THERE ARE SEVERAL areas of medical practice which almost inevitably involve legal questions or difficulties. While each case must be approached individually, taking into account the patient's needs and the physician's own moral standpoint, certain basic guidelines exist.

**Euthanasia**

Euthanasia or mercy killing may be described as the bringing out of a gentle and easy death in the case of an incurable disease. It is contrary to the law, yet euthanasia is practiced extensively by many doctors.

Euthanasia for convenience sake can be divided into three degrees or categories. The first degree would be the actual administration of a poisonous or noxious substance to a person with intent to kill. At law this is unquestionably murder, or at least manslaughter.

The second degree might be described as administering a therapeutic dose of pain killing medication in the knowledge that the increasing dosage required to keep the patient pain free and euphoric will eventually contribute to his death.

The third degree would be the withholding of further therapeutic measures. This involves no activity, but rather the physician's failure to act. At law, this involves less culpability, due to the Common Law's tendency to punish for malfeasance or improper conduct and to cast little or no blame on one who fails to act.

There is little doubt that all three degrees of mercy killing are variously practiced in Canada today. The administration of therapeutic but harmful drugs and the withholding of further care are probably practiced by all doctors in almost every case of terminal illness.

Every doctor in every fatal situation reaches a point where he weighs the benefits and the disadvantages of further treatment. He must act according to his own conscience in deciding further treatment for the dying patient.

Euthanasia raises many religious, moral and legal questions. It has probably always been practiced, except in times of extreme religious or moral fervor when suffering was held to be a just punishment for mortal sins or preparation for entry into the life beyond. Such beliefs are held by few today.

Roman gladiators, mortally wounded in combat, were stripped of their armor and quickly dispatched by the thrust of an official's dagger. Also, the administration of poison to people otherwise doomed was common practice. Francis Bacon wrote in *The New Atlantis*: "I esteem it the office of a physician not only to restore the health but to mitigate the pain and dolour; and not only when such mitigation may conduсе to recovery but when it may serve to make a fair and easy passage".

While religious and moral questions may be decided by personal conviction, the legal question is not avoided so easily. The Criminal Code of Canada states under *Homicide*, Section 194: "a person commits homicide when directly or indirectly by any means, he caused the death of a human being".

Under *Acceleration of Death*, Section 199, it states: "When a person causes bodily injury to a human being 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".

Under *Punishment for Manslaughter*, Section 207, it states: "Everyone who commits manslaughter is guilty of an indictable offence and is liable to imprisonment for life".¹

In investigating such cases, the type of euthanasia would undoubtedly affect a court's decision. Probably a judge or a jury would be loath to impose guilt of any sort in a case of withholding medical care or the administration of larger doses of pain killing medication in a proper situation. However, if the situation were not a proper one, the administration of poisons would not be condoned and the doctor would be liable for imprisonment and loss of his license to practice medicine.

The sanctions of the law could be brought on by a nurse or other members of the hospital staff, or perhaps by discontented relatives who suspect what was taking place. This situation has arisen several times in the past.

The doctor might well provide the evidence for his own conviction by
Apresoline
the unique “ADD ON” antihypertensive

INDICATIONS: Various forms of hypertension: fixed essential hypertension, whether of benign or malignant character; hypertension associated with acute and chronic glomerulonephritis; nephrosclerosis; hypertensive toxemias of pregnancy, pre-eclampsia, and eclampsia.

DOSEAGE: Hypertension: Orally: In general after initiating therapy gradually increase dosage, adjusting according to individual response. As a single agent, initially 10 mg, four times daily increasing slowly to a maximum practical dosage of 200 mg daily. In combination with other hypotensive agents, lower dosages of APRESOLINE will be appropriate.

Parenterally: When there is venously or intramuscularly. Usual dose is 20 to 40 mg, repeated as necessary. Certain patients, especially those with marked renal damage, may require a lower dose. Pressure may begin to fall within a few minutes after injection, with an average maximal decrease occurring in 10 to 30 minutes. Most patients can be transferred to oral APRESOLINE within 24 to 48 hours.

Toxemia of Pregnancy: a) Early toxemia and hypertension of pregnancy: One 10-mg tablet orally 4 times daily, slowly increasing the dosage up to 400 mg per day, or until a therapeutic result is obtained.

b) Late toxemia and pre-eclampsia: Give 20 to 40 mg intramuscularly, or slowly by direct intravenous injection or infusion. Repeat as necessary.

SIDE EFFECTS: Tachycardia, headache, palpitation, dizziness, weakness, nausea, vomiting, postural hypotension, numbness and tingling of the extremities, flushing, nasal congestion, lachrymation, conjunctival injection, dyspnea, anginal symptoms, rash, drug fever, reduction in hemoglobin and red cell count, giant urticaria, and a lupus-like syndrome (arthralgia) in some cases following administration for long periods.

CAUTIONS: Use cautiously in the presence of advanced renal damage and recent coronary or cerebral ischemia. APRESOLINE may potentiate the narcotic effects of barbiturates and alcohol. Peripheral neuritis evidenced by paresthesias, numbness and tingling has been observed.

Published evidence suggests an anti-pyridoxine effect and addition of pyridoxine to the regimen if symptoms develop.

OVERDOSAGE: Symptoms: Hypotension and tachycardia.

Treatment: Gastric lavage or, in the absence of coma, emetics. In the presence of hypotension, cautiously give norepinephrine (intravenously) or ephedrine to raise the blood pressure without increasing tachycardia. Avoid epinephrine.

General supportive measures include intravenous fluids, external heat, and elevation of foot of bed.

SUPPLIED: All forms contain hydroizaline hydrochloride. Tablets of 10 mg (yellow, scored); tablets of 100. Tablets of 25 mg (blue, coated); bottles of 100 and 500. Tablets of 50 mg (pink, coated); bottles of 100 and 500. Ampoules of 1 ml aqueous solution containing 20 mg; boxes of 10.

CIBA
DORVAL, QUEBEC

CANADIAN FAMILY PHYSICIAN/JUNE, 1975

recording his actions in the hospital records. In one case a doctor injected air into his patient’s blood stream to hasten death and noted the fact in the patient’s records — conviction followed. The solution, of course, is to act reasonably under all circumstances.

In cases of withholding further medical care and giving larger doses of medication to relieve pain, legal action against the doctor would be more difficult. There would be hesitation at prosecuting a well meaning and well reputed doctor, since a conviction would be almost impossible to achieve. Realistically in these cases, then, the doctor practicing euthanasia is relatively safe.

But the possibility of adverse publicity remains. A patient’s family or friends questioning the procedure or actually bringing criminal or civil proceedings could utterly destroy the doctor’s reputation and practice.

At present euthanasia in Canada remains a matter for the individual practitioner, who must wrestle with it if he believes in euthanasia at all.

(Note: at its General Council Meeting last year, the Canadian Medical Association passed a resolution stating that in certain conditions of ill health where recovery is not possible, the writing of the words ‘No resuscitation’ on the order sheet is ‘appropriate and ethically acceptable’. This resolution is currently under consideration by the CMA’s legal advisers. Ed.)

Abortion

The role of the physician in Canada today in dealing with abortions is a significant and troublesome one. If he sends his patients to the abortion committee of a liberal hospital, abortion will follow; if he doesn’t, it won’t. This leaves a great deal of discretion within the law to the doctor of first contact. Patients, who are generally unaware of the situation, will be guided by their doctor’s directions, which is desirable or undesirable according to one’s general views on abortion.

Medical practitioners will vary as widely in their views on abortion as do the general public. As a result great variation in availability of abortion will be found.

Central to the resolution of some of the legal problems is the time at which the fetus becomes entitled to the legal protection generally offered to human life. The Roman Catholic Church has concluded that the soul enters the embryo at the moment of conception. Until 1869, Catholic doctrine taught that the soul entered the growing fetus about 40 days after conception for a male and 80 days after conception for a female. If spontaneous abortion occurred before that time, no burial rites were performed! Probably this practice was a result of convenience for the local priest rather than any doctrine emanating from Rome.

The time at which this emergent human being acquires civil rights still remains a problem, leaving the whole situation still in a most unsatisfactory state.

Current Canadian legislation on abortion is to be found in Section 236 of the Criminal Code. It was originally part of the Omnibus Bill to amend the Criminal Code, drafted in 1969. The terms of this legislation are vague and open to many kinds of interpretation by hospitals, patients and doctors.

Before the amendment was passed, abortion for any reason was illegal under the Criminal Code. It is still illegal except under the following conditions:

“4a. a qualified medical practitioner other than a member of a therapeutic abortion committee for any hospital, who in good faith uses in an accredited or approved hospital any means for the purpose of carrying out his intention to procure the miscarriage of a female person, or

b. a female person who, being pregnant, permits a qualified medical practitioner to use in an accredited or approved hospital any means described in paragraph (a) for the purpose of carrying out her intention to procure her own miscarriage.

If, before the use of those means, the therapeutic abortion committee for that accredited or approved hospital, by a majority of the members of the committee at which the case of such a female person has been reviewed

c. has, by certificate in writing stated that in its opinion the continuation of the pregnancy of such female person would or would likely endanger her life or health, and

d. has caused a copy of such certificate to be given to the qualified medical practitioner . . .

e. ‘accredited hospital’ means a hospital accredited by the Canadian Council on Hospital Accreditation in which diagnostic services and medical, surgical and obstetrical treatment is provided; ‘approved hospital’ means
the board of governors, management or directors or the trustees, commission or other person or group of persons having the control and management of an accredited or approved hospital;...qualified medical practitioner' means a person entitled to engage in the practice of medicine under the laws of the province in which the hospital referred to in subsection 4 is situated; 'therapeutic abortion committee' for any hospital means a committee, comprised of not less than three members, each of whom is a qualified medical practitioner, appointed by the board of that hospital for the purpose of considering and determining questions relating to terminations of pregnancy within that hospital.2

There are several problems manifest in this legislation. No hospital is required to establish a therapeutic abortion committee, which means that the law may not be followed to the same degree in Canada's approximately 275 Roman Catholic hospitals which are supported by public funds. This has resulted in overcrowding of the more liberal hospitals which do perform abortions, so that many women who legally qualify for an abortion are turned away for want of space.

There are other problems for the medical practitioner: his responsibility to his patients, civilly and under the Code, require him to refer the patient to a committee. Once he has done this from the forensic point of view his liability would end, but morally his dilemma remains. Since he refers to certain committees at certain hospitals by his own discretion, he is usually responsible for the ultimate disposition of pregnancy.

Artificial Insemination

There are two types of artificial insemination: homologous, using the husband's semen, and heterologous, using another donor's semen. Homologous insemination gives rise to few legal ramifications, since the husband will also be the father of the child, but heterologous insemination can present problems. Since this is an area of possible litigation, exceptional care should be taken in recording what transpired in all phases of the procedure.

The donor should be subjected to a careful physical examination, blood typing and a Wasserman test. The physician should ascertain and record that the donor is free of any physical disease.

The written consent of husband, wife and donor is necessary, giving the physician broad powers, with the right to select the donor and maintain that donor's anonymity. If possible the husband's and the donor's semen should be pooled so that paternity cannot be ascertained.

The identity of all parties should be closely guarded. Certain legal recommendations have been made concerning donor semen.3

1. The donor must not be a relative of either spouse; he should be potent; should be of age; his age should not exceed 40, and he should have had children of his own.

2. His race and characteristics should resemble as closely as possible those of the husband of the woman to be inseminated, his mental and physical history, together with his personal, familial, and general health must have proved satisfactory, and such examination should include the Wasserman reaction and RH grouping, and should exclude such diseases as tuberculosis, diabetes, epilepsy, endocrine dysfunction, and psychosis.

3. He must be willing to donate his seminal fluid for the purpose, and his wife must agree that he may do so.

4. He should be unaware of the destination of the donated seminal fluid and of the result of the insemination.

5. The woman to be inseminated and her husband must desire in written form that a donor, preferably unknown, should be used.

6. The physician in charge of the case should keep the relevant documents in his possession, with instructions that in the event of his death, they should be destroyed unread. He should never undertake the procedure without the knowledge and full consent of both spouses and a nurse should be present when the insemination is undertaken.

Artificial insemination presents unfortunate possibilities for incestuous relationships; for instance, if a donor is used repeatedly, there is a chance that his offspring will intermarry. There are many other possibilities; therefore the physician should obviously take great care in selecting a donor for such a procedure.

References

2. ibid page 217-220, Sections 251-253.