EUTHANASIA AND LAW REFORM

Robert Samek*

I. LEGAL, METAPHYSICAL AND SOCIAL LAW REFORM

In 1983, the Law Reform Commission of Canada published its Report on Euthanasia, Aiding Suicide and Cessation of Treatment, following its Working Paper and Study Paper in the Protection of Life series. The Report is interesting more for its approach than for its recommendations. A close examination of it reveals some fascinating parallels between what I have called "legal law reform", which starts off with the existing law, and what may be called "metaphysical law reform", which is based on the accepted philosophical categorization of a particular field of inquiry. In both approaches the law often follows certain accepted logical distinctions as if they were normatively crucial and shows a reluctance to go beyond the established ideological framework. The result is that what purports to be an argument leading to a certain conclusion, in fact amounts to a rationalization of that conclusion.

* Late of the Faculty of Law, Dalhousie University. Professor Samek died on 1 July 1984. He had been working on this article before his death and it seems certain that had he had more time to revise it he would have done so. In the interests of clarity, some minor editorial changes have been made, but in the circumstances they have been kept to a minimum.

5 "It is important to distinguish between two meanings of 'ideology'. According to the first, it denotes what Marxists described as the 'false consciousness' of the superstructure of a social system or theory. According to the second, it stands for the basic ideas which lie at the foundation, without any judgment as to their objective validity." R. Samek, The Meta Phenomenon 146 (1981).
Legal and metaphysical law reform lack the curiosity and dynamism of what I have called "social law reform". The starting point of legal law reform is dissatisfaction with some technical, or with some non-political social aspect of the law. This dissatisfaction is usually voiced (and nearly always articulated) by lawyers. Its object is to change the law to meet the complaint, if such a change is thought to be warranted. The matter is investigated by lawyers, and any proposed change — except in the case of judicial law reform — is implemented by legislation, which is drafted by, and for the use of lawyers.

The starting point of social law reform is dissatisfaction with a social practice which may raise doubts about the humanity, justice or efficiency of the established legal system. This dissatisfaction may be with a "primary" or with a "secondary" social practice. Primary social practices are the things that people do for their own sake, and are to be distinguished from secondary social practices, which are the things that some people do to control or affect what other people do. For instance, the starting point of social law reform may be dissatisfaction with certain negative primary social practices, such as dangerous driving, mugging, tax avoidance, patronage in public contracts, pollution, over-fishing, price gouging, loan sharking, shoddy public housing, racial and sexual discrimination, and so on; or with certain positive secondary social practices controlling the primary practices.

The social law reformer will look at primary social practices not through legal eyes, that is, in terms of legal dogma, but with an open mind that takes into account their manifold implications. For instance, he will consider the very diverse social circumstances in which social "crimes" are committed, and not simply accept conventional legal categories. Similarly, the social law reformer will look at the reality of secondary social practices, to which legal practices belong. He will not consider dissatisfaction with a legal practice as anything more than a symptom that may help to put him on the right track.

Dissatisfaction with a social practice may be voiced by anybody, and may be articulated by such spokesmen as political parties, interest groups, churches and community associations of every kind and size. The object of social law reform is to change the primary or secondary social practice with which dissatisfaction is expressed, if such change is warranted. The social law reformer need not have any legal or institutional standing; he may be simply a concerned citizen who wants to take part in law reform.

I do not want to get involved here in technical distinctions between social and legal law reform. My main concern is with euthanasia. It is wrong to start off with the law as it is, or with existing philosophical

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6 The following discussion of legal, as opposed to "metaphysical" law reform is taken from Professor Samek's article, A Case for Social Law Reform, supra note 4, at 412-14.
categorizations. Rather, we should look at the dissatisfaction that is expressed with the primary or with the controlling secondary social practice.

The Law Reform Commission in its *Working Paper* partly justifies its attitude against legalizing euthanasia by citing the absence of an insistent demand or strong social pressure for reform.

Law exists to meet real needs. The Commission has concluded, independently of all other arguments, that in Canada today, there are neither wrongs nor needs sufficiently great to justify overturning a well-established tradition based on time-honoured morality. The extraordinary development of palliative care and pain control in recent years is certainly a safer and far more positive response to the problem of pain and suffering for the terminally or incurably ill.  

The complaints that surface are about the roadblocks that face the dying and incurably ill who want to be released from their suffering and from the meaninglessness of their lives. It is beside the point to say that they do not usually ask for euthanasia. What is important is that their complaints call for an inquiry as to what is to be done. Expressions of dissatisfaction with a social practice should be the starting point, not the end of the inquiry. Certainly euthanasia is not the answer to all complaints, but it is a solution that must not be dismissed out of hand merely because it has been repressed in our consciousness.

It is significant that if euthanasia is mentioned at all, it is with opprobrium, to prove its superfluousness within a health care system that claims to be capable of handling all problems. The recital of the familiar “objective” arguments for and against it is no more than a graveside service for a cause that has already been buried. The deficiencies of our health care system, like those of our economic and political systems, will never be discovered if we listen only to the official experts, for their criticism as well as their praise comes from a common perspective and has a common depth.

We must concentrate on the similarities within the various systems rather than on their superficial differences. Thus, the preoccupation of our health care system with physical survival is closely linked to the preoccupation of the “welfare” state, which limits itself to keeping the unemployed and the poor physically alive. The more powerless a society feels to tackle its underlying problems, the more adamantly it insists that everything is under control. The real reason for society’s opposition to euthanasia is not its antagonism to killing, but its fear of losing the monopoly over killing. If citizens were free to arrange their own ends, the authority and the prestige of the state might suffer irreparable harm. In this respect the democratic state has merely taken over where the Church and the King left off.

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7 *Supra* note 2, at 48.
II. EUTHANASIA, KILLING AND PAIN-KILLING

Keyserlingk, in his Study Paper, places euthanasia under ‘‘killing’’:

[Its common] meaning in our times is that of directly killing the dying patient. Nor do all the various qualifiers often attached to ‘‘euthanasia’’, really . . . make the distinction between its usages sharply enough. ‘‘We speak of ‘active’ or ‘passive’ euthanasia, of ‘directly’ or ‘indirectly’ disposing a patient to death, of whether death came by acts of omission or by acts of commission, by action or by refraining. I would get rid of all of these terms. We are misled to them by our popular and irreformable usage of the word ‘euthanasia’ — for choosing death as an end. Since we cannot restore the word to its original meaning, I think we simply must speak of the immorality of euthanasia and of the morality of ‘dying well’ — or, more soberly of ‘dying well enough’.”

The Law Reform Commission, of course, is not the first to throw this stone. It is in good company in doing so. Louisell, for instance, takes much the same approach:

In its precise meaning, ‘‘euthanasia’’ is the desideratum of religion as well as any morally or ethically based social policy that has to do with death. Coming from the Greek words meaning ‘‘good’’ and ‘‘death’’, it specifies the kind of a death that must be as much the ideal of the moral theologian as it is of the philosopher and secular humanist — a happy death. Yet its corruption seems pervasive in popular usage. It has come to mean the deliberate, intended painless putting to death of one human person by another, the willed termination of human life, which is a euphemism for murder as defined by our law. It would have been better to adhere to the original meaning of ‘‘euthanasia’’ and use another word, perhaps ‘‘biathanasia’’ for deliberate, affirmative killing in the mercy-death context.

In its Working Paper, the Law Reform Commission does use the term ‘‘euthanasia’’ and restricts it to the ‘‘positive act of causing a person’s death from compassionate motives’’. It gives us as an example of it administering poison to end someone’s life. The Commission limits euthanasia to positive, direct, or active conduct (as contrasted with negative, indirect or passive) and to voluntary (as contrasted with involuntary) euthanasia, that is, where the killing is at the patient’s explicit request, or where consent to it can be implied from the patient’s circumstances.

In its Report, the Law Reform Commission defines euthanasia as ‘‘the act of ending the life of a person, from compassionate motives, when he is already terminally ill or when his suffering has become unbearable”.

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8 Supra note 3, at 120-21.
10 Supra note 2, at 43-44.
11 Supra note 1, at 17.
Much of the confusion surrounding the issue of euthanasia is caused by the false view that words have a basic meaning that remains constant regardless of the context in which they are used. It is on the strength of this fallacy that euthanasia is identified with killing. Once we grasp that words are merely part of language and may be used in many different ways, we can understand that all "killing" is not the same and all is not necessarily bad. Words are not static units in a sort of jigsaw puzzle, but dynamic parts of a language which mean different things in different contexts and at different times. "Euthanasia" is an excellent example. Derived from the Greek, where it signified a good or happy death, it is now often labelled "murder".

Yet, if euthanasia is "killing", it is clearly killing of a very different kind from murder. I shall for practical reasons limit lawful euthanasia to the case of a competent person who is dying, or suffering from an incurable and fatal illness, and who requests a registered medical practitioner to terminate his suffering, which the practitioner does primarily out of compassion. Whether the procedure followed by the practitioner is active or constitutes a passive withholding or discontinuance of treatment is immaterial. The rationale for euthanasia is the pointlessness of an existence that has lost its meaning because the person concerned is no longer viable as a human being. Pain is merely one important factor in the situation.

It is important to distinguish between "dying" and "death". Unlike dying, which is eventually experienced by everyone although not everyone is conscious of it, death transcends the limits of human experience. There is no better way of describing the distinction than to quote Lucretius' famous saying that "where death is I am not, and where I am death is not". An understanding of this profound truth will not merely enable us to purge ourselves of the fear of death, but will help us to see euthanasia in a new light. Once we focus on dying, euthanasia can be perceived as a happy, peaceful, painless way to die, and not as a sort of execution.

It is only because words reflect prevailing social values that we put euthanasia in the same bag as murder. In fact it is much more like assisted self-defence. The patient defends himself against a fate worse than death, the fate of dying inch by inch in a way that makes a mockery of his life. Killing is not the objective, but rather an unfortunate necessity. To outlaw it as a method a priori is to decide the issue before it is argued. If euthanasia is killing, it is justified killing, and one of the gentlest and most humane known to man.

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12 Supra note 5, at 229-30.
13 The author appears to be referring here to Lucretius' interpretation of the Epicurean view of death. See Lucretius, III De Rerum Natura, line 830 (W. Leonard & S. Smith eds. 1942).
14 Supra note 3, at 126.
Although there are connections between euthanasia and suicide, the differences between them are sufficiently important to keep the two concepts apart. In suicide a person takes his own life. Euthanasia is a type of assisted suicide, but it is limited to the case of a person who is dying or suffering from an incurable and fatal disease. Suicide is not limited in this way: it may be committed for many reasons or for none. There may be a single rationale for euthanasia, but there is no one justification that explains all types of suicide, and indeed it would be hard to argue that all suicides were justifiable. Pain is not limited to cases of dying, and euthanasia is not limited to cases of pain.

The effect of pain on the patient is significant. Some people are only minimally affected even by acute pain, and are able to lead full lives in spite of it. Others cannot put up with even the side-effects of analgesics; they will, rightly or wrongly, regard their lives as at an end and find it quite impossible to adjust to that kind of existence. Patients also respond differently to various kinds of treatment and to institutionalization.

Pain-killing is socially respectable today because it reinforces the power of the prevailing ideology. In the days when religion ruled the roost, people were encouraged to flagellate themselves to show their spiritual strength; now they are persuaded to resort to drugs to show the technological power of a consumer society that is no longer at the mercy of pain. The patient is not allowed to ask to be “killed”, but he may be killed legitimately under the guise of fighting his pain.

We live in an age of political manipulation, where the acceptable way to solve a problem is to bury it for a while. This is all the more reason why we should speak out to stop the deception. Modern palliative treatment has not made euthanasia superfluous. Indeed, anyone must know that the claims popularly made for pain-killing are grossly exaggerated in practice. In many chronic cases pain is not killed at all effectively.

Analgesia is a tricky procedure. It has different effects and side-effects on different patients, and is usually both psychologically and physically addictive. Many doctors are reluctant to administer strong analgesics for fear of creating dependence and so further undermining the patient’s health. They find it difficult to treat the palliative patient differently from any other patient, and so approach his treatment in a series of routine steps that involves graduating from lower to higher doses. The growing fear of legal liability tends to slow down the process further.

We must beware of the double-talk of pain-killing. If pain-killing is limited to the treatment of pain, it cannot be a substitute for euthanasia. Far from congratulating ourselves that pain-killing can do that job, we should at least weep crocodile tears over its deadly consequences. We may have to resort to pain-killing as a subterfuge for euthanasia, but to do this is to fuzz the problem, not to solve it.

There is everything to be said for restricting pain-killing to what it is supposed to do: killing pain, or minimizing it as much as possible in the
circumstances. In order to make a decision to administer an analgesic it is necessary to evaluate the merits of such treatment, and its possible side-effects, for each individual patient. Euthanasia is a different matter. Although it may take much the same form as pain-killing treatment, it should be administered to a patient in its own right.

III. ACTIVE AND PASSIVE EUTHANASIA

We have seen that Keyserlingk draws a sharp distinction between "killing", that is, active euthanasia, and "allowing to die", that is, passive euthanasia, which he would rather not regard as euthanasia at all. While the former is always illegitimate, the latter may be legitimate. The Law Reform Commission, both in its Working Paper and in its Report, accepts this distinction unquestioningly. It is of course based on the common law distinction between an act and an omission. Its philosophical foundation appears to be that an act consists of certain muscle movements that give rise to liability when they set off a causal chain leading to damage or injury. Since in an omission there are no such movements, there is generally no liability for failing to act unless there is a duty to do so.

I have previously criticized this view, and defined an act as an intervention in an existing state of affairs. If an act is to be considered intentional, the actor must know what he is doing at the time, without having to engage in research. That knowledge cannot be distinguished from his description of his act, for there is no such thing as an authoritative version of what he does.

Thus, to borrow Anscombe's classic example, "sawing a plank" may also be described as "sawing oak", "sawing one of Smith's planks", "making a squeaky noise with a saw", "making a great deal of sawdust", etc. Hence, if the agent thinks that he is sawing his own plank, his act cannot be intentional under the description "sawing Smith's plank".

There is no easy answer to the question of "what amounts to an intervention"? Everything depends on our point of view in the given situation. Take the above example: if the agent is not a handyman, and we see him sawing away at a plank, we will be inclined to pick out this factor as the intervention. The innumerable other disturbances that he sets up will be treated as part of the existing state of affairs, for we could not care less that he is, for example, mopping his brow, or smoking a cigarette. But if he is working in a sawmill where smoking is strictly

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15 Supra note 3, at 123-24.
16 Supra note 2, at 44.
17 Supra note 1, at 17-18.
prohibited, and he is smoking a cigarette, we will be inclined to pick out that factor as the intervention, and treat “sawing a plank” as part of the existing state of affairs.

We must always beware of the trap of identifying acts with muscle movements. Anscombe, for instance, seems to take the view that there is only one act in the above illustration. But if we are asked what the agent is doing, we may well reply, “He is sawing a plank and making a terrible mess scattering sawdust everywhere.” Here there is only one set of muscle movements, but two interventions are picked out: the plank is cut in half and the tidy shed is desecrated.\(^1^9\)

If an act is regarded as an intervention in an existing state of affairs, then an omission may be validly described as an act. In these cases a person intervenes by not doing anything because in the ordinary course of events he had a duty to do something. The law absolves a bystander who fails to rescue a drowning man, not because the bystander did not move a muscle, but because the law does not impose a duty on him to attempt a rescue. If he were under such a duty, then the failure to exercise it would not excuse him. His non-intervention would be deemed to be an intervention that caused the death of the victim.

The alleged distinction between not connecting a patient to a life-support system in the first place and disconnecting him by “pulling the plug” at a later stage can be explained in this way. In the former case, it is assumed that there is no duty to do anything in the ordinary course of things, and therefore the omission is not regarded as an intervention; in the second case, it is taken for granted that there is a duty to continue support in the ordinary course of things, and that, therefore, to disconnect the life-support system is an intervention that gives rise to legal liability. The difference between the two cases does not lie in the muscle movement of “pulling the plug”, which may in fact be done automatically by not resetting the mechanism; it is the difference between what is considered normal and what is considered abnormal. We shall see that the Law Reform Commission comes out against drawing a hard and fast distinction between not treating a patient at all and terminating the treatment.

Given the highly developed state of medicine in our society, few patients are in a natural state at the crucial time. They are nearly always already dependent on some pharmaceutical or electronic support system, and therefore to stop the treatment may kill them. The typical patient is very different from the drowning man who falls into the water, and his doctor is very different from the bystander who witnesses the event. The two are bound by a professional relationship that in effect puts the patient’s life in the doctor’s hands. If the doctor wishes, he can often spin out the patient’s life for a long time, but if he does not want to do so, the

\(^{19}\) Id. at 208.
patient’s days may be numbered. To try to separate the patient’s dying from his treatment in this environment is to accept a fiction as a reality.

There is both a legal and a moral duty on a doctor to treat his patient by any reasonable means. We cannot jump from the legal premise that there is no legal duty to save a drowning man to the conclusion that a doctor is under no duty to save his patient, let alone to the further conclusion that while he need not prolong the patient’s life, he must not administer active euthanasia. Even if this further conclusion were justified under the present law, it does not follow that there is no case for active euthanasia.

Whether we ought to permit active euthanasia is a normative question calling for a value judgment, one that cannot be answered by an is statement about the law. The case for euthanasia does not depend on a purely logical distinction, such as that between an act and an omission. Administering euthanasia is not wrong because it is a positive act any more than allowing a patient to die is right because it is an omission. If such an argument seems plausible it is so simply because we have come to accept it as sound. Admittedly, there is a difference between injecting a patient and not injecting him, yet no one in his right mind would base the decision to do or not do so on this ground. Active and passive euthanasia are not at opposite poles from one another. Both shorten an ongoing process of dying; active euthanasia does so at the request of the patient directly, while passive euthanasia does so indirectly through an officially recognized “act of omission”.

To switch off a respirator is only passive if we assume that there is no duty to continue the treatment. To say that nature is allowed to take over again, and that therefore the patient dies naturally and not because of the act of “pulling the plug”, is to forget that today the patient is hardly ever in a state of nature. The very fact that he is called a “patient” shows that he is hooked into the health care system; his life is medically controlled from beginning to end. To disconnect a patient from a resuscitator condemns him to death as surely as injecting him with a fatal dose. On the other hand, if we recognize that the patient is already dying, the latter is no more the cause of death than the former.

IV. THE “WEDGE” AND OTHER ARGUMENTS

It is “frequently argued”, the Working Paper says, “that the existing rules of law are illogical and cynical”.

20 Cf. the extraordinary rationalization by G.P. Fletcher that to switch off a respirator is an omission. Fletcher, Prolonging Life, 42 Wash. L. Rev. 999 (1967).

21 Supra note 2, at 45.
to refusal of treatment, and even provides penalties for a physician who disregards his patient's express wishes to refrain from treatment.

[W]ould it not be consistent to recognize the same grounds for the positive act of killing as well? What is the essential difference . . . between discontinuing aggressive treatment and providing a fatal injection at the patient's request?

More importantly, the advocates of euthanasia argue that since the law no longer punishes attempted suicide, it implicitly allows the terminally ill patient to take his own life. Would it not be more compassionate, for those who wish to kill themselves but are physically unable to do so, and for those who wish to have help in doing so under the best possible conditions, to allow death to be administered in some scientific, medically certain and humanly acceptable manner? Would not the legalization of active and voluntary euthanasia be essentially realistic? Would it not represent respect for individual freedom and all its consequences?22

The Working Paper then refers to a number of legislative proposals for legalizing euthanasia both in Britain and in the United States. It points out that these proposals are limited to incurable or terminal diseases and that they provide some system for determining the patient's wishes, compliance with which exempts a physician acting in good faith from criminal and civil liability. While recognizing "the very laudable intentions behind these recommendations", the Law Reform Commission concludes that "from both the legal and social policy points of view, . . . legislation legalizing voluntary active euthanasia would be quite unacceptable".23 The Commission purports to justify its conclusion largely by means of three key arguments that are discussed by Keyserlingk in his Study Paper: "The first is an argument from medical fallibility; the second is a form of 'wedge' argument; the third is an argument from medical care and trust."24

The argument based on medical fallibility is self-explanatory. Even the most seemingly irrefutable prognosis may be wrong. "To kill is to preclude any chance for life in the event of such error . . . but to stop life sustaining treatment may not deny the patient that chance."25

This argument subliminally links euthanasia with capital punishment. The analogy is incorrect. Capital punishment is imposed; euthanasia is chosen. It can only be chosen where there is no chance that a patient will recover short of a medical miracle. These miracles do occur, but this is hardly a reason for withholding from the patient the release he desires. In any event, the argument applies equally to the administration of pain-killing drugs that hasten death, or to the removal of life-support systems.

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22 Id.
23 Id. at 46.
24 Supra note 3, at 126.
25 Id. In addition, the Working Paper mentions the possibility of a new, or the refinement of a known, treatment. Supra note 2, at 46.
The so-called "wedge" principle is the one most frequently invoked in arguments against legalizing euthanasia. Glanville Williams quotes the following definition of the principle: "The wedge principle means that an act which, if raised to a general line of conduct would injure humanity, is wrong even in an individual case."\(^{26}\) Williams swiftly disposes of it as follows:

The author supposes, for the sake of argument, that the merciful extinction of life in a suffering patient is not in itself immoral. Still it is immoral, because if it were permitted this would admit "a most dangerous wedge that might eventually put all life in a precarious condition." It seems a sufficient reply to say that this type of reasoning could be used to condemn any act whatever, because there is no human conduct from which evil cannot be imagined to follow if it is persisted in when some of the circumstances are changed. All moral questions involve the drawing of a line, but the "wedge principle" would make it impossible to draw a line, because the line would have to be pushed farther and farther back until all action became vetoed. Logically, the only "general line of conduct" involved in permitting a particular case of voluntary euthanasia of a suffering patient in a fatal illness is that all suffering patients in fatal illnesses may have voluntary euthanasia. It is illegitimate to ignore these limitations of the principle in pronouncing upon the morality of the act.\(^{27}\)

The "wedge" objection, Williams states, is sometimes based on psychology:

It is said that a person who has taken life lawfully will then have his inhibitions so far removed that he is likely to take it unlawfully. This may be true in some applications but it is ridiculous as applied to the physician who gently and humanely extinguishes his patient's life as the last service that he can perform for him. If the argument has any validity, it is valid for the executioner and above all for the soldier. . . .\(^{28}\)

I entirely agree with Williams. Keyserlingk himself shows the weakness of the wedge argument insofar as he speaks of the "likely consequences for individuals and society of any move in the direction of allowing killing".\(^{29}\) I can think of nothing less likely than that a society that is honest and courageous enough to recognize the need for euthanasia would turn the world into a paradise for killers.

The argument from medical care and trust is based on the claim that patients must be "secure in the knowledge that physicians will not kill them, but also will not needlessly prolong dying".\(^{30}\)

Voluntary euthanasia is radically different from refusing treatment, allowing a patient to die, or securing the right to die. What proponents of voluntary euthanasia want is much more than any of those, and more than suicide as well. What is being asked for seems closer to a "right to be dead" than a right

\(^{27}\) Id. at 280-81.
\(^{28}\) Id. at 281.
\(^{29}\) Supra note 3, at 127.
\(^{30}\) Id. at 128.
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... to die, in that the patient should be allowed to be dead *when he wishes to*, and the *physician* is to be the agent of that death. Such an agency would radically transform the physician's present role and ethics, and in my view to the detriment of both. In the absence of arguments which convincingly dispel fears for the continued health of patient trust in physicians in the eventuality of such a policy shift, we seem bound to conclude that the present policy in this regard has not been proven essentially wanting, that a shift is not necessary and would not be generally beneficial to patients.\(^{31}\)

Keyserlingk does not tell us how such arguments could possibly be successful. It is like being asked to win when your opponent is using loaded dice. And as if this were not enough, Keyserlingk adds that "this conclusion holds even in the face of cases of excruciating and intractable pain and suffering".\(^{32}\) Pain, he says, can be discounted on the grounds that its "control is now so well advanced that [cases of real suffering] are increasingly rare...[It would be undesirable to] build a social ethic...on...the boundary case. Hard cases make bad...professional ethics."\(^{33}\)

According to the *Working Paper*, the principal consideration in terms of legislative policy remains that of possible abuses. Euthanasia, it admits,

would perhaps be arguable if it were possible in each case to be absolutely sure that requests to be killed were free, voluntary and informed... We forget too readily that [there are terminal patients] whose faculties have been weakened by disease or drugs, who are suffering anguish and who may see themselves as a burden on their loved ones.\(^{34}\)

Apparently refusal of treatment and consent to the use of pain-killing drugs are of a different order than a wish to be killed. There is an assumption here that to express such a wish is a sign of instability. Surely a dying patient who requests release from his terminal suffering does not have to be examined for his competence. That would only lead to the absurd conclusion that a "neutral" observer, such as a physician, could overrule the wishes of a dying patient.

Another argument in the *Working Paper* is made in response to Glanville Williams' position. "A patient seeking active euthanasia", it states, "clearly...seeks a quick end to his suffering. Yet any proposal for the legalization of euthanasia must necessarily include some process of ensuring that the patient is in fact suffering from an incurable disease and that his decision is free, voluntary and informed."\(^{35}\) The resulting

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\(^{31}\) *Id.* at 128-29.

\(^{32}\) *Id.* at 129. Keyserlingk will not tolerate any exceptions. Even in the case of permanently and deeply unconscious persons, he would prohibit active euthanasia. Indeed, the physician may still have a duty to provide appropriate care, although it may be no more than a glucose drip. *See, id.* at 130.

\(^{33}\) *Id.* at 129.

\(^{34}\) *Supra* note 2, at 47.

\(^{35}\) *Id.*
red tape, it is argued, would "create the very delays which the euthanasia movement seeks to avoid. [In any event,] the medical profession [should not] be involved in this kind of bureaucratic activity."\textsuperscript{36}

This is a very curious argument. It claims that euthanasia is self-defeating. The patient who longs for release must have patience because if he had his wish the process would take longer. It is like arguing that we must not distribute food to the starving because to do so would require bureaucratic procedures that would make it impossible to feed them in time.

In its \textit{Report}, the Law Reform Commission brushes aside the argument that "if persons are the masters of their own bodies, they ought to have the right to demand that society allow someone else to end their life if it has become unbearable".\textsuperscript{37}

As maintained in [the] Working Paper, the legalization of euthanasia is unacceptable to the Commission because it would indirectly condone murder, because it would be open to serious abuses, and because it appears to be morally unacceptable to the majority of the Canadian people. The Commission believes that there are better answers to the problems posed by the sufferings of the terminally ill. The development of palliative care and the search for effective pain control methods constitute a far more positive response to the problem than euthanasia on demand. To allow euthanasia to be legalized, directly or indirectly, would be to open the door to abuses, and hence indirectly weaken respect for human life.

\textit{The Commission therefore recommends against legalizing or de-criminalizing voluntary active euthanasia in any form and is in favour of continuing to treat it as culpable homicide}.\textsuperscript{38}

\section*{V. Cessation and Refusal of Treatment}

The Law Reform Commission in its \textit{Working Paper} acknowledges that the present law

promotes certain biases in favour of heroic or aggressive treatment. . . . Medicine's first duty is to fight for life and against death. No one will seriously dispute this fact. Medicine, like law for that matter, must however recognize that at a given point the optimal treatment for a patient is no longer to struggle to maintain a purely vegetative or clinical life but to allow death to occur, while providing the individual with all the palliative care required to relieve his pain. A person who is conscious and capable of expressing his informed wishes should be the sole master of this decision.\textsuperscript{39}

With respect to the incompetent person, that is, one who "because

\textsuperscript{36} Id.
\textsuperscript{37} Supra note 1, at 18.
\textsuperscript{38} Id.
\textsuperscript{39} Supra note 2, at 56.
of infancy, temporary or permanent unconsciousness or some other handicap, is unable to express his wishes, make an informed decision, or exercise choice", the Working Paper recommends:

(i) "[The] law should strenuously avoid and forbid any form of discrimination against such persons. Insistence on heroic but useless measures is no more justified for the incompetent patient than it is for the competent. . . . It would be unthinkable that a person should lose his right to die with dignity as soon as one becomes incapable of expressing wishes". What is required are special protective mechanisms to "leave as little room as possible for error and arbitrary decisions".

(ii) "[The] law must recognize what is now a medical and scientific reality. . . . Treatment is a measure designed to help the patient recover from his illness, to halt its progress at least temporarily or to relieve its symptoms. . . . With an incompetent patient this dialogue is . . . impossible", but the guiding principle should still be the "patient's overall welfare".

In most instances, this welfare imposes the maintenance of life, but this is not always the case. It is not the case when the prolonging of life has become purely artificial. It is not the case when the maintenance of life can only be achieved by an undue prolongation of the patient's agony. It is not the case when the maintenance of life results only in the infliction of additional suffering. In other words, it is not the case when treatment is diverted from its proper end and merely prolongs the dying process rather than life itself.

(iii) The cases where treatment is stopped and not initiated "because it offers no reasonable hope of improvement" must be distinguished from those where "the prognosis of the incompetent patient does not measure up to the 'accepted norm'". For example, "not to undertake treatment in the case of an anencephalic newborn is medically justified since there is no treatment at the present time to save that newborn's life. [Operating] for atresia of the digestive tract in such a case would be futile and only prolong the inevitable suffering." Conversely, corrective surgery for atresia would be mandatory in the case of an otherwise normal child to help it to absorb its food. The fact that the child also suffers trisomy 21...
(Down's syndrome or mongolism) does not abrogate that duty merely because "the treatment will not change the child's mental handicap". 49

The Commission thus proposes that we accept as fundamental the principle of non-discrimination between the competent person and the incompetent, on the one hand, and on the other hand, the rule that when it is impossible to obtain an expression of the patient's wishes, life-saving treatment should be administered, providing it is medically useful.

If these principles are accepted, the problem then becomes one of determining the presumed wishes of the incompetent patient. On what basis and according to what criteria should another person make the decision for him to terminate or not to initiate treatment which is apparently useless? 50

The Working Paper recommends that a person who "becomes unconscious or incompetent, but who had previously expressed his wishes regarding treatment [either informally or in a formal document] such as a 'living will' [should have] these wishes respected, [provided that] treatment offers no further reasonable hope of recovery or improvement". 51 If, however, the "treatment offers such hope, it is then the physician's duty to initiate or to continue it unless he has been forbidden very clearly to do so by the patient". 52

The situation is, however, "different in the case of . . . newborns, severely retarded, and comatose patients. . . . [T]he decision must be made by someone else. The difficulty then lies in determining who this someone else should be. . . ." 53 The Working Paper examines three possibilities: "the first is to leave everything to the physician's judgment"; the second "would involve the 'judicialization' of the decision-making process"; the third allows the family or guardian "to make the decision independently". 54 After examining the advantages and disadvantages of each possibility, the Commission recommends the first. 55

In its Report, the Law Reform Commission states that "even if the physician must remain ultimately responsible for the decision in the eyes of the law", 56 the decision must be made only after consultation with those close to the patient, and normally only after a second medical opinion is obtained. An anticipatory recourse to the court may also be desirable, especially "when there is an obvious conflict of opinion

49 Id.
50 Id. at 61.
51 Id.
52 Id. at 62.
53 Id. at 65.
54 Id.
55 Id. at 62-65. See also Knezevich, Decisionmaking for the Incompetent Terminally Ill Patient: A Compromise in a Solution Eliminates a Compromise of Patient's Rights, 57 IND. L.J. 325 (1981-82).
56 Supra note 1, at 26.
among the parties about what should be done", such as arose in the Dawson case. The criminal law seeks only to ensure that the physician has made a reasonable decision in terms of his expertise, the medical data and the particular circumstances; it can only dictate a general standard of conduct, not a detailed procedure for each set of circumstances that might arise.

The Commission recommends the following amendments to clarify the Criminal Code:

199.1 Nothing in sections 14, 45, 198, 199 and 229 shall be interpreted as requiring a physician
(a) to continue to administer or to undertake medical treatment against the expressed wishes of the person for whom such treatment is intended;
(b) to continue to administer or undertake medical treatment, when such treatment has become therapeutically useless in the circumstances and is not in the best interests of the person for whom it is intended.

199.2 Nothing in sections 14, 45, 198, 199 and 229 shall be interpreted as preventing a physician from undertaking or obliging him to cease administering appropriate palliative care intended to eliminate or to relieve the suffering of a person, for the sole reason that such care or measures are likely to shorten the life expectancy of this person.

VI. NON-VOLUNTARY, INVOLUNTARY AND INDIRECT EUTHANASIA

The argument for euthanasia is based on the wish of the dying or incurably ill patient to be released from his plight. It is patient-, rather than community-oriented. Hence, "involuntary" euthanasia is a contradiction in terms.

A distinction should be made between "non-voluntary" and "involuntary" euthanasia. In the former case, the patient is not competent to express a wish; in the latter case he expresses a wish not to be released, that is, so far from wishing to hasten his death, he protests against being put to death. However, even the first case, that of the patient who is not killed against his will, is not truly a case of euthanasia, because the patient has not expressed any wish to have his life ended. In my view, neither active nor passive euthanasia can be justified simply on the ground that if the patient had been competent to consider the matter he would have wanted to be so released; there must be some supporting evidence of such a wish. A formal declaration to that effect, such as a

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57 Id. at 27.
60 Supra note 1, at 32, 35.
“living will”, or clear informal instructions from the patient to his family or his attending physician, should be sufficient unless there are supervening circumstances that rebut such declaration or instructions.

Where the patient is incompetent, the patient’s next-of-kin should be entitled to make the request on his behalf. If they refuse to do so, the attending physician should be allowed to intervene by certifying that in his opinion no purpose would be served in prolonging the patient's agony. There should be confirmation of the physician's opinion by a second medical practitioner, and by a hospital representative in the event that the patient is hospitalized. Although euthanasia is, strictly speaking, limited to the case where the patient expresses a wish to have it administered, it may be legitimately extended to cover this situation.

It should be noted that a person may be legally incompetent, that is deemed incapable of expressing a wish, without being incompetent in fact. For instance, a child under sixteen is generally regarded as legally incompetent to refuse treatment, yet such a child may understand his condition sufficiently well to have his wish respected. We must not make the mistake of confusing the legal category with the underlying reality. On the other hand, a young infant is clearly incompetent. In the case of an incompetent child, his parents should be entitled to exercise the choice on his behalf.

As Bernard Dickens has pointed out, patients who reject “life-prolonging” medical care, which may be merely death-postponing, are all too often treated as suicidal and incompetent. Disregard of patients' refusal of treatment is reinforced when they are elderly. . . . Accordingly, . . . the famous observation of Justice Cardozo that “every human being of adult years and sound mind has a right to determine what shall be done with his own body” may be subverted by denying the attribute of soundness of mind and authentic free will necessary for its exercise.

Moreover, unlike the situation in the United States, in Canada a right to privacy cannot be invoked to protect the patient’s wishes regarding his body, although sections 7 and 12 of the Canadian Charter of Rights and Freedoms may possibly offer some protection in this regard.

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62 Dickens, id. at 849-51. See also Kennedy, The Legal Effect of Requests by the Terminally Ill and Aged not to Receive Further Treatment from Doctors, [1976] CRIM. L. REV. 217.


Keyserlingk distinguishes between the treatment of competent and incompetent patients on the ground that in the first case the standard is subjective, while in the second it is objective, namely that of the reasonable person. The foundation of elective as distinguished from required treatment is the "patient's right to refuse treatment".\(^6\) In the first case, that of the competent patient, his subjective perspective is decisive; in the second case the governing perspective should accord with "a patient-centered 'reasonable person' test".\(^6\)

I agree with Keyserlingk that a competent person should have the legal right to reject any form of treatment, subject, as he emphasizes, to a duty to receive advice regarding his responsibilities to his family and others.\(^7\) In the case of an incompetent person the standard must necessarily be objective. It is the community through its representatives — who may be family, physicians or bureaucrats — which must make the decision for the patient. However, neither the competent nor the incompetent patient can be allowed an unlimited right to treatment. A competent patient may refuse treatment in the teeth of pressure from the community, but he cannot insist on unreasonable treatment at the community's expense. The standard here must be objective, not subjective. Euthanasia is not only reasonable, but a bargain compared to expensive life-support systems.

Euthanasia is voluntary both for the patient and for the doctor. The patient has the option of requesting euthanasia, and the doctor the option of administering it. No doctor should be forced to administer euthanasia any more than he is now obliged to provide an abortion. Those who support euthanasia are pro-choice; they do not seek to impose their views on anyone. On the other hand, the option given must be a real one. Unless proper facilities are made available to those who want them, it would be a sham to hold euthanasia out as an option.

In Keyserlingk's analysis the term "'indirect voluntary' is normally only used when two effects are caused by the same action and in this context that is not really what takes place with most decisions to stop or withhold life-sustaining treatment".\(^6\) In the case of an omission, no human agent causes the patient's death directly or indirectly. In Paul Ramsey's words, "[h]e dies his own death from causes that it is no longer merciful or reasonable to fight... Doing something, and omitting something, are different sorts of acts which may be subject to different moral evaluations".\(^6\)
According to Keyserlingk:

The only medical act in caring for the dying which might be called "indirect euthanasia" is the use of pain killing drugs which may . . . hasten death. The use of such drugs is justified on the ground that relief of pain is the "directly voluntary" action, whereas the fact that death may be hastened is "indirectly voluntary". Here, we do have two effects of the same action. . . .

First of all there is still a difference . . . between the giving of pain killing drugs and the withdrawing or withholding of life-sustaining treatment. In the second case, . . . there is no double effect, and therefore no "indirect" euthanasia. 70

Consequently, Keyserlingk does not treat active euthanasia as a viable procedure. What is at stake is not the theological "double effect" argument, but whether there is a significant difference between acting directly to release a dying patient from his suffering, and indirectly speeding his end by withholding treatment. Why does the patient die his own death in the second, but not in the first case? In both cases the patient is dying anyway. Moreover, the passive act of withholding treatment may hasten his death just as much, and perhaps more so, than the active act of euthanasia.

VII. ORDINARY AND EXTRAORDINARY TREATMENT

As Dickens reminds us:

[Medical law emerged at a time when physicians visited the sick . . . and treated them from the meagre contents of the black bags they carried. The relationship was contractual, based upon payment for services requested and rendered. The patient could accordingly terminate the relationship . . . [or] control the choice of treatments. . . . Hospitals were . . . usually maintained as legal charities by religious denominations. . . . As recipients of charity, inhabitants of hospitals enjoyed few rights, but were required to conform to religious and secular discipline.

As medicine developed its scientific basis, especially in the eighteenth and nineteenth centuries, the needs of medical education and of medical research were increasingly recognized. . . . [Hospitals grew in importance . . . as healing institutions] for the delivery of modern health services]. With the advent of nation-wide health insurance in Canada, most hospitals have passed from [contract to government subsidized health schemes]. The law has been slow to note these developments. . . .

The institutional and financial structure of health care delivery has an important bearing upon the distinction which has arisen in medicine in recent decades between ordinary and extraordinary treatment. In the [old] days [all medical care] was measured by a standard of the ordinary. . . . 71

The distinction has only become important with the advent of enormous developments in medical technology; difficult decisions must now be

70 Id.
71 Dickens, supra note 61, at 856-57.
made to resolve the dilemma of scarce resources. Again, as Dickens points out:

A resource . . . which is in too limited supply to meet all the demands which could be made on it, . . . will by definition be extraordinary. Accordingly, its withholding in any specific case will not be a breach of duty. On the other hand, everyone expects hospitals to be able to provide patients with nutrition, warmth, sanitary care and . . . basic drugs.  

Louisell emphasizes that the extraordinary/ordinary distinction is not the same as that between “action” and “inaction”. At common law a physician may refuse aid to a stranger in an emergency without incurring legal liability. However, if he voluntarily renders aid he must observe due care. The attending physician is not a volunteer, and is bound to the standards of normal medical performance. If he fails to meet these standards, he cannot plead that his failure constituted inaction rather than action. “But a failure to use ‘extraordinary’ means is a different matter and, in a given context, may be legally justifiable.”

The extraordinary/ordinary distinction is usually illustrated with a reference by Pius XII:

Natural reason and Christian morals say that man [and whoever is entrusted with the task of taking care of his fellowman] has the right and the duty in case of serious illness to take the necessary treatment for the preservation of life and health. This duty that one has toward himself, toward God, toward the human community, and in most cases toward certain determined persons, derives from well ordered charity, from submission to the Creator, from social justice and even from strict justice, as well as from devotion towards one’s family.

But morally one is held to use only ordinary means — according to circumstances of persons, places, times, and culture — that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends. On the other hand, one is not forbidden to take more than the strictly necessary steps to preserve life and health, as long as one does not fail in some more serious duty.

Louisell points out that physicians and theologians use the extraordinary/ordinary distinction in different ways. To physicians the distinction is between unusual as opposed to usual medical practice; to theologians all factors relevant to a moral decision must be considered in making the distinction, including the patient’s philosophical preference, the conditions of his family, and the relative hardship of one course of

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72 Id. at 859.
73 Supra note 10, at 730-31.
74 Id. at 734, quoting from 4 The Pope Speaks 393, at 395-96 (Spring, 1958). See also Dickens, supra note 61, at 858.
conduct compared to another. Means that are "ordinary" from the viewpoint of medical practice may be "extraordinary" in the context of life's dilemmas.

Louisell cites the following theological definitions:

*Ordinary means* are all medicines, treatments, and operations, which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience. *Extraordinary means* are all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit. \(^75\)

The shift from a definition of extraordinary/ordinary in terms of unusual/usual to one in terms of unreasonable/reasonable, based on a sort of cost-benefit analysis, masks an intervening normative judgment. What is and what is not usual is a question of fact that can be answered by looking at the state of medical practice at a given time. On the other hand, what is reasonable is a question of values to which there is no one objective answer. The physician cannot answer this question for the patient. Although in current medical practice, active euthanasia is unusual, it cannot be said *a priori* to be unreasonable; and it certainly cannot be said to be unreasonable simply because it is active.

It may be argued that administering euthanasia is not a "treatment", but a similar objection can be raised about any medical treatment that is not usual, with the result that the distinction between what is usual and what is reasonable would collapse. In fact the distinction can only be maintained by keeping it open to normative revision as a question of values. As soon as it is reduced to a fact, it becomes merely a matter of convention.

In his *Study Paper* Keyserlingk notes three related, yet fundamentally different, uses of "extraordinary": (1) usual vs. unusual; (2) useful vs. useless; and (3) reasonable vs. unreasonable. If, he observes, only usual treatment were "morally obligatory", then not only would no improvement in such treatment be possible, but it would always be required however useless it might be. On the other hand, the mere usefulness of a treatment should not make it compulsory, since there are other factors involved in prescribing it, such as the repugnance of the procedure, its cost, and its social consequences. Conversely, certain procedures might be useless in preserving life, yet imperative for the patient's comfort. Keyserlingk suggests that the extraordinary/ordinary distinction should be replaced by one between elective and imperative treatment that is based on the standard of the reasonable person. \(^76\)

The reason for the breakdown of the extraordinary/ordinary distinction is its static conventional nature. Although that distinction will

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\(^{75}\) Id. at 736, quoting from Kelly, *The Duty to Preserve Life*, 12 Theological Studies 550 (1951).

\(^{76}\) Supra note 3, at 110-11.
remain a factor that must be considered in most situations, and although
the force of convention can never be ignored, an open normative criterion
is required. An extraordinary procedure will still tend to be regarded as
elective rather than as imperative. But by removing the dead weight of
the extraordinary/ordinary distinction, the way is cleared for considering
the possible role of euthanasia in the treatment of certain patients.

VIII. SANCTITY OF LIFE AND QUALITY OF LIFE

Keyserlingk arrives at the following conclusions about the relation-
ship between the sanctity of life and the quality of life:

1. The indeterminate sanctity of life principle alone cannot be used to
determine in advance all treatment decisions, without consideration as well of
the quality of the lives in question. To do so would be to use that principle as
a “decision-avoiding” not a “decision-making” guide.
2. The meaning of quality of life in the medical context need not mean
wholly subjective judgments about the relative worth, value, utility or
equality of the lives of persons. Purged of connotations of “relative worth”
or “social utility”, the function of quality of life thinking in this context . . .
can be one of improving and benefiting the patient, and can focus on
objective criteria and needs.
3. In particular there are two such quality of life criteria relevant to
decisions to treat, or to continue treatment or to stop treatment. The first
considers the capacity to experience, to relate. The second considers the
intensity and susceptibility to control of the patient’s pain and suffering. If
despite treatment there is not and cannot be even a minimal capacity to
experience, and to relate, or if the level of pain and suffering will be
prolonged, excruciating and intractable, then a decision to cease or not
initiate treatment (of for instance a comatose patient) can be preferable to
treatment.77

The Law Reform Commission’s Working Paper proposed three
principles based on these conclusions. The first is a presumption in
favour of life. “[T]he intent of a terminally ill patient to give up life”, it
declares, “should normally not be assumed without a clear, free and
informed expression of the will to do so”.78 Where the patient cannot
express his wishes, it should be assumed that:

[His] choice, if he could express it, would be to receive treatment . . . [T]his
rule is applied every day to emergency cases. When a patient arrives
unconscious at a hospital’s emergency ward, the physician will normally treat
him [even in the case of an apparent suicide]. [The] presumption in favour of
life does not oblige that physician to give an unconscious patient a treatment
which, under the circumstances, appears unreasonable or useless. The
practical effect of such a presumption . . . is to place the burden of proof on
those proposing a course of action or inaction which will not prolong or
maintain human life.79

77 Id. at 70.
78 Supra note 2, at 36.
79 Id. at 37.
The second principle is that of personal autonomy and self-determination. "It is essential to recognize that every human being is, in principle, master of his own destiny . . . except where the exercise of this right is likely to affect public order or the rights of others".\textsuperscript{80} The repeal of the criminal offence of attempted suicide in 1972 was not "an endorsement of an act which most people regard as profoundly contrary to human nature";\textsuperscript{81} it simply recognized the principle of self-determination. "Since the person concerned probably needs help and certainly not punishment, prosecution would be inhuman. . . . The case-law rule that an individual of sound mind is free to refuse treatment takes a similar approach."\textsuperscript{82}

The third principle is that human life should be considered not only from the "quantitative", but also from the "qualitative" perspective.

The autonomous person has the right to define his own priorities and requirements in terms of the effects of treatment or non-treatment upon the quality of his life. Others should respect these priorities. If the person is not autonomous, others must determine these priorities, taking into account the utility of the act in light of the benefit to the person involved.\textsuperscript{83}

An interesting dichotomy should be noticed from the outset. In the case of a competent person, the refusal of treatment is a right that is not limited to the situation where he is dying. For example, a person with a painful but not fatal illness, who might be kept alive with the help of treatment, may choose to refuse treatment even though this in effect terminates his life. In practice it is difficult for a patient to make this choice, particularly in a hospital setting.

For instance, in the infamous Bouvia case,\textsuperscript{84} a California Superior Court judge ruled that a twenty-six year old cerebral palsy patient did not have the right to starve herself to death, and that if necessary the hospital could force-feed her in order to save her life. The issue, according to the Court, was whether or not a severely handicapped, mentally healthy person who was not terminally ill had the right to end her life "with the assistance of society". The Court concluded that she did not. Although the plaintiff had a fundamental right to terminate her own life, this right had been overcome by the stronger interest of the state.

One of the most disquieting features of this and other cases is the intervention of lawyers on behalf of special interest groups, such as organizations for the handicapped. The result is that what is in issue is no longer the wishes of the dying or incurably ill, but abstract political or religious considerations that claim to override those wishes.

\textsuperscript{80} Id.
\textsuperscript{81} Id. at 38.
\textsuperscript{82} Id.
\textsuperscript{83} Id. at 39. These three principles were adopted in the Report of the Law Reform Commission, \textit{supra} note 1, at 11-12.
\textsuperscript{84} Bouvia v. County of Riverside (unreported, Cal. Super. Ct., 16 Dec. 1983).
An incompetent person, however, does not have even a theoretical "right" to refuse treatment, but will be kept alive if there is a good chance that he will survive, even if he is severely handicapped or retarded. For example, in the notorious Baby Jane case, the Surgeon General of the United States, the Department of Justice, and lawyers on behalf of special interest groups have sought to keep a severely retarded and deformed child alive, contrary to the wishes of her parents. A heroic operation promises her at best twenty years of sedated pain in an institutional bed and her parents twenty years of unmitigated anguish.

Keyserlingk seeks to justify this dichotomy between competent and incompetent persons on the ground that the "quality of life" argument cannot be used to devalue "inferior" lives to the point of extinction. There is a basic inconsistency, in his opinion, between insisting that the value of life lies in its very existence, not in its quality, and weighing the relative value of each life according to some external standard. Human personal life is something more than vital metabolic processes.

The word "life" can mean two things in this context. It can mean vital or metabolic processes alone, a life incapable of experiencing or communicating and one which therefore could be called "human biological life". Or it could mean a level or quality of life which included both metabolic functions and at least a minimal capacity to experience or communicate, which together could be called "human personal life".

Any definition of life must necessarily be related to a definition of death. According to Keyserlingk, "death is best spoken of as a single event which occurs when the brain dies. It would be incorrect to say", he states, "that there are different human deaths, or that the moment of death is arbitrary, even though different cells and organs die at different points on the dying continuum", or because technical life is possible even after real (personal) death has occurred.

I must say I find all this very confusing. If, as I entirely agree, we need a normative human standard for deciding in what circumstances a patient should cease to be considered a living person for certain purposes, then brain death or respiratory/circulatory death can only be considered as a sort of cut-off point. A great deal of confusion is caused by failing to distinguish between an objective-event criterion of death.

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66 Supra note 3, at 71.
67 Id. Robert Veatch distinguishes four different levels in the analysis of "death". The first sets out the formal structure that must be filled in. The second considers the concept with which this is done: what is so essentially significant about life that its loss is termed "death"? The third decides the locus of death: where in the organism ought one to look to determine whether death has occurred? The fourth specifies the criteria of death: what technical tests must be applied at the locus to determine whether an individual is living or dead? R. VEATCH, DEATH, DYING AND THE BIOLOGICAL REVOLUTION 24 (1976).
and a subjective-process criterion of dying. The patient, as I have already indicated, never experiences death. An observer, on the other hand, never experiences the patient’s dying. The former is a point in time, the latter a continuum. If he has to die at all, a patient wants to die as well as possible, which does not only mean to die free of excruciating pain. Dying is still living; death is an abstract point.

The dying patient is concerned with the quality of his life, and he wishes to protect that quality regardless of any metaphysical or scientific distinctions. He may want merely to be relieved of pain and allowed to go in his own time; or he may want to be relieved of what is left of his life, a life which he now regards as a crushing burden, even though he feels no pain. If the patient were truly master of his own fate, as Keyserlingk declares, then he should be master of whether to terminate his life. Active euthanasia cannot be ruled out a priori on the ground of sanctity of life, when refusal to be treated is allowed on the ground of quality of life. The two are merely different sides of the same coin.

The opponents of both euthanasia and abortion take their stand on the ground of the sanctity of life. Their arguments are based on the idea that physical life is sacred independent of its quality. Yet, as Glanville Williams points out, there is something wrong with this kind of argument:

The absolute interdiction of suicide and euthanasia involves the impossible assertion that every life, no matter what its quality or circumstances, is worth living and obligatory to be lived. This assertion of the value of mere existence, in the absence of all the activities that give meaning to life, and in face of the disintegration of personality that so often follows from prolonged agony, will not stand scrutiny.88

The assertion Williams objects to reeks of crude materialism and is diametrically opposed to the spiritual claims made by those who support it. “Life” is a word in a language, and not a physical element in the world. It is only by identifying life with certain phenomena that it appears to be homogeneous, apart from circumstances and quality. But if it were in fact homogeneous, then it would not be limited to human life; human life would be merely part of a greater whole. The Buddhists at least accepted that point and preached reverence for all forms of life.

The pro-life crusaders want to have it both ways: on the one hand they restrict their concerns to human life, and on the other hand they insist that life as such must be protected regardless of quality. In fact their focus is very narrow. Their special concern is with unwanted embryos, with the severely handicapped and retarded, and with the dying. This contrasts with their relative indifference to the children and adults who could lead perfectly normal lives if they were given a fraction of the resources now spent on intensive care.

88 Supra note 26, at 316.
The explanation is probably that the pro-life crusaders are not so much concerned with saving bodies as with saving souls. The history of the Church demonstrates only too well the contradictory nature of this enterprise. Admittedly there has been a change of tone in some quarters recently. Until then pro-life groups had not figured prominently in the anti-war and anti-capital punishment movements where one would have expected to see them. "Respect for life" was concentrated on rather a narrow front.

IX. SUICIDE AND MERCY KILLING

The Law Reform Commission in its Working Paper addresses itself to both these topics. Ever since the criminal offence of attempted suicide was abolished, it says, the decriminalization of the act of aiding suicide has been proposed as the logical next step. "At first view", the Commission admits, "it seems highly incongruous to regard as criminal the participation in an act which itself is no longer criminal". There does not appear to be any practical difference "between watching a terminally ill person swallow poison he has obtained himself . . . and watching him doing so after having provided him with the poison in question". Although the Working Paper concedes that "[t]his distinction is difficult to justify on grounds of logic alone", it claims that it can be maintained on grounds of policy:

What of the person who takes advantage of another's depressed state to encourage him to commit suicide, for his own financial benefit? What of the person who, knowing an adolescent's suicidal tendencies, provides him with large enough quantities of drugs to kill him? The "accomplice" in these cases cannot be considered morally blameless. Nor can one conclude that the criminal law should not punish such conduct. To decriminalize completely the act of aiding, abetting or counselling suicide would therefore not be a valid legislative policy. But could it be in the case of the terminally ill?

The probable reason, the Working Paper states, "why legislation has not made an exception for the terminally ill lies in the fear of the excesses or abuses to which . . . [this] could lead. . . . [T]he law may legitimately fear the difficulties involved in determining the true motivation . . . " Moreover, adds the Commission, aiding suicide and homicide are sometimes extremely closely related. . . . [Is] the doctor who holds the glass of poison and pours the contents into the patient's mouth . . . aiding

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89 See, e.g., supra note 2, at 52-55, 68-69.
90 Id. at 53.
91 Id.
92 Id. at 53-54.
93 Id. at 54.
him to commit suicide . . . or is he committing homicide, since the victim's willingness to die is legally immaterial? . . . [H]omicide of the terminally ill . . . may readily be disguised as suicide.\(^{94}\)

As the *Working Paper* points out, suicide is not limited to situations where a person is already dying. Hence, although a person who takes his own life in these circumstances is committing suicide, these cases, I suggest, belong more properly to the relief of the terminally ill. Nonetheless, there is a common factor that precludes rigid differentiation among suicide, aiding suicide, withholding or stopping treatment and euthanasia. The difficulty involved in attempting such a differentiation is highlighted by an example that Glanville Williams gives:

Suppose that a physician supplies his dying cancer patient with a poison, and watches him take it. According to the Swiss and Soviet rule, the physician is not guilty of a crime in thus abetting the suicide of a non-dependent person for unselfish reasons. Now suppose that the physician raises the poison to the patient's lips so that he may voluntarily make the motion of swallowing. Is this an abetment of suicide, or a killing by consent? It would be absurd to distinguish it from the first case. Finally, suppose that the physician pours the poison down the patient's throat, or injects it into his veins. Again there is no reason of penal policy for distinguishing the case: either the physician should be punishable in all cases, or he should be immune in all.\(^{95}\)

Williams admits that there is a danger here. Relatives of invalids might be able to murder them and then plead consent, safe in the knowledge that their victims cannot give evidence on the subject. But, he says, the danger of false evidence is one that the law has to meet anywhere. If voluntary euthanasia were legalized, there would be no reason for secrecy; rather the reverse would be true. There are many situations in criminal law in which the *bona fides* of an act is tested by whether it is done furtively or in the open.

On the whole, then, it is submitted that the law might well exempt from punishment the unselfish abetment of suicide and the unselfish homicide upon request. This rule would solve at a stroke the problem of voluntary euthanasia in cases of fatal illness. It would, of course, go much beyond the legal change usually advocated by supporters of euthanasia, because it would not be limited to persons suffering from an incurable and painful illness.\(^{96}\)

Admittedly there is a difference between a dying and a non-dying situation, and euthanasia in the strict sense is limited to the former. But there is often a close analogy between the two cases: in one the patient is physically dying; in the other, the quality of life of the patient is so poor that, although he is not physically dying, he would prefer to do so.

I suggest that the dying situation can be extended to include chronic conditions which, although not in themselves fatal, make a person's life

\(^{94}\) *Id.*

\(^{95}\) *Supra* note 26, at 309.

\(^{96}\) *Id.* at 310.
unbearable by reason of physical pain or mental suffering, or by the need for constant stressful care or treatment. One excellent criterion for determining the existence of such a condition is the degree to which the patient is viable, that is, able to lead a more or less normal life. If heroic measures are required to keep him alive, then we could say that he would be in a dying condition were it not for constant medical intervention that seriously interferes with his life.

The law allows such a person, if competent, to refuse any further treatment, or to commit suicide unaided, but the former might expose him to long drawn-out suffering, and he might not have the strength or knowledge to do the latter. It seems to me that whatever we might think of aiding suicide generally, a patient should have the right to euthanasia in this type of case. If the person is incompetent, he should be given similar relief with the benefit of appropriate protective procedures.

Since we must use normative criteria to decide into what category to place the patient, no precise boundaries can be drawn between them. Of course, this involves certain risks, but at present the overwhelming danger is society’s ideological worship of the body and its collective fear of death. Almost every day we read or hear of horror stories in which persons have been subjected to painful and demeaning medical treatment against their will. The so-called “mercy deaths” are an exception, and they have become more and more rare as more and more busybodies organize for their own ends to enforce outdated legal standards against the defenceless hopelessly ill. What could be more undignified than having to fight long drawn-out legal battles against the powers of the state in order to be allowed to die with dignity?

It follows from what I have said about euthanasia that so-called “mercy killing” is a misnomer insofar as it implies criminal culpability. The Law Reform Commission shied away from opening the floodgates of “motive” on the ground that it might be extended to passionate as well as compassionate murder, and to political killing. It also stressed the danger that a motive might not be as pure as it appeared, and the victim’s consent tainted. In its Report, the Commission recommends that “mercy killing not be made a separate offence, and that there be no formal provision for special modes of sentencing for this type of homicide”. 97

X. Conclusion

The recommendations of the Law Reform Commission of Canada concerning euthanasia are a good example of metaphysical and legal law reform. Social law reform looks at social practices in an openminded way and takes as its starting point the dissatisfaction expressed by the

97 Supra note 1, at 20.
ordinary citizen. Complaints have surfaced concerning the roadblocks that face the dying and incurably ill who want to be released from their suffering. The fact that these people do not usually call for euthanasia is beside the point. Euthanasia certainly is not the answer to all complaints, but it is a solution that must not be dismissed out of hand simply because it has been repressed in our consciousness.

Much of the confusion surrounding the issue of euthanasia is due to the false view that a word has a basic meaning that remains identical regardless of the context in which it is used. It is on the basis of this fallacy that euthanasia is identified with killing. If euthanasia is “killing”, it is clearly killing of a very different kind. There is something more than a little ridiculous in condemning euthanasia as killing in a world in which murder, war and wholesale genocide are endemic.

For practical reasons I have limited euthanasia to a case where a competent person who is dying, or suffering from an incurable and fatal illness, requests a registered medical practitioner to terminate his suffering, and the practitioner grants his request, primarily out of compassion. Whether the procedure followed by him is an active act of assistance or a passive act of withholding or discontinuing treatment is immaterial. The rationale for euthanasia is the pointlessness of an existence that has lost its meaning because the person concerned is no longer viable as a human being. Pain is merely one important factor in the situation. Euthanasia is always voluntary; involuntary euthanasia is a contradiction in terms.

The real problem with euthanasia is that it should be considered a problem at all. The issue is not one of technology, but of thinking straight. Who is being denounced as a killer? The physician who, out of compassion, grants the request of a dying patient? The patient’s request is simple. He sees no point in going on when he has nowhere to go; he wants to end his days without being a further burden to himself and to his family.

What right has the state to say no? I suggest none. The wedge principle is a double-edged sword. To have to come to the state, cap in hand, in extremis, to be allowed to die a little faster shows the condition of slavery to which we have sunk. If it is right to keep the government out of the bedrooms of the nation, it surely has no place on our deathbeds.

We must keep our eyes fixed on the principle, not on the process. There are many ways of protecting patients from the abuses of euthanasia. Of course no protection can be foolproof, but let us keep a sense of proportion. The danger of being murdered through euthanasia is a good deal less than that of being killed through drug abuse.

Whatever the method, euthanasia must be simple, speedy and humane. In a highly medicalized and institutionalized society, certain formal requirements must be met. However, bureaucracy and judicialization must be kept to a minimum, or the means will get in the way of the end. For reasons given earlier, active and passive euthanasia should be
dealt with in the same way. The procedural requirements should be limited to obtaining written proof of the patient’s medical condition and of his competence to consent from the attending physician, supported by a second opinion. If the patient is hospitalized, a representative of the institution should attest the consent form.

Where the patient is incompetent, the patient’s next-of-kin should be entitled to make the request on his behalf. If they refuse to do so, the attending physician should be allowed to intervene by certifying that in his opinion no purpose would be served in prolonging the patient’s agony. The physician’s opinion should be confirmed by a second medical opinion and by a hospital representative in the event that the patient is hospitalized. Although euthanasia is, strictly speaking, limited to the case where the patient expresses a wish to have it administered, it may be legitimately extended to cover this situation. A "living will", or clear instructions to the patient’s family or his attending physician, should be sufficient unless there are supervening circumstances that rebut it.

I realize that these guidelines are very general, but my purpose is not to submit a detailed blueprint for law reform. One might question the wisdom of proposing a solution that appears to be unacceptable today. This would be wrong. The social law reformer must be beyond political and ideological considerations. He must follow his lead wherever it may take him. Progress is not incremental; it proceeds in cycles; the seed is laid in our consciousness long before it is allowed to flower.

Notwithstanding appearances, the time for legalizing euthanasia is ripe. The new medical technologies are pushing health budgets to the limit. It will soon become economically impossible to stretch out the dying process further. Euthanasia is already widely practised under the guise of "allowing to die" and "pain-killing". Behind these fictions, euthanasia as an acceptable practice is beginning to gather strength. The idea is there, and its acceptance is being prepared by focusing on the passive side of euthanasia. In sanctioning "allowing to die" we have in fact accepted euthanasia even if we balk at the name.