

## YOU ARE A CHILD OF THE UNIVERSE:

### YOU HAVE A RIGHT TO BE HERE

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#### INTRODUCTION

The purpose and intent of this paper is to deal with the frequently pressed and topical issue of euthanasia. Upon such a controversial issue, being more moral, ethical and sociological than legal, it is incumbent on one to 'take a stand'. The writer will endeavour to canvass and contrast the law as it now exists with the law as it is said it should be along with the arguments used to buttress the call for change and the cry for 'status quo'.

Having considered the stance adopted by the competing camps the writer has chosen to ally himself with those of the reactionary forces. Nevertheless it is necessary to recognize the argument of those lobbying for euthanasia, and the writer, despite his admitted bias, proposes to explore the strengths and weaknesses of the competing platforms.

#### HISTORICAL FOUNDATIONS

The writer sees little merit in developing a historical background, or in searching antiquity for cultural precedents supporting either bench's position. All that should be noted is that by-gone societies have in varying degrees been fans of both teams.<sup>1</sup> It is suggested that the legal maxim *similitudo legalis est casuum diversorum inter se collatorum similis ration; quod in uno similitium valet, valebit in altero*<sup>2</sup> has no application to the present inquiry. The question must be decided by considering the requirements of our present society and culture for it is our culture which will feel the effect of our decision.

#### DEFINITION

Euthanasia (from the Greek word meaning good death) has come to envelop a number of concepts, therefore there is a need for clarification as it is a *sine qua non* to any meaningful discussion to state one's terms of reference.

The classical meaning is a doctor using his skill to relieve pain, console anxieties and make death when it comes as easy

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1. See Elliot, Neil, *The Goods of Life*, 1974, pp. 3 — 27, for a brief discussion on the death customs of early cultures.

2. Legal Similarity is a similar reason which governs various cases when compared with each other; for what avails in one similar case will avail in another.

and painless as possible. Euthanasia in this sense will never be the subject of controversy or objection and no act of government is needed to legalize it.

Coined comparatively recently and now common currency is another usage. It means the painless killing of men, women and children to end their suffering — whether it is mercy killing is a matter of debate.<sup>3</sup>

It is with the latter usage that this paper is concerned.

## REASON VS. BELIEF

Those who contest that legalization of euthanasia is long overdue often assert that those who oppose them do so on essentially religious grounds. They say today the governing social force is reason, and as the bearers of the torch of reason they tell us euthanasia is rational and must be had.

Not only is it the case that the claim made above is empirically unsupportable, (many men of the cloth as well as a significant number of church supporters defend the movement) but it is also without a theoretical foundation. People alienated from the church and its doctrines are those with the most at stake. The Philosophy of the agnostic admits only one life and one death; as such the matter of euthanasia is with him of the highest priority. The maxim of the non-religious is *mortis momentum adest ultimum vitae momentum*<sup>4</sup> whereas the religious are content with *instans est finis unis temporis et principium alterius*.<sup>5</sup> The reason vs. religion fallacy should it last be administered euthanasia.

## THE MAJOR PREMISES

The proponents of voluntary euthanasia are for the most part of the existentialist persuasion. 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.

Those advocating the enactment of legislation so as to legitimize euthanasia say that it is an evolutionary extension of liberty, comparable to divorce and birth control.<sup>6</sup> With the coming of recent measures such as the Abortion and Suicide Acts which are clearly indicative of a change of attitude towards the freedom of the individual it was safe to prophesy that with

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3. Gould, J. and Craigmyle, Lord, *Your Death Warrant?* (1971).

4. The last moment of life is the moment of death.

5. An instant is the end of one time and the beginning of another.

6. *Your Death Warrant?* p. 47.

this new impetus motions for euthanasia would again be pressed.<sup>7</sup> Such measures reflecting the change in social attitude, show less inclination to demand that the State should legislate in areas of private conscience and behavior. On the contrary, these measures show a demand for the repeal of laws thought to be unwarrantably restrictive of private choice.

The movement goes as far as to say that the chief reason why euthanasia has not yet been legalized is that the patients who are its beneficiaries have not been in a position to campaign for it.

The doctrine advanced is that of 'individualism'. It is said that the principle at stake is one of individual choice which as an adult the euthanasian claims a right to be able to make.<sup>8</sup> Those who claim the right are not asking religious people or others who find themselves opposed to the principle to adopt it — only to tolerate it when practised by those who do not share their views.

One writer commenting on the controversy put it this way: "Only in a mature culture can death be received and accepted as a natural companion to life. The death preoccupation we are witnessing is probably a clumsy but significant rite of passage."<sup>9</sup>

No one doubts that we are more sophisticated than the ancients but we are not in any real way better equipped to cope with death itself. In a multi-religious society it is difficult to argue seriously that we have even escaped the superstitious aspect of death. Freud stated that "in the subconscious every one of us is convinced of his own immortality," and indeed we all flee from the reality of our eventual deaths. Needless to say, man's subjective belief and the unalterable objective reality of death contemplates one of man's most deep-seated anxieties. With our present social and psychological paradigm it is possible to conceive of not being at this place at this time, or of not being at that place at a given time but to conceive of not being anywhere at any time is not possible in our culture. Available empirical data seems to support our belief in personal immortality. While death occurs all around us every day; obituary columns, daily traffic tolls and the like, it never happens to us.

The writer suggests that there is a fundamental flaw in the claim for euthanasia as the argument presently exists. The claim (euthanasia) is greater than the right (choice) upon which it is said to be supported. The two admittedly overlap but this in

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7. See Downing, A.B., *Euthanasia and the Right to Death*, 1969, for a history of the proposed legislation.

8. *Your Death Warrant?* p. 65.

9. Maguire, Daniel C., *Death By Chance, Death By Choice*, Atlantic, January, 1975.

itself is insufficient. The claim demands more than a right to one's own death; a necessary and essential ingredient of the claim is the participation of other individuals. By necessary implication then the right assumes a duty; a duty of others to become actively involved in the active inducement of death. Although this apparent defect does not necessarily invalidate the entire claim, it does illustrate the implications of such a right/duty relationship and as such admits to the area of discussion matters which although not germane per se are at least collaterally relative.

Although those in favour of voluntary euthanasia appear content to rest their argument on their underlying principle alone, they seek to buttress their claim by pointing out that the benefits to society at large from State recognition of the fundamental human right to death would be multifarious.

What follows is a cursory look at the suggested benefits and the arguments in volley.

#### PAIN AND SUFFERING

A primary aim of the Euthanasia Societies is the alleviation of pain and suffering. Lord Ponsonby of Shulbrede in introducing the first Bill to the House of Lords in 1936 is reported to have said, "Briefly our desire is to obtain legal recognition for the principle that in cases of advanced and inevitably fatal disease, attended by agony which reaches or oversteps the boundaries of human endurance, the sufferers, after legal inquiry and after due observance of all safeguards, shall have the right to demand and be entitled to receive release."<sup>10</sup>

The plea for the elimination of pain is the euthanasiasts' most well-documented argument. In fact, the greater proportion of those who speak in favour of euthanasia have usually been convinced after personal experience. Paul Wilks expresses the feeling when he says that "using the marvels of modern medicine to keep a dying man alive for a few more weeks, days or hours can be needlessly cruel."<sup>11</sup>

Pro-euthanasiasts liken the suffering human to the suffering animal. It is said that we consider allowing an animal to suffer is a crime and fully endorse the quick termination of the life and pain of such animals. It is the ultimate irrationale that horses and dogs are put down painlessly, leaving only human beings to suffer to the end.

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10. *Your Death Warrant?* p. 39.

11. Wilks, Paul: "There are Times When Keeping Someone Alive May be Crueler Than Death" *Life*, January 1972.

An anti-euthanasian raises no argument against the euthanasian's concern for the relief of pain. It is, however, necessary to point out that the euthanasians tend to cloud the distinction between the pain and suffering of the proposed euthanasia recipient and that of the family, relatives and friends, and in most accounts of the 'dreadful last days' the focus has in fact been on those other than the patient. For a purist in the euthanasia league, the distinction is vital.

It is necessary to recognize that pain is a relative term, as there are different thresholds of pain. Moreover, pain is difficult to assess as to degree and intensity and many individual factors enter into the mode of its endurance and the way it is regarded by sufferer and by observer.

Furthermore, with the drugs available today, it will only be in the very rarest of cases where actual and unbearable pain is likely to occur.

It can be suggested that rather than reducing pain there will in fact be an increase in pain, both to the patient and to those close to him. This increase in pain will be of a psychological nature.

Even those pressing for new legislation recognize that there will be a series of checks on the procedure where euthanasia is to be implemented. As a necessary result, those patients who continue in a conscious state are bound to experience the psychological pressures of having the 'death-bed-bureaucracy' tramp in and out of the hospital room checking to see that the safeguards have been met when the time for a final decision appears to be at hand. For the family, relatives and friends, it is difficult to escape the conclusion that guilt and anxiety will be felt by having a loved one put to death.

The confusion between 'patient pain' and 'family suffering' is the real danger with this branch of the advocating camp's argument, and if the former is truly the only relevant factor of the two, it is suggested that as a practical matter neither the courts nor the medical profession will be capable (even if willing) to make the distinction. When matters extraneous to the personal state, condition, and request of the individual concerned are taken into account, there can at best remain a blurred distinction between voluntary and involuntary euthanasia.

#### DEATH WITH DIGNITY

Dr. Wenger asserts that "the relief of suffering is one of the principal aims of society, as well as of doctors. Prolonged and

hopeless physical anguish degrades and dehumanizes."<sup>12</sup>

Dignity in death is said to be as important as the dignity of life, and if that is true then we need legal assurance that dignity will be recognized. Dr. Millard contrasts the situation in some countries, e.g., Japan and India, where suicide under certain circumstances was regarded with respect, with that in Christian countries. He says that suicide because of its motivating factors must always be wrong whereas euthanasia must always be right. Legalizing the latter would place it in quite a different category as an act which is rational, courageous and often highly altruistic.

The classical deathbed scene, with its loving partings and solemn last words is practically a thing of the past. In its stead is a sedated, comatose, betubed object manipulated and subconscious if not subhuman.<sup>13</sup> In present societies where man is so often denied his dignity through life we cannot be justified in denying him his demand for the last chance of dignity — the dignity in death. When we place so much emphasis on a nice burial and where the corpse is in a doll-like fashion dressed for the last 'big event' should that body have not have had the right to declare that while alive his dignity shall not be eroded by medical contrivances and contraptions? Should he not be spared the intern's comment that it is now time to 'water the vegetables'?

The writer's only remarks are that to involve the patient in the paper shuffle of the bureaucracy which must accompany euthanasia will do much to undermine the patient's self-esteem and that in the end result no dignity is to be saved.

Euthanasia is also in many ways a concession of failure, the fact of life often hinges on will; to lose the will to live is not dignifying.

## DOCTOR — PATIENT RELATIONSHIP

By making provision for the legal recognition of euthanasia it is said that the doctor — patient relationship would be greatly improved. The patient would be assured that the doctor would help him die in the manner he wishes. The doctor would be free to properly balance the amount of medical aid possible with the patient's right to dignity, his pain and suffering, etc., and when the balance could no longer be maintained, the doctor would be free to terminate life in accordance with the patient's wishes without incurring any guilt feelings or fear of repercussion.

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12. Wenger, Dr. H. Leslie, "Should Mercy Killing Be Permitted?" Good Housekeeping, April 1967.  
13. Fletcher, Joseph, "The Patient's Right to Die", Harper's, October 1960.

The anti-euthanasia element emphatically denounces such a claim and argues that if such measures were adopted, the doctor — patient relationship will be seriously undermined. The doctor — patient relationship is built on trust. The patient trusts the doctor to care for him to the best of his ability. The doctor takes the Hippocratic Oath to do just that, the French aphorism of the doctors being, *quelquefois, soulager souvent, consoler toujours*. If this undertaking is altered so as to require the doctor to observe his patient's request even though he has grounds for regarding these requests as no longer relevant or applicable, then the doctor would be placed in a position where he could not longer freely serve the interests of his patient. It must be recognized that the declaration made by a patient does not in itself impose a strict legal obligation on one doctor, but notwithstanding the absence of such a legal obligation the question must be — how does a doctor who has been treating a particular patient deal with the situation if he personally is opposed to euthanasia? It is unlikely that a doctor involved up to the point spelled out by the declarations can escape its import. This will necessarily be more acute in rural than urban areas. This problem could be overcome by the referral technique already commonly practised by the medical profession. Although this is an apparent solution for the patient (his declaration being fulfilled) it is not in the writer's opinion any solution for the profession. A natural result of such a technique is that a new medical specialty (thanaology) will be created — a specialty which is in direct opposition to the existing aim of medicine. When considering this question the legal profession should have in mind the maxim *non est arctius vinculum inter hominines quam jusjurandum*.<sup>14</sup>

The patient's trust in his doctor (as well as the profession as a whole) will become impaired, rather than being bolstered. Having seen a fellow-patient taken from the room and not returned will have serious consequences on his confidence in doctors. The patient will not know whether the other patient had made a declaration or not and it is likely he will now be in fear of meeting the same fate whether he has or has not signed a declaration. He cannot be sure that he will only be administered euthanasia under the circumstances specified by him. *Non haec in foedera veni* will not be heard.

As pointed out earlier, euthanasia involves more people than the person who is to be the subject of the proposed death. Of those other persons, the most intimately involved will be those

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14. There is no closer bond between men than an oath.

who administer the euthanasia. For the most part that will be the doctor. Such a responsibility is incompatible, and destructive. In the writer's opinion those who first bring life into the world, those charged with healing, curing and saving are not to be additionally charged with actively inducing death. Medical literature points out that a good portion of the medical profession is neither properly educated to assist the dying patient nor are many willing or capable of breaking the news of a terminal disease or condition.<sup>15</sup> Wherever possible the section of the profession that cannot face the task delegates the assignments to a colleague or subordinate. Whether euthanasia would provide an alternative to delegation or would merely become another subject of delegation is of little importance — both are to be rejected.

Oulahan reports that at a recent Mid-west meeting of doctors, all doctors who had never practised euthanasia were asked to raise their hand, and not a hand was raised.<sup>16</sup> The writer doubts the weight to be attached to a negative response and particularly doubts the validity of a reply to a question which does not make any distinction between 'active' and 'passive' euthanasia. No one doubts that the latter form of euthanasia is practised and is approved of, to what extent the former is practised is questionable.

Some further problems which involve the doctor and hospital staff raise such questions as: Who will be responsible for the payment of euthanasia services? Who will negotiate the fee and set the standards?

In the writer's opinion any concept resembling a commercial undertaking is too absurd and grotesque to become a matter for serious debate.

The real question for the medical profession today, as it will be for the future, differs radically from the questions of earlier times. Whereas the old question was — may we morally do anything to put people mercifully out of a hopeless misery — the new question is — may we morally omit to do any of the ingenious things we could do to prolong people's suffering? If the writer is correct in presenting the question in this form, it follows that the traditional arguments for and against euthanasia are really outdated and completely miss the point.

In any event the concept of doctor as executioner would not improve the doctor — patient relationship. The physician must always be on the side of life.

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15. Schoenberg, Bernard, *Anticipatory Grief*, 1974.

16. Oulahan, Richard Jr., *Euthanasia — Should One Kill a Child*, *Life*, August 1962.



## MEDICAL RESEARCH

The advocates of euthanasia also contend that legalization of their cause would do much for the advance of medical research. By allowing the patient to set out in advance when he wants to die does not infringe the sacrosanct of life, or so it is said, for real life must be a self-conscious life and as such we should have no hesitation in allowing patients to die who are only organically alive. The result being manpower and finances would be freed which could be allocated to research programs.

Perhaps the most progressive thinking (though not necessarily appealing) along these lines is that of Willard Gaylin.<sup>17</sup> Mr. Gaylin indicates that there is an abundant and ever-increasing number of people who donate their bodies to medicine, (man's wish for immortality) however, under the present law needless waste occurs. Gaylin points out that the euthanasia concept, if properly implemented, would allow the person to be merely pronounced dead, and that in appropriate cases there would be no need to 'pull the plug'. This proposition would in some ways simplify the dilemma surrounding the 'active vs. passive' question. No action involving the patient in a physical sense is required at all. This suggestion assumes a slight shift in the medico-legal definition of death, and assumes that when the specified situation under a declaration occurs, death will exist *pro facto*. Euthanasia will not have to be administered — euthanasia will have occurred.

The thought itself is exciting but the possibilities it opens up are even more remarkable (though not necessarily desirable). What it would mean is that once the legal status had been changed from person to corpse the cadaver could be kept functioning. Where this procedure was adopted the cadaver would become a new source of blood, a new source of hormones, and a new source of antibodies. In the age of the transplant phenomenon, a time when the part is often considered more valuable than the whole, organs and body tissue which deteriorate quickly could be kept functioning until the moment they are required, thereby providing not only a superior commodity but also avoiding waste.

The functioning cadaver could become the new testing ground for chemicals and cancer treatments, for the testing of new medical experimentations thereby eliminating the need to employ convicts and mental patients. This new and welcome subject could be used in teaching medical students surgical

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17. Gaylin, Willard, *Harvesting the Dead*. Harper's Magazine, September 1974.

techniques, the effects of drugs, the functionings of the body and the like.

The writer's immediate reaction is "How would you be able to distinguish between the hospital wards and the morgue?" Nevertheless the thought has some appealing characteristics and should be promoted. The writer suggests, however, that this proposal can be implemented by a manipulation of the definition of death, along with an expansion of the active — passive concept and the recognition of a form of voluntary declaration, and thereby avoid adopting the active euthanasia alternative.

PROXIMUS EST CUI NEMO ANTECEDIT,  
SUP SUPREMUS EST QUEM NEMO SEQUITUR.

Those pro-euthanasia do not deny that the admitting of the euthanasia exception to the existing state of law has the effect of altering the very concept of life. They maintain however that the shift has for all practical purposes been accomplished with the new concern for over-population and abortion, and that the question has now in fact become one of quality of life not quantity of life, euthanasia only being part and parcel of the new trend.

A fraction in the euthanasia movement say that the claim is couched in too modest terms. They say that the quality of life is now so vital that those persons who could not or would not make declarations are often those to whom euthanasia should be administered; that being so, the claim should be extended to embrace those people as well. The reply from within is that they must proceed 'step-by-step'.

Those who oppose voluntary euthanasia legislation contend that not only is there an underlying flaw in the principle but that the effect of endorsing such a radically unsound principle will have the most detrimental effect on society imaginable.

Those setting up the *protestando* do so on the basis of the principle *Rerum Progressus Ostendunt Mutta Quea In Initio Praecaveri Seu Pracvideri Non Possunt*.<sup>18</sup>

The claim of a right to die challenges the right to live. To admit the former is to modify the latter. By introducing euthanasia as a social phenomenon, it is suggested that the natural and inevitable progression is that what is made legal is thereby morally or ethically justified and in due course society will come to regard that made legal as virtually compulsory.<sup>19</sup>

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18. The progress of events shows many things which, at the beginning, could not be guarded against or foreseen.

19. *Your Death Warrant?* p. 99.

Once the concept of life as we know it is qualified, the question will be — Who's Next?

Norman Podhoretz, writing on his experience at a conference in Washington, called to explore the question of whether mongoloid infants should be permitted to live, in the context of the overpopulation problem, observes that a substantial body of biologists, medical men, writers, philosophers and theologians are by no means willing to grant mongolois an undisputed right to live, based on the reasoning that they were an intolerable burden to their parents, to society and themselves.<sup>20</sup>

Mount, in a facetious article revolving around a Bill to the House of Lords in '1984', fears that the next step on the 'slippery-slope' would be for an Act to provide for the voluntary euthanasia of persons experiencing marital problems.<sup>21</sup>

It is argued that if mongoloids are defective, so are the crippled, the blind, the lame, the dismembered, the made, diabetics, dwarfs, alcoholics and addicts. The list of physical and social handicaps is omnifarious. If there is a beginning, can there be an end?

Julius Paul in *Eugenics*<sup>22</sup> indicates that in the early part of this century the extreme hereditarians were successful in lobbying for sterilization legalization in 24 States.<sup>23</sup> The classes of persons embraced were the feeble-minded, the insane, the criminal, the epileptic, the inebriate, the diseased, the blind, the deaf, the deformed, orphans, tramps and paupers. The natural extention of euthanasia is to make use of its obvious utility to accomplish the end sterilization has failed to reach.

It seems self-evident that euthanasia is truly the 'thin edge of the wedge' and the argument of quality of life versus quantity of life reduces itself to control of the character of the human stock.

The primary concern is that a new definition of the life concept carries with it the requirement that individuals make a constant assessment of the value of their lives. Even with only 'voluntary' euthanasia being admitted, it is suggested that a social obligation will be felt to avail oneself of the legal option provided where 'proper' circumstances arise.

What this means is that the old, the unemployed or what may be called the unproductive will feel pressured into assessing their value to society in tangible terms. Assuming that the

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20. Podhoretz, Norman, *Beyond ZPG*, Commentary, May 1972.

21. Mount, Ferdinand, *Another Modest Proposal*, National Review, March 1968.

22. Paul, Julius, *Eugenics*, Commentary, December 1972.

23. Twenty-six of the American jurisdictions presently retain such legislation.

present concept of life is that life is sacrosanct, that there is something intrinsically valuable in life itself, can it honestly be argued that that concept should be replaced with a concept that life is valuable where there is tangible evidence of the fact? The psychology of the person will be altered so as to place the assessment of life in its purpose to society in direct and pragmatic terms.

The situation will be most acute when there is a combination of factors (all of which are beyond the individual's control). Should the old, unemployed and unproductive person upon becoming sick be made to feel the general burden on society that they present — perhaps the grandmother living with her family in cramped accommodation should give up her room so that the younger family members will be more comfortable by taking advantage of the State plan provided. In time perhaps the family will fell, or will be interpreted as feeling that the euthanasia plan has been legislated just for such a situation and through subtle body language (e.g. a raising of the eyebrows) express their feelings to the oldest member of the family. The writer suggests that you cannot simply write an equation for the value of life let alone compare two or more lives: *Res Sacra Non Recipit Aestimationem*.<sup>24</sup>

Upon defining a new time 'for death' or 'of death', we must contemplate the other end of the life continuum; a new time for life. The proposition is that no infant should be declared human until it has passed certain tests regarding its genetic endowment. Then perhaps it could be placed on a probationary period for six or twelve months to provide for such contingencies as pneumonia or the like which may render the quasi-human a weak or sickly adult. This simply involves a new legal definition of the gestation period. *Mortuus Exitus Non Ext Exitus*.<sup>25</sup> The gestalt theory suggests that euthanasia has the potential to become the ultimate answer for all who are a burden on the community services and on the public purse.

If euthanasia is allowed and thereby certain 'obvious' forms of life eliminated, society will be presented with a new frame of reference. With a new frame of reference what at present is not so obviously undesirable will become so in the future, for if human life forms can be placed on a continuum, as the continuum is shortened we will by definition constantly be presented with a new bottom. As the first step on the slippery slope is taken a downward moral momentum will surely be set off which may

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24. A sacred thing does not admit of valuation.

25. A dead issue is no issue.

prove hard to contain. Euthanasia, it is suggested, although perhaps a blessing to a few poses a very real threat to many, as man has clearly demonstrated that it is in his present and potential ability through biological and genetic engineering to transcend his human nature that he most vividly threatens himself.

Let only the perfect live and who shall'scape killing? Who that is except for the framers of the definition of what perfection means?

"You are a child of the universe, no less than the trees and the stars; you have a right to be here."<sup>26</sup>

## THE LEGAL ASPECTS

The *Canadian Bill of Rights* provides in Part I:

s.1 "It is hereby recognized and declared that in Canada there have existed and shall continue to exist . . . the following human rights . . .

(a) the right of the individual to *life*, liberty, security of the person . . . and the right not to be deprived thereof except by due process of the law;"

With respect to euthanasia, the governing sections of the Criminal Code are s. 205 and s. 212. Reduced, for the present purposes, their effect is that deliberate action intended to cause death and having that effect is murder notwithstanding the fact that death appeared inevitable from other causes within a foreseeable future. The punishment is imprisonment for life.

As a general proposition the element of motive has been relegated to a near insignificant position in Canadian criminal law. The American and English position is presently the same.

The German Penal Code requires *inter alia* a 'base motive', and on that ground the German courts have held euthanasia cannot be murder; and apparently in Uruguay a 'good motive' by a 'mercy killer' operates as a complete bar.

An accurate statement of the American, English and Canadian position is found in *People v. Conley* (1966), 49 Cal. Rep. 815, at page 822 per Traynor C.J., ". . . one who commits euthanasia bears no ill will towards his victim and believes his act is morally justified, but he nonetheless acts with malice if he is able to comprehend that society prohibits his act regardless of his personal belief;" his act is murder.

Despite the rigidity of the black letter law, juries can usually be counted on for a compassionate verdict.

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26. *Desiderata*, Ehrmann, Max (1872 - 1945).

Perhaps the most celebrated case is that of the famous *Liege Trial*.<sup>27</sup> On May 22, 1962, a daughter was born to Suzanne Vandeput in the Rocourt Clinic in Leige, Belgium. The child's mother had sometime previously taken a pill known as 'softenon' and the baby — victim was known to the world as a thalidomide baby.

The delivering doctor stated that the baby was intellectually normal but had the following physical deformities: spotting on the face, no arms, and an unusual placing of the anus and vagina. The child would have been able to sustain life without life-support systems.

The facts of the case are that for seven days five persons rationally and deliberately planned to put an end to the baby's life, despite the fact that the State had offered to place the child in an institution and accept the responsibility for its care. The mother, father, a sister and grandmother with the aid of a doctor (all charged as co-accused) rejected the option and seven days after the baby's birth the mother by means of a feeding bottle administered a fatal dose of poison.

No one ever disputed the fact that all accused were compassionate, and citizens of strong moral character.

On November 5, 1962, Suzanne Vandeput was tried on a charge of 'having voluntarily and with intention to kill, brought death upon the person of Corinne Vandeput'.

As part of the case, a city referendum was tendered in evidence which showed that public opinion was that 16,732 approved, while 938 disapproved of Suzanne Vandeput's act. Belgium gamblers considered the odds so overwhelming they declined bets.

The accused all but admitted the facts but the gamblers were right; the jury brought down a verdict of not guilty. The accused during the course of the trial emerged a sort of heroine and the killing was described as a courageous act.

An author writing some four months after the *Leige Case* noted that since the decision, two other Belgium mothers had killed their deformed children: one by strangling, one by gas.

Where the jury does not bring in an absolute acquittal, the judge can be expected to show the greatest leniency permitted. In the case of *George Ernest Johnson* (1960), where a father killed his youngest son, a mongoloid child, a charge of murder resulted in a verdict of manslaughter, and a sentence of 12 months — the minimum alled by English law.<sup>28</sup>

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27. Gallahue, John; *Tragedy at Leige*, Look, March 1963.

28. "The Quality of Mercy" Time, July 1960.

Other than the *Vandeput Baby Case* where the doctor was charged as an accomplice, cases involving doctors are comparatively rare. The first American case involving a doctor was the *Sander Case* (1949).<sup>29</sup> Dr. Sander entered a plea of not guilty and was acquitted for lack of proof on causation, despite the fact that the prosecutor had an admission of an injection of air into the veins of the victim. The second American case occurred in 1974 when Dr. Montemarano was charged with injecting potassium chloride into a dying cancer patient. The *Montemarano Case*<sup>30</sup> returned an acquittal on the basis of lack of proof on causation. An earlier American case involving *Dr. Haiseldelen* (1917)<sup>31</sup> is not directly on point but a mercy killing was alleged (discontinuance of intravenous drip) and an acquittal resulted. In all there appears to date to be nine cases involving euthanasia claims against doctors; the only two convictions being registered in the Netherlands, where minimum sentences were imposed.

On the Canadian scene there appears to be only one case against a doctor and only circumstance prevented the case from becoming a truly euthanasia affair.

In 1973, *Dr. Ernest W. Pedley*<sup>32</sup> entered a plea of guilty to attempted murder. The case against Pedley was that he had watched his wife struggle with cancer for a number of years and finally 'he' could not bear it. Mrs. Pedley is reported to have clung preciously to life at all times, never giving up hope. The accused substituted medication being taken by his wife for a poison, however, she discovered the plot and charges were brought. In passing it is worth noting that Mrs. Pedley supported her husband throughout the trial. The conviction resulted in imprisonment for six months.<sup>33</sup>

Cases such as those discussed above have resulted in the suggestion that the common law countries should introduce 'motive' as an element in the appropriate cases.<sup>34</sup> One of the major principles in sentencing is that of rehabilitation<sup>35</sup> and in cases where such extraordinary circumstances exist there is little likelihood that the actor will commit a similar crime. The only actor, however, to pose any siminal threat is a doctor whose exposure to possible euthanasia situations is continuous.

The writer is against the euthanasia principle and as such

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29. *Time*, January 16, 1950.

30. *Newsweek*, January 28, 1974.

31. *New York Times*, January 8, 1950.

32. *Canadian Magazine*, October 1973.

33. In addition to the cases mentioned, there are some 30 additional cases alleging a mercy-killing.

34. A number of European countries have already taken up the suggestion.

35. *R. v. Morrisette* (1970), 1 C.C.C. 307, 310.

opposes breaking new legal ground on its account. For practical purposes, sentencing considers the motivating factors behind crime and wherever a conviction has resulted the greatest leniency possible has been shown.

Nichols said that "such an examination, if honestly conducted inevitably compels the questor to face the ultimate problem of suicide. This obliges him to make up his mind about voluntary euthanasia — the legalized inducement of death."<sup>36</sup>

Suicide is no longer a crime, nor is attempted suicide. However, counselling, procuring, aiding or abetting a person to commit suicide whether death ensues or not is an offence carrying a sentence of up to fourteen years imprisonment. (Criminal Code s. 224). It appears that in the European countries where suicide is not an offence, making poison available at a patient's request cannot be an offence based on the reasoning that aiding and abetting a lawful act cannot constitute an offence. In Texas, Davidson J., held that "suicide not being an offence there could be no act of aiding or abetting". *Grace v. State* (1902), 69 S.R. 529.<sup>37</sup> The Canadian position however is clear as it has found legislative pronouncement; aiding or abetting suicide are very serious crimes.

The writer has pointed out earlier that euthanasia and suicide are neither theoretically nor factually the same matter.

Euthanasia can be likened to 'assisted-suicide' but in so doing the element 'assisted' is introduced; a factor not involved in suicide. It is with precisely this distinguishing element that the law (and this writer) has its difficulty.

It should also be noted that everyone who administers or causes to be administered to any person or causes any person to take poison or any other destructive or noxious thing is guilty of an indictable offence and is liable to imprisonment for fourteen years, if he intends thereby to endanger the life of that person. (Criminal Code, s. 229.)

## THE PROPOSAL

Under the existing state of law the victim's actual or implied consent is not a defence to culpable homicide.<sup>38</sup>

The existing state of the law has been attacked as being archaic and merciless by such formidable figures as the legal scholar Glanville Williams.<sup>39</sup> The defence of consent is the primary area of disagreement.

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36. Nichols, Beverly; *A Right to Die?* Calgary Herald, May 12, 1975. (Reprinted from *The Spectator*).

37. In 1974, the Texan Legislature passed an act having the effect of overturning the *Grace Case*.

38. Cannon, William P., *The Right to Die*, (1969) 7 *Houston L.R.* 654.

39. Williams, Glanville, *The Sanctity of Life and the Criminal Law*, 1957.



On a number of occasions, Euthanasia Bills have been submitted to various legislative bodies in an attempt to gain legal status for euthanasia.<sup>40</sup> The proponents of euthanasia claim that it is desirable in certain circumstances, and ought to be made lawful, for a person to deliberately kill another, where that person consents to the act and as most persons are not in a position to consent at the relevant times there should be a procedure established whereby consent can be expressed in advance.

For present purposes the proposed legislation need not be set out seriatim; the essential provisions will suffice.

Such a bill would provide that: (1) Any person, who being apparently of the age of majority, may make a declaration. (2) Once made, the declaration would not become effective until the expiry of thirty days (unless revoked). (3) Thereafter it would remain in force for three years (unless revoked). (4) If re-executed within twelve months preceding its expiry it would become valid for the lifetime of the declarant (unless revoked). (5) Revocation could be effected by either destruction of the declaration or by a notice of cancellation on its face, either being accomplished by the declarant or at his order.

A person would be a 'qualified patient' if two physicians certified in writing that he appeared to them to be suffering from an irremedial condition, being defined as meaning a serious physical illness or impairment reasonably thought in the patient's case to be incurable and expected to cause him severe distress or make him incapable of rational existence.

A declarant who became a qualified patient might have euthanasia administered to him by a physician or a state registered nurse carrying out the discretion of a physician.

Before euthanasia could be administered to a mentally responsible patient the physician was to make sure to his reasonable satisfaction that the declaration and all steps to be taken accorded with the patient's wishes.

Protection would be afforded to all who administered euthanasia to a qualified patient in accordance with what was believed to be the patient's declaration and wishes.

To wilfully conceal, destroy, falsify or forge a declaration under the Act would be an offence punishable by life imprisonment.

A conscientious objection clause would be provided for.

The Secretary of State could make regulations.

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40. A partial list of the jurisdictions where Euthanasia Bills have reached the legislature is as follows: England, 1838, 1950, 1969, 1970; Ohio, 1906; Nebraska, 1937; Connecticut, 1951, 1959; Florida, 1968, 1970, 1971, 1972, 1973; Idaho, 1969; Wisconsin, 1971; Delaware, 1973; Virginia, 1973; California, 1974; Illinois, 1973; Hawaii, 1972; U.S. Senate, 1971.

Reaction to the proposed legislation has been varied but to date sufficient support for the passing of a Bill of this nature has not been found.

An initial criticism can be leveled at the Bill itself even if one adopts its principle. The key elements and sections are so imprecise that they defy interpretation. It should be kept in mind that legislation of this nature bears no analogy to much of the social reform legislation presently being pressed, and as such, loose phrases and imprecise wording will not accomplish the extreme exception asked for. This is not the sort of legislation which can be passed and the mechanics worked out 'trial and error' as we go along. The subject matter prohibits such experimentation.

One might presume that a declarant would have to be of sound mind at the time of effecting a declaration but to this element the Bill is silent.

The revocation sections are defective. There is inadequate provision for the safekeeping of declarations so as to provide for quick revocation. Furthermore, the Bill does not determine whether a later declaration revokes an earlier one or whether the two can simultaneously stand.

The 'irremedial physical condition' section is so encompassing in its ambit that the loss of a limb would fall within its scope.

The provision for the making of regulations leaves too much for the imagination when one considers the scope, purpose and intent of the Bill.

Those campaigning for the enacting of euthanasia legislation argue that we need to give legal certainty to the acts of doctors.

The law on the books is, as it stands, uncompromising; it condemns all mercy killing, provided there is an active element. That in itself does not prevent mercy killing, of course. There is, however, a high incidence of failure to indict, acquittals and suspended sentences. The lack of certainty of a sentimental verdict is said to create an inequality before the law.

The writer suggests that the law must face up to the existing imperfections and uncertainties, but the euthanasia legislation to date contains many more uncertainties and ambiguities; as such it can hardly be said to be a clarification.

The statutory defence which is provided for under the suggested legislation would have to be pleaded and established where the accused sought to rely on it. Whether in any given situation the defence is available would have to be proven, as

such an uncertainty is inherent in the Act itself, as the defence flows from words which provide no certainty.

The offence-creating section presents what the writer suggests to be an absurdity. The part of the section which provides for the forging or falsifying of a declaration and thereby a non-consenting patient being administered euthanasia would in any event be implied by the law itself. But that portion of the section which would make it an offence to conceal, destroy or falsify a declaration is preposterous. We end up with the possibility of two trials being held at the same Court House, one for causing death of another person by an unlawful act, the other for preventing the death of another. The confusion to the entire body of the criminal law itself is a factor to be carefully considered.

Regina lawyer, Dr. Morris Schumiatcher<sup>41</sup> said of active euthanasia "the issue does not lend itself to precise legal definition. I don't think these are matters for law or politics."<sup>42</sup> The writer agrees.

The effect of such legislation could have on tort law should also be anticipated. Would an action lie for improperly or negligently or illegally (violation of penal statute) administering euthanasia? On the other hand, would an action lie for delaying or failing altogether to perform euthanasia and thereby causing pain, suffering, injury to character, mental suffering, or what have you, by an omission? If anything, the legislation would destabilize the medical profession's position rather than giving it added predictability. Criminal and civil actions for not killing — ridiculous!

#### NEGATIVE VS. POSITIVE EUTHANASIA

Lawyers are confident in asserting in law (as it presently stands) culpability only attaches for active euthanasia. The distinction between commission and omission in law is vital. The single most important element of any offence is the *actus reus*; without it there can be no conviction, for by definition there is no offence. The issue at hand is really that of *causa causans*.

To go further the law distinguishes between *causa causans* and *causa sin qua non* which recognizes the dual aspect of an act; that dealing with the laws of natural science and that dealing with the principles of philosophy.

What I have been discussing so far is what the law recognizes as being an act in fact and consequently an act in law. Causation, however, has always been the most difficult area of law, and goes further than the discussion to date.

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41. Reported to be one of Canada's 'top ten' criminal lawyers. The Canadian Magazine, July 19, 1975.  
42. Saskatoon Star Phoenix, September 30, 1975.

Even if one were to satisfy himself with respect to *causa causans* and *causa sine qua non* and found the event not to be caught by these concepts the law may come along and niftily obliterate any apparent distinction by finding a duty situation. If a duty is found the issue is not "what did the accused do, but — what should he have done?" The law then states that the criminal act is not doing that which ought to have been done — 'the act of not acting.'

Under the Criminal Code, s. 198, "Every one who undertakes to administer surgical or medical treatment to another person or to do any other lawful acts that may endanger the left of another person is, except in cases of necessity, under a legal duty to have and to use reasonable knowledge, skill and care in so doing."

Section 199 reads: "Every one 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."

What should be recognized here is that at times an omission may be as obvious as an act and at other times may require considering in depth the *causa sine qua non* and *causa causans* problem but under the further difficulty of having to do so within the context of whether or not the field of duty encompasses the omission, if there be one, under consideration.

What was at one time considered a simple question of feaſance, nonfeaſance or miſfeaſance has through legal development and refinement become the moſt baffling of all legal iſſues.<sup>43</sup>

The iſſue of cauſation and *actus rea* are further complicated by the iſſue of intention, uſually in our preſent context deſcribed as 'primary purpoſe.' So, it is ſaid that where a doctor adminiſters a drug for the primary purpoſe of reducing pain, yet knowing that the drug will have the effect of ſhortening the life of the recipient, the act falls excluſively within the field of non-culpability. Primary purpoſe, reſembling motive, is much like the defence of ſelf-defence. The law recognizes the poſſibility of a dual character in acting where the line is that divides the one from the other has not been ſtrictly drawn.

With the increasing uſe of extraordinary meaſures, the occaſions for paſſive euthaſia are becoming more frequent.<sup>44</sup> The confuſion muſt therefore be increasing proportionately.

William Cannon<sup>45</sup> ſummed up the area as follows, "Conſider the caſe of a patient who is alive becauſe his body is connected to

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43. For a more complete understanding of the iſſue of cauſation, ſee, Proſſer, W., *The Law of Torts* (3d ed. 1964), and Williams, G., *Cauſation in Homicide*, [1957] Crim. L.R. 429.

44. Cant, Gilbert, "Deciding When Death is Better Than Life" *Time*, July 1973.

45. Cannon, William P., "The Right to Die" (1969) 7 *Houston L. Rev.*

a mechanical respirator. He requests death by the hand of the doctor. Is the act of unplugging the respirator akin to the pulling of a trigger in that it is an external manifestation of the actor's will? Or is this to be considered an omission, or nonfeasance, by the doctor in that he is omitting to provide further lifesaving medical aid?"

Cannon concludes by saying, "It is fallacious to argue that a cessation of such treatment is a mere omission to provide therapeutic treatment and not an act in the legal sense. The physician must physically turn the switch to the 'off' position. This is, in fact, positive action."

Under this factual situation, an operating element is 'certainty of result,' and intervening cause is under such circumstances difficult to establish at law. To quote Cant, "If we will the end — we will the means."

The practice of passive euthanasia has been said to be fairly widespread. Notwithstanding this, a pair of recent cases illustrate that it is either difficult in some cases to gain the cooperation of the medical profession either on moral and ethical grounds or for fear of legal consequence.

Although both cases involve children, they may find application wherever the law would not recognize the legality of an individual's exercise of consent or on the other hand where for the purposes of consent another person is entrusted with its exercise.

*The Hardest Choice*<sup>46</sup> relates a story where the parents of a newlyborn mongoloid child refused an operation for the child. As is common in the 'blood transfusion' cases, the participating doctors obtained a court order for performing the operation. Notwithstanding the operation, the child died fifteen days afterwards.

The most recent case in the area is out of Morristown, New Jersey, and came to the fore in September 1975. Parents brought a motion to have the life-support systems removed from their 21-year-old daughter who had been existing in a purely vegetative state for the past six months. The trial decision in the *Quinlan Case* came down on November 10, 1975, when Muir, J., refused to allow or order Karren Ann Quinlan to be removed from life-support systems, on what he said were medical grounds. The case clearly illustrates the present dilemma surrounding the question of what is 'action and what is 'inaction'. The Governor of New Jersey, Brendon Byrne, said that he could not approve a bill which would allow life-support systems to be withdrawn.

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46. *The Hardest Choice*, Time, March 1

In April, 1976, Chief Justice Richard J. Hughes, a former New York Governor, allowed the appeal in the *Quinlan Case*<sup>47</sup> naming the young woman's father as legal guardian of her person as well as her property. The decision is based on the principle of the right to privacy and Hughes, J., said: "the states interest (in preserving life) weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the state interest."

Although this case is undoubtedly a landmark in judicial precedent, the test expounded rests on a very delicate balancing process, and in the end result does little to clarify the murky legal picture.

What is clear under the present state of law is that the legal distinction between action and inaction is the vital link to culpability. What is equally clear is that in the medical field what is legally regarded as 'action' or 'inaction' is not clear at all.

#### DEFINITION OF DEATH

There is molecular, subcellular, cellular, organ, systym, corporeal, mental and, for those who accept the idea, spiritual life, and therefore death can also be defined in these aspects.

One should also recognize the two competing theories of death; one asserts that death is a continuing process beginning at birth — the other is that death is an event.<sup>48</sup> The case of *Terril v. Public Adm'r*, 4 Bradf. Sur., N.Y. 245, stands for the proposition that the last moment of life is the moment of death. Legal reasoning requires precision wherever possible and with respect to death the 'event' theory is the only theory acceptable in law. The event theory does not involve the issue of causation and as has been pointed out, a murder victim can be the subject of more than one fatal blow delivered at separate times, and in such a situation there can be two murders; the acts are separate in time and place but they result in one death. Both acts will support a charge of murder.<sup>49</sup>

The process theory fails to discriminate between when a man is dead and when life is no longer worth living; the writer on principle rejects this theory.

It is probably safe to state the present legal definition of death as follows: Death is the final irreversible cessation of a perceptible heartbeat and respiration. As long as any heartbeat

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47. Newsweek, September 1975; April 12, 1976.

48. Morris, Robert S., *Death: Process or Event?* Science, August 20, 1971.

49. Williams, Glanville, *Causation in Homicide* (1957), Crim. L.R. 429.

or respiration can be perceived, either with or without mechanical aids, death has not occurred.<sup>50</sup>

The definition for present-day purposes appears to be based on the wrong criteria and as such should be updated. What separates man from other animals is his personality. Where that personality is lost and cannot be regained the person should be considered dead. The focus should be shifted to the mental aspect of being.

The medical definition appears to be 'absence of brain activity for 24 hours.'<sup>51</sup>

It appears a rare occurrence in the process of a case to argue the issue of the definition of death. A recent California case was based on a rather novel defence. Lyons was accused with the murder of one Allen. Allen was pronounced 'neurologically dead' and then he had his heart removed for transplant purposes. The defence contended that the causal connection was missing as death could not result until the heart was removed. The defence was rejected<sup>52</sup> but dicta suggests that judges would be receptive to 'mental death' in some cases.

Capron and Kass suggest the following definition of death. "A person will be considered dead if in the announced opinion of a physician based on ordinary standards of medical practice, he has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, a person will be considered dead if in the announced opinion of a physician, based on ordinary standards of medical practice, he has experienced an irreversible cessation of spontaneous brain functions. Death will have occurred at the time when the relevant functions ceased."<sup>53</sup>

The following definition was suggested to the General Assembly of Virginia in 1973: "A person shall be medically and legally dead if, (a) in the opinion of a physician duly authorized to practice, there is the absence of spontaneous respiratory and spontaneous cardiac functions and, because of the disease or condition which directly or indirectly caused these functions to cease or because of the passage of time since these functions ceased, attempts at resuscitation would not, in the opinion of such physician, be successful in restoring spontaneous life-sustaining functions, and, in such event, death shall be deemed to have occurred at the time these functions ceased; or (b) in the opinion of a consulting physician, who shall be duly licensed

50. Scher, Edward M., *Legal Aspects of Euthanasia* (1972), Albany L.R. 36, 374.

51. Cant, Gilbert, *Deciding When Death is Better Than Life*, Time, July 1973.

52. New York Times, May 24, 1974.

53. Capron, Alexander M., and Kass, Leon R., (1972) Pennsylvania L.R.

and a specialist in the field of neurology, neurosurgery, or electroencephalography, when based on the ordinary standards of medical practice, there is the absence of spontaneous brain functions and spontaneous respiratory functions and, in the opinion of the attending physician and such consulting physician, based on the ordinary standards of medical practice and considering the absence of the aforesaid spontaneous brain functions and spontaneous respiratory functions and the patient's medical record, further attempts at resuscitation or continued supportive maintenance would not be successful in restoring such spontaneous functions, and, in such event death shall be deemed to have occurred at the time when these conditions first coincide. Death as defined in subsection (b) hereof, shall be pronounced by the attending physician and recorded and attested by the aforesaid consulting physician."

The Ad Hoc Committee of the Harvard Medical School considered the following criteria relevant: unreceptivity and unresponsivity, no movements or breathing, no reflexes, (and most important) flat electroencephalogram. They suggest a series of tests based on these criteria and a later repetition of all tests 24 hours later to establish no change.

The essence of all these definitions is the addition of an alternative definition of death based on the indication of irreversible cerebral damage.

#### RECOMMENDATIONS (Anti-dyathanasia)

The legal profession owes a general duty to society at large, but the legal profession also owes a duty to itself to maintain and promote respect for the law. Where the law is so wrought with uncertainties as is the medical area not only is the integrity of the law itself impaired but the body which has become so uncertain loses any resemblance to law it may once have had. Where the issues are ones of life and death, the law must strive for the greatest certainty that can be had. To the medical profession this is a duty at which law makers and law enforcers have miserably failed. While speaking of duties the writer recalls the words of Cicero: "There is no duty more indispensable than that of repaying a kindness . . . all men distrust one forgetful of a benefit." The legal profession owes just such a duty.

The writer is of the opinion that legalization of euthanasia is not desirable for contemporary society. However, there is much contained in the arguments advanced by the Euthanasia Society and the Bills prepared by them which can, and should, be salvaged. What the movement has accomplished is to point out



certain discrepancies in the law and various uncertainties contained therein.

Although the writer rejects the concept of active euthanasia even where it is 'voluntary' on the grounds that the danger of involuntary euthanasia is too likely to occur, the writer suggests that much is to be said in favour of passive euthanasia.

The principle upon which the claim for euthanasia is made is not an absolute principle — freedom of choice, as all (save the radically existentialist) admit, must have some bounds. (For example, no one would permit another to commit murder per se or kidnapping). If this is so the writer argues that the euthanasia movement would have us improperly draw the line. Yet, the present state of law is equally to be faulted. The writer suggests an eclectic approach.

Where a person has passed into a purely vegetative state, adopting one of the new definitions of death would quickly dispose of many of the cases which presently cause much of the concern. If the law was to recognize (as the writer suggests it should) the 'absence of brain activity' as establishing death, then not only in law but in fact death will have occurred and a major position of the controversial cases will be solved. Under such definition the physician can act freely and with the assurance that the law recognizes his actions as lawful. For most cases all that need be done is to have a physician pronounce death, anything which occurred subsequently would not be done in relationship to person but rather to a cadaver — by legal status.

Legislation should be the vehicle by which the law recognizes any new definition of death, rather than judicial pronouncement so as to give maximum predictability to the matter.

If the definition of 'absence of brain activity' for 24 hours is accepted (or any analogous definition) the Act should specify the time of death as either at the commencement of the 24-hour period or upon the expiry of that period so as to take care of succession problems and the like.

The writer further takes the position that a great deal can be accomplished by giving certainty to the concept of 'active and passive' in the medical context.

The writer suggests that where a patient is conscious we should exploit the principle found in *Natanson v. Kline* (1960), 350 P. 1093. Per Schroeder J. at page 1104 "... each man is master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of lifesaving surgery or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary but the law does not

permit him to substitute his own judgment for that of the patients . . .”

The present difficulty which prevents this proposition from being fully exploited is the uncertainty surrounding the concept of *causa causans*.

As Cannon pointed out it is fallacious to argue that pulling the plug is not a positive act — however, the patient may expressly prohibit further lifesaving aid.

To make absolute use of the principle, legislation should be drafted so as to embody the principle and for the purposes of clarification give an exhaustive listing for all situations where the withdrawal of medical aid and life-support apparatus will by statutory definition amount to a lawful omission to provide further treatment. By statute, the law with respect to ‘extraordinary measures’ can be made explicit and thereby give legal assurance to the medical profession when involved with such practice. The writer considers an exhaustive list the only method of giving clarification to the situation and when one considers that we are dealing with only one area of human activity, little difficulty should be experienced in compiling such a list. The writer further suggests that a ‘catch all’ provision would destroy the certainty created by the listing provision and as such should be avoided at all costs.

Notice should be given to the fact that at one time when trying to explain the active-passive question the physician’s duty was said to be to provide food, liquid and ordinary medication, as a corollary to this duty then extraordinary medication and/or treatment was not mandatory. What was, is, and will be considered ‘extraordinary’ is as uncertain as what is ‘action’ and what is ‘inaction’. Ergo, the writer suggests we stop short of active euthanasia; the means for accomplishing this is legislation clarifying the category of acts not to be considered as active euthanasia.

There should also be a provision for establishing a review board whose function it would be to annually consider the new medical advances and procedures to determine whether they ought to be recommended to the legislature for addition to the listing provision.

The euthanasians suggest that the declaration concept is a necessary element of their plan as it is most often when a person would want to exercise his discretion, exercise his will and express his consent that he is least able to do so, legally and factually. The writer advises adopting this suggestion and tailoring it so as to fit the passive euthanasia concept. By this

method a person could express his consent beforehand but within the statutory limits expressed by the 'listing provision'.

Under the writer's suggested 'Pure-Consent-Passive-Euthanasia' legislation an express provision should set out the demarcations of the area of consent which may be exercised by a third person. This would cover the situation where an incompetent, child or imbecile has for some purposes his consent exercised by a third person.

The writer's suggestion is that the listing provision could set out the scope of what would be permitted in all cases, while the declaration would set out what the declarant desires should be discontinued in his case. It is obvious that either the Act or the declaration would override the other. The writer suggests that for present purposes the declaration, if there be one, would override the legislation; this order of priority could be reversed by an amendment at a later time if desirable.

In the absence of a declaration or any present operative consent or instruction by the patient or person entrusted to exercise his consent, the doctor should be free to act on his discretion as long as his acts remain within the scope of the listing provision.

Legislation drafted in this form would exhibit the following features:

1. Society would more clearly set out what is unlawful by more clearly stipulating that which is lawful.
2. Certainty would be given to the recognized area of freedom of choice, by means of the listing provision.
3. If the patient has not effected a declaration he is deemed to have opted to leave the matter to (a) those by law permitted to exercise his consent to further medical treatment, or in the absence of such a third person or where the third person abdicated the power, to (b) his doctor's discretion.
4. The doctor has no duty imposed on him.
5. The patient retains his right to refuse further medical treatment.

The writer suggests that a treatment added to the listing provision and not yet specifically dealt with by a declaration would be deemed 'extraordinary' and fall within the doctor's area of discretion.

The writer suggests that by these measures a doctor will be guaranteed that his activity is a pure omission and that he does not incur any liability for his omission providing that it falls within the listing provision. All this is accomplished without in

any way evading the area presently recognized as murder.

Eligibility for making a declaration and validity of a declaration, revocation and similar matters could be governed by sections paralleling those contained in the 'voluntary (active) euthanasia bills'. What is important to notice is that under the writer's proposed declaration provision the declaration plays a less important role, the declaration amounting to little more than an opting out of the bill preventing any automatically fatal result, as any situation not dealt with in a declaration remains in the area of the doctor's discretion, that discretion to be exercised in accordance with good medical practice of the day. As such a forged or destroyed declaration can only have one of two immediate results; either the patient will not be subject to passive euthanasia, or the matter will be left to the doctor's discretion. The writer suggests that this provided the greatest certainty with the greatest safety for all concerned.

### CONCLUSION

In a consideration of proposed change the effect on the future of such a change is always a desirable inquiry; however, insight may be gained by considering the effect of no change.

Doctors predict that in a matter of time they will be able to remove an egg cell from a woman, fertilize and grow it as an embryo in a test tube and then implant it in the mother or even in a volunteer. What is to be done with the mistakes? Doctor James Watson suggests that doctors who create laboratory-conceived babies should be given the right to terminate the lives of those infants if grossly abnormal.<sup>54</sup>

The great medical advances have added enormously to man's potential control over the entire life and death process. These advances to an even greater extent have had an often-denied effect on the medical men themselves. Science once basked in the illusion that what was somehow 'value-free' is suddenly up to its neck in value-loaded questions. More and more medicine is forced to ask itself if it may do what it suddenly and often surprisingly can do. We should all become aware of the new power of choice that can be exercised at both ends of the life spectrum; the options are not for the medical profession to exclusively exercise, but for all of society.

Presently there are a number of research teams which, despite their competing theories, consistently assert that death can be solved. They say that society has accepted the fact of death just as previous societies had; but we will soon be no

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54. *Endorsing Infanticide*, *Time*, May

longer forced to accept the fact of death. Just as our predecessors feared certain disease for which medicine has since found a cure, medicine will find the cure for the disease known as death.<sup>55</sup> If these assertions are true, the question for the future to face will be not — who shall be put to death, but — who shall be cured of the death disease?

When death can be prevented or when man's life span can be multiplied by five or ten times, along with the advances in genetic selection, conception, production, the time will have come to face the issue of the types of human life forms that will be permitted to survive and in what proportion and perhaps for what length of time. Whether man wants to maintain a balance of life forms or whether he wants to reduce the number of life forms will have to be answered. Who will be permitted to be called 'born' will become a crucial question. Who will not be born and who will no longer live will be questions of necessity rather than convenience or conscience.

Assuming all of this to be true, the question of euthanasia is premature. Those advocating it fail to recognize that the question is being asked out of context and in the wrong time period. The writer anticipates that euthanasia will be adopted and one day become common practice. Man will face the question of whether the physical aspects of living are greater, lesser or equal to the intellectual aspects of living and what, where, why and how either or both shall survive.

Eventually a 'grand plan' will have to be drawn. A plan to predetermine the complexion of the human species. Until such a grand plan is formulated, the proper role of euthanasia will not have been worked out. Without taking all factors into account it would be folly to attempt to formulate one aspect of the life plan. Presently we do not have sufficient data to chart the destiny of mankind, nor is there sufficient reason to do so, ergo we have no right to try.

The writer has made certain suggestions with respect to possible legislation. By adopting these suggestions the law can be clarified so as to protect both physician, patient and contemporary society.

By maximizing the concept of anti-dysthanasia we can eliminate the greatest proportion of dysthanasia without entering the arena of euthanasia. For present requirements this is all we have need for and all we can intelligently manage.

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