Is Senate Bill S-2 about Euthanasia?

An Analysis of Proposed Legislation on
Withholding and Withdrawing Medical Treatment

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I. <u>SOMETIMES</u> WITHHOLDING OR WITHDRAWING TREATMENT IS KILLING

> ***"You can practice euthanasia by turning off a respirator. For instance, you have Nancy B. lying there and saying, "I want to go on this respirator for as long as I can live", and the hospital saying, "We want to turn it off because it's too expensive and you're never going to get off it."***
>
> **Dr. Margaret Somerville**, Senate Euthanasia Committee, *Proceedings* (1994-95) 6:21

Can you kill by withholding or withdrawing medical treatment?

You can kill someone two ways - by an act of commission and an act of omission. Withholding and withdrawing are acts of omission. <u>*Sometimes*</u> they are also acts that kill.

What is an example of an omission that kills?

If a parent starves their child to death, they are surely killing the child. But they do it by *omitting* something - food.

But how can you kill by withholding or withdrawing medical treatment?

Suppose your young daughter has accidentally swallowed a toxic chemical. You rush her to the emergency room of your local hospital. The doctor recognizes her life is in danger but, for no good reason, refuses to treat. Maybe he dislikes you because of your ethnic group. In any case, your child dies because of this doctor's culpable omission. Was he responsible for the death? Certainly.

What are some other examples of homicide involving the omission of medical treatment?

We are all familiar with mass killings like Littleton, Colorado. Suppose some sociopath takes control of a hospital, and goes around pulling the plug on all the patients. He terminates all life-preserving means - respirators, IV lines, feeding tubes, everything. He also destroys all medicines, and interrupts lifesaving surgeries. As a result, of course, a lot of people die. Their deaths were caused by the sociopath. Ethically, it is technically correct to say that he *killed* them.

Okay, perhaps it is possible to kill by omitting treatment. But your examples seem far-fetched.

Let us take an example well-documented in medical literature. Children with Down's Syndrome are commonly born with a life-threatening bowel obstruction. This obstruction can be removed with fairly routine surgery. Yet in both Canada and the U.S. there have been numerous cases where parents have refused to allow the surgery, evidently because of quality of life concerns.

Children died as a result. One can assume that if the children had not been disabled, the parents would have preserved their lives. These parents were guilty of two things: 1. Discrimination. 2. Taking the lives of their children.

But parents who omit treatment for disabled children are probably only doing what they think best. That seems very different from the sociopath who goes around pulling the plug on every patient.

There is a distinction. The sociopath acts with malice toward the patients. The parents act for the supposed benefit of the patient. But in both cases death is caused by the omission of medical treatment.

Should we recognize the ethical difference?

Yes. Both are acts of culpable homicide. The parents, however, are motivated by the good of their child. Therefore, we may classify their act (of omission) as *euthanasia*.

What is your definition of euthanasia?

An act or omission that causes someone's death in order to end their suffering. It is killing for a compassionate motive.

You say euthanasia is "an act or omission". Do you mean there are two types of euthanasia?

Yes, broadly speaking. Since both types involve moral action, perhaps it would be helpful to say that euthanasia is an act by *omission or commission*.

What do you call these two kinds of euthanasia?

I suggest the terms, "omissive" euthanasia and "commissive" euthanasia. Others have used different language with the same meanings: "euthanasia by omission" and "active euthanasia", or "passive euthanasia" and "active euthanasia."

When I hear the term "passive euthanasia" I think of letting people die by stopping extraordinary treatment - it could be CPR, a respirator, etc. This is something doctors do every day in our country. Would you classify those medical decisions as euthanasia?

Definitely not. A decision made to forego an extraordinary or heroic measure - for instance, because it is not medically useful in the circumstance - is only good medical care, not homicide or euthanasia. It is allowing to die, without causing that death.

I am a bit confused. Did you not say that withholding and withdrawing medical treatment is equivalent to euthanasia?

Not exactly. Sometimes withholding or withdrawing treatment is euthanasia. Sometimes it is not.

There are three possible ethical positions on omitting life-preserving treatment: (1) All omissions are homicide / euthanasia (the latter if the motive is to relieve suffering). (2) No omissions are homicide / euthanasia. (3) Some omissions are homicide / euthanasia. Mine is the third stance.

The fundamental question seems to be: When is non-treatment euthanasia, and when is it not?

Exactly. The answer is: it depends on the reason or intent of the omission. If the intent is to bring about death - say, because the person is disabled and someone figures they would be better off dead - then you have euthanasia. If, on the other hand, the intent is to omit treatment judged as useless, risky, painful or otherwise a significant burden to the patient, there is no choice of death per se.

If I may paraphrase your last statement, I think you are saying that when you forego or stop extraordinary treatment, it is not a choice to kill, and therefore not euthanasia.

That is correct.

Is there something called "ordinary" treatment as distinct from extraordinary treatment. If so, how would you define it?

Ordinary treatment is also called "proportionate" treatment, as opposed to extraordinary or disproportionate treatment. It is treatment that is medically useful, without great risk or expense, and otherwise not a significant burden on the patient. It is up to the patient to determine whether a specific treatment is ordinary or proportionate in the circumstances at hand.

Ethically, ordinary treatment is due to the person who is sick. He or she has a right to obtain it. And those who care for the patient, whether family members, on whom the patient is dependent, or professionals, have a duty to provide it.

Is the choice to omit ordinary treatment homicidal in nature?

When the treatment is life-sustaining, to disregard the duty to provide such treatment is to intend death. When the motive is to end the patient's suffering, you have an instance of what I have termed omissive euthanasia.

The phrase "omissive euthanasia" is new to me. I am familiar with "passive euthanasia." When moral authors use the terms "passive euthanasia", is their meaning generally equivalent to "omissive euthanasia"?

There are two basic meanings in the literature: any omission that *results in* death, and any omission that *causes* death. Mine is the latter. Admittedly, it makes for confusion among readers. If I may defend the tradition I represent, it makes for more ethical precision. To say that any

omission that results in death is euthanasia completely glosses over the distinction between those omissions that cause death and those that do not.

What support is there for the concept that euthanasia - in the sense of mercy-killing - can occur by omission of medical treatment?

The concept of killing by omission appeals to common sense, as in the example above of the parent starving a child. This concept is very old in our society and was part of our common law tradition. It entered Canada's *Criminal Code* in its original 1892 formulation.

The Catholic Church, reflecting a long tradition, is very explicit, even today, that euthanasia is "an act *or omission*" that causes death (*Catechism of the Catholic Church*, n. 2277; emphasis added). Orthodox Judaism, with an even longer tradition, says likewise.

Contemporary support among respected secular ethicists is by no means lacking. At the Senate hearings on euthanasia in 1994-95, supporters of an omissive understanding included Edward Keyserlingk, Margaret Somerville, and Abbyann Day Lynch.

II. CANADIAN LAW PROHIBITS KILLING SOMEONE BY WITHHOLDING OR WITHDRAWING MEDICAL TREATMENT

> ***"I cannot accept [the parents'] view that Stephen would be better off dead . . . This would mean regarding the life of a handicapped child as not only less valuable than the life of a normal child, but so much less valuable that it is not worth preserving."***
>
> **McKenzie J.**, *Re Stephen Dawson* (1983), 3 W.W.R. 629 (B.C.S.C.)

Under Canadian law is homicide an act of commission rather than an omission?

Definitely not. Under common law and the *Criminal Code* homicide can involve both commission and omission. For example, "at common law it was unlawful homicide for parents to let their children die for lack of necessaries." (Law Reform Commission of Canada [LRCC], *Homicide* [1984] p. 31). For the *Code*, "death can be caused by acts or by omissions." (ibid., p. 29). "Omissions resulting in death can be either murder or manslaughter depending on the fault element" (ibid., p. 100 at note 48).

But do homicidal omissions include the withholding and withdrawal of medical treatment?

Definitely. Sections 216 and 217 impose duties on medical providers. Section 217 states that *"Every one who undertakes an act is under a legal duty to do it if an omission to do the act is or may be dangerous to life."* Breach of this duty may be considered as murder or other offences (David Watt and Michelle Fuerst, *The 1995 Tremeear's Criminal Code*, p. 375), and may apply to the cessation of medical treatment (LRCC, *Euthanasia, Aiding Suicide and Cessation of Medical Treatment* [1982] pp. 19-20).

I understand how Section 217 may apply to physicians who irresponsibly withdraw treatment they have undertaken. What about a physician's obligations prior to undertaking treatment? Can withholding treatment also be considered a crime?

Yes. Section 215 defines the duty of persons to provide the necessaries of life to certain dependent persons under one's charge. As courts have determined, this duty applies to health care providers (LRCC, *Medical Treatment and Criminal Law* [1980] pp. 22-23). Thus, a physician who refuses to provide necessary treatment can be found culpable.

Where does the Criminal Code draw the line between culpable omissions of treatment and legitimate instances of withholding and withdrawing treatment?

The *Code* indicates what is crime, rather than what is not. There is obviously, however, a line between the two. The withholding or withdrawing of treatment under certain circumstances has

long been a normal part of medical practice; there is no reason to assume the *Code* ever intended to proscribe all omissions. Moreover, there seem to be no cases where physicians who have responsibly omitted treatment have been found guilty of a crime.

What the *Code* prohibits, therefore, are omissions involving a wilful disregard for human life (LRCC, *Euthanasia, Aiding Suicide and Cessation of Treatment*, p. 17).

Is there not a need for clarification as to where the line is between justified and unjustified omissions? I understand that in the past there have been calls to reform the Code in this area. Did the Law Reform Commission not make such recommendations?

There have been calls for reform, to remove undue fear of criminal liability that physicians may have in carrying out legitimate omissions of treatment. But in light of court decisions in recent years upholding patient liberty to refuse treatment (*Hopp v. Lepp* [1980] [S.C.C]., *Nancy B. v. Hôtel-Dieu de Québec* [1992] [Que.S.C.], etc.), it would be an exaggeration to say such fear is widespread among physicians today.

In its working paper *Medical Treatment and Criminal Law*, the Law Reform Commission called for reforms to clarify the *Code*'s meaning (pp. 89-100). However, it recommended “that the substance of the present provisions of the *Criminal Code* concerning duties tending toward the preservation of life be retained” (p. 92).

Can you cite some cases where courts have upheld the duty to provide medical treatment?

Hôpital Notre-Dame v. Patry (1972) (C.A.), *R. v. Senior* (1899), *R. v. Brooks* (1902) (C.A.), *R. v. Lewis* (1903) (C.A.), *R. V. Sidney* (1912) (C.A.), all cited in LRCC, *Medical Treatment and Criminal Law*, 22-23, 30-31; *R. v. Fortin* (1957) (N.B.C.A.), cited in LRCC, *Homicide*, 101; *Reedy* (No. 2) (1981) 60 C.C.C. (2d) 104 (Ont. Dist. Ct.), cited in Don Stuart, *Canadian Criminal Law: A Treatise* (1987), p. 76 at note 99; *Re Stephen Dawson* (1983) (B.C.S.C.).

Have the courts dealt with cases of what you term omissive euthanasia?

In regard to the example presented above earlier, viz., parents refusing routine lifesaving surgery to their disabled children, Canadian courts have ordered treatment in such cases (Gerry Ferguson, “The Canadian Charter of Rights and Individual Choice in Treatment,” *Health Law in Canada* 8, no. 3 [1988], p. 68).

Has the Supreme Court of Canada, in recent years, addressed the question of whether omission of treatment can be a criminal act?

R. v. Tutton (1989) 69 C.R. (3d) 289, dealing with a parent's duty to preserve a child's life, was based on assumption that treatment omissions can be legally culpable.

III. WHETHER THE SENATE REPORT ON EUTHANASIA (1995) IS AN ADEQUATE BASIS FOR REFORMING THE LAW ON WITHHOLDING AND WITHDRAWING MEDICAL TREATMENT

> ***"Our own members constantly face situations where a person with a disability goes to a physician with an easily correctable ailment and the recommendation of the physician will be that, if they do not operate, the person will die and that would be better for everyone.***
>
> ***"Parents find that they have to fight for medical treatment for their children with disabilities, particularly if the disability is significant. The assumption by many people in the medical profession is that those lives are not of equal value and that in fact the family will be happy if they do not intervene."***
>
> **Diane Richer**, Canadian Association for Community Living, *Proceedings* 23:49

The Senate Committee on Euthanasia made recommendations on withholding and withdrawing treatment, did it not?

Yes, it did. However, the primary focus of the Committee's deliberations, and of the testimony presented to the Committee, was what I have termed commissive euthanasia. The extensive examination of palliative care and pain relief was all part of that main focus.

What did the Committee recommend on omitting treatment?

The primary recommendation was that "the *Criminal Code* be amended and necessary legislation be enacted in order to explicitly recognize and to clarify the circumstances in which the withholding and withdrawal of life-sustaining treatment is legally acceptable."

Do you see any objection to such a recommendation?

In principle I would not object to legislation that *clarifies* the *Code*'s meaning with respect to the provision and omission of medical treatment. However, we should be wary of legislative proposals that purport to clarify the *Code*, but actually *change* the meaning of the law, its definition of homicide, etc. Furthermore, I add a three-part caveat:
(a) Any proposal that would weaken the law's prohibitions against behavior that, ethically, constitutes omissive homicide or euthanasia must be found wanting;
(b) For any legislative proposal to provide clarification it must, first of all, properly distinguish between omissions that are legally homicidal and those that are not;
(c) It must furnish coherent language to enable the public to discern, in real life situations, which omissions are homicidal.

How did the Senate Committee deal with the question of homicidal omissions of treatment?

In its report, *Of Life and Death*, the Committee completely failed to acknowledge that any omissions could be homicidal.

Are you saying, in other words, that the report flatly disagreed with the positions you have set forth in Parts I and II above?

Essentially, yes.

How does the Committee define euthanasia, then?

The Committee defines euthanasia as "a deliberate act undertaken by one person with the intention of ending the life of another person to relieve that person's suffering where that act is the cause of death" (14).

Is that definition accurate?

In formal terms, it is accurate as far as it goes. But at the same time, again in *formal* terms, it is incomplete, inasmuch as it fails to settle the key issue of whether euthanasia is a commission, omission or both. Now in practical terms the definition is fundamentally flawed. By "practical terms" I mean the real meaning which this definition has for the Committee. For the Committee this definition clearly applies only to acts of commission, never to acts of omission.

Where does the Committee define euthanasia in exclusively active or "commissive" terms?

Rather than being explicitly stated, the practical meaning which the Committee assigns "euthanasia" is suffused throughout the report. To understand this definition requires a careful reading of the whole report, which I did for my postgraduate dissertation at the Pontifical Lateran University. The definition is implied in pages 11-12 of the terminology chapter. One place where the definition is explicit is page A-145. In referring to Dutch data about "non-treatment decisions that were taken at least partly for the purpose of hastening the end of the patient's life," the report states: "Clearly, from the Canadian point of view, ... non-treatment decisions are not euthanasia."

In light of the information and argument that you have presented in Parts I and II, the Committee's position that withholding or withdrawing treatment is never homicidal seems surprising. Did the Committee offer support for its views?

With all respect to the members of the Committee, the support their report offers is hardly substantial.

On page 13 the report suggests the idea of "the fundamental moral or ethical difference between acts of withholding and withdrawing treatment and acts of euthanasia." In defense of this idea, it quotes four witnesses it heard. But the *Proceedings* of the Committee reveal that none of the

witnesses actually supported the idea! Two held that euthanasia could involve omission of treatment (Keyserlingk, 1:28, Adams, 18:40), one held that all omissions leading to death were "justifiable homicide" and morally equivalent to euthanasia (Schafer, 18:123), while the fourth only spoke about omitting burdensome and futile treatment and conceivably might still agree that *some* omissions involve euthanasia (McGregor, 4:54).

In short, whether from misunderstanding testimony or other error, the report misrepresents the witnesses. In addition to the above example, on page 44 the report states that witnesses "were almost unanimous in finding that withholding and withdrawal of life-sustaining treatment is morally acceptable in principle." Having examined the testimony of the 153 witnesses, I can tell you that there was no real consensus to support such a statement (most took no position).

As for its view that treatment omissions are legally never euthanasia, the report essentially begs the issue. It offers a legal survey on omitting treatment (pp. 38-40) that somehow manages to neglect the many relevant sections of the *Criminal Code* that deal with homicidal omissions.

What do you think is the underlying basis for the Committee's position?

I think it may be bound up with the ethical fallacy that if you omit medical treatment, it is only letting nature take its course, not causing death or killing. I suppose you could argue that if a parent takes away a child's food, they are letting nature takes its course. But surely that argument is false: the parent is starving the child to death! Similarly, if I deprive my grandmother of medicine she needs to stay alive, so that she dies and I get a big inheritance, that is not letting nature takes its course, it is causing her death.

Unfortunately, the fallacy I mention has found its way into some American jurisprudence, and subsequently showed up in the court's reasoning in the *Nancy B*. case. Perhaps the latter was a source of influence on the Committee.

Can you give some examples of witnesses who appeared before the Committee and took a stand against omissive euthanasia?

Professors Edward Keyserlingk (*Proceedings* 1:28) and Margaret Somerville (6:21-22) of the McGill Centre for Medicine, Ethics and Law, the Canadian Conference of Catholic Bishops (22:44), Dr. Abbyann Day Lynch, Director of the Bioethics Department at Toronto Hospital for Sick Children (11:18), the Canadian Association for Community Living (23:49), and Dick Sobsey of the Developmental Disabilities Centre at the University of Alberta (18:137).

Did any witnesses provide data about the actual practice of "omissive euthanasia." Are people being deliberately deprived of treatment so they will die?

Quite a few witnesses presented evidence of actual cases or near-miss cases, suggesting there is already a serious problem in Canada. People involved with disabled persons, like Dick Sobsey and officials from the Canadian Association for Community Living, reported how common it is

for disabled people to face denial of treatment simply because of perceptions about their quality of life.

Then there was the evidence pointing to the extensive practice in Holland, cited in the Committee's report (A-148). In 1990 there were Dutch 8,750 deaths from non-treatment decisions which were "partly with the purpose " or "with the explicit purpose to shorten life."

Yet Committee members were unanimous in the view that omissions do not represent euthanasia?

I am not so sure they were. On page 87 of the report, the minority of the Committee that favor legalizing voluntary (commissive) euthanasia appear to take the view that omissions leading to death are morally equivalent, or at least similar, to euthanasia via lethal measures.

Above you mentioned that a law reform proposal concerning the withholding and withdrawal of treatment should meet certain criteria. In your view does the Senate Committee's report provide these criteria, or otherwise lay the necessary foundation for reforming the Criminal Code?

With all respect to the members of the Senate Committee, whose report is excellent in so many respects, *Of Life and Death* is deeply flawed in its understanding of, and approach to, the omission of medical treatment. In my judgment, it cannot offer a sound ethical or legal foundation for undertaking law reform in this important area.

IV. SENATE BILL S-2 (1999) WOULD CIRCUMVENT AND NULLIFY CRIMINAL CODE PROVISIONS THAT PROHIBIT KILLING SOMEONE BY WITHHOLDING OR WITHDRAWING MEDICAL TREATMENT

> ***"My sister has the same disability as I, which is spinal muscular atrophy. She had pneumonia and was severely ill in 1976. I discovered a year later that the doctor decided that when she required a respirator to live, he would not give her one. That was not his decision to make.***
>
> ***"It is unfortunate that there has always been and always will be this tendency for well persons and persons with power to force their opinions onto people who do not have the same power.***
>
> ***"For people with developmental disabilities, passive euthanasia continues to be a problem. People are dying who do not ask to die.***
>
> ***"Recently we were doing research on medical records in an institution. In reviewing 32 records, we found that 28 [mentally handicapped] people had "do not resuscitate" orders with no justifying health problem. . . . We found in all 32 of those cases, the physician had asked the families for "do not resuscitate" orders. He had asked for advance directives."***
>
> **Dick Sobsey**, Director, Developmental Disabilities Centre, University of Alberta, Senate Euthanasia Committee, *Proceedings* 18:150 , 137.

Senate Bill S-2 is called the Medical Decisions Facilitation Act. What medical decisions is this act designed to facilitate?

It is designed to facilitate decision-making in two main areas: the administration of pain relief, and the withholding and withdrawal of treatment.

From an ethical standpoint, how do you evaluate this bill?

The bill's approach to pain relief is basically ethically sound. The reason is it distinguishes between two types of moral acts: an act whose intent is to control pain not to cause death, but whose side-effect may be to hasten death, and an act whose intent is to cause death.

The approach to the omission of treatment is flawed for the same reason the pain relief section is sound: it fails to make any distinction between omissions that do not cause death and those that do.

In your opinion why does the bill not make any such distinction?

It appears to be based on the same serious flaw as the Senate Euthanasia Committee's report: the mistaken assumption that there is no such thing, ethically or legally, as a homicidal omission of treatment.

The Senate Committee recommended amending the Criminal Code so as to clarify the circumstances under which omitting treatment is legal? Would Bill S-2 carry out that recommendation?

The bill would not amend the *Code,* at least not directly. Neither would it clarify the *Code*'s meaning, since it fails to address the *Code*'s prohibitions against homicidal omissions. Consequently, it is questionable whether the bill would fulfill the Committee's recommendation.

What would the bill's legal effect be?

If the legislation the bill introduces is accepted by Parliament, I believe the effect could be to circumvent and nullify present *Criminal Code* provisions that prohibit killing someone by withholding or withdrawing medical treatment.

How could it have such an effect?

By allowing health care providers and other agents to carry out treatment omissions that, ethically, constitute homicide or euthanasia and that, legally, are now prohibited by criminal law.

For example, let me return to the example given earlier, of the parents who carry out euthanasia on their disabled child by denying routine life saving surgery. Section 3 of Bill S-2 could allow parents to deny medical treatment to disabled children for any reason. It could thus allow omissive euthanasia.

From what you were saying earlier, the Criminal Code outlaws euthanasia, whether by act or omission. I thought Bill S-2 would not amend the Code?

It would not directly change the *Code*. But indirectly it would, as the bill's author has acknowledged (Debate at Second Reading, 2 November 1999). Ultimately, I foresee its effect being to render the *Code* a dead letter in the area of treatment omission.

What is the legal basis for this type of legislation?

I am not a lawyer. But from the remarks made by the author at second reading, the bill is an attempt to codify common law on treatment omission. As such, it may assume (as perhaps the Senate Committee report did as well) that common law has more or less already bypassed *Criminal Code* provisions on homicidal omissions. If so, I submit the assumption is mistaken. The courts have *not* found that omissions of medical treatment are always non-homicidal.

Bill S-2 has extensive provisions for advance directives. Do you have any comments from a moral perspective?

There is a valid role for certain types of advance directives, for example, those where you designate someone else to be proxy decision-maker when you can no longer decide for yourself. However, the greatest danger is that, in the wrong hands, advance directives can be a vehicle for omissive euthanasia. Legally, we should not be rushing into advance directives until we have a better ethical understanding of withholding and withdrawing treatment.

How would you reply to the assertion that Bill S-2 is not controversial, that it is not about euthanasia?

The bill is non-controversial only if you assume that a laissez-faire approach to denying medical treatment to children, the disabled, the elderly etc. is not a matter for debate. It is non-controversial only if you assume there is no such a thing as homicidal omission of treatment. It is not about euthanasia only if it is impossible to kill someone by cutting off life-sustaining medicine, surgery, nutrition and hydration, etc.

Do you expect Senate debate to deal with the issue of whether the bill would engender a laissez-faire situation, that it could lead to abuse and so on?

It is difficult to predict. It appears the issue has not yet been raised. One senator has commented that he thought the bill would allow for *extraordinary* treatment to be omitted (my emphasis). In reply the bill's author quoted the *Catechism of the Catholic Church*, including the statement, "Even if death is imminent, the *ordinary* care owed to a sick person cannot be legitimately interrupted" (emphasis added).

The problem with the foregoing discussion is that it in no way squares with the language of Bill S-2. The bill makes no distinctions whatever between *ordinary* care and treatment that must always be provided, and *extraordinary* treatment that may be omitted.

How would you describe the real issue with Bill S-2?

First of all, the real issue is *not* the removal of extraordinary treatment. If it were, one might say that it is doubtful we need new legislation to facilitate the removal of extraordinary treatment.

The real issue is the omission of *ordinary* treatment. The bill would allow ordinary life-sustaining treatment to be withheld or withdrawn under certain circumstances for any reason. Objectively, *that* constitutes homicide. When the motive is the relief of suffering, it also constitutes euthanasia.

What do you think would be the likely impact if Bill S-2 passes?

I see it opening the door to abuse of children, disabled persons, older people, and other vulnerable members of society. It would engender disregard for human life. It would deprive non-competent patients of the right to life and remove the legal obligation that physicians and others have to preserve the lives of such patients. It would permit physicians to become directly involved in causing human death.

Over the long term the effects could be enormous. It could easily lead to both involuntary euthanasia and commissive euthanasia. The danger of involuntary euthanasia is closer than we may realize, as two recent cases illustrate. In Manitoba doctors tried to place a Do Not Resuscitate order on Andrew Sawatsky, 79, apparently against the will of both patient and family. In Quebec Herman Krausz, 76, died after a doctor ordered his respirator discontinued, again against the wishes of patient and family, apparently. If Bill S-2 passes, we can expect more of these cases, a fallout from severing the legal link between non-treatment and homicide.

You also see it leading to euthanasia cases like Tracy Latimer?

The effect of the bill would be to legalize the omissive killing of sick and disabled people. It would create an enormous ethical and legal foundation for legalizing commissive or active euthanasia.

I predict that, sooner or later, cases of treatment omission would come to light through the media, where it would become obvious that what occurred was the deliberate ending of someone's life. And everyone would realize that this killing was now permitted (whether the law officially recognized it as killing would be immaterial).

From that point the cry to allow killing by lethal means would become more and more compelling: "We already allow people's lives to be ended by non-treatment. Why not let them be ended by other means, at least if the person chooses?" And, after all, other means would arguably be quicker and more painless.

V. THE PATH TO LEGISLATIVE REFORM

> ***"As a parent, what scares me a little is that some doctors are making some decisions they should not be making. That scares me. I am an aging person. I wonder who will give me the treatment I may need tomorrow morning. I am not talking about extraordinary treatment, but ordinary treatment that anyone should have, that any child with a disability should have."***
>
> **Paulette Berthiaume,** Chair, Canadian Association for Community Living, mother of disabled son, Senate Euthanasia Committee, *Proceedings* 23:44

Are you opposed to making any law reform on the withholding and withdrawal of medical treatment?

In principle, no. I am not sure what practical necessity there is for legislation to facilitate decisions to omit extraordinary treatment. However, I recognize that the *Criminal Code* is not as clear in its meaning as it could be. A good legislative proposal could have the benefit of promoting better public understanding of the whole area of treatment vs. non-treatment, which is in fact a complex ethical area.

To facilitate public education and good decision-making, there is also much that can and should be done outside the legislative sphere. For example, it would be desirable for governments and professional bodies to examine their current guidelines on omitting treatment.

If there is legislative reform, should it involve direct amendment of the Criminal Code?

I should think so. As I mentioned, the *Code*'s language can use clarification. And amending the *Code* directly has the great benefit of putting a public spotlight on just what conduct is unlawful, which by implication also indicates what is lawful. The legal situation would be more transparent for the general public than if the *Code* were changed indirectly, as with Bill S-2.

Can you mention some ethical principles that you believe should guide law reform?

First of all, any reform should preserve the *Code's* principle that some omissions of medical treatment are culpably homicidal. Secondly, it should provide language helpfully elucidating two classes of life-sustaining treatment - that which morally and legally certain care givers must provide, and that which they may omit.

What kind of language do you have in mind?

I believe the language of *ordinary vs. extraordinary* treatment, or the parallel language of

proportionate vs. disproportionate, is useful and workable if these terms are properly defined.

Should artificial nutrition and hydration be legally classified as extraordinary treatment?

I prefer the terms "medically assisted" nutrition and hydration. It should not be classified as extraordinary for two reasons. First, while it can sometimes be extraordinary - for example, when a patient is dying and can no longer absorb food and fluids, it becomes useless - many times it is quite ordinary and warranted.

Secondly, it is questionable whether nutrition and hydration should be designated as treatment at all. Food and water are an essential part of our normal bodily *care,* unlike typical treatment like surgery and medicine. When they are medically assisted, they acquire a certain treatment dimension, but I think they are still more appropriately termed care rather than treatment. As care, there should be a presumption to administer a feeding tube unless or until there is evidence it is useless or a serious burden.

Do you have any further suggestions pertinent to future legislative reform?

The Linacre Centre for Health Care Ethics in the Great Britain has a statutory proposal that I think merits consideration. It would certainly help to clarify the meaning of our criminal law. The statute would read:

> ***No person may in or in connection with providing to another person medical, nursing or other treatment, services, or care do or omit anything with the intention of terminating that other person's life. A person who by any such act or omission with such intention causes the other person's death shall be guilty of murder.***
> (L. Gormally, ed., *Euthanasia, Clinical Practice and the Law* [1994], p. 157).

I suggest that the *Criminal Code* be amended to incorporate this type of clarifying language within the sections dealing with duties tending to the preservation of life (215-216), criminal negligence (219-221) and homicide (222-240).