

Death in a Halifax hospital: a murder case highlights a profession's divisions

Nancy Robb

In brief

IN THIS EXHAUSTIVE REPORT, NANCY ROBB discusses the murder charge laid against respirologist Nancy Morrison following the death of a patient in a Halifax hospital. There appear to be no blacks and whites in the sea of grey surrounding this case, she reports.

En bref

DANS CE RAPPORT DÉTAILLÉ, NANCY ROBB discute de l'accusation de meurtre pesant sur la respirologue Nancy Morrison suite au décès d'un patient dans un hôpital de Halifax. Elle explique que rien ne semble clairement tranché dans ce cas.

By all accounts, Halifax respirologist Nancy Morrison is a well-respected physician and teacher. Last December she won the prize Dalhousie University medical students present for excellence in clinical teaching. Her colleagues and patients call her dedicated, competent, compassionate. Some say she's a physician who goes by the book.

When Morrison, 41, was arrested and charged with first-degree murder in May, her peers were stunned. The charges involved the death of a terminally ill cancer patient in the intensive care unit at the Queen Elizabeth II Health Sciences Centre (QE II).

This is the sequence of events. Cancer patient Paul Mills died in November. In a peer review following his death, Morrison was suspended from the hospital's Critical Care Unit (CCU) for 3 months; she later resigned from it. In March another physician went to police because of his concerns about Mills' death. On May 6 she was arrested at the hospital and charged by Halifax police.

"I was shocked and astonished," says Dalhousie Dean John Ruedy, who has known Morrison since she was a respirology fellow in Vancouver. "If you were to identify someone in faculty who would have been in this situation, I suspect Nancy Morrison would have been almost last on my list."

The case has resonated far beyond Halifax. "This is the highest-profile case of a physician being accused of murdering a patient in the context of an intensive-care setting," says Dr. Philip Hebert, director of the ethics centre at the Sunnybrook Health Science Centre in Toronto. "Physicians are involved in various ways in the death of their patients on an extremely routine basis. If the only thing it's going to do is put a chill through what intensivists do every day in terms of stopping or withdrawing treatment for patients . . . it will be felt throughout the profession."

A patient dies

Mills, 65, of Moncton, NB, died while under Morrison's care in the CCU at the Victoria General Hospital Division of the QE II. (A publication ban prevents *CMAJ* from reporting the details of his death.) After her May arrest Morrison pleaded not guilty. "I have done nothing wrong," she told the *Toronto Star*.

When lawyer Joel Pink arrived at Morrison's office the morning of her arrest, police were milling around her floor. "She was in a state of shock," he recalls. Pink, who turned down a request for an interview with Morrison, says the case



Features

Chroniques

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reveals "great confusion" about care of the terminally ill. "Doctors have to stop thinking that because there is a therapeutic component to [a] drug, that [is] justification for allowing the person to die with dignity," he says. "It may be very difficult to find a prosecutor who will prosecute a doctor who is giving a morphine drip, but the bottom line is exactly the same. I don't believe doctors should be charged, but if you believe in dying with dignity and dying in comfort, there has to be a set of rules for doctors to follow."

Pink stressed that Mills' death is not a case of euthanasia or assisted suicide:



Dr. Hugh Devitt: discussion needed

"What this was is nothing more than a doctor making a judgement call that this person should be dying in comfort."

Morrison isn't the first Canadian physician to face this type of criminal charge. In 1993 Timmins, Ont., general surgeon Alberto De La Rocha was charged with second-degree murder after a cancer patient received a potassium-chloride injection. He pleaded guilty to administering a noxious substance, received a suspended sentence and lost his medical licence for 90 days. In Toronto, Dr. Maurice Genereux is awaiting a preliminary hearing on a charge of assisting in the suicide of an HIV-positive pa-

Morrison case raises questions for coroners, medical board

Nova Scotia's chief medical examiner says the Queen Elizabeth II Health Sciences Centre (QE II) shirked its responsibility by failing to report the death of patient Paul Mills to outside authorities.

Hospital personnel did not inform the coroner because the province's Fatality Inquiries Act does not require anyone but peace officers to report suspicious deaths. "The issue of whether the death is notifiable begs the question, 'What about their responsibility under the Criminal Code and what kind of notification does that require by persons in the community when they are aware a crime [may have] been committed?' " says Dr. John Butt, who intends to revise the Nova Scotia statute. "Hospitals are expected to direct their concerns about suspicious issues . . . to the police."

After a peer review of Morrison's alleged treatment of Mills, senior physicians suspended her from the Critical Care Unit (CCU) for 3 months. Several of her colleagues later expressed concern to the CCU head and an administrator about her pending return to the unit and the decision not to inform appropriate authorities.

The hospital did not notify the coroner or police nor did it go to the provincial medical board, even though the Nova Scotia Medical Act stipulates that any suspension of privileges exceeding 2 weeks must be reported. (The board is now reviewing the case.)

Morrison ultimately resigned from the CCU "to

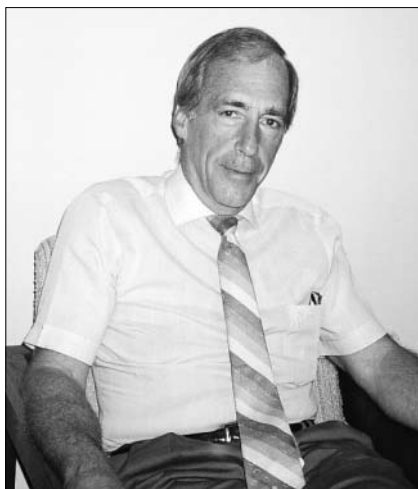
achieve more of a balance between work and my private life," she told the *Toronto Star*. In an Apr. 17 memo CCU head Dr. Richard Hall, who had sought legal advice on the obligation to report Mills' death to the coroner, asked unit staff to keep quiet about details surrounding her departure, but he was too late. QE II respirologist Arthur Macneil, citing a heavy conscience, had already gone to the police.

When nearly 40 police officers descended on the QE II May 6, they conducted 19 searches at the hospital, which encompasses several buildings, and took copies of computer records and patient files. About 5 of those officers arrested and guarded Morrison, who was in her office going over laboratory results and preparing for rounds.

The police actions sparked a formal complaint from a physician at the IWK-Grace Health Centre, which is next door, and a commentary in a local newspaper by Halifax otolaryngologist David Kirkpatrick, an outspoken critic of the "over-reaction" by police and the Crown prosecutor.

"It shouldn't have gone to police yet," says Kirkpatrick. "Physicians see the police action as an intrusion into the realm of medical practice. If a physician is unhappy about a colleague, the avenue is clear: go to the provincial medical board and lay a complaint."

Kirkpatrick says the coroner has been "underutilized in this whole process," but thinks the CCU had gone through "a self-cleansing process" and Morrison had



Dr. John Ruedy: A case for the coroner?



tient. In 1992 a Toronto nurse pleaded guilty to administering a noxious substance after first being charged with first-degree murder. He gave potassium chloride to a dying patient.

"The fact that these types of cases keep occurring means we must have a public discussion," says Dr. Hugh Devitt, president of the Canadian Critical Care Society (CCCS) and assistant director of the Intensive Care Unit at Sunnybrook.

Devitt, who heads Sunnybrook's Department of Anesthesia, says there are moral, ethical and legal issues surrounding Morrison's case. "In many instances there



Dr. Philip Hebert: A chill across country?

are no absolute answers and the approach to the dying patient is going to be different in each circumstance."

In June the CCCS endorsed an education and consensus paper that helps intensivists negotiate this slippery terrain. Devitt says the paper, "Withholding or withdrawal of life support", concludes that "the duty of the health care team and the physician is to the patient. Essentially the patient's and patient's family's wishes must be respected."

The secrecy issue

According to media reports, Mills' fam-

already been disciplined. "You can debate whether it should have gone to the next level or whether there should have been a harsher punishment, but the process did work . . . so I don't think there's any evidence that there was a cover-up or that this was sanctioned."

Dr. John Ruedy, dean of medicine at Dalhousie University and a member of the QE II's Board of Directors, learned of Morrison's predicament only a few hours before the arrest. "Due processes were carried out in the institution to a certain point, and the Nova Scotia statute being what it is notifying the coroner wasn't a requirement. I don't think it was an excuse."

Nevertheless, Ruedy says Mills' death should "automatically" have been a coroner's case, as it would have been in other provinces. He adds that many doctors believe Macneil should have reported Morrison to the medical board and that police should have been more discreet.

However, Butt says the hospital missed its "opportunity to have this done another way." He says police actions were understandable because "under the Criminal Code a crime was committed and the hospital failed to notify the police. To the police there's no difference between raiding a hospital and raiding a warehouse. . . . Is there a different rule for doctors than there is for everyone else?"

Butt says hospitals risk losing public respect when they put privilege ahead of community interest. "I would ask doctors who are critical of Dr. Macneil how they expect institutions to obey the law. Or does the medical profession want to decide which issues are important and not important in the eyes of the Criminal Code?"

In Ontario, Chief Coroner Jim Young says hospitals shouldn't try to handle such cases internally for other reasons. "They run into exactly the problems they did

here. They discover that there is no solution. They can neither get unanimity nor can they bring closure."

He says hospitals should bring in independent experts to conduct investigations. "We can perform that function in Ontario because our coroners are medical doctors and we operate in that sphere between doctors and police and Crown attorneys every day."

Young says Ontario's Coroner's Act stipulates that any such case be reported to the Medical Examiner's Office, which would investigate and then turn the case over to police if it is a potential criminal matter. "It is very important to work with the hospital. Don't draw a cloak over it."

Is it in the community interest for these cases to become public? "You can make a strong argument that it's important for the profession to know what's going on and where the guidelines are," he says. "I can also see some reasons why not. It potentially undermines confidence in medicine."

He says initial investigations are best conducted "out of the public glare," but once charges are laid it becomes part of the public record. "Once the press becomes aware, it's different enough and a hot enough topic that you have to assume it will hit the public sphere."

The QE II, it seems, learned this lesson the hard way. Shortly after Morrison's arrest, the hospital commissioned an external review of its handling of the case.

In a report released Aug. 13, the panel that conducted the review said it is unlikely Morrison would have been charged if the QE II had conducted a proper review. "If [the death] had been promptly and openly reported . . . it is likely the whole thing would have been handled differently with different charges," Dr. Charles Wright, who headed the 5-member external-review team, told the *Globe and Mail*.



Morale of Halifax physicians, medical students takes a hit

The Morrison case has shaken morale at Dalhousie University medical school and the Queen Elizabeth II Health Sciences Centre (QE II).

"The negative impact has been huge," says Dr. Elizabeth Anne Cowden, head of the Department of Medicine at Dalhousie and the QE II. "That's extraordinarily unfortunate, because the reality is that medical staff, nursing staff and paramedical staff are truly committed to providing optimal care."

When respirologist Nancy Morrison was arrested and charged with first-degree murder last May, many faculty and hospital personnel knew nothing of the events surrounding the November 1996 death of 65-year-old cancer patient Paul Mills at the QE II.

"The reaction among faculty, particularly in the Department of Medi-

cine, was one of absolute shock," says Dr. John Ruedy, dean of medicine at Dalhousie. "In the Department of Respiratory Medicine, it was one of almost acute grief reaction, with some members being almost immobilized in their ability to continue to provide clinical care."

He says undergraduate medical students, who had recently named Morrison professor of the year, were "extraordinarily upset" and weren't sure "what to do or what action to take."

"The word 'murder' is very disturbing," he says, noting that students "overwhelmingly" support Morrison. "Part of the shock to the students was their uncertainty . . . as to the greys in this situation." Ruedy says some observers do see the case in black and white "but for most people our values and our beliefs are not firmly entrenched, and we're insecure. Of course, students are even more insecure about what they should value and believe [about] the end of life."

In addition to the charge and the handling of the arrest — nearly 40 police officers descended on various sites at the QE II — Ruedy says the rumour that another QE II doctor had reported Mills' death to police fuelled suspicion and "seriously undermined physicians' confidence in the processes and system within the institution." Morrison's colleague, respirologist Arthur Macneil, contacted police in late March.

For students, final exams "cut short what might have been a much more difficult and troubling time," Ruedy says. But for clinical faculty and other QE II personnel, the timing of Morrison's arrest couldn't have been worse.

For about a year, staff had been gearing up for the merger of the hospitals and other institutions that form the QE II, and by early spring the move had started.

"On top of all the fatigue and stress that had resulted from the preparation and implementation of the merger, [the Morrison case] has taken an enormous toll, not simply on physicians within the Department of Medicine but on everyone who functions in the institution," says Cowden.



Dr. Elizabeth Anne Cowden: "the negative impact has been huge"

Cowden, whose department includes the

Division of Respiratory, learned of Mills' death in December. "I was quite shocked and apprehensive and concerned. I was concerned about the patient, the patient's family, Dr. Morrison, the Critical Care Unit and how it functions, and the Division of Respiratory and how it functions."

Cowden points out that health care delivery depends heavily on trust and cooperation. "[The health care teams] are not functioning normally right now. There is not the comfort or the communication or disclosure. The normal team relationship is clearly fractured."

After the arrest, the hospital brought in a "stress team" and tapped its employee assistance program to help distressed staff. Cowden says the Department of Medicine has since decided to use an assistance program that has debriefing and facilitation phases to "develop a strong functional team once again," especially in the Division of Respiratory.

Morrison, who was suspended and then resigned from the CCU, returned to work at a QE II outpatient clinic in July. The strain created by her arrest isn't expected to disappear overnight. "The intensity of the reaction has diminished," says Ruedy. "Quite clearly, it will reintensify as each new snippet of information becomes available."



Peter Parsons, Chronicle-Herald and Mail Star



Dr. Nancy Morrison is led away after she was arrested by Halifax police in May

ily did not find out how he died until Morrison was arrested. Nor did the QE II notify the province's chief medical examiner, the police or the provincial medical board (see sidebar). "The secretive-ness bothers me," says Sunnybrook's Hebert. "If you're doing something that is ethically right, you should be prepared to pass the publicity test. If you have an internal inquiry into a patient's death, it's only proper respect to let the family know you're looking at this. . . . Often these things have bigger legal and professional consequences because people don't share information."

Hebert says most doctors know the boundaries concerning terminally ill patients. "It's quite acceptable ethically and legally to stop someone's life-sustaining treatment but to do something in a more active way to hasten the dying process, unless it's in the context of palliative care, is unacceptable legally. . . ."

"Frankly, I find that reasoning a bit specious. Everybody knows that when you stop somebody's ventilator you intend for the person to die. There's a bit of fudging of the issues these days. We . . . do end people's lives in an active way every day in Canada."

long-term-care facilities in West Vancouver. In August 1994 he and another BC physician led the move to have the CMA adopt its current policy on physician-assisted death.

The resulting policy summary (*Can Med Assoc J* 1995;152:248A-B) flatly rejects a neutral stand and speaks out firmly against physician participation in euthanasia.

"We felt the CMA should take a strong stand . . . because physician-assisted suicide is a horrifying abrogation of our responsibility," MacCarthy says. "If you have good palliative care and people are assured that the pain and, to some extent, the anguish will be treated well and compassionately, then the need for euthanasia goes away."

MacCarthy says there is "a massive difference" between giving dying patients a fatal injection to end suffering and giving them narcotics such as morphine for symptom relief, even if it may shorten life. "If the intent is to relieve symptoms, either pain, anxiety, agitation or anguish, then it is completely acceptable. People in other provinces have got into trouble because of the inappropriate and one-time use of something."

MacCarthy stresses that he is not referring to the Mor-



Dr. Dan MacCarthy: "We felt the CMA should take a strong stand."



rison case because its facts have not yet come to light but thinks the case "is a symptom of an ongoing question."

Amend the law?

Although MacCarthy believes that failure to treat euthanasia as a crime amounts to passive acceptance, it is not an easy crime to prosecute. "Trying to charge someone with murder or manslaughter or administration of a noxious substance is like trying to fit square pegs in round holes," says Dr. Jim Young, Ontario's chief coroner.

In 1994 he told a Senate subcommittee that the Criminal Code should be amended to include an offence called euthanasia that has its own set of penalties. "It's very difficult to say to a jury that if someone who is about to die dies hours, days or months before [he is supposed to], this is first-degree murder."

For Young, cases like Morrison's are old hat. Five cases, including the ones in Timmins and Toronto, have proceeded in Ontario since 1992, and his office conducts 2 to 4 euthanasia investigations a year. "Our approach has been fairly aggressive. If we find cases we report them to police."

About 5 years ago, when euthanasia and assisted suicide were emerging as issues, Young and deputy chief coroner James Cairns developed guidelines on acceptable palliative care. They stipulate that palliative care should be offered to appropriate patients but shouldn't be implemented without the informed consent of the patient or family. The guidelines, which recognize that some drugs may hasten death, outline criteria for appropriate therapy and recommend that drug use be documented.

"It's the right drug in the right dose," says Young, who notes that there has to be a demonstrated need for a drug. "If the dose increases dramatically and quickly, then the intent would appear to be to end life and that line must never be crossed. That line of judging intent is not cut and dried, and I wouldn't want to pretend it is. However, I wouldn't think any practitioner would want to take it that close to the line."

Young says the Morrison case will make doctors in At-

lantic Canada aware of that line. "Each time there's a case, a new group of people are asking questions about where the line is and how to stay [on the right side of] it."

The question of "what should be done and can be done to relieve suffering in the terminally ill" is a "societal issue of beliefs and values," says John Ruedy, "and in Canada society has not been placed in a position to address it."

Ruedy, who hopes Morrison's trial offers that opportunity, says Canadians "must come to grips" with whether they want to legalize euthanasia, under what circumstances and with what safeguards.

It's a tall order, but John Butt, Nova Scotia's chief medical examiner, says "these are the very things" that comprise new laws. "If one looks down the road 10 years, where does the [Morrison] case stand in the scheme of developing public information and the consideration necessary to change the law?"

Ruedy predicts that the controversies ignited by this case and others "will gain momentum. Eventually the issue will be dealt with, and the name Morrison will be remembered . . . and not necessarily for bad reasons."

But Jim Young isn't looking that far ahead. "There is always a place for debate. I don't think there is a place for unilaterally changing the law or stretching the law until it is changed. We risk having Jack Kevoorkians running around — [doctors] become judge and jury on their own."

Young adds that the public is not "very discriminating" about euthanasia. The Morrison case and others like it "help focus the issues" but he wishes issues would be decided at forums like Senate hearings, not in a courtroom.

Nancy Morrison would likely agree. Morrison, whose preliminary hearing is set for February 1998, returned to work at a QE II outpatient clinic in July. "I think it is an issue that has to be discussed," she told the *Toronto Star* nearly a week after her bail hearing. "This is not just a medical issue; it's a public issue.

"But I don't like that I'm the person people are talking about. I want to say that I wish it was somebody else, but that's not even fair. Because I wouldn't wish this experience on anybody else." ?



Dr. Jim Young: "Where is the line?"