How the Courts Kept Me Alive:
Is Pulling the Plug on Life Saving Interventions Ever Euthanasia?

INTRODUCTION

The presenters have prepared this monograph as a complete or supplementary mini-curriculum on the medical and legal issues surrounding "End of Life." Sample questions are provided for the classroom.

Part One describes three legal terms, Euthanasia, Removal of Life Support and Assisted Suicide, all from a Canadian perspective.

Part Two is an "unofficial" introduction into the medical language of the Intensive Care Unit, where many of the human dramas unfold.

Part Three provides an objective debriefing of the American saga of Terry Schiavo, without the hyperbole to which the public was subjected in the print and electronic media.

Part Four is an extract from Justice Sopinka's majority ruling in the Sue Rodriguez case, for classroom discussion.

PART ONE

Euthanasia, Removal of Life Support and Assisted Suicide: What's the Difference?

By R. Lee Akazaki, B.A., LL.B., of the Ontario Bar

Euthanasia

The word comes from the Greek *eu* for 'well' and *thanatos* for "death." In modern use, it commonly describes the painless killing of a patient suffering from an incurable disease or in an irreversible coma. It is *killing*, which means that it is an active intervention taken by one person (usually a doctor or a nurse, but sometimes not: see *R. v. Latimer*, [2001] 1 S.C.R. 3) to end the life of another or to hasten death. Consider overdoses of morphine administered to cancer patients or other lethal injections of opiates designed to end both pain and life.

The difference between euthanasia and assisted suicide, when a distinction is required, is that euthanasia is a term and concept indifferent to the will of the patient to carry on life. Assisted suicide, as discussed below, requires the patient's complicity.

The hastening of death is a form of homicide, for which the person causing death may be liable for murder and other forms of homicide under sections 226 and 229 of the *Criminal Code*, which comes under federal jurisdiction. Section 226 reads:

> "Where a person causes to a human being a bodily injury that results in death, he causes the death of that human being notwithstanding that the effect of the bodily injury is only to accelerate his death from a disease or disorder arising from some other cause."

In the mainstream of Ontario society, no reasonable person could argue that euthanasia can be sanctioned against the will of the patient. Where the patient is in an irreversible coma, however, and the patient survives the withdrawal of life support, society is confronted with an ethical, political and spiritual dilemma. While some jurisdictions have decriminalized or institutionalized euthanasia, it is illegal in Canada.

Questions for the classroom:

1) Under what circumstances could euthanasia be justified?
2) How might the diversity of faiths and cultures in Canadian society affect any future legislative reform?
3) Who should be authorized to perform such acts under future legislation?
4) Are doctors the best people to be granted such power?

Removal of Life Support

In the United States, the saga of Terry Schiavo polarized Republicans and Democrats, the Christian Right and "Liberals", Pro-Life and Pro-Choice, and a host of other social groups and "groupies." (See article by Joseph Colangelo, below.)

In Ontario, substitute decision makers such as next-of-kin may be appointed in "living wills" to make health care decisions when the patient is no longer mentally capable of making such decisions. Under s. 21 of the *Health Care Consent Act*, substitute decision-makers must make these decisions according to the previously expressed wishes of the patient, or, if no prior wishes exists, decisions must be made in the patient's best interests. Best interests are subsequently defined in the legislation. This decision-making standard applies when consenting to or refusing any treatment including life-sustaining interventions. Often people have not had any discussions with their chosen substitutes regarding their thoughts or beliefs regarding future medical treatments. Often multiple treatment options exist, each of which has its own set of potential benefits, risks and

discomforts. Deciding which course of action is in a given patient's best interests can be a daunting task. Not surprisingly, conflicts arise within and among families and healthcare teams. Most of these conflicts can be resolved outside of the legal system. If disagreements persist, and the healthcare team is questioning the decision-making of a substitute, legal recourses do exist to help. A doctor managing the care of a patient relying on intensive care treatments to stay alive can also apply to the Consent and Capacity Board for a ruling on whether decisions are departed from the legal standards set out in s. 21 of the *Act*.

Decisions to withhold or withdraw life support are made for a number of reasons. The most important reason is that the patient does not wish to continue on these therapies. Other decisions to stop are based on the discomforts outweighing any chance of benefit, of return to a quality of life that person considers worth living. Still others are based on the fact that life support will not be able to "save" a person's life, that such treatments are only prolonging their death. A large number of deaths in an Intensive Care Unit ensue after decisions to withhold or withdraw life support are made

Sometimes, these decisions may mean "pulling the plug" on life support for permanently comatose patients. Doctors will explain that there is no actual plug that is pulled. Instead, life support is removed in stages, making sure the patient is comfortable at each stage of the process. For while life support may cause pain and discomfort, it is a double-edged sword in that its removal can also cause a patient distress. To ensure comfort, drugs--narcotics and sedatives—are routinely given as life support is withdrawn. There is no indignity in removing life support. Rather, there are protocols for preparing the patient for natural death without prolonged suffering. The foregoing description of end-of-life care may offend some members of the community, especially those of different generations or faiths. What is important for students to glean from this curriculum is that this *is* treatment, and that it involves a medically accepted protocol that adheres generally to the code of "doing no harm." It is for students to reach their own conclusions, after discussion with their peers, teachers and family.

The cases are more difficult when the patient is kept alive artificially but is mentally competent. In *Nancy B. v. Hotel-Dieu de Quebec* (1992), 86 D.L.R. (4th) 385 (Superior Court, Quebec), the patient applied for an injunction requiring her physicians and the hospital to discontinue her reliance on a ventilator, which discontinuance would result immediately in her death.

In other occasions, it may mean a doctor opines that it would do more much more harm than good to initiate life support to keep a patient alive. There, the proposed alternative to keeping the patient alive whatever it takes, is to provide more conservative/palliative treatment under which the patient runs the greater risk of dying for lack of aggressive intervention. This second scenario was illustrated in the recent court decision in *Scardoni v. Hawryluck* (2004), 69 O.R. (3d) 700 (Superior Court of Justice, Ontario), which involved the author of the second part of this monograph.

Questions for the classroom:

1) What is the difference between "pulling the plug" and giving the patient a lethal overdose of pain medication?
2) How might your own personal belief, faith or cultural background impact on a decision you might have to make as a substitute decision-maker?
3) How would you view the health care provider who contests your decision as a substitute decision-maker?

Assisted Suicide

Assisted Suicide differs from euthanasia in that the person committing the offence is actively carrying out an act of suicide for a person who, due to a physical disability, is inacapable of performing the act by himself or herself. The most famous example in recent memory was that of Sue Rodriguez, *sub nom Re Rodriguez and Attorney-General of British Columbia et al.* (1993), 107 D.L.R. (4th) 342 (Supreme Court of Canada) Ms. Rodriguez suffered from amyotrophic lateral sclerosis (ALS), a disease widely known as Lou Gehrig's disease. ALS is a condition which causes rapid loss of voluntary and involuntary bodily function, eventually leading to confinement to bed and life support. She wanted help from undisclosed friends or family to end her life and applied to the courts for an order striking down s. 241 of the *Criminal Code of Canada*, which reads:

> **241.** 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.
>
> R.S., 1985, c. C-46, s. 241; R.S., 1985, c. 27 (1st Supp.), s. 7.

The majority ruling was by the slenderest of margins (5-4) in favour of upholding the provision, i.e. that assisting suicide would remain a crime in Canada.

The dissenting opinions of four of the Supreme Court justices discuss how the section violated Sue Rodriguez' *Charter* rights to equality (s. 15) and to die with dignity (s. 7). The argument which clashes most squarely in principle with the majority is the equality argument, i.e. that a physically able person is legally entitled to end her own life and cannot be penalized for attempting to commit suicide. As a disabled person, the law was discriminatory.

From a philosophical perspective, the majority opinion is a *tour de force* in legal writing. It provides a fascinating illustration of Canadian law being rooted in the legal, religious and ethical history of Western Society itself. Mr. Justice Sopinka concludes that the right to die is an "autonomy interest" which falls short of a right worthy of remedy under the *Charter*. To get there, he spans Classical Greek ethics, propounded by Plato and Aristotle, to Roman stoics, to the development of the criminal law in Anglo-Canadian society. He does so, with remarkable clarity, in but one and a half-pages (pp. 397-98 D.L.R.).

Sopinka J. also navigates the distinction between assisting suicide and "pulling the plug" in the medical context, and uses the prohibition against euthanasia to argue against decriminalizing assisted suicide.

Despite the elegance of Sopinka J.'s reasoning, a critical observer of the logic of the decision might feel some unease with the correctness of the following statement, made in support of legislation prohibiting assisted suicide: "the matter of suicide was seen to have its roots and its solutions in sciences outside the law, and for that reason not to mandate a legal remedy."

Questions for the classroom:

1) Some might argue that the majority's ruling in *Rodriguez* favoured the Anglo-Canadian legal heritage, rooted also in Western philosophy, and the dissent chose *Charter* jurisprudence, the source of the equality-rights "revolution." Which approach, if you accept the distinction, do you feel is more just in resolving the ethical issues presented by Sue Rodriguez' request?
2) If the decision had gone the other way, how would you, as Minister of Justice, draft legislation for Parliament which assures that the law does not unintentionally decriminalize euthanasia?

PART TWO

The Critical Care "Lingo": Not for the Squeamish

By Dr. Laura Hawryluck, MSc, MD, FRCPC

In the world of the intensive care unit of a modern Canadian general hospital, patients are kept alive at the precipice of their bodies' biological function. Teams of doctors and nurses have an arsenal of machines, drugs and techniques behind which it may be hard to see men and women devoted to one calling: to do no harm. Here is a quick glossary of procedures and situations you might hear or see in this world. I hope that, once they get to know the lingo and get over any squeamishness, your students will not fear to consider some of the tough questions that face the doctors, nurses, patients and family.

ICU: intensive care unit of a hospital. The most technological unit in any hospital

Stepdown Units: A specialized unit on a providing transitional care after patient stabilized in ICU or for patients too sick to be caredfor on a regular ward but not siuck enough to need ICU care

Life support: mechanical ventilation, inotropic support, dialysis (whether intermittent or continuous). Unfortunately, usually no explanation of "what is life support" or the context in which it might be needed, the likelihood of helping, the discomforts involved, is provided to patients or to the substitute decision maker (SDM). Such treatments can only be given in an ICU. People may need life support for a variety of reasons including but not limited to : any kind of shock e.g. really bad infections (septic shock), cardiogenic shock, after cardiac arrest, pneumonia, liver failure, kidney failure, trauma, burns, brain or spinal cord injuries

ICU Treatments:

Mechanical ventilation/ INVASIVE Ventilation : Modern version of the "iron lung" machine which takes over the body's breathing function. The original device derived its name from the fact that the inventors used an iron box and two vacuum cleaners to create negative pressure around the chest to suck air in and imitate normal breathing. Modern ventilator, in contrast, are said to be positive pressure ventilators since they push air into the lungs. How people are placed on ventilators is described below under the intubation heading. Different levels of support may be given, depending on how sick the patient is. Patients are initially heavily sedated of, if REALLY sick, are even paralyzed with drugs (neuromuscular blockers). As the patient improves, he/she can be awake and communicate (by lip reading or writing). Patients cannot talk and cannot eat. They are fed liquid food through a nasogastric or orogastric tube into their stomach. ONLY provided in ICU

Intubation: a plastic tube size of garden hose goes into the throat, through the mouth and sits in the windpipe. Balloon on the end holds it in place, provides a seal and prevents

aspiration (swallowing the wrong way). The tube (endotracheal tube or ETT) is inserted with a "blade" or laryngoscope and hooked to the ventilator or breathing machine. Patients are suctioned to clear the sputum/phlegm from their lungs by inserted another thinner plastic tube down the ETT and suctioning. Causes coughing and is very uncomfortable/downright painful for some people. Pain cannot really be effectively treated. Some say it's the worst part of being in the ICU.
ONLY used in ICU

NON- Invasive Ventilation or BIPAP/CPAP: non-invasive ventilation --- ventilation which does not require a tube into the windpipe. A tightly fitting mask, resembling a toilet bowl plunger, is fitted to face or just to the nose. Air is then forced into the lungs by help of a machine which is similar but more simple than traditional ventilator ("iron lung"). Used in ICU and on very specialized wards on occasion for patients with chronic lung diseases.

Inotropes/Vasopressors : Drugs called "pressors", vasopressors, similar to epinephrine (adrenalin) to either increase strength of contractions of the heart (inotrope part of the drug's action) or to squeeze the blood vessels (increase vascular tone: vasopressor part) to raise the BP. Must be given through a central line. ONLY used in ICU.

CPR: Cardiopulmonary resuscitation. The ICU version involves more than what is seen by firefighters on TV shows. This means the **heart has stopped**, the **person is dead** and attempts will be made to revive her/him by doing cheat compressions, putting a tube down his throat into the windpipe (intubation) and breathing for him with Ambu bag (also known as bag-mask-valve ventilation) and oxygen. In the course of CPR, electricity may be used to shock the heart out of 1) a non-viable chaotic rhythm (ventricular fibrillation), or 2) a slightly more organized rhythm (ventricular tach) without a blood pressure. Drugs may be administered. Adrenaline (epinephrine) may be used to kick start the heart and provide a blood pressure. Atropine, if the electrical rhythm is very slow, does not give you a blood pressure unless its very low. Intravenous bicarbonate may be given to correct the acid in the blood from your tissues not having enough oxygen. If successfully resuscitated, the patient remains in ICU until stable.

DNR: Do Not Resuscitate! This order is used most commonly to refer to situation of cardiac arrest only. However, once DNR for cardiac arrest is made, the patient will never undergo intubation and ventilation, be brought to the ICU even if needed in other situations with better prognosis---This is why ICU care must be discussed separately from CPR and clear orders written on the patient's chart to avoid misunderstandings

Artificial Nutrition: liquid food provided through a tube inserted through the nose into the stomach (nasogastric tube) or the mouth into the stomach (orogastric food) in the case of a temporary inability to eat. In cases where the problem is chronic(as in Schiavo case), the tube is inserted through the abdominal wall into the stomach or small bowel. Artificial nutrition is very common and is considered a medical therapy. Decisions to remove feeding tubes can be very emotional ones (feeding someone is a sign of caring) and are influenced by cultural and religious beliefs. People fear starving their loved ones

to death – we all know the discomforts associated with hunger. Yet as we near the end of life, we do not feel hunger – in fact appetite tends to be lost and there is no discomfort when feeding is stopped

Dialysis specifically CVVHD: continuous venovenous hemodialysis. Dialysis involves a machine that takes over from the kidney to maintain the blood chemistry in the tight balance we all need to live. In the case of really sick patients whose blood pressure is low and who requires a lot of support with drugs (hemodynamically unstable), we do it 24 hrs a day. It can only be done in ICU. It differs from intermittent hemodialysis , the kind many people come to hospital for, which is done for 4-5 hours 3x /week

Monitoring devices:**Arterial line** tube inserted into the artery of the wrist (radial or ulnar), arm (brachial—at the elbow), groin (femoral) or foot (pedal). This allows constant monitoring of blood pressure (BP), blood samples to measure blood gases (oxygen and carbon dioxide), andelectrolytes, and other factors This procedure is only used in the intensive care unit (ICU), some "stepdowns."

Central line; VERY large intravenous line (IV) inserted into the main veins (in neck (internal jugular/ IJ), under collarbone (subclavian) or groin (femoral). This allows monitoring of filling pressures to get a sense of the volume status (dehydrated/ overloaded) of the patient and the administration of drugs like inotropes (see below).

PICC line: peripherally inserted central catheter: This is a long IV inserted in the elbow and fed into the larger vein. It can be left in a long time and have decreased risk of infection. It is more comfortable than central lines, and is used in longer term stays in ICU, for patients with difficult IV access on wards, and in stepdown units

Critical Illnesses (not an exhaustive list by any means!):

Septic shock: again all organs are not receiving enough blood to keep them alive (this is what shock means). The cause is severe infection – can be from pneumonia, kidneys, GI tract, etc… 50% mortality or higher

Respiratory arrest: The patient has **stopped breathing and needs life support on an emergency basis.** If we don't breathe for him, he will have a cardiac arrest (heart will stop) and he *will* die. Variety of causes: can be final culmination of resp. distress from CHF, pneumonia, pulmonary embolism (blood clot to lungs)

Myocardial infarction (Heart attack., MI): A section of heart muscle does not receive enough blood and dies. If enough muscle dies can lead to CHF or cardiogenic shock

Heart failure (myocardial dysfunction): the heart is not pumping blood properly so its 1) backing up into the legs (swelling), the lungs (congestive Heart failure i.e. CHF), the liver (congestive liver failure/) and not reaching other organs: liver, kidneys, skin on toes, legs.

Cardiogenic shock: All organs are not receiving enough blood to survive because the heart is not able to pump it out to the rest of the body. Person is on life support. Very high mortality

Cardiac arrest: **The heart has stopped**. This can happen independently from respiratory arrest or almost simultaneously. This is the usual situation that doctors envision when they discuss CPR/No CPR or DNR orders. Only a small portion of people who need ICU or life support need it because they have sustained a cardiac arrest

Palliative Interventions:
Drugs: Narcotics (e.g. morphine) and sedatives (e.g. drugs similar to valium) are given to treat any signs of pain or distress when a patient is on life support. Trying to make patients as comfortable as possible while they are on life support is very important.. Drugs may be given as bolus doses as needed or as continuous infusions to provide constant background relief of pain and other symptoms. When life support is withdrawn, patients may have increased needs for these drugs to treat pain, shortness of breath, and anxiety. Continuous infusions of drugs may be started and they will be continued if a patient is already on them. Some people have called the continuous infusion of narcotics and sedatives , **terminal sedation** during which a patient is sedated into unconsciouness and death ensues from underlying illness. In some circles, there is concern that terminal sedation blurs the border between assisted death and palliative care. The great majority accept terminal sedation as a palliative care practice: the intent is to palliate not to kill using continuous infusions of drug (which often mean less drug can be given then if attempts were made to manage the same amount of distress with bolus doses)

Bolus doses and increases in infusion rates will be given if there are signs of distress. Since many patients in this situation cannot speak (too sick, intubated), facial expressions, labored breathing, heart rate and blood pressure are used by the medical team to assess and treat discomfort. Sometimes high doses and rapid escalations are needed to control distress. In all cases, the medical team should document which drugs were chosen, why they were increased and the patient's response.

Studies have not revealed any difference in time to death among ICU patients who received morphine and sedatives as life support was withdrawn and those who did not .

Principle of Double effect: Principle arising from Catholic theology and now used by Medical Associations around the world to guide use of narcotics/ sedatives at the end of life. Narcotics and sedatives may be given to dying patients to control their pain and distress even if they can foreseeably hasten death, as long as the intent of the person giving the drugs is to palliate

PART THREE

Who Owned Terry Schiavo's Life?

By Joseph J. Colangelo, B.A., LL.B., of the Ontario Bar

The case of Terry Schiavo in the United States demonstrates the pitfalls of the failure to give an advanced directive concerning medical treatment. When she was 26 years old, Terry suffered a cardiac arrest as a result of alleged medical malpractice in February, 1990. This caused permanent brain damage. She required aggressive physical therapy and was dependant upon a feeding tube to provide her with nourishment. Despite aggressive and extensive therapy provided by her family, her condition did not improve. She left no written directive concerning medical treatment.

Her spouse commenced an action for medical malpractice damages against the doctors who were allegedly responsible for the cardiac arrest that she has suffered. In January, 1993, the action was settled for $1 million. Of that amount, $700,000 was paid to Terry for damages to compensate her for the physical harm that had been done to her and for the on-going cost of medical care that she would require. $300,000 was paid to her spouse for "loss of consortium."

In May, 1998, her spouse filed a petition with the Florida state court to determine whether the feeding tube should be removed. Without the tube, she would die. The facts were complicated by a dispute between her spouse and her parents regarding the settlement funds paid in the malpractice action. They had quarreled over whether her spouse should pay to her parents a portion of the damage award paid to him for loss of consortium. Further, if Terry died, the remaining funds from the damages paid to her would be inherited by her spouse.

The Florida state court granted the petition and permitted the removal of the feeding tube. It held that there was clear and convincing evidence that Terry would have wanted the feeding tube removed based on testimony of wishes she had expressed prior to the suffering of the brain damage. It also found that Terry was in a persistent vegetative state and would not likely recover.

Following this decision, there were many years of further legal proceedings and government interventions. Most notable were:

- Proceedings in the federal courts by her parents to allege a violation of her civil rights.

- The enactment by the state legislature of a law that permitted the governor to stay a court decision authorizing the termination of medical care. This law was found to be unconstitutional.

- The issuance of a subpoena by a congressional committee requiring Terry's spouse, parents and doctors to appear at a hearing to be held in the hospital where Terry was receiving care.

At the conclusion of these lengthy and expensive proceedings, the initial decision of the Florida state court was upheld and the feeding tube was removed.

Had this case taken place in Ontario, the applicable law would have been the *Health Care Consent Act, 1996,* S.O. 1996, c.2, Sch. A. As Terry would have been incapable of providing consent to her doctors, her substitute decision makers would have been consulted. In the absence of a person who had a power of attorney for personal care, the doctors would have consulted Terry's spouse as required by section 20(1)4 of the *Act*. A conflict could arise because of the rights of the parents to be consulted under section 20(1)5 of the *Act*. The power of the substitute decision makers to consent to treatment would have included a consideration of Terry's best interests, including whether she had expressed any wishes concerning treatment while she was capable. The decisions made would be subject to review by the Consent and Capacity Board. The decisions of this Board are subject to appeal to the Superior Court of Justice.

The case raises a number of issues for discussion and further study for students, not only in the classroom but at home with their families.

Questions for the classroom:

1) How would this case have been decided in Ontario?
2) Are the facts of the case more like the situation in the *Nancy B* case or more like the situation in the *Rodriguez* case?
3) Is it appropriate for legislatures to intervene in the process by enacting laws giving the executive branch of government the right to stay decisions of the courts on medical care?
4) Terry's parents submitted a video to the Florida courts showing how she looked in the hospital with the feeding tube in place. This video was broadcast in the public media. Is this properly respectful of Terry's privacy interests?

PART FOUR

Extract from the majority in the Sue Rodriguez case, *sub nom Re Rodriguez and Attorney-General of British Columbia et al.* (1993), 107 D.L.R. (4th) 342 (Supreme Court of Canada)

The judgment of La Forest, Sopinka, Gonthier, Iacobucci and Major JJ. was delivered by

SOPINKA J. -- I have read the reasons of the Chief Justice and those of McLachlin J. herein. The result of the reasons of my colleagues is that all persons who by reason of disability are unable to commit suicide have a right under the *Canadian Charter of Rights and Freedoms* to be free from government interference in procuring the assistance of others to take their life. They are entitled to a constitutional exemption from the operation of s. 241 of the *Criminal Code*, R.S.C., 1985, c. C-46, which prohibits the giving of assistance to commit suicide (hereinafter referred to as "assisted suicide"). The exemption would apply during the period that this Court's order would be suspended and thereafter Parliament could only replace the legislation subject to this right. I must respectfully disagree with the conclusion reached by my colleagues and with their reasons. In my view, nothing in the *Charter* mandates this result …

…

As is noted in the above passage, the principle of sanctity of life is no longer seen to require that all human life be preserved at all costs. Rather, it has come to be understood, at least by some, as encompassing quality of life considerations, and to be subject to certain limitations and qualifications reflective of personal autonomy and dignity. An analysis of our legislative and social policy in this area is necessary in order to determine whether fundamental principles have evolved such that they conflict with the validity of the balancing of interests undertaken by Parliament.

(i)History of the Suicide Provisions

At common law, suicide was seen as a form of felonious homicide that offended both against God and the King's interest in the life of his citizens. As Blackstone noted in *Commentaries on the Laws of England* (1769), vol. 4, at p. 189:

... the law of England wisely and religiously considers, that no man hath a power to destroy life, but by commission from God, the author of it: and, as the suicide is guilty of a double offence; one spiritual, in invading the prerogative of the Almighty, and rushing into his immediate presence uncalled for; the other temporal, against the king, who hath an interest in the preservation of all his subjects; the law has therefore ranked this among the highest crimes, making it a peculiar species of felony, a felony committed on oneself.

This is essentially the view first propounded by Plato and Aristotle that suicide was "an offence against the gods or the state" (M. G. Velasquez, "Defining Suicide" (1987), 3 *Issues in Law & Medicine* 37, at p. 40).

However, the contrary school of thought has always existed and is premised on notions of both freedom and compassion. The Roman Stoics, for example, "tended to condone suicide as a lawful and rational exercise of individual freedom and even wise in the cases of old age, disease, or dishonor" (Velasquez, *supra*, at p. 40). A more humane tone was struck by the Chancellor Francis Bacon who would have preferred leaving to the doctors the duty of lessening, or even ending, the suffering of their patients (L. Depaule, "Le droit à la mort: rapport juridique" (1974), 7 *Human Rights Journal* 464, at p. 467). There has never been a consensus with respect to this contrary school of thought. Thus, until 1823, English law provided that the property of the suicide be forfeited and his body placed at the cross-roads of two highways with a stake driven through it. Burial indignities were also imposed in *ancien régime* France where the body of the suicide was often put on trial before being crucified (G. Williams, *The Sanctity of Life and the Criminal Law* (1957), at p. 259; Depaule, *supra*, at p. 465, citing the *Ordonnance de 1670*, title XXII).

However, given the practical difficulties of prosecuting the successful suicide, most prohibitions centred on attempted suicide; it was considered an offence and accessory liability for assisted suicide was made punishable. In England, this took the form of a charge of accessory before the fact to murder or murder itself until the passage of the *Suicide Act, 1961* (U.K.), 9 & 10 Eliz. 2, c. 60, which created an offence of assisting suicide which reads much like our s. 241. In Canada, the common law recognized that aiding suicide was criminal (G. W. Burbidge, *A Digest of the Criminal Law of Canada* (1890), at p. 224) and this was enshrined in the first *Criminal Code*, S.C. 1892, c. 29, s. 237. It is, with some editorial changes, the provision now found in s. 241.

The associated offence of attempted suicide has an equally long pedigree in Canada, found in the original *Code* at s. 238 and continued substantively unaltered until its repeal by S.C. 1972, c. 13, s. 16. The fact of this decriminalization does not aid us particularly in this analysis, however. Unlike the situation with the partial decriminalization of abortion, the decriminalization of attempted suicide cannot be said to represent a consensus by Parliament or by Canadians in general that the autonomy interest of those wishing to kill themselves is paramount to the state interest in protecting the life of its citizens. Rather, the matter of suicide was seen to have its roots and its solutions in sciences outside the law, and for that reason not to mandate a legal remedy. Since that time, there have been some attempts to decriminalize assistance to suicide through private members bills, but none has been successful.

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