude that the Chief Medical Examiner applied his own idiosyncratic definition of suicide. His perspective is illustrated by his response to the question at the inquest whether, assuming the patient had refused the tracheostomy in April 1991 and had then died of respiratory failure, he would have categorized that manner of death as suicide. Although he answered "no," he qualified his response as follows:

Every patient has the right to discontinue treatment or to refuse treatment. However, the question arises: does this mean that when a patient refuses or discontinues treatment and death follows, that these deaths are suicide? In (my) opinion...the answer lies in the intent. Whereas a person may be aware

³⁴ *Inquest* at 39–40.

³⁵ *Ibid.* at 34.

³⁶ *Fatal Inquiries Act*, *supra* note 29 at section 1.

that death may follow, he or she may, until the very end, wish that this not be so, however inevitable the outcome. This is not the case here. There was a specific act at a specific time made with clear intention for death to follow — a death that would not have taken place at that date and time without the discontinuation of the respirator and the administration of the morphine.³⁷

And as he later elaborated:

If a person chooses an act...if he chooses the time and the place and without this act, the death would not have taken place at that time and at that date, that an element of intent has sneaked in here which classifies ... as a suicide.³⁸

The Chief Medical Examiner's idiosyncratic definition of suicide was emphatically rejected by Collerman, P.C.J., who concluded that there was nothing in the W.H.O. document (the International Classification of Diseases, Injuries, and Causes of Death) that obliged the labelling of the patient's death as a suicide. As he stated in his Summary of Findings:

The evidence ... points clearly to the conclusion that Mr. [L]'s death occurred naturally... . Given the evidence which clearly supported the conclusion that the natural progression of his disease had rendered him totally incapable of breathing, I concur with the substantial evidence that was presented to the effect that the morphine injections were administered in order to prevent Mr. [L] from experiencing anxiety and discomfort upon the disconnection of his ventilator, and thus to permit him to die with dignity.

The conclusion by the Chief Medical Examiner that Mr. [L]'s death resulted from suicide, assisted by one or more persons, does not in any way accord with the evidence, and additionally, the conclusion that death resulted from suicide runs contrary to the substantial medical and legal opinions presented in this Inquiry.³⁹

III. CONCLUSION

IN THE RESULT, the inquest resulted in a complete vindication of Dr. B. In fact, one can conclude that it was patently obvious (except to the Chief Medical Examiner) that Dr. B had acted without ethical or legal reproach in the actions that he took to facilitate his patient's demise. The legality of his conduct will be examined by posing a two-fold question: (i) did Dr. B aid the patient to commit suicide; and (ii) if not, then did he otherwise act so as to unlawfully cause death?

³⁷ *Inquest* at 58.

³⁸ *Ibid.* at 62.

³⁹ *Ibid.* at 83.

A. Suicide

If Mr. L committed suicide, it was an act facilitated by the actions of Dr. B. In that event, Dr. B would clearly have breached section 241 of the *Criminal Code*, which prohibits the act of aiding suicide. But did Mr. L commit suicide? One might be tempted to respond along the following lines: "Of course, he committed suicide. He had suffered enough and decided that it was time to die. If I had been in his shoes I don't think I would have waited as long as he did. It was a rational suicide, and it is only the stigma that attaches to suicide that might cause one to answer otherwise."

From a philosophical or theological standpoint, one might well agree with that sentiment. But it is otherwise in the realm of law and public policy. For one thing, if the patient committed suicide, then it was only because Dr. B had helped him to that end. It would thus follow that Dr. B had committed the crime of aiding suicide. But in the context of law and public policy, the patient clearly did not commit suicide. There are two reasons that compel that conclusion.

First, since the common law has enshrined the no-treatment-without-consent principle, it follows that the care-giver who treats a mentally competent patient over her objection commits an assault in criminal law and a battery in civil law. When Mr. L requested that the respirator be disconnected, he thereby not only released his care-givers from their duty to so treat but also obligated them to enforce his will. The no-treatment-without-consent principle does not contain a rider that a patient can refuse treatment, but not when the treatment would lead to the patient's death. Since the physician is legally obliged to honour the patient's withdrawal of consent to continued treatment, it cannot follow that the physician thereby commits an offence by complying with his legal duty. The principle applies to the instant case even if, as the Chief Medical Examiner had initially thought, Mr. L had selected the time for his respirator to be disconnected.

There have been a number of American cases that have addressed the question of suicide when a patient refuses artificial life-support, and they have all come to the following conclusion: (i) that the patient's intent is simply to exercise her legal right not to be treated without consent; and (ii) that suicide is an inappropriate label because the patient dies a natural death attributable to the underlying disease process. And, as the courts have added, it would mock not only the principle of consent to treatment but also the nature of the patient-physician relationship if the physician's compliance with the patient's refusal of life-prolonging treatment were defined as the crime of aiding suicide.

In the first such reported case, *Satz v. Perlmutter* (Florida, 1978),⁴⁰ which involved an ALS patient who had petitioned for an order compelling his care-givers

⁴⁰ 362 SO.2d 160 (1978).

to disconnect his respirator, the Court stressed that the patient's death would not be deemed a suicide. In granting the order, the Court commented that "his basic wish to live" was not incompatible with his rejection of continued mechanical ventilation.⁴¹ Moreover, "the fact that he did not self-induce his horrible affliction" would preclude the label of suicide attaching to his decision to halt treatment and allow death to occur from natural causes.⁴² In all the American cases involving similar scenarios, not one has branded a mentally competent patient's refusal of life-prolonging treatment as equivalent to a suicide bid.

Furthermore, there is Canadian case law to the same effect. In the 1992 case of *Nancy B. v. Hotel-Dieu de Quebec et al.*,⁴³ the Quebec Superior Court affirmed the principle that compliance with a mentally competent patient's rejection of continued artificial life-support does not implicate the care-giver in an act of suicide. Nancy B. was afflicted with a neurological disease, Guillain-Barre syndrome, that had caused total and permanent paralysis. When her physician refused her request to disconnect the respirator keeping her alive, the 24-year-old patient was forced to petition the Superior Court for an order to enforce her will. The petition was granted, and in the course of his judgment Justice Dufour referred only briefly to section 241. As he stated, the provision did not apply to the facts before the Court:

Homicide and suicide are not natural deaths, whereas in the present case, if the plaintiff's death takes place after the respiratory support treatment is stopped at her request, it would be the result of nature taking its course.⁴⁴

Secondly, there is another reason why such manner of death is not suicide, a reason that is well known to the notorious Dr. Jack Kevorkian. In a 1968 case, *People v. Campbell*,⁴⁵ the Michigan Supreme Court overturned the murder conviction of the accused, who had provided a gun to a friend for the express purpose of enabling the friend to kill himself. (That the friend had admitted to Campbell that he was having an affair with his wife was no doubt a factor leading him to play the role of the good Samaritan.) There was at that time no assisted-suicide provision in the Michigan Penal Code, and the Court consequently ruled that the accused was wrongfully convicted of murder — that the act that he committed was to assist suicide, which was not a crime in Michigan. So when Dr.

⁴¹ *Ibid.* at 163.

⁴² *Ibid.*

⁴³ 69 C.C.C. 3d 345 (1992).

⁴⁴ *Ibid.* at 460.

⁴⁵ 335 N.W.2d 27 (1983).

Kevorkian launched his career, he was especially careful to ensure that the physical act that directly caused death was performed not by him but by the client who had come to him for help.⁴⁶ His original suicide machine was in a sense simply a sophisticated way for a physician to leave a lethal dose of drugs by a patient's bedside. It consisted of an intravenous (i.v.) tube connected to three bottles, one containing a harmless saline solution, another an anaesthetic called thiopental, and the third the lethal drug, potassium chloride. Kevorkian would insert the intravenous tube into the client's arm and begin the saline solution. The client would then follow his instructions to press a button switching the line to the thiopental (causing her to lose consciousness). A minute later a timing device would then switch the line to the potassium chloride, stopping the client's heart and causing death within minutes.⁴⁷ The point is that by activating the device, the client took her own life. When a permanent injunction was issued against his suicide machine, he then turned to carbon monoxide, once again arranging for the client to pull the switch to trigger the flow of the lethal gas. In short, what Kevorkian knew was that he had to be especially careful to ensure that his client, not he, performed the physical act that directly caused death. He assisted that act — he set the process in motion — but that was not a crime. But he had to arrange that the client, not he, performed the fatal act.

Furthermore, in the realm of semantics, let alone law and public policy, the very meaning of suicide is of an act that is directly performed by the individual. Consider, for example, the definition of suicide in Webster's New World Twentieth Century Dictionary: "the act of killing oneself intentionally." The Concise Oxford Dictionary provides two definitions: "Person who intentionally kills himself (and) intentional self-slaughter." In other words, suicide is something that one does to oneself. One may assist the suicide, but still it is the person committing suicide who performs the act that directly causes death. In the case we have considered, the patient, Mr. L, was totally incapacitated and therefore could not commit suicide. With all due respect to the Chief Medical Examiner, it is as simple as that.

B. Murder

One is thus led to the conclusion that if any wrongdoing was committed by Dr. B, it was not suicide but murder because, after all, it was Dr. B who completely

⁴⁶ I advisedly use the word "client" and not "patient" to describe each of the 26 individuals who has so far sought out the services of Jack Kevorkian. Firstly, Kevorkian was stripped of his licence to practice medicine in 1993. Secondly, one cannot refer to a patient-physician relationship to describe the connection between Kevorkian and those who show up at his doorstep for the sole purpose of persuading him to help them die. He is not sought out for his medical skills but simply for his death-assisting skills.

⁴⁷ "Doctor Tells of First Death Using his Suicide Device" *New York Times* (6 June 1990) A1.

controlled the physical process that brought about death. It was he who disconnected the respirator and it was he who administered the morphine. What, then, of the morphine; did its administration implicate Dr. B in the crime of murder? Furthermore, since he had planned and deliberated his actions, if it were murder it was murder in the first degree, which carries the mandatory penalty of life imprisonment with no eligibility for parole for 25 years.⁴⁸

However, it is clear that Dr. B did not commit murder for two fundamental reasons. First, he lacked the *mens rea*; it was never his intention deliberately to administer a lethal dose of morphine to his patient. Second, regardless of his *mens rea*, he could not have committed the *actus reus* of murder for one very simple reason: the patient, as he well knew, could not breathe on his own. As explained, morphine kills by suppressing respiration; it stops the patient from breathing. In this case, there was no respiration to suppress because the patient was incapable of spontaneous respiration. Even a cursory look at the case would have made this clear; in other words, it was patently obvious (albeit not to the Chief Medical Examiner) that morphine had nothing to do with the patient's death, no more so than it did in the death of Nancy B.

By the way, when Nancy B.'s physician was interviewed on CBC television, she was asked what her patient's death would be like if the court order were granted. Since the patient could not breathe on her own, the physician responded that taking her off the respirator "would have the same effect as drowning her or putting a tight bag over her head and letting her suffocate." For that reason, she explained that it would be necessary to sedate her with narcotic drugs before removing the respirator.⁴⁹ And that is, of course, what happened.

It is true that section 14 of the *Criminal Code* provides that:

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

If Mr. L had been able to breathe on his own and if Dr. B had given him a deliberate lethal injection at his request, then section 14 would preclude the defence of consent to a charge of murder. But the point is that because he died a natural death, death was not inflicted upon Mr. L. Simply put, section 14 has no bearing upon the manner of death in this case.⁵⁰

⁴⁸ *Criminal Code*, s. 742.

⁴⁹ CBC Television, National News, 27 November 1992.

⁵⁰ On the question of murder by morphine, the Riverview case is easily resolved because the patient was incapable of breathing on his own. But consider this scenario. The patient is respiratory-dependent albeit capable of laboured breathing, and when the respirator is removed he is gasping for breath. The physician responds to his distress by the prompt administration of a deliberate lethal

As noted, that manner of death was also the scenario in the *Nancy B.* case, and no one at that time suggested that her physician had committed a culpable act. Ironically, about ten years before the death of Mr. L, the *Winnipeg Free Press* had featured a front page story about a local medical conference in which Dr. B had spoken about the trauma that a physician faces when disconnecting a mentally competent patient's respirator. Dr. B had talked about an ALS patient who had insisted that her respirator be disconnected, and he was quoted as saying that: "Sometimes I think there is a special place in hell for physicians who disconnect respirators." No one at that time, years before the ruling in *Nancy B.*, suggested that he had done something wrong when the sedated patient quickly died after he disconnected her respirator.

When the Chief Medical Examiner altered Mr. L's death certificate, the patient's widow responded that his registering the death as suicide was tantamount to a slap in the face to the family and to her husband's memory.⁵¹ She attended all four days of the inquest, and she must have heard her husband's death described a half dozen times. She went through that ordeal not only because the inquest so intimately involved her husband and her family but also to show her unwavering support for Dr. B.⁵²

Was all this really necessary? Dr. B and Riverview's medical director were obliged to hire counsel to represent their interests at what was essentially a quasi-criminal proceeding. One can well imagine the stress that they underwent from October 1993, when the death certificate was changed, until January 1995, when Collerman, P.C.J. released his findings, which amounted to a complete vindication of Dr. B. When the Chief Medical Examiner announced that he was calling an inquest, he said that the main reason was to "clear the air." Yet, the air in the case was crystal clear as it was patently obvious from the beginning that the Riverview case had nothing whatsoever to do with "assisted suicide or euthanasia" (quoting his comment as reported in the *Winnipeg Free Press* when it broke the story). The case did not warrant a public inquiry by way of an inquest, which was not only

dose of morphine. Time also precludes his asking the patient for his consent (although section 14 would make a consent issue irrelevant). Is it murder? The likely response is that it is murder — that even though the patient was doomed to die by respiratory arrest, still the process was intentionally hastened by the physician. It is doubtful that such a case would be prosecuted; and if it were it is unlikely that a jury would convict. But in theory the physician would be guilty of murder, even though he had acted in compelling circumstances where not acting would have consigned the patient to a horrible death. There is the common law defence of medical necessity, which has led to acquittals of physicians charged with criminal abortion. However, that defence has never even been pleaded in a euthanasia case and in any event would not likely be permitted by the trial judge to go to the jury.

⁵¹ "Inquest Slap in Face for Grieving Family" *Winnipeg Free Press* (2 March 1994) A1.

⁵² Personal communication from Mrs. L.

unnecessary but also regrettable because of the anxiety that it caused to the family, to the Riverview Medical Director, and to Dr. B, whose impressive credentials and distinguished 30-year career in critical care and academic medicine were noted by the judge in his Inquest Findings.

Although Dr. B never doubted the correctness of his actions, he reacted to the *Winnipeg Free Press* articles by expressing the fear that the public airing of the case could adversely affect medical practice. His concern was apparently well warranted, as a number of local physicians and nurses have described incidents in which patients were undermedicated because of paranoia engendered by the questioning of the amounts of morphine given to Mr. L.⁵³ And that is surely the most disturbing aspect of the case of the “doctor who allegedly helped a man die by disconnecting his respirator.”

⁵³ Personal Communications.