CASE COMMENTS
CHRONIQUES DE JURISPRUDENCE

Medically Assisted Death: *Nancy B.* v. *Hôtel-Dieu de Québec*

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In *Nancy B.* v. *Hôtel-Dieu de Québec*, the Quebec Superior Court held that a patient was legally entitled to discontinue and decline medical treatment when she found it unacceptable. The author discusses how this case is consistent with several other decisions, yet distinguishable from certain Canadian decisions which contributed to its outcome. Through an analysis of *Criminal Code* provisions against homicide and on the duty to preserve life, the doctrine of informed consent, and related jurisprudence, the author argues that the *Nancy B.* decision narrows the gap between allowing a patient to suffer natural death and medically assisting death. The author also raises issues associated with the notion of medical futility. He concludes that the *Nancy B.* case moves the discourse in medical ethics and law towards the feminist "care-based" paradigm and suggests that the carefully-circumscribed judicial response was an appropriate legal answer to the question of how best to care for Nancy B.

Dans *Nancy B.* c. *Hôtel-Dieu de Québec*, la Cour supérieure du Québec a décidé qu'une patiente pouvait légalement refuser des soins si elle les trouvait inacceptables. L'auteur explique que cette décision s'inscrit dans un courant jurisprudentiel déjà amorcé, mais qu'elle se distingue d'autres jugements canadiens dont elle s'inspire. L'auteur examine les dispositions du *Code criminel* relatives à l'homicide et au devoir de préserver la vie, la doctrine du consentement éclairé et la jurisprudence, et en arrive à la conclusion que l'affaire *Nancy B.* réduit l'écart entre le fait de permettre à un patient de mourir naturellement et le fait de l'aider à mourir par des moyens médicaux. Il examine également la notion de futilité médicale. En terminant, l'auteur dit que l'affaire *Nancy B.* constitue un pas vers une approche féministe basée sur l'efficacité des soins et que la solution consciencieuse du juge dans cette affaire représente une réponse juridique appropriée à la situation de Nancy B.

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Synopsis

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Introduction

There is a sense in which *Nancy B.* v. *Hôtel-Dieu de Québec*[1] is an unremarkable decision that is consistent with several others. Justice Dufour of the Quebec Superior Court held that a patient was legally entitled to discontinue and decline the medical treatment she was offered when she found it unacceptable. The fact that national news media proclaimed the judgment "a precedent" is explained less by its inherent significance than by their lack of understanding of what in law constitutes precedent. In another sense the case may mark a significant turning point in Canadian law, however, and form an important building block in a new structure of jurisprudence on medical and hospital care of both non-terminal and terminal patients, particularly in light of the subsequent *Rodriguez* decision of the British Columbia Court of Appeal that the Supreme Court of Canada upheld by a five to four majority in September 1993.[2]

The *Nancy B.* and *Rodriguez* cases are not simply dissimilar but the diametrical reverse of each other. Nancy B. was surviving by means of artificial life support when her case arose, and wanted to be let die naturally. Sue Rodriguez was living naturally at the time of her application, anticipated dying naturally in a condition she feared, and sought artificial intervention in order to die in conditions and at a time of her choice. The cases relate to each other in that both applicants wanted to control the circumstances of their deaths, and to be spared indignity and helplessness. The decisions contribute to an emerging perception of how far Canadian courts will go to accommodate physician-assisted death.

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[1][1992] R.J.Q. 361, 86 D.L.R. (4th) 385 (Sup. Ct.) [hereinafter *Nancy B.* cited to D.L.R. (translation from the original French)].

[2]*Rodriguez* v. *British Columbia (A.G.)* (1993), 76 B.C.L.R. (2d) 145, 79 C.C.C. (3d) 1 (C.A.), aff'd (30 September 1993), Doc. 23476 (S.C.C.) [hereinafter *Rodriguez* cited to C.C.C.].

The January 1992 judgment in *Nancy B.* is like, but also distinguishable from, other Canadian decisions that contributed to its outcome. In *Malette* v. *Shulman*[3] in May 1991, the Ontario Court of Appeal had held that a patient was legally entitled to decline a form of treatment she found unacceptable, even when the predicted outcome of her refusal was death. Mrs. Malette was awarded $20,000 in damages for battery when the defendant doctor took what he believed was a life-preserving initiative. In the *Astaforoff* case,[4] the British Columbia Court of Appeal held that a prison inmate could be allowed to continue a hunger-strike to the point of death. The Court found that, because the hunger-striker was not a free person, force-feeding would be lawful if it were to be imposed, but that it was not mandatory. The prisoner subsequently resumed her hunger-strike, and died. *Nancy B.* differs from both of these cases in that the plaintiff in the former wanted to die, whereas Mrs. Malette, a Jehovah's Witness, did not want to die but was willing to risk death rather than be transfused with blood, and Mrs. Astaforoff was also willing to risk death but did not necessarily wish to die. Nevertheless, in each of these cases the Courts rejected a life-at-any-cost approach, and recognized individuals' legal rights to set limits to life-preserving interventions, even though they were not necessarily terminally ill.

I. The Facts

Nancy B. was a woman, aged 25, who by late 1991 had suffered for two and a half years from Guillain-Barré syndrome, a disabling neurological disorder. At onset of the condition the prognosis is not unfavourable, and patients are usually put on mechanical respiratory support pending improvement. Unfortunately, Nancy B. did not improve, and in January 1991 she was informed that her condition was irreversible. Her respiratory muscles had atrophied, and degeneration of the motor nerves left her tied to her hospital bed, entirely dependent for survival on mechanical ventilation by intubation. Medical treatment had prolonged her life well beyond her capacity for natural survival.

In the months following her January 1991 diagnosis, Nancy B. determined that she was unwilling to survive in her intubated, dependent existence. She initiated two hunger strikes to make this point, but ended them voluntarily. It was not illness caused by the Guillain-Barré syndrome that caused her suffering, but her immobile confinement in a bed she could never leave. As the judge observed, "[w]hat Nancy B. is seeking ... is that the respiratory support treatment being given her cease so that nature may take its course; that she be freed from slavery to a machine as her life depends upon it. In order to do this, as she is unable to do it herself, she needs the help of a third person."[5] She was not diagnosable as clinically depressed, but was distressed that life could afford her nothing more than limited head movement, and utter dependency for comfort on others and a machine.

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[3](1990), 72 O.R. (2d) 417, 67 D.L.R. (4th) 321 (C.A.) [hereinafter *Malette* cited to O.R.].

[4]*British Columbia (A.G.)* v. *Astaforoff* (1983), [1984] 6 W.W.R. 385, 6 C.C.C. (3d) 498 (B.C.C.A.) [hereinafter *Astaforoff*].

[5]*Nancy B.*, *supra* note 1 at 392.

Nancy B.'s intellectual faculties were intact, and she was lucid and logical in expression of her wish to be disconnected from the mechanical respirator. She knew that the consequence would be that she would die in a very short time since, being unable to breathe without artificial support, she would suffocate. Evidence from a range of medical, psychiatric, nursing and social work professionals confirmed her mental health and consistent wish that her respirator be disconnected. Her mother said that her family had come to accept her wish, and the Quebec Superior Court judge who himself attended her in hospital found that Nancy B.'s preference that artificial respiration be discontinued was "real and enlightened."[6]

Since anticipated death would be by suffocation, the issue was raised of whether Nancy B.'s attending physician, Dr. Danièle Marceau, would have a role preparing her for the consequence of withdrawal of artificial ventilation.[7] The options included inducing deep sleep so that the patient would be spared the experience and distress of suffocation, but would die in her induced sleep.

II. The Law and the Judgmeut

Nancy B. invoked her right to decline medical treatment. Article 19 *Civil Code of Lower Canada* ("*C.C.L.C.*") provides that:

> The human person is inviolable.
>
> No one may cause harm to the person of another without his consent or without being authorized by law to do so.

On June 22, 1989, curiously coinciding with the time Nancy B. suffered onset of her illness, article 19.1 *C.C.L.C.* was added, which provides:

> No person may be made to undergo care of any nature, whether for examination, specimen taking, removal of tissue, treatment or any other act, except with his consent.
>
> Where the person concerned is unable to consent to or refuse care, a person authorized by law or by mandate shall replace him.[8]

The *Code of Ethics of Physicians*[9] provides in section 2.03.28 that:

> Except in emergency, a physician must, before undertaking an investigation, treatment or research, obtain informed consent from the patient or his representative or any persons whose consent may be required by the law.

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[6]*Ibid.* at 388.

[7]Medically, a contrast may be drawn that a physician "ventilates" a patient artificially, and the patient undertakes "respiration" artificially. Here, reference will be made interchangeably to artificial or mechanical respiration and to artificial or mechanical ventilation.

[8]See also the new *Civil Code of Québec*, S.Q. 1991, c. 64 (coming into force 1 January 1994), articles 10 and 11 of which read:

> **10.** Every person is inviolable and is entitled to the integrity of his person.
>
> Except in cases provided for by law, no one may interfere with his person without his free and enlightened consent.
>
> **11.** No person may be made to undergo care of any nature, whether for examination, specimen taking, removal of tissue, treatment or any other act, except with his consent.
>
> If the person concerned is incapable of giving or refusing his consent to care, a person authorized by law or by mandate given in anticipation of his incapacity may do so in his place.

[9]R.R.Q. 1981, c. M-9, r. 4.

Dufour J. noted the evolution of Canadian law regarding the doctrine of informed consent in *Hopp* v. *Lepp*[10] and *Reibl* v. *Hughes*,[11] and found that: "The logical corollary of this doctrine of informed consent is that the patient generally has the right not to consent, that is the right to refuse treatment and to ask that it cease where it has already been begun."[12] The question therefore had to be addressed of whether this right recognized in the civil law of Quebec is absolute, or is limited by the federal criminal law.

The *Criminal Code*[13] opens with the general principle expressed in section 14 that:

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

Under the heading of Duties Tending to Preservation of Life in Part VIII of the *Criminal Code*, section 215 provides that:

> (1) Every one is under a legal duty ...
> (*c*) to provide necessaries of life to a person under his charge if that person
> (i) is unable, by reason of ... illness ... to withdraw himself from that charge, and
> (ii) is unable to provide himself with necessaries of life.
>
> (2) Every one commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse, the proof of which lies on him, to perform that duty, if ...
> (*b*) with respect to a duty imposed by paragraph 1(*c*), the failure to perform the duty endangers the life of the person to whom the duty is owed ...

Section 216 provides that:

> Every one who undertakes to administer surgical or medical treatment to another person or to do any other lawful act that may endanger the life of another person is, except in cases of necessity, under a legal duty to have and to use reasonable knowledge, skill and care in so doing.

The Court emphasized the dependency on section 216 of section 217,[14] the latter providing that: "Every one who undertakes to do an act is under a legal duty to do it if an omission to do the act is or may be dangerous to life." Section 219 defines criminal negligence, in the terms that:

> (1) Every one is criminally negligent who
> (*a*) in doing anything, or
> (*b*) in omitting to do anything that it is his duty to do,
> shows wanton or reckless disregard for the lives or safety of other persons.
>
> (2) For the purposes of this section, "duty" means a duty imposed by law.

Section 220 makes criminal negligence that causes death to another person punishable on indictment with up to life imprisonment. Attempted suicide was decriminalized in 1972,[15] but section 241 provides that:

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[10][1980] 2 S.C.R. 192, 112 D.L.R. (3d) 67.
[11][1980] 1 S.C.R. 880, 114 D.L.R. (3d) 1.
[12]*Nancy B.*, *supra* note 1 at 390.
[13]R.S.C. 1985, c. C-46.
[14]*Nancy B.*, *supra* note 1 at 393.
[15]S.C. 1970-71-72, c. 13, s. 16.

> Every one who
> (*a*) counsels a person to commit suicide, or
> (*b*) aids or abets a person to commit suicide, whether suicide ensues or not,
> is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

The act of killing another constitutes homicide, in particular murder or manslaughter, under section 222, which provides that:

> (1) A person commits homicide when, directly or indirectly, by any means, he causes the death of a human being.
> (2) Homicide is culpable or not culpable.
> (3) Homicide that is not culpable is not an offence.
> (4) Culpable homicide is murder or manslaughter or infanticide.
> (5) A person commits culpable homicide when he causes the death of a human being,
> (*a*) by means of an unlawful act,
> (*b*) by criminal negligence ...

In light of such *Criminal Code* provisions,[16] Dufour J. posed himself the questions: "Can the conduct of a physician who stops the respiratory support treatment of his patient at the freely given and informed request of the patient, and so that nature may take its course, be characterized as unreasonable? Or does such conduct denote wanton and reckless disregard?"[17] Dufour J. answered both questions, "I do not believe so."[18]

The resulting judgment was that, on expiration of the time for appeal from the judgment, the Court:

> PERMITS Dr. Danièle Marceau, the plaintiff's attending physician, to STOP the respiratory support treatment being given to the latter, when she so desires; her consent must however be checked once again before any act in this regard is done;
>
> PERMITS Dr. Danièle Marceau to request from the defendant hospital, the Hôtel-Dieu de Québec, the necessary assistance in circumstances such as these, so that everything can take place in a manner respecting the dignity of the plaintiff.[19]

III. Reasoning of the Court

Dufour J. found that the circumstances of Nancy B.'s proposed death would constitute neither homicide nor suicide, but rather natural death. She had survived by virtue only of artificial respiration and, while this might prolong her survival for years, it would not improve her medical condition nor her health, which in the Constitution of the World Health Organization, to which Canada subscribes, is analysed as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Without artificial life-support, she would succumb to her natural fate, not to suicide nor to medically-

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[16]See also section 45, protecting from criminal liability every one performing a surgical operation on any person for that person's benefit if in the circumstances it is reasonable to perform the operation, and it is performed with reasonable care and skill.

[17]*Nancy B., supra* note 1 at 394.

[18]*Ibid.*

[19]*Ibid.* at 395.

induced death. Dufour J. cited the extremely influential New Jersey Supreme Court case of *Re Conroy* to the effect that:

> declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury.[20]

This statement of principle is significant because in the case of Nancy B., death was anticipated to occur not "eventually" but within minutes, so that there would be an appearance of immediate cause and effect between her requested removal from artificial respiration and her death. Nevertheless, death would result from the patient's inability to breathe spontaneously.

Similarly, Dufour J. found that *Criminal Code* provisions against homicide and on the duty to preserve life would not be offended by termination of artificial respiration leading to death. He observed that: "Sections 222 to 241 of the *Criminal Code* deal with different forms of homicide ... [T]he person who will have to stop Nancy B.'s respiratory support treatment in order to allow nature to take its course, will not in any manner commit the crimes prohibited by these sections. The same goes for s. 241, aiding suicide."[21]

In finding that the patient's withholding of consent limited duties to her under the *Criminal Code* and did not constitute her consent to the infliction of death,[22] the judge approved and adopted the reasoning proposed by counsel representing the Attorney-General of Quebec. He had submitted that this broad interpretation of the *Criminal Code* reflected coherence and logic between sections 222 to 241 and the *Civil Code of Lower Canada* provisions on individual autonomy and individuals' rights to decline and discontinue unwanted medical treatment. Accordingly, the judge found no conflict between the power of patients to control their medical care and physicians' and others' duties under the *Criminal Code* to sustain human life. The objective and impersonal thrust of the *Criminal Code* is refined and fine-tuned by provincial law on individuals' consent.

The abstract and necessarily prospective application of the *Criminal Code* is brought to the individual and immediate level of human application by the courts when they are presented with the facts of actual cases. Dufour J. cited Gonthier J. in the Supreme Court of Canada in *R.* v. *Jobidon*[23] observing that Parliament cannot be taken to intend absurd results such as conflicts or competition between laws and contradictions to follow from legislation. Parliament must be taken to intend the courts to explain the contents of legislation cohesively and coherently in the light of subsequent litigation, by bringing the law down from the high plane of general principle expressed in legislation to meanings applicable to the proven facts of specific real instances. Gonthier J. was approved by Dufour J. in finding that:

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[20]*Ibid.* at 392. Dufour J. refers to *Re Conroy*, 486 A.2d 1209 at 1224 (N.J.S.C. 1985).

[21]*Nancy B., ibid.* at 394.

[22]See *Criminal Code*, s. 14 at text accompanying note 13.

[23][1991] 2 S.C.R. 714 at 744, 66 C.C.C. (3d) 454 [hereinafter *Jobidon* cited to S.C.R.].

> Policy-based limits are almost always the product of a balancing of individual autonomy (the freedom to choose to have force intentionally applied to oneself) and some larger societal interest. That balancing may be better performed in the light of actual situations, rather than in the abstract, as Parliament would be compelled to do.[24]

The *Rodriguez* case required the Supreme Court again to undertake this task.

IV. Analysis of the Judgment

In *Malette*,[25] the Ontario Court of Appeal upheld an award of damages for battery notwithstanding the observation of the trial judge that the imposed blood transfusion that the patient was legally entitled to decline may have saved her life.[26] Both trial and appeal courts accepted that the defendant physician would have incurred no legal liability had the patient's refusal of transfusion been respected and resulted in her death.[27] Similarly, Mrs. Mary Astaforoff[28] did die when she was not force-fed following her resumption of a hunger-strike when she was reimprisoned, and no question arose of her guardians' legal liability. The reasoning of Dufour J. in *Nancy B.* fits comfortably into this setting, which, in light of extensive compatible United States case-law going back to the case of Karen Quinlan[29] and subsequent judgments in England[30] and, for instance, New Zealand,[31] may now be described as the consensus reached[32] in Common law countries. Quebec's Civil law tradition was interpreted consistently with the Common law through the significance Dufour J. gave to Supreme Court of Canada decisions on appeal from Alberta and Ontario respectively.[33]

Since the death of Nancy B. was found to be neither suicide nor homicide, the case does not contribute directly to the increasingly sympathetic literature and understanding on physician-assisted suicide and compassionate homicide, better known as mercy-killing or euthanasia. The former has been opposed[34] and retains negative connotations associated with the controversy surrounding Dr. Jack Kevorkian's "suicide machine,"[35] but in contrast is the wide legal, medical and ethical acceptance of the conduct Dr. Timothy Quill disclosed in his cele-

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[24]*Nancy B.*, *supra* note 1 at 393. Dufour J. refers to *Jobidon*, *ibid.* at 744.

[25]*Malette*, *supra* note 3.

[26]*Malette* v. *Shulman* (1987), 63 O.R. (2d) 243 at 274, 47 D.L.R. (4th) 18 (H.C.) [hereinafter *Malette*].

[27]*Malette*, *supra* note 3 at 434.

[28]*Astaforoff*, *supra* note 4.

[29]See *In the Matter of Karen Quinlan*, 355 A.2d 647 (N.J.S.C. 1976). See also *Re Conroy*, *supra* note 20.

[30]*Airedale National Health Service Trust* v. *Bland*, [1993] 1 All E.R. 821 at 858 (H.L.).

[31]*Auckland Area Health Board* v. *A.-G.*, [1993] 1 N.Z.L.R. 235 (H.C.) [hereinafter *Auckland Area Health Board*].

[32]See A. Meisel, "The Legal Consensus About Forgoing Life-Sustaining Treatments: Its Status and Prospects" (1992) 2 Kennedy Institute of Ethics J. 309.

[33]See *Hopp* v. *Lepp*, *supra* note 10; *Reibl* v. *Hughes*, *supra* note 11.

[34]See P.A. Singer & M. Siegler, "Euthanasia — A Critique" (1990) 322 New England J. Medicine 1881.

[35]See J. Persels, "Forcing the Issue of Physician-Assisted Suicide: Impact of the Kevorkian Case on the Euthanasia Debate" (1993) 14 J. Legal Medicine 93.

brated description[36] of how he assisted a patient to end her life.[37] Sue Rodriguez similarly persuaded Chief Justice McEachern of British Columbia that assistance in committing suicide could be rendered lawfully in Canada, under the conditions he identified in his dissenting judgment in the British Columbia Court of Appeal.[38] Authorizing physicians to take steps to end the lives of competent patients who request such steps has less support,[39] but approved and lawful methods of palliative care may shorten life as a known secondary effect,[40] and discussion of medically-induced death as accepted in The Netherlands[41] is now leading to non-judgmental questioning[42] and issues of process in North America.[43] The significance of the *Nancy B.* decision to this discussion is that it narrows the gap between letting a patient suffer natural death and assisting suicide. It fits within a category of lawful, medically assisted natural death, in that it authorizes a physician to prepare a patient for death that continuation of medical treatment could postpone for years and perhaps decades. Nancy B. could not have survived without artificial respiration, but she was not dying nor in a terminal stage while receiving such support. Once it was withdrawn, however, she would die of suffocation in a few minutes of acute distress. To avoid sensational publicity, neither Nancy B. nor her hospital or physician discussed circumstances of her death or management of those circumstances. In his judgment, Dufour J. simply permitted the named attending physician to stop respiratory support treatment and to request the hospital to provide "the necessary assistance in circumstances such as these."[44] The informed speculation is that the physician would induce deep sleep or coma in the patient and then remove the ventilation tube that achieved respiration, so that the patient would die naturally in her sleep, without distress. The humanity of permitting peaceful death is obvious.

Nancy B. was held to have a right to die, in that neither a physician nor a hospital could treat her without her consent, but she was not necessarily held to have a right to peaceful death. She could refuse all treatment by legal refusal to be a patient, but the judge did not necessarily hold that she had a right as a patient to be eased into death in a particular way. Legally binding rules of good medical, nursing and associated practice might impose the duties that would constitute patients' rights to humane treatment and dignified, minimally painful deaths. There is medical resistance, however, to patients' rights to die and particularly to assisted suicide, for fear, perhaps, that legal recognition of such a

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[36]T.E. Quill, "Death and Dignity — A Case of Individualized Decision Making" (1991) 324 New England J. Medicine 691.

[37]See P.A. Ubel, "Assisted Suicide and the Case of Dr. Quill and Diane" (1993) 8 Issues in L. & Medicine 487.

[38]*Rodriguez, supra* note 2 at 24-25, and Lamer C.J.C. in the Supreme Court of Canada.

[39]See W. Gaylin *et al.*, "Doctors Must Not Kill" (1988) 259 J. American Medical Association 2139.

[40]D.G. Casswell, "Rejecting Criminal Liability for Life-Shortening Palliative Care" (1990) 6 J. Contemp. Health L. & Pol'y 127.

[41]M. Battin, "Voluntary Euthanasia and the Risks of Abuse: Can We Learn Anything from the Netherlands?" (1992) 20 L., Medicine & Health Care 133.

[42]F.G. Miller, "Is Active Killing of Patients Always Wrong?" (1991) 2 J. Clinical Ethics 130.

[43]G.I. Benrubi, "Euthanasia — The Need for Procedural Safeguards" (1992) 326 New England J. Medicine 197.

[44]*Nancy B., supra* note 1 at 395.

right would result in reciprocal legal duties on physicians to end patients' lives or collaborate in suicide in accordance with patients' wishes or directions.

Dufour J. held back from finding that Nancy B. had a legal right to face natural death in specified comfort. She sued for an injunction to require withdrawal of treatment, but the judge did not grant an injunction. He gave a judgment that simply "permits" the physician to stop respiration, and to "request" the hospital's assistance. Accordingly, the physician's initiative and the hospital's collaboration would be lawful, but not in themselves mandatory by virtue of the judgment. In light of *Malette*, however, one may speculate that Nancy B. was entitled to a mandatory injunction or comparable order that intubation be withdrawn in a particular way designed to maximize her comfort and protect her dignity, of which comfort may be a major component. This might not go beyond the significant finding in *Nancy B.* of physicians' powers to assist patients' natural deaths, not as secondary effects of palliative care[45] but as deliberate life-terminating alternatives to palliative care chosen by patients and implemented through physicians' collaboration.

The reasoning of Dufour J. that Nancy B.'s death would be natural and not amount to suicide or homicide has been commented to be "patently artificial,"[46] not as criticism of the judge but in recognition of the problem he faced due to the over-inclusive language of the *Criminal Code*. The commentators propose that

> it is difficult to see how the disconnection of the respirator does not fall within the case law definition of "cause" or even of "unlawful act." An example clarifies both the artificiality and the danger of claiming that disconnection of the respirator would not cause death. Imagine a patient similar in every respect to Nancy B. except that she wishes to live, but her physician disconnects her respirator. Surely no one would deny that the patient's death was caused by the disconnection of the respirator.[47]

The *Criminal Code* does indeed warrant reconsideration in this area, and proposals on recodification of the criminal law include a narrowing of the scope of life-shortening medical treatment that would attract punishment.[48] Nevertheless, the example alleged to clarify artificiality and danger offered above by critics of the judgment is not persuasive. The conclusion that, if Nancy B.'s physician would not be criminally liable for causing her death by disconnecting the respirator with her consent, as Dufour J. held, then a person disconnecting the respirator without her consent would also not be legally liable, is incorrect.

The consensus in Common law countries that terminating artificial life-support with appropriate consent is lawful, raising no liability for causing death,

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[45]See Casswell, *supra* note 40.

[46]A. Fish & P.A. Singer, "Nancy B.: The Criminal Code and Decisions to Forgo Life-Sustaining Treatment" (1992) 147 Can. Medical Association J. 637 at 639.

[47]*Ibid.*

[48]See Law Reform Commission of Canada, *Recodifying Criminal Law* (Report 31, revised and enlarged edition of Report 30) (Ottawa: Law Reform Commission of Canada, 1987); Casswell, *supra* note 40 at 128.

with which the *Nancy B.* judgment is consistent, has been noted above.[49] Writing of the United States, Alan Meisel has observed that:

> Since the *Quinlan* case ushered in this era of right-to-die litigation, close to 75 similar cases — the precise number depends on what one considers a "right-to-die case" to be — have been decided in the state appellate courts or the federal district courts in 21 states and the District of Columbia. From these cases, from an even larger body of unreported trial court cases,[50] and from legislation enacted in almost every state, a consensus has gradually emerged in law, medicine, and public opinion that termination of life support is legitimate under certain circumstances.[51]

This wide consensus of cases, reinforced by decisions of superior courts elsewhere, finds nothing strained in concluding that physicians who withdraw artificial or mechanical life-supports with legal consent do not face legal liability for causing patients' deaths. Many of these U.S. cases involved prospective withdrawal of artificial feeding, but Dufour J. found that placing a person on a respirator "is a technique of the same nature as that of feeding a patient. One cannot therefore make distinctions between artificial feeding and other essential life-sustaining techniques."[52]

Scientific or mechanical tests of causation do not necessarily coincide with legal tests.[53] Although if death is inflicted on a person that person's consent is not exculpatory,[54] absence of consent may make a person criminally liable for causing death when consent would exclude legal causation. In law, defendants may be held liable for causing what they have failed to prevent, when they have a duty of prevention. For instance, physicians have been held liable for causing pregnancy in patients whose sterilizations they have undertaken negligently.[55]

There is no duty to prevent the death of a patient such as Nancy B. who wishes to die, and disconnection of a respirator for that purpose is not a legal cause of death. When a patient wants the respirator to remain connected, however, there may be a duty to maintain it. Disconnecting the machine without the patient's consent violates that duty, and constitutes criminal negligence. The duty to provide care may be found under sections 215, 216, 217 and, for instance, section 219 of the *Criminal Code*, setting the scene for liability at least for manslaughter, or under section 220 for criminal negligence causing death. Accordingly, a physician who disconnects a respirator with the consent of a patient such as Nancy B. does not in law cause the death that follows, but a person who disconnects a respirator without consent is convictable for causing death. Death is caused not by disconnection of the respirator *per se*, but by

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[49]See Meisel, *supra* note 32.

[50]It has been estimated in the U.S. that between 2,900 and 7,000 trial court cases on forgoing medical treatment were heard between 1975 and 1989; T.L. Hafemeister, I. Keilitz & S.M. Banks, "The Judicial Role in Life-Sustaining Medical Treatment Decisions" (1991) 7 Issues in L. & Medicine 53.

[51]*Supra* note 32 at 309-10.

[52]*Nancy B.*, *supra* note 1 at 391.

[53]D. Danner & E.L. Sagall, "Medicolegal Causation: A Source of Professional Misunderstanding" (1977) 3 Amer. J. L. & Medicine 303.

[54]*Criminal Code*, s. 14, at text accompanying note 13.

[55]See *e.g. Cataford* v. *Moreau* (1978), 7 C.C.L.T. 214, 114 D.L.R. (3d) 585 (Que. Sup. Ct.). See also *Dendaas (Tylor)* v. *Yackel*, [1980] 5 W.W.R. 272, 109 D.L.R. (3d) 455 (B.C.S.C.).

breach of the duty to maintain connection until the patient consents to disconnection.

The principles of legal causation that show potential legal liability of a person who disconnects a patient's respirator without consent answer the charge that the judge's reasoning in *Nancy B.* is dangerous. The principles may appear patently artificial from a purely scientific or mechanical perspective of relating cause to effect, but they are well established in law. The criminal courts recognize, for instance, that there can be more than a single cause of death.[56] Comparable principles are applied outside the law. The medical equivalent exists in how physicians determine causes of death for purposes of death certification.

Although Nancy B. was claiming to exercise powers of the most profound significance, she did not invoke the *Canadian Charter of Rights and Freedoms*.[57] Public hospitals are not usually liable under the *Charter* since they are not a branch of government,[58] so the defendant hospital could not itself have been in violation, but Nancy B. might have claimed that any restrictions on her pursuit of her goal presented by the *Criminal Code* violated her *Charter* rights. She may have been reluctant to take joint proceedings against the federal or provincial government, such as for a declaration that any *Criminal Code* restrictions on her right to natural death are inoperative, because this would have widened her action, increased her costs and made an appeal against her success at trial more likely. In the event, the judge, of his own motion, made the Attorney-General of Quebec a party. Counsel for the provincial Attorney-General presented submissions of law that happened to be sympathetic to Nancy B.'s claim, and were influential in her success. His submissions were that *Criminal Code* provisions did not restrict Nancy B. since the *Code* was to be read compatibly with her freedom under the *C.C.L.C.* to reject medical treatment she no longer wanted in order to succumb to natural death. By this reading, the *Criminal Code* did not violate her freedom of action, and the Attorney-General was not called on to take a position on the status of *Criminal Code* provisions on the preservation of life under the *Charter*. The submission by Nancy B. and the Attorney-General that her purpose was not in violation of the *Criminal Code*, since it involved neither suicide nor homicide, made it unnecessary to assess whether the *Criminal Code* was in violation of the *Charter*. This claim is relevant, in contrast, to the claim of Sue Rodriguez that she was entitled to assisted suicide.

V. Wider Aspects of the Case

When Nancy B. sued the Hôtel-Dieu de Québec for a permanent injunction restraining any administration of artificial respiration after she requested its removal, the hospital entered an appearance but did not file a defence. After obtaining a certificate attesting that the defendant had failed to plead to the action, the plaintiff proceeded *ex parte*. She could not simply obtain judgment

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[56]See *R.* v. *Kitching and Adams* (1976), 32 C.C.C. (2d) 159 at 175, [1976] 6 W.W.R. 697 (Man. C.A.).

[57]Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [hereinafter *Charter*].

[58]*Stoffman* v. *Vancouver General Hospital*, [1990] 3 S.C.R. 483, 76 D.L.R. (4th) 700.

in default of defence because she sought an equitable remedy that was therefore discretionary and required her to prove her conscientious conduct and entitlement. At the hearing, the defendant and other parties, namely her attending physician and the provincial Attorney-General, were represented. The Attorney-General intervened to present submissions of law that supported the legal basis of the plaintiff's claim. Although the defendant hospital, the attending physician and the Attorney-General had interests in the criminal law being upheld and Nancy B.'s rights under provincial law being defined and respected, none actually opposed Nancy B.'s legal argument, or subjected it to vigorous scrutiny. Thus, the occasion was not taken, nor compelled, to test whether the treatment Nancy B. had received and might continue to receive was either necessary to preserve life, or medically futile.

Inadequate disclosure of information for consent to treatment entitles a patient to sue for negligence,[59] but treatment that lacks or exceeds consent permits a civil suit for battery[60] and criminal prosecution for assault or aggravated assault.[61] However, the legal excuse of necessity, particularly in its historic form of necessity to save human life, is available as a defence to resist charges of violation of criminal law[62] and of civil liability.[63] Necessity was not pleaded to the complaint of battery in *Malette*, but in 1975 was recognized as an available defence to criminal abortion.[64] At that time, this was an offence punishable with up to life imprisonment,[65] so presumably the defence is available to a lesser charge of criminal assault, which in its most aggravated form is punishable with imprisonment for a term not exceeding fourteen years.[66] In criminal law, demanding tests have been set before necessity can be accepted as a legal excuse for unlawful conduct, including "moral involuntariness" of the wrongful action and lack of a reasonable legal alternative.[67]

Courts in such cases as *Astaforoff*, *Malette* and *Nancy B.* itself have rejected a vitalist or "life-at-any-cost" philosophy, and have accepted the legal option of mentally competent free individuals to risk preventable death rather than be compelled to live under conditions they find objectionable. It may therefore be doubted that courts would accept an excuse that it was necessary to save the life of a competent person who priorized other values above survival and refused consent to life-sustaining treatments. Necessity requires an objective or socially-supported ordering of priorities.[68] Legislative decriminalization of attempted suicide[69] suggests that society does not place a higher value on individuals' survival than do competent individuals themselves, although the con-

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[59]*Reibl* v. *Hughes*, *supra* note 11.
[60]*Malette*, *supra* note 3.
[61]*Criminal Code*, *supra* note 13, ss. 265-68.
[62]*Perka* v. *R.*, [1984] 2 S.C.R. 233, 13 D.L.R. (4th) 1 [hereinafter *Perka* cited to S.C.R.].
[63]See *e.g.* A.M. Linden, *Canadian Tort Law*, 4th ed. (Toronto: Butterworths, 1988) at 75.
[64]*Morgentaler* v. *R.* (1975), [1976] 1 S.C.R. 616, 53 D.L.R. (3d) 161.
[65]See *Criminal Code*, *supra* note 13, s. 287(1) (in 1975, s. 251(1)).
[66]*Ibid.*, s. 268(2).
[67]*Perka*, *supra* note 62 at 259, Dickson J. (as he then was).
[68]*Ibid.* at 260.
[69]See *supra* note 15.

cept of "rational suicide" has been accepted only in more recent times,[70] and not necessarily universally. The defence of necessity may not be successful to resist applications such as Nancy B. made in order to be allowed not suicide, but natural death.

An argument that Nancy B. might have made, which the defendant hospital, her physician and the provincial Attorney-General showed no disposition to deny, was that her continued treatment by artificial respiration was medically futile, and therefore legally refusable. The concept of medical futility is legally and ethically unshaped,[71] and most often raised regarding mentally incompetent patients, particularly those in a persistent vegetative state. Their physicians, hospitals or families seek legally secure grounds to discontinue treating them by artificial or mechanical means, including withdrawal of artificial nutrition and hydration, usually resulting in death from dehydration. The bioethically pioneering Hastings Center provided Guidelines in 1987 that defined "physiologic futility" as applying to treatment that is "clearly futile in achieving its physiological objective and so offering no physiologic benefit to the patient."[72] Nancy B.'s artificial respiration would probably not satisfy this test of futility, since its objective was to keep the patient alive and it achieved this objective. Nancy B. considered this achievement non-beneficial on psychological and emotional grounds rather than on physiological grounds.[73]

Although of relatively recent origin and still poorly defined, the claim of medical futility is attracting skepticism when invoked by physicians to limit treatment of patients, who tend to be the more severely disabled patients whose care requires use of expensive resources or skills. It has been observed that:

> The term "futility" allows the [medical] profession to medicalize a difficult personal, familial, and social decision. Once a decision is framed by the term "futility," it provides a justification for physicians to either 1) override the wishes of the patient, family, or other surrogates, or 2) make a non-treatment decision without even obtaining informed consent by not discussing the unilateral decision with the patient, family or surrogate at all.[74]

Treatment may be considered futile when it will not achieve its objective of improving the quality or duration of a patient's life, when it will probably be actually harmful to a patient, or when it employs scarce health care resources that could serve apparently more needy patients or other patients more effectively.[75] It has been observed in the United States that "[t]he current debate about medical futility is one of the most important and contentious in medical ethics,"[76] and the same will probably become so, if it is not already so, in Can-

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[70]See C.K. Smith, "What about Legalized Assisted Suicide?" (1993) 8 Issues in L. & Medicine 503.

[71]R. Cranford & L. Gostin, "Futility: A Concept in Search of a Definition" (1992) 20 L. Medicine & Health Care 307.

[72]Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* (Bloomington: Indiana University Press, 1987) at 32.

[73]See text accompanying note 5.

[74]Cranford & Gostin, *supra* note 71 at 308.

[75]*Ibid.*

[76]S.H. Miles, "Medical Futility" (1992) 20 L., Medicine & Health Care 310.

ada, particularly under the impact of pressure on health care resources and of institutional downsizing. It is of legal interest rather than significance that in the most widely discussed modern legal case concerning care physicians proposed to withhold as medically futile,[77] a trial court in Minneapolis found the appropriate legal guardian of an 86-year-old patient in a persistent vegetative state to be her husband who wanted her to receive mechanical life-support that her physicians considered not to be in her best interest.[78]

Whether physicians have a legal duty to provide care they consider futile, nonbeneficial or medically inappropriate, and whether patients or their families can legally compel such care, competent patients can make legally binding decisions that actual or proposed care is futile for them, and refuse it. It has been seen that the decision in *Nancy B.* is consistent with the general finding that competent patients have the right to refuse medical treatment of any kind, even if the abatement of treatment will result in their death.[79] Courts' acceptance of patients' assessments that identified care is futile for them could reinforce the concept that "futility" is relevant to patients' views of their circumstances as well as to physicians' or hospitals' ideas of appropriate uses of resources.

A New Zealand case in August 1992 involved an application by physicians of a patient who also had an extreme case of Guillain-Barré syndrome, but whose brain was apparently irreversibly disengaged from his body, placing him in suspended animation or the so-called "locked-in syndrome," for a declaration clarifying whether they would be guilty of homicide were they to withdraw the artificial respiration that kept him alive.[80] Following a thorough review of the law in New Zealand, England, the United States and Canada, including specific reference to *Nancy B.*, the court granted a declaration that, if his physicians concluded that there was no reasonable possibility of the patient's recovery from his clinical condition and no therapeutic or medical benefit from continued maintenance of artificial respiration, and his wife consented on his behalf, deliberate withdrawal of artificial ventilation would not constitute culpable homicide.

The judgment includes a relevant discussion, not undertaken in *Nancy B.* or the British Columbia Court of Appeal in the *Rodriguez* case, of the appropriateness of courts entertaining civil claims, for declarations, injunctions or the like, involving rulings on the meaning, scope and application of criminal law. Where Attorneys-General are involved on behalf of the Crown, this raises issues of possible *res judicata*, perhaps more complex in Canada because of the prosecutorial capacities of provincial and federal Attorneys-General,[81] and in any

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[77]See R.E. Cranford, "Helga Wanglie's Ventilator" (1991) 21:4 *Hastings Center Report* 23. The case arose when the hospital went to court to have a third party appointed guardian of the patient rather than her husband; *Conservatorship of Wanglie*, No. PX-91-283 (Minn., Hennepin Co. Dist. Ct., 1 July 1991).

[78]See the discussion in D.H. Johnson, "Helga Wanglie Revisited: Medical Futility and the Limits of Autonomy" (1993) 2 Cambridge Q. of Healthcare Ethics 161.

[79]See R.F. Weir, *Abating Treatment with Critically Ill Patients: Ethical and Legal Limits to the Medical Prolongation of Life* (Oxford: Oxford University Press, 1989).

[80]*Auckland Area Health Board, supra* note 31.

[81]See P.C. Stenning, *Appearing for the Crown* (Cowansville, Que.: Brown Legal Pubs., 1986) at 165.

event may affect prosecutorial discretion, even though rulings of law by civil courts do not contribute to criminal law precedents or criminal *stare decisis*. It has been noted that "[t]he criminal court would not be bound by the decision [of the civil court]. In practical terms it would simply have the inevitable effect of prejudicing the criminal trial one way or another."[82] Adverse effects on the integrity of a subsequent criminal trial, and on the exercise of prosecutorial discretion by authorities charged with the just and non-discriminatory enforcement of the criminal law, are matters that weigh in the balance against civil courts accepting jurisdiction to rule on the consequences in criminal law of possible future events. The reluctance of courts of law to issue prospective rulings even within their conventional jurisdiction is based on sound experience.

Issues of the integrity of legal process, of uncertainty and certainty of future events, and of the obligations of justice to those who act conscientiously can also weigh, however, on the other side of the balance. If fear of criminal liability were to cause physicians to maintain invasive treatments over patients' objections, they would be in peril of subsequent civil liability for battery and criminal liability for assault, and their patients would be in peril both of denial of their lawful preferences and of unlawful invasions of their bodies, integrity and dignity. In cases such as *Nancy B.* where the facts are agreed among all parties,[83] and where the facts are scientifically or medically settled or future variations can be accommodated in the conditional terms of judicial orders or judgments, as in the New Zealand case,[84] the balance of justice and convenience may occasionally favour civil courts ruling on the status of prospective conduct under criminal law. When individuals such as doctors are charged with the exercise of difficult choices that affect important interests of others, and vulnerable people seek to vindicate important rights without penalization of conscientious caregivers, it is appropriate that civil courts should come to their aid, and offer if only imperfect protection. As Thomas J. stated in *Auckland Area Health Board*, "[t]he doctors are surely entitled to exchange the threat of the sword of Damocles for the protection of the sword forever proffered in the outstretched hand of justice."[85]

The New Zealand case is distinguishable from the overwhelming majority in this area of litigation in that, exceptionally, it involved a man.[86] Cases from *Karen Quinlan* in 1976 through to *Nancy B.*, including the Canadian cases of *Malette* and *Astaforoff*, and now *Rodriguez*, and a plethora of U.S. cases including *Cruzan*,[87] *Dinnerstein*,[88] *Bouvia*,[89] *O'Connor*,[90] *Colyer*[91] and

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[82]Per Lord Lane in *Imperial Tobacco Ltd.* v. *Attorney-General*, [1980] 1 All E.R. 866 at 884 (H.L.).

[83]*Supra* note 1 at 387.

[84]*Auckland Area Health Board, supra* note 31 at 244.

[85]*Ibid.* at 242.

[86]See generally S.H. Miles & A. August, "Courts, Gender and 'The Right to Die'" (1990) 18 L., Medicine & Health Care 85.

[87]*Cruzan* v. *Missouri Department of Health*, 110 S. Ct. 2841 (1990).

[88]*In re Dinnerstein*, 380 N.E.2d 134 (Mass. App. Ct. 1978).

[89]*Bouvia* v. *Superior Court*, 225 Cal. Rptr. 297 (C.A. 1986).

[90]*In re Westchester County Medical Center (O'Connor)*, 531 N.E.2d 607 (N.Y.C.A. 1988).

[91]*In re Colyer*, 660 P.2d 738 (Wash. S.C. 1983).

Conroy,[92] centred on women, as did publicity of the first recorded user of Dr. Kevorkian's "suicide machine," Janet Adkins.[93] The distinction has been recorded in a review of many U.S. cases that:

> The final state appellate court rulings ordered continuation of life-prolonging care in two of 14 cases about profoundly ill, previously competent women who had not authored living wills. No such order was made in eight similar cases involving men. This difference is the result of an even more asymmetric gender-patterned reasoning within the cases.[94]

The contrast is interpreted as based not on sex *per se*, but on gender. Sex is biological, but gender is the social understanding of sexual difference. Male gendered beings are regarded as strong, public, rational, material and capable of taking responsibility for the preferences they exhibit, whereas female gendered beings, including effeminate men, are weak, private, expressive, spiritual and in need of protection against their own instincts. Masculine decisions are firmly based and decisive, whereas feminine decisions are merely emotional, liable to change and open to masculine, including judicial, better judgment. Canadian courts have shown a somewhat finer sensitivity to respect female preferences than have United States' courts, in terminal treatment, abortion[95] and other areas.

The contrast has also been observed that "life-support dependent men are seen as subjected to medical assault; women are seen as vulnerable to medical neglect."[96] Canadian decisions in *Astaforoff*, *Malette* and *Nancy B.* do not conform with this observation, but may be more sympathetic to feminist analysis.[97] Feminism embraces a wide range of orientations,[98] but a common characteristic is recognition of the significance of caring about and for others,[99] an attribute perhaps of the passive feminine function of nursing rather than of the active masculine role of doctoring and giving "doctor's orders." In her essay addressing voluntary active euthanasia as an act not of assault but of care, Leslie Bender writes that

> because of our dominant, liberal paradigm premised on a society composed of autonomous individuals who interact with others by choice out of self-interest, we look for resolutions of problems about end-of-life medical care in an ethic of justice and rights ... Our current analysis prevents people from aiding others to die with dignity because we understand rights as barriers to interference by others, rather than as enabling conditions ... When applying our existing rules to the legality of physician assistance in the dying process, we may talk of "mercy seasoning

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[92]*Supra* note 20.

[93]"Case Against 'Dr. Death' Dropped after MI Judge Throws Out Charge" (1991) 7 *Medical Ethics Advisor* 13.

[94]Miles & August, *supra* note 86 at 85.

[95]*R.* v. *Morgentaler*, [1988] 1 S.C.R. 30, 44 D.L.R. (4th) 385; *Tremblay* v. *Daigle*, [1989] 2 S.C.R. 530, 62 D.L.R. (4th) 634.

[96]Miles & August, *supra* note 86 at 87.

[97]L. Bender, "A Feminist Analysis of Physician-Assisted Dying and Voluntary Active Euthanasia" (1992) 59 Tennessee L.R. 519.

[98]S. Sherwin, *No Longer Patient: Feminist Ethics and Health Care* (Philadelphia: Temple University Press, 1992).

[99]N. Noddings, *Caring: A Feminine Approach to Ethics and Moral Education* (Berkeley: University of California Press, 1984).

> justice," but I would prefer an understanding that speaks of "justice tempering care." We can change the substance of our normative discourse in medical ethics and law by moving to a care-based paradigm.[100]

The judgment in *Nancy B.* moves us towards this paradigm. It is respectful of Nancy B.'s choice of death, approves a process of death that cares for her comfort and dignity, does not speak of a right to die, and shows care too for the caregiver's comfort and conscience, empowering without ordering the physician to act. The physician's prospective relationship to the patient is treated as giving medical care rather than as potentially assaulting, failing to prolong life or killing. Care is permitted to be given that responds to the patient's needs. Medical assistance in dying provides a legal answer to the question of how best to care for Nancy B.

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[100]Bender, *supra* note 97 at 534.