

# Dr. Nancy Morrison and Her Dying Patient: A Case of Medical Necessity

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## 1. Prologue

On May 6, 1997, 60 police officers swarmed into the Queen Elizabeth II Health Sciences Centre (QEII) in Halifax, Nova Scotia, in order to effect the arrest of a physician, Dr. Nancy Morrison, on a charge of first-degree murder in connection with the death of a patient six months earlier. They also carried out searches of 21 locations pursuant to a search warrant. The patient had died in the intensive care unit (ICU) two and a half hours after his removal from artificial life support, and months later a physician at the hospital had informed the police that Dr. Morrison had unlawfully caused his death.

A preliminary inquiry was held in Provincial Court where Randall P.C.J. discharged Dr. Morrison after ruling that “a Jury properly instructed could not convict the accused of the offence charged, any included offence, or any other offence.”<sup>1</sup> When the Crown’s appeal was denied by a Supreme Court judge,<sup>2</sup> it decided to pursue the matter no further. The case of *R. v. Morrison* thus never went to trial.

This article has a dual purpose: to present and analyze the legal repercussions of the patient’s death, and then to consider the viability of a defence of medical necessity if the case had gone to trial.

On the day of his death the patient received massive infusions of drugs, and the precise dosages and times of administration will be duly noted.<sup>3</sup> A brief review of the drugs in question will assist the lay reader to appreciate the situation as it

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<sup>1</sup>*R. v. Morrison*, [1998] N.S.J. No. 75, Case No. 720188, at para 21 (N.S. Prov. Ct.), online: QL (NSJ).

<sup>2</sup>*R. v. Morrison*, [1998] N.S.J. 441, S.H. No. 147941 (N.S. S.C.), online: QL (NSJ). In Nova Scotia the Supreme Court is the highest level trial court; depending on the province the highest level trial court is called either the Supreme Court or the Court of Queen’s Bench.

<sup>3</sup>We have reported the facts of the case from the official transcript of the preliminary inquiry, *In The Matter of Her Majesty The Queen v. Nancy Morrison*, 9 February 1998, Case No. 720188, The Honourable Judge Hughes Randall [hereinafter Transcript]. Subsequent references to the transcript have been placed in parentheses in the text. The specific drug dosages are discussed by the manager of the Health Records Department at the QEII Health Sciences Centre at 37-40 and 46, and also by Nurse Bland-MacInnes at 288-93.

unfolded. All told, between 6:50 a.m. and 2:30 p.m. on his last day the patient received intravenously four drugs to ease his dying: Ativan, Versed, morphine, and Dilaudid.<sup>4</sup> Ativan (generic name lorazepam) and Versed (generic name midazolam) are sedative-hypnotic and anti-anxiety drugs. He received 10 mg of Ativan which is not an unusual amount. However, the amount of Versed was in excess of 230 mg, whereas the recommended "common range" of Versed for the intractable distress of a dying patient is 30-60 mg/24 hours. Hence the total given (mostly between 12:30 p.m. and 2:30 p.m.) was four times the highest daily dose recommended for such cases. Morphine is an opiate analgesic (in lay terms, a pain-killer), whereas Dilaudid is a synthetic opiate and is five to eight times more potent than morphine. The patient received 40 mg of morphine and in excess of 800 mg of Dilaudid. In effect, then, this amounted to somewhat more than 4400-6800 mg of morphine equivalents.

To place this drug history in context, consider a study appearing in the journal, *Palliative Medicine*, which reviewed 30 cases in which morphine was administered to relieve the intractable distress of dying patients. The dose range over 24 hours was between 150-600 mg for 18 patients, 600-2500 mg for nine patients, 2500-5000 mg for one patient, and in excess of 5000 mg for two patients.<sup>5</sup> In other words, Mr. Mills was given more opiates than 90 per cent of these patients and comparable amounts to the other 10 per cent. Beyond that, the time frame for all 30 patients was 24 hours whereas his was only seven hours and 40 minutes.

A case reported in the journal, *Clinical Pharmacy*, provides the drug history of a terminally ill cancer patient "who required exceptionally high doses of narcotic analgesics to control chronic, severe pain."<sup>6</sup> Over the last few days of her life, her daily intravenous (IV) intake of morphine was in the range of 8100-8500 mg.<sup>7</sup> Again, note that in less than eight hours Mr. Mills received in excess of 4400-6800 mg of morphine equivalents. In sum, one can say that Mr. Mills received what was clearly an extraordinary (although not unheard of) amount of opiates.

## 2. The Day of the Patient's Death

Paul Mills was 65 years old and he was a very sick man; on November 9, 1996 his caregivers and family agreed that the time had come for him to die. His medical history was as follows.

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<sup>4</sup> The reason that morphine is not capitalized is that it is a generic name whereas the others are capitalized because they are brand names.

<sup>5</sup> S. Chater *et al.*, "Sedation for intractable distress in the dying - a survey of experts" (1998) 12 *Palliative Medicine* 255 at 260.

<sup>6</sup> L. Lo & R.C. Coleman, "Exceptionally high narcotic analgesic requirements in a terminally ill cancer patient" (1986) 5 *Clinical Pharmacy* 828.

<sup>7</sup> *Ibid.* at 832.

Mr. Mills was admitted to the Moncton (New Brunswick) General Hospital in April 1996 with cancer of the esophagus. The cancer was removed but complications ensued. A portion of his stomach had been used to replace his excised esophagus, but necrosis (death of the stomach tissue) led to leakage of gastrointestinal fluid and infection of surrounding tissue. Three further surgeries in Moncton failed to correct the problem, which led to the patient's transfer to the QEII in Halifax. He there underwent six additional surgeries which likewise proved fruitless. The two hospitalizations thus resulted in 10 surgical procedures (the last on October 28). Between October 15 and November 6 the patient's weight dropped by 19 kilograms (42 pounds), and infection developed to the point where healing from all of his surgical procedures had become impossible. By the time of his eighth operation on October 15, Mr. Mills was "heavily sedated, on narcotics, on antibiotics, multiple IVs running. Probably in the realm of 10 tubes in him, fully catheter arterial line, central lines for administration of antibiotics, and tubes in his stomach and tubes in his chest" (p. 464). And since the surgeons were unable to close his chest wall, pus was continually oozing out. Suffice it to say that his body had come to resemble a war zone.<sup>8</sup>

By mid-October he was profoundly depressed and although quite congested was refusing to cough up secretions. When advised by the nurse on October 12 that he was at risk of contracting pneumonia if he did not cough, he replied: "I just want to die" (p. 36). On October 15 he was admitted to the ICU and placed on a respirator (ventilator) because he could not breathe adequately on his own. Two days later his physicians and family (wife and adult son) agreed to the entry of a Do Not Resuscitate (DNR) order on his chart. As explained by his thoracic (chest) surgeon, Dr. Bethune (p. 465):

We felt that probably his course was going to be progressively downhill and the Do Not Resuscitate order is written so that if he develops any kind of a catastrophic deterioration, that attempts to resuscitate him would not be done. Because certainly if he got any worse than he was, there would be absolutely no reason to resuscitate him. It would just prolong the agony.

According to Elizabeth Bland-MacInnes, his ICU nurse on his last two days of life, he was "incredibly sick...his last few weeks were certainly tortuous" (p. 282). The severity of his condition is reflected in the fact that from October 10 until his death on November 10, he received infusions of Dilaudid around the clock.

The patient's persistent chest wall infection was pronounced incurable by Dr. Bethune on November 6. In his clinical opinion, there was "virtually, virtually definitely no chance of him surviving, no chance at all" (p. 477). Consultants in infectious diseases and plastic/reconstructive surgery, who were involved in the

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<sup>8</sup> The patient's surgical history, as presented in graphic detail by Dr. Bethune, is found at pages 439-77 of the Transcript, *supra* note 3.

patient's on-going care at the QEII, also concluded that there was nothing more that they could do. On November 9 the family agreed with Dr. Bethune that it was time to call a halt to artificial life-support, and it was arranged for this to happen the next day. At that time, the patient was not mentally competent to make that decision, although as noted he had stated a month before that he wanted to die. Nurse Bland-MacInnes said that throughout her 12 hour shift on November 9, "he was not responsive ... did respond to painful stimuli ... and had episodes of restlessness" (p. 283).

On the morning of November 10 Mr. Mills was taken off antibiotics and tube-feeding. Between 6:50 a.m. and 12:30 p.m. he received 10 mg of Ativan in four doses (the last being 4 mg). At 7 a.m. his Dilaudid drip was increased to 10 mg per hour, and then per hour to 12 mg at 8:20 a.m., to 16 mg at 9:15 a.m., and to 20 mg at 10:35 a.m. It was 30 mg by 11:04 a.m. and 40 mg by 12:10 p.m. The drugs were administered through two lines in the left femoral vein. At 12:30 p.m. the patient was extubated to room air (in other words, the respirator's tubing was removed from his throat where it had been surgically implanted).<sup>9</sup> It was assumed that without the support of the breathing machine he would expire in short order. At that time the resident ordered the following: Dilaudid increased to 100 mg/per hour, morphine 10-20 mg PRN, and Versed 10-50 mg PRN.<sup>10</sup>

Surprisingly, Mr. Mills did not die as anticipated but rather exhibited extreme shortness of breath. Between 12:42 p.m. and 1:03 p.m. Nurse Bland-MacInnes injected 40 mg of morphine in the IV line in four doses in order to relieve his respiratory distress. Still, he continued to gasp for air. The nurse then turned to Versed, giving him 10 mg at 1:10 p.m., followed by 20 mg at 1:16 p.m., and 50 mg at 1:25 p.m. Recall that at 12:30 p.m. the Dilaudid was increased to 100 mg/hour. By 1:20 p.m. it was 200 mg/hour, and at 1:50 p.m. it was 250 mg/hour. By 2:25 p.m. it was up to 500 mg/hour. Versed in a 50 mg dose was injected at 2 p.m.; the same amount was given at 2:15 p.m. and again at 2:30 p.m. In total that day, Mr. Mills received in excess of 800 mg of Dilaudid, in excess of 230 mg of Versed, and 40 mg of morphine (p. 269). Yet although these were enormous amounts, the patient's air hunger continued unabated.

When defence counsel suggested to Nurse Bland-MacInnes that the patient's struggle for air was "a horrible & hideous scene," she replied, "Yes, that is correct"

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<sup>9</sup>On November 10 Dr. Morrison was the attending physician in the ICU. It was not Dr. Morrison's decision to extubate the patient instead of leaving the tube in and simply shutting it off. (Nor was she involved in the decision by Dr. Bethune and the family to stop treatment.) According to the Transcript, it was the ICU resident, Dr. Cohen, who wrote the order to extubate (Transcript, *supra* note 3 at 258). A colleague of Dr. Morrison's told one of us that: "Doing it this way (extubating) was messy and caused discomfort" (interview with anonymous source (7 April 1998)). This view is shared by intensive care physicians in Winnipeg who as a matter of practice do not extubate when respiratory therapy is withdrawn.

<sup>10</sup>PRN is a Latin acronym which directs the nurse is to "give as much as is required according to your clinical judgment."

## Drug Chart

From 6:50 a.m. until 12:30 p.m. when extubated

Ativan 10 mg in four doses

Dilaudid - 7 a.m. - increased to 10 mg/hour  
8:20 a.m. - up to 12 mg/hour  
9:15 a.m. - up to 16 mg/hour  
10:35 a.m. - up to 20 mg/hour  
11:04 a.m. - up to 30 mg/hour  
12:10 a.m. - up to 40 mg/hour

Drugs from 12:30 p.m. to 2:30 p.m.

Dilaudid - 2:30 p.m. - up to 100 mg/hour  
Morphine - 12:30 p.m. 10-20 mg PRN  
Versed - 12:30 p.m. 10-50 mg PRN  
Morphine - 12:42 p.m. -40 mg (four doses)  
1:03 p.m.  
Dilaudid - 1:20 p.m. - up to 200 mg/hour  
1:50 p.m. - up to 250 mg/hour  
2:25 p.m. - up to 500 mg/hour  
Versed 1:10 p.m. - 10 mg  
1:16 p.m. - 20 mg  
1:25 p.m. - 50 mg  
2:00 p.m. - 50 mg  
2:15 p.m. - 50 mg  
2:30 p.m. - 50 mg

Total drugs administered on November 10

In excess of 800 mg of Dilaudid.

In excess of 230 mg of Versed.

40 mg of morphine.

(p. 309). She said that in 11 years of ICU experience she had never witnessed that much suffering in a patient and that “it was beyond a shadow of a doubt the worst death I have ever witnessed” (p. 320).

The ICU resident, Dr. Cohen, testified that following extubation Mr. Mills “continued to live and persist in a distressed state, gasping for breath” (p. 260). As he elaborated (p. 261):

From time to time, pus would ooze from his chest as he gasped. He had an infection in...the subcutaneous tissue...in his chest. It was filled with pus.... And there were wounds & incisions...made...to drain the pus. And the physical action of breathing involves contraction of...muscles in your chest... And this had the effect of causing some pus at time to dribble from...these open wounds.

When asked if he thought that the patient was conscious after being extubated, he replied: “Well, consciousness is a relative term, but he did not appear very conscious” (p. 262). He added that “he remained in distress, remained apparently in discomfort, and continued to gasp for breath” (p. 264). When asked why he qualified discomfort by saying “apparently,” Dr. Cohen responded (pp. 264-65):

Well discomfort is a subjective term and it relates to the patient’s ability to perceive stimuli that ordinary conscious people would consider uncomfortable. When somebody makes reactions that are typical of somebody in discomfort, you assume that they are in discomfort because it’s cruel not to.

He further stated that there were no “independent means of verifying” whether the patient was “consciously aware of pain” (pp. 276-77). In other words, no one can say with certainty whether Mr. Mills died in agony. At the time of his death, his systolic blood pressure was 50mm Hg (where it had hovered for most of that day), which would likely result in greatly reduced blood flow to his brain. For that reason a physician at the QEII later expressed the opinion to one of us that “[h]e probably lost consciousness when the tube was removed. Agonal breathing isn’t necessarily agonizing. His blood pressure was so low as to suggest that there was no conscious awareness of suffering.”<sup>11</sup>

On the other hand, Nurse Bland-MacInnes was at the patient’s bedside for hours and was convinced that he was suffering. Her intuition is supported by anecdotal evidence of patients with comparable systolic blood pressure who were able to communicate with their physicians.<sup>12</sup> So perhaps he was experiencing an

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<sup>11</sup> Interview with anonymous source (7 April 1998).

<sup>12</sup> For example, a Winnipeg physician (internist) with ten years ICU experience told one of us that he had had two patients with a systolic blood pressure of 50mm Hg who were nonetheless able to communicate with him (interview with anonymous source).

agonizing death and perhaps he was not. But the point surely is that this may well have been the case and that it was not unreasonable for his caregivers to assume so.

Be that as it may, Nurse Bland-MacInnes was appalled at what she clearly perceived as unconscionable suffering and she did not hesitate to convey her concerns to Dr. Morrison. After the nurse expressed her exasperation that the sedatives and narcotics were accomplishing nothing, Dr. Morrison returned to the bedside at 2:52 p.m. where she injected 10cc of nitroglycerine into the patient's IV line. According to the nurse, Dr. Morrison told her that "it would decrease blood pressure to end patient's suffering" (p. 294). His systolic blood pressure immediately dropped to 50mm Hg although it then increased to 55-60 (p. 294). At 2:59 p.m. Dr. Morrison returned to the bedside with a 10cc syringe of clear liquid that she began to inject into the IV. When the nurse asked what it was, she answered: "It is KCl" (p. 294). (KCl is potassium chloride, about which we will have much to say later.) Within a minute there was no electrical activity in the heart. Both the nitroglycerin and the KCl were administered by IV push, which caused the drugs to move more quickly into the bloodstream than when given by infusion (p. 302).

Dr. Cohen had left the ICU sometime around 2:30 p.m. for lunch, and when he returned shortly after 3 p.m. he was not surprised to learn that Mr. Mills was dead. He then completed the death certificate because, as he said, that was a task for house staff. As the cause of death, he wrote: "refractory thoracic abscess due to or as a consequence of failed esophageal anastomosis due to or as a consequence of esophageal resection for carcinoma" (p. 266).

Nurse Bland-MacInnes testified that she said to Dr. Morrison, just before the latter left the unit to get the KCl, words to the effect that: "Mr. Mills appeared to be indestructible and I could not imagine what it would take to end his suffering unless it was something like KCl" (p. 299). It was, however, what she described as "a facetious statement" that was not meant to encourage Dr. Morrison to act unlawfully (p. 298). When asked whether "it was the most agonizing death you'd ever witnessed," she replied, "Yes, that's true" (p. 305). She added that Dr. Morrison never asked her to keep quiet about what had happened (p. 322). When asked whether she would have drawn up the KCl if asked, she emphatically replied, "No, sir, I would not" (p. 298). When then asked, "And why not?", she responded: "Because I have three children to put through university and I need to work" (p. 298). When queried about the actions of Dr. Morrison, she said that she was "completely stunned" (p. 301).

Four days after the patient's death Nurse Bland-MacInnes informed the nurse manager what had happened, and the latter promptly confronted Dr. Morrison with this startling news. According to the nurse manager, Dr. Morrison responded that it was true and when asked why she had done it, she answered: "I, Oh, my God! I don't know why" (p. 354). When asked whether Dr. Morrison had told her that the patient "had been gasping for hours and was in the process of dying a horrible death," the nurse manager replied "Yes" (p. 356). When asked whether Dr. Morrison had told her that Nurse Bland-MacInnes "was begging (her) to do

something to relieve Mr. Mills' pain and suffering from his agonizing death," she again answered "Yes" (p. 356).

It was not the hospital that reported the incident to the police but rather a physician who had seen an internal review of the patient's death and concluded that Mr. Mills was a victim of "active euthanasia."<sup>13</sup> The QEII had responded to the internal review by suspending Dr. Morrison's hospital privileges for three months but did not report the matter to either the provincial College of Physicians and Surgeons or the provincial chief medical examiner.<sup>14</sup> Fearing that the hospital would cover up the incident, the physician notified the police who responded by charging Dr. Morrison with first-degree-murder. As noted, this did not happen until May 1997, six months after the incident.

The criminal responsibility of Dr. Morrison will be considered in due course, but what about Nurse Bland-MacInnes? If there was evidence that she had encouraged (abetted) Dr. Morrison to kill the patient, then she would become a party to the offence pursuant to section 21(1)(c) of the *Criminal Code*.<sup>15</sup> Yet there was no evidence to that effect. When she told Dr. Morrison that she did not know what would kill him short of KCl, she was likely speaking out of frustration. As she testified, it was a "facetious" comment and there was no reason to believe otherwise.<sup>16</sup>

### 3. The Preliminary Inquiry

Seven months after Dr. Morrison's arrest, a preliminary inquiry was held in Provincial Court to determine whether she should be committed to stand trial for first-degree murder. In Nova Scotia the police, who are empowered to lay charges without consulting the Crown, had refused the latter's request to withdraw the first-degree murder charge. However, just before the inquiry opened the Crown attorney informed Randall P.C.J. that even if there were a committal for murder, he would reduce the charge to manslaughter if the case went to trial. The Nova Scotia Public Prosecution Service had received cards, letters, and petitions (one

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<sup>13</sup>K. Cox, "Nova Scotians asking why doctor charged with murder" *The Globe and Mail* (2 March 1998) A10.

<sup>14</sup>K. McArthur, "Hospital bungled murder probe" *The Globe and Mail* (14 August 1997) A4.

<sup>15</sup>R.S.C. 1985, c. C-46. According to s. 21(1), "[e]veryone is a party to an offence who ... (c) abets any person in committing it."

<sup>16</sup>This brings to mind that celebrated line from T.S. Eliot's *Murder in the Cathedral*, his masterpiece about the death and martyrdom of Thomas Becket in medieval England. When Henry II says in despair, "Who will rid me of this troublesome priest?," four knights take him literally and slash Becket to death. In a contemporary setting the King is not a party to murder if he did not intend his words as an act of encouragement even if the perpetrators took them as such and acted accordingly. In any case, only Dr. Morrison would know whether she was prompted to act not only because of the patient's apparent agony but also because of the nurse's anxiety and frustrating reference to the KCl. But this is beside the point as the legal question is simply whether there was the intent to encourage Dr. Morrison to administer the KCl. Since Nurse Bland-MacInnes was adamant that her words were not intended as encouragement to the deed, there would have been no way for the Crown to prove otherwise.

with 5,000 signatures) calling for the dismissal of the charge. The Crown attorney acknowledged that this was a factor in his decision that it was “not in the public interest” to proceed with first-degree murder because the mandatory life sentence for that offence was “too harsh and oppressive” to apply to the case.<sup>17</sup> Although the Crown could have responded with a preferred indictment for manslaughter, thereby eliminating the need for a preliminary inquiry, it chose, for whatever reasons, to allow the inquiry to proceed.

From the defence standpoint, the charge hinged upon the issue of causation. Two days before the patient’s death his pain and discomfort during a procedure to drain pus had been relieved by 5 mg of Dilaudid and 2 mg of Versed (p. 381). These doses were a mere fraction of the amounts administered two days later to no apparent effect (in excess of 800 mg of the former and 230 mg of the latter), and the groundwork for an argument on causation lay in explaining why such massive doses had failed to relieve Mr. Mills’ distress.

According to Dr. Geoffrey Barker, a specialist in intensive care (also called critical care), the amounts of Dilaudid and Versed given on November 10 were outside his range of experience. He agreed with the suggestion of one of the three defence counsel that the levels of Dilaudid (up to 500 mg/hour) were “in the lethal range” (p. 408).<sup>18</sup> He answered “Yes” to the question: “You would anticipate that this level of Dilaudid would have a profound depressant effect on respiration and blood pressure” (p. 408). Dr. Barker stated that if he had been in attendance, the apparent ineffectiveness of such massive doses would have prompted him to check whether the intravenous (IV) line was intact. Given the small amounts of Dilaudid and Versed that had relieved the patient’s distress two days earlier, Dr. Barker agreed with defence counsel that one possible explanation was that the tip of the IV line had migrated and that the drugs were only getting into a body cavity (p. 418). In that event, they would work far more slowly than if the IV line were functioning properly. Since the line was apparently working two days before, the contention of the defence was that it had somehow slipped out since that earlier procedure. (Presumably because the Crown did not anticipate the migrating IV theory, it did not ask Bland-MacInnes whether anyone had bothered to check the line.)

The pathologist who examined the body after it was exhumed testified that, although there should have been traces of Dilaudid and morphine in the liver, he could not find any. He agreed with defence counsel that the absence of these drugs in the liver was consistent with the theory that the drugs were not getting into the bloodstream (p. 495). The reason that he could not find evidence of nitroglycerine or KCl was that they dissipate in the body fluids and quickly become undetectable.

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<sup>17</sup> B. Bergman, “The Crown Reconsiders” *Maclean’s* (17 November 1997) at 15.

<sup>18</sup> One cannot really generalize that an infusion of narcotics, no matter how massive, is in a “lethal range.” It really depends on the patient’s level of tolerance to the drugs. As the study by Lo & Coleman, *supra* note 6, points out (at 832): “For [terminally ill cancer] patients, there is no set maximum dose of narcotic analgesics.”

It was the theory of the defence that if the IV line was not working and the pain-killers thus not reaching the patient, then the same would be true of the nitroglycerine and KCl. As defence counsel put it in his summation, "Whatever the intention was, the act didn't occur" (p. 565).

In the result, Randall P.C.J. accepted the defence causation argument and accordingly discharged Dr. Morrison, ruling that there was no case to go to the jury for murder or any included offence.<sup>19</sup> The Crown appealed but Hamilton J. of the Supreme Court denied the appeal, notwithstanding that she agreed with the Crown that "at the very least the preliminary inquiry judge should have committed Dr. Morrison to stand trial for (the) attempt to commit murder."<sup>20</sup> Still, she refused to overrule Randall P.C.J. on the grounds that the decision of a preliminary inquiry judge stands even if he errs with regard to the sufficiency of the evidence. Even though she disagreed with Randall P.C.J.'s finding, she concluded that "a preliminary hearing judge can come to the wrong conclusion on the sufficiency of evidence without losing jurisdiction, this being an error of law, not an error of jurisdiction."<sup>21</sup>

Notwithstanding Hamilton J.'s refusal to carry the case forward, the Crown could have responded by charging Dr. Morrison with manslaughter as it had previously indicated it would do, or it could have appealed her ruling. But it did neither and that was the end of the case as far as the courts were concerned.<sup>22</sup>

What remained was the judgment of Dr. Morrison's peers, and in 1999 she was reprimanded by the provincial College of Physicians and Surgeons (the profession's disciplinary arm). The College ruled that her actions were inappropriate and "outside the bounds of currently acceptable medical practice."<sup>23</sup> At the same time, the College commended Dr. Morrison for not abandoning her patient and acknowledged her belief that she was acting in his best interest. In accepting the reprimand, Dr. Morrison acknowledged wrongdoing; and on her behalf one of the defence counsel issued the following statement: "She now realizes after much thought that there was a mistake made by herself. Sometimes when you have a person who is dying and going through an agonizing death, you have to make a

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<sup>19</sup> *Supra* note 1.

<sup>20</sup> *Supra* note 2 at para 38.

<sup>21</sup> *Supra* note 2 at para 19.

<sup>22</sup> Three weeks after Hamilton J.'s ruling, the Crown prosecutor announced that there would be no further legal proceedings against Dr. Morrison. He stated that the Crown would respect her decision and would not exercise its right to force Dr. Morrison to trial by way of a direct indictment. See K. Cox, "Morrison case comes to an end" *The Globe and Mail* (12 December 1998) A11. According to the local media there was overwhelming public support for Dr. Morrison; three months before the preliminary inquiry, it was reported that the Crown had received over 4,000 cards and letters asking that the case be dropped. K. Cox, "Doctor's reduced charge explained by prosecutor" *The Globe and Mail* (7 November 1997) A5. It may be that what explains the outcome of the case is that the courts and the Crown got the message and responded accordingly.

<sup>23</sup> A. Auld, "Doctor accepts reprimand over death of patient" *The Globe and Mail* (31 March 1999) A3.

snap call, and she made it and she made the wrong one. It was a mistake on her part.”<sup>24</sup>

There were, however, expressions of support for Dr. Morrison from her peers. The Medical Society of Nova Scotia responded to the reprimand by writing her that “[i]t is our sincere desire that any further legal or regulatory actions will be considered unnecessary. As a practicing physician you have discharged your duty with diligence and compassion, and have acted in what you believed to be your patient’s best interest.”<sup>25</sup> And two highly respected physicians working in the intensive care unit of the I.W.K. Grace Hospital in Halifax released to the media the following letter sent to Dr. Morrison: “As physicians, we respect the college and accept its mandate to govern the practice of medicine, but we do not believe that your actions in the Mills case required formal reprimand. We think it is important for the public to know that we believe that your actions were compassionate and motivated only by your desire to help a dying, suffering man.”<sup>26</sup>

These sentiments were endorsed by Paul Mills’ brother, who publicly stated: “I don’t think she meant to murder him. I think she meant to alleviate the pain.” He then added: “Nobody ever convinced me that Dr. Morrison meant to kill my brother.”<sup>27</sup> Dr. Morrison, who was trained as a respirologist, no longer works in intensive care.

#### 4. Commentary on the Preliminary Inquiry

The Crown’s function at a preliminary inquiry is not to prove guilt beyond a reasonable doubt but simply to establish a *prima facie* case – that a reasonable jury properly instructed might return a guilty verdict. In our view such a case could have been made if the Crown had pursued its task with more diligence. To begin with, the spectre of the malfunctioning IV line could have been countered with a rather more plausible explanation for the apparent inefficacy of the drugs. The reference here is to a phenomenon called hyperalgesia or opioid hyperexcitability, in which high doses of narcotics paradoxically aggravate instead of ease pain. Cases have been reported in the medical literature, although a clear explanation of their occurrence remains elusive.<sup>28</sup>

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<sup>24</sup> *Ibid.*

<sup>25</sup> G. Galloway, “Morrison receives support from fellow Nova Scotia doctors” *National Post* (1 April 1999) A10.

<sup>26</sup> *Ibid.*

<sup>27</sup> C. Szklarski, “Compassionate killing case dropped” *Winnipeg Free Press* (12 December 1998) A14.

<sup>28</sup> See N. MacDonald *et al.*, “Opioid hyperexcitability: the application of alternate opioid therapy” (1993) 53 *Pain* 353. Dr. MacDonald is Professor of Palliative Medicine, Alberta Cancer Foundation, Department of Medicine, The University of Alberta. The authors present three cases of patients who experienced central nervous system adverse effects on high-dose hydromorphone (Dilaudid). Two had received 200 mg per hour and the third 65 mg per hour. (Recall that Mr. Mills was on 200 mg per hour at 1:30 p.m., which was increased to 250 mg per hour at 1:50 p.m. and finally to 500 mg per hour at 2:25 p.m.)

Furthermore, it should have occurred to the nurse and the two physicians (Dr. Cohen and Dr. Morrison) to check the IV line when it became evident that massive infusions of drugs were not sedating the patient. An extraordinary and nightmarish situation had unfolded, and surely the first thing that would normally come to mind is to determine whether the drugs were actually getting through. (As noted, the Crown did not raise the issue with Nurse Bland-MacInnes. Obviously, if there was evidence that the line had been checked and found working, then this would collapse the causation theory of the defence.) Admittedly, given human nature it may be that the caregivers were so focussed upon the stressful situation at hand that they simply overlooked the obvious. On the other hand, it would seem more likely that at some point the line was checked and was found intact.

What about the evidence of the pathologist that, because he could detect no traces of Dilaudid and morphine in the liver, their absence was consistent with the theory that the drugs were not getting into the bloodstream? Because Mr. Mills had been embalmed, there is a counterargument that this process may have interfered with the drug assay. In fact, there is medical evidence that embalming can block the detection of these drugs.<sup>29</sup>

Finally, consider the two drugs, nitroglycerin and KCl, that were administered by Dr. Morrison in the waning minutes of the patient's life. Nitroglycerin lowers blood pressure, and right after she injected it into the IV line that is precisely what happened - Mr. Mills' blood pressure dropped immediately to 50 although it then climbed up temporarily to 55-60 (p. 294). KCl is used to balance electrolytes and to stop the heart temporarily during heart surgery. In such instances it is diluted and given by way of slow infusion. On the other hand, giving an undiluted bolus of 10 cc (that is, pushing it in all at once) will inevitably prove fatal by causing cardiac arrest in well under a minute. In this case, that is precisely what happened - according to Nurse Bland-MacInnes the patient's heart stopped beating "within seconds" of the injection (p. 294).

Again, the issue at the preliminary inquiry stage is simply whether there is any evidence that could support a guilty verdict at trial. But none of the matters that we have highlighted, especially the apparent effectiveness of the nitroglycerine and KCl, was brought home by the Crown.

It is thus understandable why Randall P.C.J. ruled that the Crown had not proved a *prima facie* case of murder. But, if not murder what then of attempted murder? Here it is only necessary to prove that the accused acted with *mens rea* (intent) for murder since the thorny issue of causation is beside the point. It is a fundamental rule of criminal law that, even if it cannot be proved that an accused

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<sup>29</sup>W.W. Wanders & B.R. Keppler, "The effect of formaldehyde solution in the gas chromatographic determination of morphine, (1980) 51 Aviation, Space, and Environmental Medicine 993.

charged with murder caused death, she can still be convicted of the included offence of attempted murder if the Crown can prove the *mens rea* for murder.<sup>30</sup>

To illustrate the point, consider a hypothetical case in which an elderly lady swaying back and forth in her rocking chair is shot between the eyes by her beloved nephew who stands to inherit her estate. Even though the nephew assumed that he had killed his aunt, the medical evidence is that she had died of a heart attack moments before the shot was fired. In that event, the nephew cannot be convicted of murder because he did not cause the death; but still he is clearly guilty of attempted murder because the only inference of intent that can be drawn from his act is that it was to kill the deceased. The same principle applies here. Given that there was no therapeutic indication for KCl for this dying patient, the only inference of intent that can be drawn from its administration is that it was for the express purpose of killing the patient by causing cardiac arrest. When all is said and done, there is no other conceivable explanation for what she did.

This insight was grasped in a 1992 English case, *R. v. Cox*.<sup>31</sup> Dr. Nigel Cox, a 48-year-old rheumatologist, was charged with attempted murder after he gave an ampoule of KCl to a 70-year-old patient who had begged him to end her life. According to a nurse, the patient died within one minute. She was dying of rheumatoid arthritis, complicated by gastric ulcers, fractured vertebrae, internal bleeding, gangrene, and body sores. Massive doses of heroin were unable to relieve her pain because her ravaged body could not absorb them. A nurse testified that “she howled and screamed like a dog” when anyone touched her and a hospital chaplain stated that he had never seen anyone else “so much eaten by pain.”<sup>32</sup> The reason that Dr. Cox was not charged with murder was that, since the patient’s body had been cremated, the Crown concluded that it could not prove the medical cause of death. But since KCl is naturally present in the body, an autopsy cannot in itself produce the forensic evidence necessary to prove causation. The Crown thus has a rough hurdle to prove causation when the alleged lethal drug is KCl. The best case scenario from a prosecution standpoint is when the patient’s death is not relatively imminent, his heart stops within roughly one minute after the drug is given, and the pathologist can find no other apparent cause of death.

But still there was never any question but that the case could go forward on a charge of attempted murder. In that regard, the trial judge explained to the jury that if Dr. Cox’s “primary purpose” was to kill the patient, he was guilty of attempted murder and that it was legally beside the point whether the KCl was in fact the cause of death.<sup>33</sup> Given the undisputed medical evidence that there was no

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<sup>30</sup> Section 229(a)(ii) of the *Criminal Code* defines the *mens rea* of murder as the intent to cause death or to cause bodily harm that the accused “knows is likely to cause death, and is reckless whether death ensues or not.”

<sup>31</sup> (1992), 12 BMLR 38.

<sup>32</sup> Robert Porter “Doctor Convicted of Attempted Murder” *London Sunday Telegraph* (20 September 1992) 1.

<sup>33</sup> *Supra* note 31.

therapeutic rationale for the KCl in this case, the jury convicted although a number were in tears when the verdict was announced. Dr. Cox received a one year suspended sentence and although reprimanded by the General Medical Council he was not stricken from the medical rolls.

Aside from attempted murder, consider section 245 of the *Criminal Code*, according to which it is an offence to administer “poison or any other destructive or noxious thing” to a person. In two unreported Ontario mercy-killing cases, *R. v. Mataya* and *R. v. de la Rocha* in which a nurse and a physician, respectively, injected a dying patient with KCl, the end result was a guilty plea to this offence.

In 1992 Scott Mataya, a 25 year old Toronto nurse, was charged with first-degree murder after informing hospital authorities that he had given a lethal dose of KCl to his dying 79 year old patient. The comatose patient was suffering from kidney, liver, and lung failure. After consultation with the family, the attending physician disconnected his ventilator after injecting him with 40 mg of morphine and 30 mg of Valium and leaving an order calling for repeated dosages in 30 minutes if needed. Mataya was then left alone with the patient, whose laboured breathing prompted the second infusion 30 minutes later. However, as the Toronto nurse explained his actions:

And he still goes on breathing with 80 milligrams of morphine and 60 of Valium - a massive dose. And then he started to twitch. He started to produce tons of mucous, which was frothing out of his tracheostomy. I was trying to suction this stuff up. He was coughing and hacking. The twitching was getting more and more severe. It was going against all the drugs we had given him. I didn't like the man's wife to come back and see him like this. I didn't want her to learn that he had choked and suffocated to death. I looked at the heart monitor and could see its strong, steady beat. It was a healthy, bloody heart and I thought this guy's heart has got to stop. I knew there was a drug right on my tray that would stop it. I drew up some potassium chloride; we use it all the time to balance electrolytes. I diluted it in an i.v. chamber because I didn't want it to burn going in. And I gave it to him.<sup>34</sup>

The patient's heart stopped four minutes later, and when Mataya told another nurse what he had done she informed senior staff. When asked to explain his actions, he replied: “I just thought a man shouldn't have to choke and suffocate to death. It wasn't as if he was going to recover. His fate was decided when the respirator was turned off. I thought he shouldn't suffer.”<sup>35</sup>

In the result, the Crown agreed to a guilty plea to the section 245 offence and Mataya was placed on probation for three years. (The evidence that it took minutes

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<sup>34</sup> A. Mullins, “A question of mercy killing” *Toronto Star* (15 October 1994) A4.

<sup>35</sup> *Ibid.*

after the injection of the KCl for the patient's heart to stop is enough to explain the Crown's decision.) When the verdict was announced, the patient's family expressed its gratification that the nurse was not imprisoned.

The following year Dr. Alberto de la Rocha, a 48-year-old Timmins surgeon, was charged with second-degree murder after giving an injection of 20 milliequivalents of KCl to a 68-year-old dying patient afflicted with cancer of the mouth, cheek, and lungs. Expressing the wish to die the patient asked that the respirator be turned off; immediately after doing so Dr. de la Rocha administered 40 mg of morphine to prevent her from experiencing the terrors of suffocation. However, he then injected the KCl which was likely the direct cause of death.<sup>36</sup> The patient's family refused to condemn the actions of the accused, and her sons went so far as to state publicly that he had given their mother a "very peaceful, very dignified, and very humane death."<sup>37</sup> The accused was allowed to plead guilty to administering a noxious thing and received a three year suspended sentence.

It likewise follows that because the injections of nitroglycerine and KCl were given by Dr. Morrison for the express purpose of ending the patient's life, they fall under the category of a "noxious thing." However, since the charge against her did not spell out the means by which the patient was allegedly killed – it simply stated that the accused "did unlawfully cause the death of Paul Mills" – the noxious thing offence was technically not an included offence. (Recall, however, that Randall P.C.J. did rule that "a jury properly instructed could not convict the accused of the offence charged, any included offence, or any other offence."<sup>38</sup>) On the other hand, attempted murder is always an included offence to murder.

In any event, Randall P.C.J. erred in law when he ruled that, aside from murder, there was no *prima facie* case for any included offence. There were clearly two counts of attempted murder because the evidence was uncontested that two drugs were given with no other explanation than the intent to relieve the patient's distress by ending his life, and in law that translates into the intent to commit murder.

Not surprisingly, Hamilton J. agreed with the Crown that "at the very least, the Preliminary Inquiry Judge should have committed Dr. Morrison to stand trial for attempt to commit murder."<sup>39</sup> But as noted she refused to overrule Randall P.C.J.'s decision to discharge the accused. So much, then, for the passage of the Morrison case through the courts.

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<sup>36</sup> The reason we say "likely" is that, since KCl is naturally present in the body, its role in directly causing death cannot be proved at autopsy. It is rather an inference that may be drawn from evidence that cardiac arrest followed almost immediately after it was given (recall that such was the evidence of Nurse Bland-MacInnes).

<sup>37</sup> C. Mungan, "Sentence suspended in euthanasia case" *The Globe and Mail* (25 August 1992) A1 at A11.

<sup>38</sup> *Supra* note 1.

<sup>39</sup> *Supra* note 2 at para. 38.

But what if Dr. Morrison had been committed to stand trial for first-degree murder or attempted murder, or if the Crown had preferred a direct indictment for manslaughter? In that event the defence would no doubt have raised the common law fence of necessity: that given the urgent and compelling plight of Mr. Mills, Dr. Morrison acted upon the reasonable belief that ending his life was a lesser evil than allowing his agony to go on. We turn now to a scenario in which the actions of Dr. Morrison are measured against the jurisprudence on necessity as formulated by the Supreme Court of Canada.

## 5. The Supreme Court and the Common Law Defence of Necessity

Bear in mind that at the interface between law and medical ethics there is an ongoing debate whether Parliament should legalize physician-administered euthanasia (mercy-killing) and physician-assisted suicide.<sup>40</sup> For that reason it is conceivable that the trial judge would be loathe to allow a plea of necessity by Dr. Morrison for fear that recognition of this defence would amount to de facto legalization of mercy-killing by physicians. The judge might thus decide that the matter was more properly addressed by Parliament.

But if that was not the trial court's position, then the question is whether the accused could meet the evidentiary burden (also called the "air of reality" test) that applies to any proposed defence. As the Supreme Court ruled in *R. v. Osolin*:

A defence should not be put to the jury if a reasonable jury properly instructed would have been unable to acquit on the basis of the evidence tendered in support of that defence. On the other hand, if a reasonable jury properly instructed could acquit on the basis of the evidence tendered with regard to that defence, then it must be put to the jury. It is for the trial judge to decide whether the evidence is sufficient to warrant putting a defence to a jury as this is a question of law alone.<sup>41</sup>

That said, we turn to the leading Canadian case on necessity, the 1984 decision by the Supreme Court in *R. v. Perka*.<sup>42</sup> In *Perka*, Dickson J. (as he then was) crafted a common law defence pursuant to which an accused would be excused from criminal responsibility if he had acted in a state of "moral involuntariness." As he explained:

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<sup>40</sup>In the former instance, the physician performs the act that directly causes death by giving a lethal injection at the request of the patient. (The patient's consent is no defence to a charge of murder because section 14 of the *Criminal Code* provides that "no one can consent to have death inflicted upon him.") In the latter instance, it is the patient who performs the act that directly causes death by ingesting lethal drugs provided for that purpose by the physician. In other words, the patient commits suicide and the physician commits the offence of aiding suicide under section 241(b) of the *Criminal Code*.

<sup>41</sup>[1993] 4 S.C.R. 595 at 676.

<sup>42</sup>[1984] 2 S.C.R. 232, 14 C.C.C. (3d) 385 [hereinafter cited to C.C.C.].

The lost Alpinist who, on the point of freezing to death, breaks open an isolated mountain cabin is not literally behaving in an involuntary fashion. He has control over his actions to the extent of being physically capable of abstaining from the act. Realistically, however, his act is not a “voluntary” one. His “choice” to break the law is no true choice at all; it is remorselessly compelled by normal human instincts.<sup>43</sup>

Necessity is thus a “back-to-the-wall” defence compelling the accused to ask the rhetorical question: “What other choice was there?” Still, as Dickson J. noted, it is not enough that the accused honestly believed that she was caught on the horns of a dilemma and had no option but to commit the offence in question. He accordingly stipulated three “limitations” on the defence: urgency, no legal way out, and proportionality. To begin with, the defence is restricted to “urgent situations of clear and imminent peril when compliance with the law is demonstrably impossible ... [when] normal human instincts cry out for action and make a counsel of patience unreasonable.”<sup>44</sup>

Second, could the accused “realistically have acted to avoid the peril or prevent the harm, without breaking the law?” Was the crime “truly the only realistic reaction open to the actor?” If, on the other hand, the actor “was in fact making what in fairness could be called a choice,” then there was a “reasonable legal alternative to disobeying the law.”<sup>45</sup> In that event the defence fails. Third, the law cannot excuse the “infliction of a greater harm to allow the actor to avert a lesser evil.” It follows that “the harm inflicted must be less than the harm sought to be avoided.”<sup>46</sup> Otherwise the defence fails.

In the recent case of *R. v. Latimer*,<sup>47</sup> the Supreme Court took another look at the defence of necessity, ruling that on the facts the trial judge was right to keep the defence from the jury because there was no air of reality to it.<sup>48</sup> In *Latimer* the Court further refined the defence by stipulating that its first two components — urgency and no legal way out — were to be governed by a so-called “modified objective standard,” according to which an objective evaluation of the situation would take into account the personal circumstances and characteristics of the accused.<sup>49</sup> The Court derived the concept from its ruling in a 1995 case, *R. v.*

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<sup>43</sup> *Ibid.* at 398.

<sup>44</sup> *Ibid.* at 400.

<sup>45</sup> *Ibid.*

<sup>46</sup> *Ibid.* at 401.

<sup>47</sup> [2001] 1 S.C.R. 3. For a critique of the Supreme Court’s analysis of the necessity defence in the *Latimer* case, see B. Sneiderman, “Latimer in the Supreme Court, Necessity, Compassionate Homicide, and Mandatory Sentencing” (2001) 62 Sask. L. Rev. 511.

<sup>48</sup> The air of reality test refers to the evidentiary burden upon an accused to present sufficient evidence that, if believed, would allow the jury to acquit. In other words, if there is no air of reality to his defence, then there is no point in allowing the jury to consider it.

<sup>49</sup> *Supra* note 47 at para 33.

*Hibbert*.<sup>50</sup> Although *Hibbert* involved the defence of duress, Lamer C.J.C. concluded in that case that duress and necessity “apply to essentially similar fact situations and should be interpreted in the same manner.”<sup>51</sup> He went on to say that “[i]t is appropriate to employ an objective standard that takes into account the particular circumstances of the accused, including his or her ability to perceive the existence of alternative courses of action.”<sup>52</sup>

After quoting this sentence in *Latimer*, the Court added the following:

While an accused’s perception of the surrounding facts may be highly relevant in determining whether his conduct should be excused, those perceptions remain relevant only so long as they are reasonable.... There must be a reasonable basis for the accused’s beliefs and actions, but it would be proper to take into account circumstances that legitimately affect the accused person’s ability to evaluate his situation.<sup>53</sup>

However, the Court in *Latimer* went on to say that proportionality must be measured by a “purely objective standard”: that the “evaluation of the seriousness of the harms must be objective.”<sup>54</sup> That is because “evaluating the nature of an act is fundamentally a determination reflecting society’s values as to what is appropriate and what represents a transgression.”<sup>55</sup>

Assuming, then, that Dr. Morrison had gone to trial charged with either murder or attempted murder, could she have met the air of reality test for the three limitations mandated in *Perka*? Although the facts in Morrison’s case occurred before the Supreme Court decision in *Latimer*, we will apply the latter’s so-called “modified objective” and “purely objective” standards. For one thing, the groundwork for the standards was set in *Hibbert*, which was decided before the death of Paul Mills (and thus would be a precedent case applicable to the facts in Morrison). For another, as we will have occasion to point out, the standards as refined in *Latimer* would not constitute an impediment to the air of reality test that Dr. Morrison would have to satisfy before a trial judge. In other words, even if applied retroactively to a necessity defence for Dr. Morrison, the *Latimer* standards would not undermine her case.

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<sup>50</sup> [1995] 2 S.C.R. 973. In *Hibbert*, Lamer C.J.C. specified that the modified objective standard was applicable to the question whether the accused had a “safe avenue of escape,” which is of course analogous to the “reasonable legal alternative” arm of the necessity defence.

<sup>51</sup> *Ibid.* at para 54.

<sup>52</sup> *Ibid.* at 59. Quoted in *Latimer*, *supra* note 47 at para 33.

<sup>53</sup> *Supra* note 47 at para 33.

<sup>54</sup> *Ibid.* at para 34.

<sup>55</sup> *Ibid.*

## 6. The Limitations to the Defence as Applied to the Morrison Case

### *A. Urgency: a “situation of clear and imminent peril.”*

Perhaps there was no conscious awareness of suffering by Mr. Mills, but then perhaps there was. In any event, Dr. Morrison was confronted with a patient struggling for air in circumstances that the nurse agreed were “horrible and hideous.” The modified objective test pays heed to the accused’s “perception of the surrounding facts,” provided that her perception was reasonable. Surely it was reasonable for Dr. Morrison to believe, as did the nurse, that the patient was dying an agonizing death. In fact, this was more than imminent peril: the peril had already arrived. It therefore follows that she clearly meets the air of reality test with respect to the urgency of the matter.<sup>56</sup>

### *B. No reasonable legal alternative*

The question here is whether any measures could reasonably have been adopted short of taking steps to kill the patient. Mr. Mills was gasping for breath because he was no longer being ventilated. If he had not been extubated (the breathing tube removed from his throat), it would have been a simple task to restart the ventilator. But because he had been extubated, this option would have required the reinsertion of the tube through the hole in his throat. Assuming that this could be accomplished it would have amounted to a holding action, putting Mr. Mills back to the situation he was in at 12:30 p.m. But at least matters could then have been reassessed. If one could state with confidence that reintubation was an option, then it would follow that there was no air of reality to the claim that there was no legal way out.<sup>57</sup> Admittedly, it is impossible from hindsight to say whether or not the breathing tube could have been reinserted. Still, it could reasonably be argued that attempting to force a tube into the throat of a struggling, gasping patient would have made matters even worse. Since it therefore follows that re-intubation was not a clear legal way out of the dilemma in this case, the accused would satisfy the air of reality test.

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<sup>56</sup> As illustrated by the *Latimer* case, the necessity defence does not require that it be the accused who is in peril. After all, Robert Latimer was not precluded from raising the defence because the peril applied to his daughter and not himself. Although the Supreme Court denied an air of reality with respect to the peril requirement, it did not do so on the grounds that Latimer himself was not in jeopardy. If the law were otherwise then there could never be a defence of medical necessity because it is not the accused physician who was in peril but rather his patient. In any event, in *R. v. Morgentaler* [1976] 1 S.C.R. 616, the Supreme Court ruled that the accused had failed to establish a defence of necessity to a charge of criminal abortion only because there was no evidence that his patient’s life or health was in immediate danger. The fact that it was not the accused who was allegedly in peril was not commented upon by the Court.

<sup>57</sup> When Nurse Bland-MacInnes was asked about re-intubation, she replied that it was not attempted because it would have been “an aggressive measure” (Transcript, *supra* note 3 at 295). Unfortunately, she was not asked to elaborate, yet given her concern about the situation it is puzzling that she would have rejected this option.

Whether there was a legal way out raises the further issue of “terminal sedation”: whether Mr. Mills could have been rendered insensate by being anaesthetized into a deep coma. Over the past few years, drug-induced sedation of terminally ill patients with intractable suffering has become a matter of increasing interest amongst practitioners of palliative care medicine. Terminal sedation has been defined as the “intention of deliberately inducing and maintaining deep sleep, but not deliberately causing death...for the relief of one or more intractable symptoms when all other possible interventions have failed and the patient is perceived to be close to death.”<sup>58</sup> The goal is thus to render the dying patient unconscious until death occurs. (However, not all patients can be so managed; a study on the use of terminal sedation that appeared in the journal, *Palliative Medicine*, reported that it was unsuccessful in 10 out of 100 cases.<sup>59</sup>) According to the medical literature, drugs used in this context include: midazolam (Versed), lorazepam (Ativan) methotrimeprazine (a pain-killer/sedative), opiates (including morphine and Dilaudid), and barbiturates.<sup>60</sup> Bear in mind, however, that terminal sedation has evolved as a treatment of last resort for palliative care patients. It is not generally within the experience of physicians practicing in intensive care because intractable suffering is so rarely encountered in that setting.

That said, the drug regimen administered to Mr. Mills – Ativan, Versed, Dilaudid, and morphine – fits within the practice of terminal sedation. His caregivers were striving to render him insensible to his (apparent) suffering, but the effort failed, as was the experience in 10% of the cases mentioned in the study just noted. One can thus conclude that the legal alternative of terminal sedation was attempted, albeit unsuccessfully, in the Morrison case. Admittedly, other drugs might have been considered. For example, an article published in November 1995 in the *Journal of Pain and Symptom Management* reported a case in which a patient was terminally sedated by propofol, a short-acting anesthetic agent with a rapid onset of action.<sup>61</sup> The article reported that propofol is commonly used in the intensive care unit for the sedation of patients. But in that setting it is employed as a short-term measure for a patient who is expected to regain consciousness.<sup>62</sup>

In *Hibbert*, the modified objective standard was specifically applied to the question whether the accused had “a safe avenue of escape” from the threat of duress. Recall that in *Latimer* the Supreme Court applied that standard to the question whether there was a legal way out of the dilemma confronting the accused. In other words, whether the defence be necessity or duress, an accused must produce evidence that there was no reasonable way to avoid committing the offence. As

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<sup>58</sup> C. Tisdale & D. Woloschuk, “Terminal sedation: is there a role for the pharmacist?” (July/August 1999) *Can. Pharmacists J.* 28 at 30.

<sup>59</sup> *Supra* note 5 at 260.

<sup>60</sup> *Ibid.* at 259-60.

<sup>61</sup> J. Moyle, “The use of propofol in palliative medicine” (1995) 10 *J. Pain and Symptom Management* 643.

<sup>62</sup> *Ibid.* at 644.

spelled out in *Hibbert*, one would thus consider Dr. Morrison's "ability to perceive the existence of alternative courses of action."<sup>63</sup> Although she must act reasonably, it is appropriate to take into account "the particular circumstances and human frailties of the accused."<sup>64</sup> Bear in mind that there are practitioners of intensive/critical care who have done residency programs in that specialty, but there are also physicians with a variety of backgrounds — anaesthesia, internal medicine, respiratory (e.g. Dr. Morrison) — who work in the field. Yet the fact is that physicians working in the ICU setting do not necessarily have training or experience specifically related to pain management (a subject of particular concern to their colleagues in palliative care). It is therefore not surprising that Dr. Morrison would not be familiar with the palliative care literature relating to drug alternatives for terminal sedation. In any event, the bulk of articles on that subject were not published until after the death of Mr. Mills.

In reprimanding Dr. Morrison, the College of Physicians and Surgeons faulted her for not seeking collegial advice before turning to the nitroglycerine and KCl. Of course, one can only speculate as to whether she would have been able to find someone (a colleague in anaesthesia or palliative care) with the expertise to relieve Mr. Mills' distress. On the other hand, it is arguable that, given the circumstances affecting her ability to evaluate the situation (her understandable lack of expertise in the art of terminal sedation), it was reasonable for her to assess the crisis as calling for drastic and unlawful measures. This is surely enough to establish an air of reality to the defence that there was no reasonable legal alternative available to the accused.

Furthermore, even if one were prepared to find Dr. Morrison negligent for not seeking consultation before doing what she did, that would not preclude the defence that there was no legal way out. In *Perka*, Dickson J. rejected the argument that the negligence of the accused was necessarily fatal to the defence. In his view that would only be true if "the necessitous situation was clearly foreseeable to the reasonable observer, if the actor contemplated or ought to have contemplated that his actions would likely give rise to an emergency requiring the breaking of the law."<sup>65</sup> Since the situation that unfolded on the day in question could not have been anticipated, a negligent failure to consult would not debar the defence.

An object lesson from the Morrison case for ICU physicians was spelled out last year in an editorial published in the Montreal-based *Journal of Palliative Care*:

Traditionally and for most institutions, it would be unusual for Intensive Care and Palliative Care practitioners to be involved in the care of

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<sup>63</sup> *Supra* note 50 at para 59.

<sup>64</sup> *Ibid.* The way the Court put it in *Latimer* was that "[t]here must be a reasonable basis for the accused's beliefs and actions, but it would be proper to take into account circumstances that legitimately affect the accused person's ability to evaluate his situation" (*supra* note 47 at para 33).

<sup>65</sup> *Supra* note 42 at 403.

the same patient. However, there is a genuine movement now towards a realization that this may not be in the best interests of our acutely and severely ill patients.... If we are to strive to provide optimal ethical and dignified care...more clarity and consistency is needed in the way ICU teams approach decision-making with patients and families, particularly when there is a need to change from a primarily curative focus to a primarily palliative approach.<sup>66</sup>

As the movement for communication between intensive and palliative care units gathers strength, one can anticipate that the kind of crisis that overwhelmed Dr. Morrison, however rare its occurrence, will find its resolution within the law. Although she can be faulted for not thinking to consult pain experts, it is arguable that the gravity of her omission is mitigated by the fact that seeking such consultation was not within the culture of the ICU at that time. It may be some consolation to Dr. Morrison that an ICU physician facing a comparable situation down the road will know enough from her ordeal to turn to palliative care for help.

### C. Proportionality

In the *Latimer* case, the Supreme Court opined that it found it difficult “at the conceptual level, to imagine a circumstance in which the proportionality requirement could be met for a homicide.”<sup>67</sup> But assuming that necessity could ever provide a defence to homicide, “there would have to be a harm that was seriously comparable in gravity to death.”<sup>68</sup>

Well, difficulty is not impossibility, as was recognized by the English Court of Appeal in the recent case of *A (children) (conjoined twins: surgical separation)*.<sup>69</sup> Although it was a civil case, its criminal law implications obliged the Court to consider necessity in the context of deliberate killing. That was because it had to decide whether it was lawful for the surgeons to separate the twins (whom it called Jodie and Mary), an act that was certain to kill Mary because “she is only alive because a common artery enables her sister, who is stronger, to circulate life sustaining oxygenated blood for both of them.”<sup>70</sup> If left in that condition both were certain to die within months. Although the surgery would prove fatal to Mary, the medical evidence was that Jodie would most likely survive to live a normal life span with at worst minor handicaps.

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<sup>66</sup>G.M. Rucker, S.D. Shemie & J. Lacroix, “End-of-life issues in the ICU: A need for acute palliative care” (2000) 16 (Supplement) J. Palliative Care S3.

<sup>67</sup>*Supra* note 47 at para 40.

<sup>68</sup>*Ibid.* at para 41. Note the shift from the requirement in *Perka*, that “the harm inflicted must be less than the harm sought to be avoided” (see *supra* note 46). Here the Court is saying that it would be enough if the two harms were roughly comparable.

<sup>69</sup>[2000] 4 All ER 961 at 1051.

<sup>70</sup>*Ibid.* at 961.

Since the medical evidence was that the surgery was certain to kill Mary, the Court concluded that it would constitute murder unless otherwise excused. After a lengthy canvas of the jurisprudence on necessity (including the *Perka* case), the Court held that the surgery could go forward on that ground. In the result, it adopted the requirements for necessity laid down by the renowned Victorian-era jurist, Sir James Stephen:

- (1) the act is needed to avoid inevitable and irreparable evil;
- (2) no more should be done than is reasonably necessary for the purpose to be achieved;
- (3) the evil inflicted must not be disproportionate to the evil avoided.<sup>71</sup>

Admittedly, the facts of the conjoined twins case were extraordinary but cannot the same can be said about the Morrison case? Beyond that, it is arguable that even if Dr. Morrison did kill the patient, she did not cause him harm - that a quick death from KCl was not disproportionate to the harm avoided (the presumed anguish of a patient whose death was imminent but whose body would not quit). Recall that in *Latimer*, the Supreme Court decided that proportionality must be measured by a “purely objective standard,” that the “evaluation of the seriousness of the harms must be objective.”<sup>72</sup> But even there, an accused cannot be faulted for acting pursuant to a reasonable perception of the gravity of the harm in question. Obviously, it is impossible to say whether Mr. Mills was in fact dying an agonizing death. Still, both the nurse — who had worked in intensive care for 11 years — and Dr. Morrison thought so, and it was clearly not unreasonable for them to come to that conclusion.

In any event, a trial in the Morrison case would have happened four years before the ruling on proportionality in *Latimer*. When dealing with that question in our hypothetical trial, the court would be free to apply either a modified objective or purely objective standard. If the former, then the court would consider Dr. Morrison’s particular ability to evaluate the situation (modified objective). If the latter, it would restrict its focus to a hypothetically ordinary/reasonable physician called upon to evaluate the identical situation. Either way, it is our view that Dr. Morrison would meet the air of reality test – in other words that she would pass the test even if subject to the purely objective standard as per *Latimer*. (Once again, the issue at this stage of the proceedings is not whether the evidence is strong enough to establish a reasonable doubt. It is simply whether the accused can meet the threshold requirement of the air of reality test.) The tension is between the harm committed (an intended quick death in the here and now) and the harm avoided (the agony of a grievous dying process). So whether the actor is Dr. Morrison or a physician without her personal characteristics, it strikes us that both would reasonably conclude that actively seeking the death of Mr. Mills would not be a disproportionate response in light of his tragic plight.

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<sup>71</sup> *Ibid.* at 1052.

<sup>72</sup> *Supra* note 47 at para 34.

In sum, a trial judge hearing the case of *R. v. Morrison* would find compelling reasons to allow the defence of medical necessity to be aired before the jury. In that event, we think it highly likely that the jury would acquit on the grounds of necessity – or at worst that a minority would preclude a unanimous verdict of acquittal and thus hang the jury. The Crown, after all, would have to disprove the defence beyond a reasonable doubt; and the evidence would not appear sufficient for that purpose.<sup>73</sup> But leaving aside burdens of proof, the jurors would come from the same community that had indicated widespread support for Dr. Morrison in her time of tribulation. As illustrated by a number of American and English cases, juries are loathe to convict physicians who are driven to acts of compassionate homicide when confronted by patients dying in agony.<sup>74</sup> Given the compelling circumstances of the Morrison case, it is unimaginable that twelve citizens would have voted to convict her of either murder, attempted murder, or manslaughter.

## 7. Summing up

“Alleged mercy killing” was a phrase that frequently cropped up during the media reporting of Dr. Morrison’s ordeal. Admittedly, it was at the very least a case of an attempted mercy-killing by a physician, but still it was not the kind of case that invokes the debate over whether physician-administered euthanasia (and physician-assisted suicide) should be legalized. For one thing, the focus of that debate is upon the mentally competent patient who asks the physician to inject lethal drugs or assist his suicide, whereas Mr. Mills was not mentally competent toward the end of his life. It is true that weeks before his death he had expressed the wish to die, but still he had never asked to be killed.

But beyond that, the circumstances of his death were radically different from the grounds over which the euthanasia/assisted suicide issue is fought. First, keep in mind that there is no point to euthanasia/assisted suicide if the patient wishing to die is dependent upon artificial life-support. If the patient who so wishes is

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<sup>73</sup> Once an accused has met the evidentiary burden by presenting credible evidence regarding a particular defence (i.e. passed the air of reality test), the burden then shifts to the Crown at trial to disprove the defence beyond a reasonable doubt.

<sup>74</sup> All such cases as of the end of 2002 are summarized in B. Sneiderman, J.C. Irvine & P.H. Osborne, *Canadian Medical Law: An Introduction for Physicians, Nurses and other Health Care Professionals*, 3d ed. (Scarborough, Ontario: Carswell, 2003) forthcoming. There are only two cases in common law jurisdictions in which physicians have been convicted of murder for alleged mercy-killings: *Naramore* (Kansas, 1998) and *Kevorkian* (Michigan, 1999). The former’s conviction was reversed by the Kansas Supreme Court; see *State vs. Naramore*, 965 P.2d 211 (1988). What explains the latter was not only Kevorkian’s bizarre and belligerent behaviour before the judge and jury but also that he chose to go to trial without legal representation. He is currently serving a 10 to 25 year sentence although he will be eligible for parole in 2005. See Detroit Free Press, November 10, 1988, at 4A; November 14, 1988 at 3A; November 22, 1988, at 3A, December 3, 1988, at 3A. It is true that an English jury convicted Dr. Cox of attempted murder, but in that case the trial judge virtually steered the jury to that result by strongly suggesting in his summing-up that the accused intended to kill his patient and that, if it so found, it had no option but to convict him of attempted murder.

mentally competent, then she can simply exercise her legally enforceable right to refuse life-prolonging treatment.<sup>75</sup> In other words, whether competent or not Paul Mills was not the kind of patient whose plight fuels that passionate debate.

Second, the question of legalized euthanasia/assisted suicide is centred upon patients with limited life expectancy measured in days, weeks, or months. These patients may be dying but are still being treated, and the issue is whether the law should allow death to be accelerated by medical interventions that are currently defined as the crimes of murder and assisted suicide.

The debate is beyond the scope of this paper; but it is pertinent to report that, when the United States Supreme Court unanimously denied a constitutional right to assisted suicide in 1997,<sup>76</sup> three of the justices (O'Connor, Breyer, and Ginsburg) invoked terminal sedation in response to the claim that such a right was necessary to ensure that patients remain free of intolerable pain in their final days. The justices grounded their position by citing the following assertion contained in a brief filed by the American Medical Association:

The pain of most terminally ill patients can be controlled throughout the dying process without heavy sedation or anesthesia.... For a very few patients, however, sedation to a sleep-like state may be necessary in the last days or weeks of life to prevent the patient from experiencing severe pain.<sup>77</sup>

The three justices concluded that, if the right to assisted suicide turned on the need to relieve pain, this need could instead be met by terminal sedation.<sup>78</sup> (And by implication terminal sedation would be the measure of last resort when a patient failed to die after removal from life-support.) However, as we have learned from the study reported in Palliative Medicine, there is no guarantee that terminal sedation will work in all cases.<sup>79</sup>

Furthermore, there is as noted a clear distinction between the fate of Paul Mills and the range of cases that are invoked to support legalized euthanasia/as-

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<sup>75</sup>The Canadian case that firmly established the right of a mentally competent patient to enforce her demand for the termination of life-prolonging treatment is *B.(N.) v. Hotel-Dieu de Quebec* (1992), 86 D.L.R. (4th) 385. The patient was called Nancy B. in the media and the case is invariably referred to by that name. While he was mentally competent, Paul Mills never asked for the removal of artificial life-support nor had he signed a health care directive expressing his thoughts on death and dying. Such cases are encountered all too often in Canadian (and American) hospitals, and what invariably happens is what happened to Mr. Mills – that when the prognosis is hopeless the physician in consultation with the family makes the decision to terminate life-prolonging treatment.

<sup>76</sup>The Court so ruled in two companion cases: *Washington v. Glucksberg*, 117B S.Ct. 2258 (1997), and *Vacco v. Quill*, 117 S.Ct. 2293 (1997).

<sup>77</sup>*Washington v. Glucksberg, ibid.* (Brief of the American Medical Association *et al.*, as amici curiae in support of petitioners at 6).

<sup>78</sup>*Vacco v. Quill, supra* note 76 at 2310.

<sup>79</sup>Chater *et al.*, *supra* note 5.

sisted suicide. The latter involve patients who are being actively treated; they may be dying but life-prolonging treatment continues. But for Paul Mills such treatment was over. A train of events had been set in motion with the express purpose of ending his life. A decision — a lawful decision — for death had been reached by the surgeon and family.

The presumed outcome was then set in motion. Antibiotics were stopped. The feeding tube was removed. So was the breathing tube (the life-line attached to the ventilator). All these actions were directed to one goal — the patient's imminent death — and all were legally sanctioned. A death watch had been set and the expectation was that the dying process would run its course in a short time. But when that did not happen, the law that allowed the drama to unfold demanded that the players scrupulously follow the script ("let him die but don't try to kill him"), even when the expected conclusion turned out to be beyond their reach.

Instead of a quick death there was a two-and-a-half hour nightmare. It is true that death was at hand because Mr. Mills' blood pressure was insufficient to perfuse his organs. But it was remarkable that he was still alive, and no one can say how much longer it would have taken until his ravaged body finally gave up the struggle for life. Dr. Morrison acted to make her patient's passage the least worst death under the circumstances, and for that the heavy hand of the law descended upon her. The message stemming from the charge of murder filed against her is that it were better that his agony continue for any length of time than that she seek to end it as she did. In other words, go ahead and help him die by removing his life-line — no feeding tube, no antibiotics, no breathing machine. But *caveat medicus!* Beware, Doctor, how you manage the death that we authorize!

It is trite to say that the law is a blunt instrument of social control but, alas, so it is. The merits of the arguments for euthanasia/assisted suicide are not our concern here. What we say is that this was truly an extraordinary case and that the letter of the law makes a mockery of the law if it will never bend. Fortunately, the law did bend here thanks to the two judges who reviewed the case. Still, it is regrettable that the case was not stopped in its tracks, as happened in 1990 when the Quebec Justice Ministry declined to lay a murder charge against a Montreal physician (referred to as Dr. X) who had administered a lethal dose of KCl to a dying 38-year-old AIDS patient afflicted with Kaposi's sarcoma. The patient's body was covered with abscesses and massive doses of morphine were insufficient to relieve his agony. The patient had repeatedly begged for a lethal injection and the physician was prompted to act after the nurse said to him in desperation: "If you don't end this, I will." The incident came to light because the physician reported his resort to KCl on the patient's chart. His action was presented in a sympathetic light by Dr. Augustin Roy, the head of the Quebec College of Physicians: "It was intolerable to suffer that much pain, and the pain was not being relieved by narcotics. Even huge amounts of morphine weren't working any more. This was a real terminal case; he was probably hours away from dying. The doctor acted in the interests of his patient." Dr. Roy also referred to Dr. X as a well-respected colleague of many years standing. The decision by the Justice

Ministry was likely the result of the recommendation by the College that Dr. X not be prosecuted.<sup>80</sup>

If there had been a stay of proceedings in the Morrison case, it would have had no meaning for the public policy issues addressed by the euthanasia/assisted suicide controversy. Rather it would have signalled that in this instance the criminal law was being tempered with mercy for one who acted out of mercy because she was and is a caring and devoted physician. Regrettably, this message did not come from the Crown before Dr. Morrison was forced to undergo the ordeal of court proceedings.

We know from surveys conducted in Canada, Australia, England, and the United States that physicians in the course of end-of-life care are committing acts that the law defines as murder. Since the respondents were not asked in any of the surveys if they had given lethal injections without consent (e.g. the Morrison case), all the cases are of so-called voluntary euthanasia. Of course, whether voluntary or non-voluntary, euthanasia is murder in all common law jurisdictions. (As noted at *supra* note 40, the former is murder in Canada because section 14 of the *Criminal Code* stipulates that “[n]o one can consent to have death inflicted upon him.”)

In 1995, a survey was commissioned by the Manitoba Association of Rights and Liberties on cases of physician assisted-suicide and euthanasia in the province.<sup>81</sup> A 33-item questionnaire was mailed to a random sample of 400 Manitoba physicians (excluding pediatricians, dermatologists, ophthalmologists, and plastic surgeons), who were provided with the following definitions:

‘Assisted suicide’ is when a physician, acting on a patient’s request, helps a patient to end her or his life, by providing the patient with the means to commit suicide. ‘Euthanasia’ is when a physician, acting on a patient’s request, administers a lethal injection to the patient, in order to end her or his life.

The respondent was asked whether a patient had ever asked for euthanasia/assisted-suicide and if so whether he or she had ever complied with the request. Although there was a guarantee of anonymity, the survey produced only 112 usable returns (28% of those canvassed). Still, the results were enough to attract nationwide media attention. Of the 111 who answered the statement, “A patient has asked me to shorten her or his life through assisted-suicide or euthanasia,” 18 (16%) answered “yes.” Of the 109 who answered the statement, “I have facilitated a patient’s request to shorten her or his life by way of assisted-suicide or euthanasia,” 15 (14%) answered “yes.”

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<sup>80</sup>M. King, “Doctor reprimanded for lethal injection” *Montreal Gazette* (19 June 1992) A3.

<sup>81</sup>Manitoba Association of Rights and Liberties, *Silence doesn’t obliterate the truth: a Manitoba survey on physician assisted-suicide and euthanasia* (1995) [unpublished].

In 1988, the Medical Journal of Australia reported the results of a survey conducted the previous year in which questionnaires were sent to 2,000 physicians selected at random from the Victoria Medical Register; there were 869 completed returns.<sup>82</sup> Amongst the questions asked was:

In the course of your medical practice, has a patient ever asked you to hasten his or her death (whether by withdrawing treatment or by taking active steps to hasten death)?

Of the 369 who had been asked to take “active steps” (i.e. euthanasia), 107 (29%) admitted to carrying out the patient’s request. Of that number, 70 (61%) had done so two or three times; 22 (19%) had done so “more frequently” than two or three times.

In 1993, a questionnaire modelled after that used in the 1987 survey was sent to a random sample of 1,667 physicians on the Medical Register of New South Wales; and the results were reported in 1994 in the Medical Journal of Australia.<sup>83</sup> Of 1,268 respondents, 46% had been asked to take “active steps to hasten death” (42% in the Victoria study), of whom 28% had complied (compared to 29% in the Victoria study). Unlike the Victoria study, the New South Wales study reported only percentages and not absolute numbers. As in the Victoria study, 80% of those who had performed euthanasia admitted to doing so more than once.

The English survey was also conducted in 1993. By means of a postal questionnaire sent to “all 221 general practitioners and 203 hospital consultants in one area of England,” the investigators sought to determine the proportion who had “taken active steps to hasten a (competent) patient’s death.” They received 312 completed returns. Since the respondents were also asked about hastening death by the withdrawal and withholding of life-prolonging treatment, the questionnaire carefully distinguished between what the investigators referred to as “active and passive euthanasia.” (The term “passive euthanasia” – which is currently out of fashion – essentially means the lawful termination of life-prolonging treatment, which contrasts with cases of [active] euthanasia which is murder in law. In effect, the law distinguishes between so-called “letting die” and killing cases: the former is lawful and the latter is murder.) As reported in the British Medical Journal,<sup>84</sup> 273 of the 312 respondents chose to answer the question whether they had ever been asked to hasten death by “active steps.” Of the 273, 45% (124) answered “yes.” Of that 124, 119 answered the next question, which was whether they had complied with the patient’s request. And nearly one-third (32%) – 38 of the 119 – answered

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<sup>82</sup>H. Kuhse & P. Singer, “Doctors’ practices and attitudes regarding voluntary euthanasia” (1988) 148 *Med. J. Australia* 623.

<sup>83</sup>P. Baume & E. O’Malley, “Euthanasia: attitudes and practices of medical practitioners” (1994) 161 *Med. J. Australia* 137.

<sup>84</sup>H.J. Ward & P.A. Tate, “Attitudes among NHS doctors to requests for euthanasia” (1994) 308 *British Med. J.* 1332.

“yes.” These results are remarkably consistent with those found in the two Australian surveys.

There is also data from the United States. A study published in *The New England Journal of Medicine* in 1998 reported the results of a questionnaire answered by 1902 physicians (61% response rate) in the 10 specialties “most likely to receive requests from patients for assistance with suicide or euthanasia.”<sup>85</sup> Of that number, 320 (18.3%) were asked to write prescriptions for the purpose of aiding patients to commit suicide, and 196 (11.1%) were asked by patients for a lethal injection; 42 of the 320 and 59 of the 196 complied with the patient’s request.

Finally, we note that American bio-ethicists David Thomasma and Glenn Graber mention anecdotal evidence on the crossing of the line separating what is lawful (giving drugs to relieve pain without intending to kill) from what is murder (giving drugs to kill in order to relieve pain):<sup>86</sup>

Physician friends confide in us that several times during their practice they have induced death through injections in order to bring the relief to patients that only death could provide. In this decision, the goal was to induce death in order to relieve pain, not the opposite...to relieve pain without directly intending the death accompanying the relief.

Although we have no data on cases of nonvoluntary euthanasia, it is reasonable to assume that such cases are occurring as well. The point is that, whether Dr. Morrison killed Mr. Mills or not, she is but one of many physicians who have not hesitated to act unlawfully to end a patient’s life. In our view, the fact that hundreds of physicians in common law jurisdictions have acknowledged that they have been driven to commit acts defined by the law as murder is reason enough to question the current state of the law.<sup>87</sup>

At the end of the day, there is much to be said for the sentiment expressed by Derek Cassels, the editor emeritus of the *Medical Post*, who wrote an opinion piece about the Morrison case that appeared there and was then reprinted in *The Globe and Mail*:

She (Dr. Morrison) could have reassured the nurse that everything that could be done was indeed being done, talked vaguely about God’s will and quietly closed the door behind her on the way out, leaving Mr.

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<sup>85</sup>D. Meier *et al.*, “A national survey of physician-assisted suicide and euthanasia in the United States” (1998) 338 *New Eng. J. Med.* 1193.

<sup>86</sup>D.C. Thomasma, & G.C. Graber, *Euthanasia: Toward an Ethical Social Policy* (New York: Continuum Press, 1990) at 147.

<sup>87</sup>We are not suggesting that such widespread criminality is reason enough to legalize voluntary euthanasia by physicians (as is the case in The Netherlands). That is not the issue here. All that we are saying is that murder seems much too harsh a judgment to make in cases in which compassionate physicians perform acts of both voluntary and nonvoluntary euthanasia.

Mills to find his way into the great beyond in his own time. Had she done this, she would have escaped the humiliation of the last year or so.... So who is the most humane, caring physician in a circumstance like this? Is it the one who turns his or her back on a horrible death. Or is it the one who makes the hard decision to put a quick end to a hopeless situation? Physicians are entrusted to do no harm. So the question arises: Is more harm done by doing nothing in cases such as this?<sup>88</sup>

Given that Dr. Morrison can be faulted for not seeking advice from a colleague, the choices facing her were not as stark as portrayed in Cassel's comment. Still, it was her compassion and humanity that got her into trouble. She took desperate measures in a desperate and hopeless situation and therein lies the most troubling aspect of this case – that the police should respond to the plight of a physician caught in such a horrible dilemma by charging her with first-degree murder, the most severe crime known to the law. And who indeed was harmed by what happened? Surely not Mr. Mills, for if the KCI did kill him it simply cut short a dying process that was by no measure a death with dignity. The only person harmed in this case was the doctor. It is true that it was a self-inflicted harm, but it was a harm that happened only because Nancy Morrison could not abandon her patient to his tragic fate.

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<sup>88</sup>D. Cassels, "Helping death" *The Globe and Mail* (21 March 1998) D3.