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Abstract
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BY MICHAEL CORMACK

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I. INTRODUCTION

Terry Graham, a resident of Brampton, Ontario, suffers from a rare degenerative muscle disease known as mitochondrial myopathy.
With little muscle to protect his nerves, he experiences overwhelming pain that cannot be entirely alleviated by morphine. He has been lobbying federal officials for the right to have a physician-assisted death, but his efforts have gone unrewarded.¹ The Graham case is only the tip of the iceberg. Euthanasia and assisted suicide are highly controversial subjects that have drawn much attention in Canada over the last two decades. The issues surrounding the prohibition of both practices are extremely complicated and demand an equally complex examination. The discussion below will outline how the Netherlands, the United States, Australia, and Canada have approached euthanasia and assisted suicide. Jurisprudence, public opinion polls, legislative developments, and the positions of medical organizations and their members will be included in the analysis. A number of arguments for and against the continued prohibition of the practices in Canada will be evaluated. As well, information regarding the extent to which euthanasia and assisted suicide are performed in these countries will be assessed. It will be shown that Canadians currently enjoy much control over decisions concerning the end of life. The principles of autonomy and beneficence provide the foundation necessary to justify lifting the prohibition of voluntary euthanasia and assisted suicide in Canada. With regard to the development of safeguards in order to prevent abuse, the way in which foreign jurisdictions have dealt with both practices is highly instructive. Legislative reform is in order; the matter should not be left to the courts. Workable legislation can be drafted and a proposal of just what that should entail will also be presented.

II. DEFINING EUTHANASIA AND ASSISTED SUICIDE

Euthanasia can be classified as voluntary, non-voluntary, or involuntary.² Voluntary euthanasia entails death at the request of the person killed. Non-voluntary euthanasia does not involve a request for assistance, because the person involved has never had the capacity or has lost the capacity to make a request. Involuntary euthanasia occurs when the person killed is capable of making a request but refuses or is not consulted in the matter. Unbearable suffering underscores the motive for killing in such an instance. However, legitimate cases of involuntary

¹ M. Mandel, “Fighting for a Chance to End his Life of Misery Terry Graham Dreams of Death with Dignity, but his Life is the Real Nightmare” Toronto Sun (2 April 2000) 5 [hereinafter “Death with Dignity in Toronto”].

euthanasia are hard to conceive of and closely parallel homicide.\(^3\)

Euthanasia can also be characterized as active or passive.\(^4\) This distinction is similar to the acts and omissions legal doctrine and rests on the manner in which a person dies. While the distinction is sometimes important, for reasons that will become evident, passive euthanasia will not generally be referred to as euthanasia. Instead, passive euthanasia will be classified as both: withholding life-sustaining treatment—foregoing treatment that is potentially life-sustaining; and, withdrawing life-sustaining treatment—ceasing previously initiated life-sustaining treatment.\(^5\)

As a result, voluntary euthanasia will be defined as a deliberate act by one party with the intention of ending the life of another, at the request of the latter, where the act causes death.\(^6\) Non-voluntary euthanasia and involuntary euthanasia differ from voluntary euthanasia with regard to the lack of a request or a refusal of death and the competence of the person killed. Euthanasia, when referred to, will encompass all three variants. Assisted suicide is less complex conceptually and will be defined as: a deliberate act by one party with the intention of assisting another to take his/her own life, by providing the knowledge and/or means to do so, at the request of the latter.\(^7\) The most important distinction between the above definitions of euthanasia and assisted suicide concerns the person performing the act that terminates life. In the case of euthanasia, another party performs the act as opposed to assisted suicide where the person dying does so. In the medical context, this difference implies that a physician administers a death-causing substance in the case of voluntary euthanasia. With regard to assisted suicide, the physician supplies the substance to the patient for self-administration.\(^8\) At this point, an examination of the legality of the above end-of-life practices in selected countries is in order.

\(^3\) Ibid. at 179.

\(^4\) Ibid. at 202-13.


\(^6\) This definition is a composite (some elements omitted) of those outlined in: Ibid. & P.J. van der Maas, J.J.M. van Delden & L. Pijnenborg, "Health Policy Special Issue: Euthanasia and Other Medical Decisions Concerning the End of Life" (1992) 22 Health Pol'y at 23 [hereinafter "Special Issue"].

\(^7\) See “Special Issue,” ibid.

\(^8\) Ibid.
III. THE LEGAL STATUS OF EUTHANASIA AND ASSISTED SUICIDE IN CANADA

Attempted suicide was prohibited in Canada's first Criminal Code.9 The ban was lifted in 1972.10 Assisted suicide was also prohibited under the Code, 189211 and, today, it remains a separate offence.12 Section 241 of the Code, 1985 prohibits counselling or aiding suicide, whether suicide ensues or not, and provides for a punishment of imprisonment for a maximum term of fourteen years.13 Acts of euthanasia fall under the provisions relating to homicide.14 Life imprisonment is the mandatory punishment for both first and second degree murder, and a person is eligible for parole after serving a minimum of twenty-five years or ten years of his or her sentence, respectively.15 Manslaughter carries a maximum penalty of life imprisonment but no mandatory minimum sentence, except when a firearm is used (four years).16 There are a number of other sections of the Code, 1985 that are also relevant to euthanasia, assisted suicide, and end-of-life decisions.17 Furthermore, Canadians cannot legally consent to have death inflicted upon them.18

With regard to medical treatment, the Code, 1985 does not require that patients accept unwanted treatment nor does it require the administration of futile treatment (completely ineffective treatment). Necessary palliative care (care aimed at relieving, as opposed to curing, a person's physical, psychological, emotional, or spiritual suffering) that results in the patient's death is not prohibited by the Code, 1985 as long

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9 Criminal Code, S.C. 1892, c. 29, s. 238 [hereinafter Code, 1892].
10 Criminal Law Amendment Act, 1972, S.C. 1972, c. 13, s. 16.
11 Supra note 9, s. 237.
13 Ibid.
14 Ibid., ss. 222, 229, 231, 234-36.
15 Ibid., ss. 231, 235. Ibid., s. 742, as am. by An Act to amend the Criminal Code (sentencing) and other Acts in consequence thereof, S.C. 1995, c. 22, s.6.
16 Ibid., ss. 234, 236.
17 See, for example, ibid., ss. 45 (surgical operations), 215 (duty of persons to provide necessaries), 216 (duty of persons undertaking acts dangerous to life), 217 (duty of persons undertaking acts), 220 (causing death by criminal negligence), 221 (causing harm by criminal negligence), 245 (administering noxious thing), 265 (assault), 266 (assault), 267 (assault with a weapon or causing bodily harm), 268 (aggravated assault), 269 (unlawfully causing bodily harm).
18 Ibid., s. 14.
as it conforms to medically accepted practice. The practice of total sedation (rendering an individual totally unconscious via the administration of drugs with no potential shortening of life) is legal if the patient, or the patient’s surrogate, consents.\(^\text{19}\) As for surrogate and proxy decisionmaking, advance directive legislation (legislation that enables competent individuals to execute documents regarding health care decisions to be made if the person becomes incapable of making such decisions) has been enacted in nine provinces and one territory.\(^\text{20}\)

At common law, medical treatment decisionmaking rests largely with the patient. Except in emergency situations, physicians are required to obtain informed consent from the patient before treatment is administered and an action in battery lies against the physician if there is treatment without consent.\(^\text{21}\) Consent that is inadequately informed serves as the basis for an action in negligence against a physician.\(^\text{22}\) A physician must adhere to a patient’s refusal of life-sustaining treatment.\(^\text{23}\) Patients also have the right to have life-sustaining treatment withdrawn.\(^\text{24}\) Respect for patients’ decisions concerning their own bodies, even though such decisions may result in death, are rooted in the notions of autonomy and self-determination.\(^\text{25}\) However, the Supreme Court of Canada decided that these principles do not justify ending the prohibition of euthanasia or assisted suicide.\(^\text{26}\)

The leading case in Canada concerning euthanasia and assisted suicide is the Rodriguez\(^\text{27}\) decision. Sue Rodriguez was forty-two years...
old and suffered from amyotrophic lateral sclerosis (ALS). Her condition was deteriorating rapidly and she would have lost the capacity to speak, swallow, move, and breathe without assistance. She sought an order entitling her to assistance in committing suicide when the condition became intolerable. She wanted a physician to establish the technological means by which she could end her life by her own hand. Thus, she sought to have section 241 of the *Code, 1985* declared invalid and to be of no force and effect pursuant to section 52 of the *Constitution Act, 1982,* to the extent that it prevented a terminally ill individual from committing physician-assisted suicide. Rodriguez claimed that section 241 violated her rights under sections 7, 12, and 15(1) of the *Charter of Rights and Freedoms.* The British Columbia Supreme Court dismissed the application. The majority of the British Columbia Court of Appeal affirmed the decision and a majority (5-4) of the Supreme Court of Canada dismissed the appeal. The justices in *Rodriguez* clearly advocated different approaches to euthanasia and assisted suicide. The majority upheld the prohibition of both practices. Chief Justice Lamer, and Justice Cory, dissenting, advocated the decriminalization of assisted suicide only, while Justices McLachlin and L'Heureux-Dubé, dissenting, indicated that euthanasia would also be permissible.

The Supreme Court of Canada is not the only body to consider legal reform in this area. The Law Reform Commission of Canada released its working paper in 1982 and its report in 1983 on euthanasia, assisted suicide, and the cessation of treatment. The Commission recommended against decriminalizing or legalizing voluntary euthanasia and assisted suicide. It suggested that the *Code, 1985* be amended to make it clear that physicians do not attract criminal liability for administering appropriate palliative care that has the effect of shortening a patient’s life expectancy. Additionally, the Commission

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30 *Rodríguez,* supra note 26.

31 Ibid. at 578-79, Lamer C.J.C., 630-31, Cory J.

32 Ibid. at 624.

recommended that the Code, 1985 be amended so that physicians would not be held criminally responsible for not initiating or discontinuing treatment for incompetent patients, when treatment was therapeutically useless and not in the patient's best interest.\(^3\) In 1987, it reiterated its recommendation regarding palliative care that shortens life. As well, it proposed that mercy killing be treated as second-, not first-degree murder, and that no fixed sentence be attached to second-degree murder.\(^4\)

In 1991, Private Member's Bill C-261 was introduced in the House of Commons. Among other things, it proposed legalizing euthanasia and would have protected physicians who administered pain-killing treatment that simultaneously hastened death.\(^5\) The Bill was dropped from the Order Paper after second reading.\(^6\) Also in 1991, the British Columbia Royal Commission on Health Care and Costs recommended that the Code, 1985 be amended to exempt health care workers from liability when assisting terminally ill patients in suicide. However, a consensus on voluntary euthanasia could not be reached and no recommendations were made on the issue.\(^7\) In 1994, Bill C-215 was introduced proposing to decriminalize physician-assisted suicide for terminally ill patients, but died in the same manner as Bill C-261.\(^8\)

In 1995, the Special Senate Committee on Euthanasia and Assisted Suicide released its report. The majority of the Committee recommended that no changes be made to section 241 of the Code, 1985. Concerns expressed included: the apprehension that legalizing assisted

\(^3\) Euthanasia, 1983, ibid. at 27-28.


\(^7\) M. Otlowski, Voluntary Euthanasia and the Common Law (Toronto: Clarendon Press, 1997) at 380-81.

suicide would undermine the social value of respect for life; the fear that changes could lead to abuses; and the worry of the slippery slope—permitting assisted suicide in cases where persons were competent would inevitably lead to changes that would allow the procedure for incompetent persons.\(^{40}\) The majority of the Committee recommended that non-voluntary, involuntary, and voluntary euthanasia remain criminal offences. However, the Committee suggested that the Code, 1985 be amended so as to provide for less severe penalties in cases of voluntary euthanasia that involve mercy or compassion. The majority opposed euthanasia for essentially the same reasons it opposed assisted suicide.\(^{41}\)

In 1996, the Ontario Law Reform Commission released a study paper that advocated an amendment to section 241 of the Code, 1985 that would have exempted health care professionals from liability when assisting in another's suicide. However, the Commission recommended that euthanasia remain a criminal offence.\(^{42}\) Bill C-304, which would have decriminalized assisted suicide for the terminally ill, was introduced in 1997, but was dropped from the Order Paper after second reading.\(^{43}\) Bill S-2 was first read on 13 October 1999 and recommended codifying the common law practices relating to withdrawing and withholding life-sustaining treatment. It also clarified that health care providers were not liable to criminal sanction when medication that might shorten life was administered for pain relief purposes. It died on the Order Paper in October of 2000.\(^{44}\)

End-of-life decisions have been continuously addressed in Canada over the past two decades. The attempts to codify Canadian jurisprudence have not borne fruit. The Canadian Medical Association's (CMA) position is that “[t]he withholding or withdrawal of inappropriate, futile or unwanted medical treatment and the provision of compassionate palliative care, even when that shortens life, is considered

\(^{40}\) Of Life and Death, ibid. at c. 7

\(^{41}\) Ibid. at c. 8.


good and ethical medical practice.”45 However, in other respects, CMA policy is reflected in the law; changes to the law regarding voluntary euthanasia and assisted suicide have outright failed. This complements official CMA policy, which condemns physician participation in both situations.46 However, the CMA’s policy does not mirror physician opinion. A 1993 survey revealed that of the 923 respondent physicians, 60.5 per cent supported some type of legal change regarding voluntary euthanasia and physician-assisted suicide, while 28.9 per cent opposed such measures.47 In 1994, 866 Alberta physicians were asked whether it is sometimes right to practice active euthanasia: 42 per cent replied yes, 47 per cent no, and 11 per cent were uncertain. In response to whether the law should be changed to permit active euthanasia, the answers were 37 per cent yes, 47 per cent no, and 16 per cent uncertain.48 In 1999, the findings of a survey administered in 1995 were published. Of the 1,855 Canadian physicians polled, 49 per cent supported changing the law to permit physician-assisted suicide; however, only 20 per cent would be willing to practice it if it were legal; 57 per cent would not, and 23 per cent were uncertain.49 The above results indicate that the medical community is extremely divided with regard to these practices.

Given the highly political nature of the debate, public sentiment must also be considered. Since 1968, Gallup Polls have been conducted in Canada using the following question: “When a person has an incurable disease that causes great suffering, do you, or do you not think that competent doctors should be allowed by law, to end the patient’s life through mercy killing, if the patient has made a formal request in writing?”50 The results indicate that support increased dramatically between 1968 (45 per cent yes, 43 per cent no, 12 per cent undecided) and 1989 (77 per cent, 17 per cent, 6 per cent, respectively). Since then,

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47 Otlowski, supra note 38 at 315.


50 Otlowski, supra note 38 at 261-62.
public support has been relatively constant. The polling question appears to encompass only voluntary euthanasia, in the medical context, for those suffering from an incurable illness; although, it should be expected that physician-assisted suicide in the same circumstances would evoke similar support. In 1997, the Angus Reid Group conducted a national poll on "Canadians’ Views on Euthanasia." While the question appeared to refer only to suicide and assisted suicide for the terminally ill, the results echoed the findings of a 1993 Angus Reid survey: 76 per cent supported the right to die, 17 per cent opposed, and 7 per cent were unsure. Overall, there is substantial public support in Canada for permitting the practices of assisted suicide and voluntary euthanasia in certain circumstances.

IV. THE LEGAL STATUS OF EUTHANASIA AND ASSISTED SUICIDE IN OTHER LEGAL REGIMES

A. Australia

Like Canadians, Australians have the right to refuse life-sustaining treatment and have it withdrawn. Currently, euthanasia and assisted suicide are illegal in all states and territories. Various bills aimed at legalizing voluntary euthanasia had been introduced in Australia during the 1990s. In 1995, after a mere three-month period, legislation legalizing voluntary euthanasia and assisted suicide was passed in a "conscience vote" in the Northern Territory Legislative Council.

51 Ibid. at 262. In response to the same question, 75 per cent answered yes, 17 per cent no, and 8 per cent undecided in 1995.

52 Angus Reid Group, "Canadians' Views on Euthanasia" (Ipsos-Reid, 1997), online: Angus Reid Group <http://www.angusreid.com/media/content/displaypr.cfm?id_to_view=878> (date accessed: 11 May 2001).

53 Ibid.


55 See, for instance, "Fundamental Justice," ibid.; and Fleming, ibid.

56 See, for instance, Fleming, ibid.; and "Conditions Required," supra note 54.
After the supreme court upheld the validity of the legislation, the Rights of the Terminally Ill Act, 1995 came into force in July of 1996, and the Northern Territory became the first district in the world to legalize the procedures. However, the legislation's life was short. In March of 1997, ROTTI was effectively repealed by federal legislation, the Euthanasia Laws Act, 1997, which prohibited the territories from legalizing voluntary euthanasia. The primary reason for the repeal of ROTTI was the fear that the legislation would lead to abuse. Only four persons ended their lives under ROTTI.

ROTTI provided that a patient, at least eighteen years of age, could request that a health care practitioner assist her or him in dying. The practitioner or the patient could have administered the lethal substance. The administering practitioner did not have to be a physician. The patient had to be inflicted with an illness causing severe pain or suffering that would have resulted in death. The practitioner must have been satisfied that there was no reasonable medical treatment acceptable to the patient that might have reasonably been undertaken in hope of realizing a cure. Such reasonable treatment was confined to the relief of suffering, pain, and/or distress, with the purpose of allowing the patient to die comfortably. The patient could not have been diagnosed with treatable clinical depression. The practitioner had to inform the patient of the nature of the condition and all forms of treatment. A practitioner, with special qualifications in the area, must have advised the patient of his or her palliative care options and was required to refuse to assist if there were alternatives reasonably available that would have alleviated the patient's suffering to a degree acceptable to the patient. A psychiatrist and another practitioner with prescribed experience in the treatment of the particular illness afflicting the patient


59 Rights of the Terminally Ill Act 1995 (N.T.) [hereinafter ROTTI].

60 "Fundamental Justice," supra note 54 at 240.


63 "Whose Decision," ibid.
must have confirmed the first provider's diagnosis and prognosis. The patient had to be of sound mind and had to have considered the effect that the decision would have had on his or her family. The practitioner must have been reasonably satisfied that the decision was made voluntarily, freely, and after due deliberation. The patient was required to have signed a request certificate no sooner than seven days after the initial request. If the patient was unable to sign, he or she could request that a disinterested party sign on his or her behalf. The medical practitioner must have witnessed the signature. A second practitioner must have signed the certificate in the presence of the patient and the first doctor. The practitioners could not have stood to gain financially from the patient's death. At least forty-eight hours must have elapsed between the time the certificate was signed and the procedure was performed. The patient had the ongoing right to rescind the request in any manner and at any time. The practitioner must have assisted the patient and/or remained present until the patient died. After the patient's death, the assisting practitioner had to submit a report to the coroner. Fines and terms of imprisonment for violations relating to objectionable or improper conduct on behalf of the practitioner or another party, and inaccurate record keeping, were also provided for in ROTTI. A practitioner was entitled to refuse to grant a patient's request at any time, for any reason. It should be noted that the patient need not have been competent at the time of administration; rather, it was adequate that the patient had not indicated to the doctor a contrary intention to go through with the procedure. Parliamentary debates indicate that this provision was intended to accommodate persons who had requested assistance but had subsequently lost decisionmaking capacity.

Although the Australian Medical Association has always opposed voluntary euthanasia, medical practitioners endorse law reform. Pooled data from Australian health practitioner surveys indicate that 57 per cent of doctors and 71 per cent of nurses support legal change to permit voluntary euthanasia. Moreover, public opinion advocates the legalization of voluntary euthanasia and assisted suicide. Since 1962, a majority of those polled have been in favour of some form

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64 ROTTI, supra note 59 at ss. 3-12, 14.
65 Ibid., s.7(1)(o).
66 Otlowski, supra note 38 at 483-84.
67 Ibid. at 318.
68 “Conditions Required,” supra note 54 at 26.
of assistance in dying. In 1995, a Morgan Gallup Poll indicated that 78 per cent of respondents were in favour of permitting the administration of a lethal dose by a doctor to a hopelessly ill and suffering patient, 14 per cent against, and 8 per cent undecided. Of the ten separate polls conducted since 1983 using the same question, the lowest level of support occurred in 1986: 66 per cent for, 21 per cent against. The results suggest that the public supports changes in the law to allow for voluntary euthanasia.

B. The United States

Americans also have the right to refuse life-sustaining treatment or have it withdrawn. The United States Supreme Court has ruled that this right, for competent individuals, is constitutionally protected and is underscored by liberty interests. Despite two federal appeal court decisions to the contrary, the Supreme Court in Glucksberg held that withdrawing and withholding treatment can be distinguished from assisted suicide and as a result of the court’s unanimous decision, Americans do not have a constitutional right to assisted suicide. Forty-one states have criminalized assisted suicide via statute. In six states and the District of Columbia, it is a common law crime. In states that do not have specific legislation, assisted suicide can be dealt with under general criminal law statutes and can be treated as murder or manslaughter. All acts of euthanasia are illegal in every state and are

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69 The question asked was: “If a hopelessly ill patient, in great pain with absolutely no chance of recovering, asks for a lethal dose, so as not to wake again, should a doctor be allowed to give a lethal dose, or not?”: Otowski, supra note 38 at 263, n. 10.

70 Ibid.


73 Compassion in Dying v. State of Washington, 79 F.3d 790 (9th Cir. 1996) (en bane); and Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996).

74 Glucksberg, supra note 72.

In 1994, Oregon's *Death with Dignity Act* was passed by a citizens' initiative. Implementation of the *DDA* was delayed by a court injunction until 27 October 1997. Oregonians voted on Measure 51, aimed at repealing the *DDA*, in November of that year. Sixty per cent of voters opted to retain the *DDA*, as opposed to 40 per cent who voted against it. Still in force, the Act legalizes assisted suicide under certain conditions. Patients, at least eighteen years old, can request lethal medical prescriptions from their physicians. The patient must be a resident of Oregon and be suffering from a terminal disease (an irreversible and incurable disease that will result in death within six months). The physician must inform the patient of his/her diagnosis, prognosis, the probable risks and results of the prescribed medication, and the feasible alternatives. The physician must also refer the patient to another physician for confirmation of the diagnosis, the patient's capability, and the voluntariness of the request. The physician must refer the patient to counselling where appropriate and recommend that his/her family be informed of the decision. The patient is required to make a total of three requests (two oral and one written). The patient must be able to make and communicate health care decisions and the request must be voluntary and signed without coercion. At least two persons, other than the attending physician, must witness the signing. Additionally, one witness cannot be related to the patient, stand to gain financially from the death, nor be associated with the health care facility. The second oral request must be made no sooner than fifteen days after the initial one, at which time the physician must give the patient the chance to rescind the request. No less than forty-eight hours must pass between the writing of the prescription and the patient's written request. Thus, patients must wait for at least fifteen days for their lethal prescription to be written. The patient has the right to rescind the request in any manner, at any time. Physicians are required to report all lethal prescriptions written to the Oregon Health Division. No physician is under a duty to provide assistance. If a physician refuses or is unable

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to fulfill the patient’s request and the patient changes providers, then the physician must deliver a copy of the patient’s medical records to the new provider. Additionally, the DDA explicitly states that it does not authorize active euthanasia or mercy killing. In 1998, sixteen people and in 1999, twenty-seven people, ended their lives pursuant to the DDA.

The American Medical Association (AMA) has approved of the withholding and withdrawing of treatment in certain circumstances. Furthermore, the AMA has unequivocally endorsed the practice of administering pain-medication to the terminally ill despite its life-shortening effect. Nonetheless, the AMA has consistently opposed active euthanasia. With regard to physician-assisted suicide, the AMA stated that it “is fundamentally incompatible with the physician’s role as healer.” However, a national survey of physicians conducted in 1996 revealed that, of 1902 respondents, 11 per cent indicated “that under current legal constraints, there are circumstances in which they would prescribe a medication for a competent patient to use with the primary intention of ending his or her life: 36 per cent...said they would prescribe a medication if it were legal to do so.” Similarly, under present legal constraints, 7 per cent stated that they could envision circumstances involving a competent patient in which they would be willing to administer a lethal injection; 24 per cent would be willing to do so if it were legal. The findings of a study conducted in Oregon in 1999 showed that, of the 144 respondents who received requests for lethal prescriptions, 51 per cent were willing to prescribe the medication, 37 per cent were not, and 12 per cent were uncertain. With regard to public opinion, Gallup Poll results reveal that support for the legalization of voluntary euthanasia has grown from 37 per cent in

80 DDA, supra note 77, §127.880, s. 3.14.
82 Otlowski, supra note 38 at 305.
83 Glucksberg, supra note 72 at 750-51.
84 Otlowski, supra note 38 at 305.
85 Glucksberg, supra note 72 at 731.
87 Ibid.
1947⁸⁹ to 75 per cent in 1996.⁹⁰ In 1994, a Harris Poll disclosed that 73 per cent of those polled approved of physician-assisted suicide.⁹¹ Once again, the medical community's official stance on both procedures does not mesh well with physician and public opinion.

C. The Netherlands

Euthanasia and assisted suicide are prohibited under the Dutch Penal Code⁹² pursuant to the articles relating to murder, manslaughter, and inciting or assisting suicide. In contrast to Canadian law, the Penal Code does not provide for mandatory minimum penalties,⁹³ the consent of the person killed mitigates the crime,⁹⁴ and assisting suicide is only punishable when a suicide actually ensues.⁹⁵ Furthermore, a person avoids criminal liability when the offence was committed as a result of a force majeure (overmacht).⁹⁶ Notwithstanding the official illegality of voluntary euthanasia and assisted suicide, both practices are legally permitted. The Dutch courts, in conjunction with the medical establishment, have developed the policy relating to voluntary euthanasia and assisted suicide.⁹⁷ The legitimacy of both practices is grounded in the principles of autonomy and beneficence.⁹⁸

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⁹¹ “Whose Decision,” supra note 62 at 122.


⁹³ Ibid., Art. 287, 289, 293, 294.

⁹⁴ Ibid., Art. 293.


⁹⁶ Penal Code, ibid., Art. 40.


⁹⁸ Euthanasia and Law, ibid. at 97, 172-74; and “Patient Autonomy,” ibid. at 393-96, 407-14.
In 1993, the law governing the disposal of corpses was amended. New forms regarding the death of patients were introduced. The form relating to voluntary euthanasia and assisted suicide outlined various points requiring attention by the reporting physician. In essence, the elements corresponded to the requirements of "careful practice" (outlined below) delineated in the case law. The amendment did not affect the legality of either practice.\(^9\) Today, both practices are permitted if certain conditions are met. The substantive requirements dictate that a patient make an explicit request that is voluntary, well considered, and enduring. The patient must be suffering unbearably and hopelessly. The suffering need not have a somatic basis and in such a case there must be no realistic prospect of treatment. If the suffering is somatically based, then other possibilities for relieving the distress or treating the condition must have been exhausted or refused by the patient. Only physicians can legally perform euthanasia. With regard to the procedural requirements (requirements of careful practice), a doctor must formally confer with at least one other physician as to the patient's condition, prognosis, and the alternatives available. A written record of the matter should be kept and the procedure should be performed in a professionally responsible manner. The physician should remain with the patient or be readily available until death. Instances of euthanasia cannot be reported as natural deaths.\(^100\) Physicians are obligated to notify the authorities, but prosecutions do not result if the guidelines are adhered to. The physician's actions are evaluated by a regional review committee whose final opinion is submitted to the Public Prosecutions Service and has much bearing on whether a prosecution will proceed.\(^101\)

The current situation in the Netherlands seems to sit well with the Dutch population. A 1991 survey conducted by the Social and Cultural Planning Office revealed that 57 per cent of respondents were in favour of a doctor administering a lethal injection in order to relieve the suffering of a patient at her/his explicit request, 32 per cent said it depends, 3 per cent were unsure, and 9 per cent were opposed.\(^102\) A

\(^9\) *Euthanasia and Law*, ibid. at 79-80.

\(^100\) Ibid. at 100-106.

\(^101\) Minister of Justice of The Netherlands, "Bill for 'Review of Cases of Termination of Life on Request and Assistance with Suicide' Sent to the Lower House of Parliament" (1999), online: Department of Justice <http:llwww.minjust.nl:8080/a_BELEID/fact/euthanasia.htm> (date accessed: 15 May 2001) [hereinafter "Review of Cases"].

\(^102\) P.J. van der Maas, L. Pijnenborg & J.J.M. van Delden, "Changes in Dutch Opinions on Active Euthanasia, 1966 Through 1991" (1995) 273 J. Am. Med. Ass'n 1411 at 1413 [hereinafter "Changes in Dutch Opinions"]. It is assumed that the totals in 1991 are rounded since the total
more recent university study claims that 92 per cent of the population supports euthanasia.103 Similar support can be found in the political realm. In 1993, the positive responses of all three major political parties (the Liberals, the Social-Democrats, and the Christian-Democrats) to the following question were overwhelming: "Do you feel that someone who is, for him- or herself, in an unacceptable and hopeless situation, always has the right to request a termination of his/her own life?" 104

Over the years, a number of legislative proposals have been made in an attempt to codify voluntary euthanasia and assisted suicide policy. They failed, not because there was a lack of majority support, but because of the needs of placating the Christian-Democrats to ensure the survival of coalition governments.105 Since 1951, nearly all coalitions have included the Christian-Democrats.106 However, in 2000, that changed; the Christian-Democrats were not part of the government.107 On 28 November 2000, the Lower House of the Dutch Parliament approved a bill that will remove voluntary euthanasia and assisted suicide from the sphere of the criminal law.108 Provisions will be added to articles 293 and 294 of the Penal Code that absolve physicians of liability.109 Sixty-six per cent of the 362 Dutch physicians surveyed in 1991 favoured similar amendments.110 The physician must fulfil the requirements of due care provided for in a new act: the Termination of

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104 D.J. Hessing, J.R. Blad & R. Pieterman, "Practical Reasons and Reasonable Practice: The Case of Euthanasia in The Netherlands" (1996) J. Soc. Issues 149 at 163-64 [hereinafter "Practical Reasons"]; The Liberals replied 95.4 per cent yes, 3.8 per cent don't know, and 0.8 per cent no. The corresponding data for the Social-Democrats was 86 per cent, 10.3 per cent and 3.7 per cent. The Christian-Democrat response was 66.3 per cent, 16.7 per cent and 17.1 per cent, respectively.

105 Euthanasia and Law, supra note 97 at 85.

106 "Practical Reasons," supra note 104 at 162.


108 The vote was 104-40: "Legalizing Euthanasia in the Netherlands" Maclean's (11 December 2000), online: LEXIS-NEXIS (news, 90 DAYS); and Minister of Justice of The Netherlands, "Review of Cases of Termination of Life on Request and Assistance with Suicide: Bill Passed in Parliament" (2000), online: Department of Justice <http://www.minjust.nl:8080/e_actual/persber/pb0668.htm> (date accessed: 28 May 2001) [hereinafter "Bill Passed"].


110 "Special Issue," supra note 6 at 103. An additional 20 per cent thought voluntary euthanasia should remain punishable in principle but not when the rules of due care were adhered to. Seven per cent opined that voluntary euthanasia was never punishable. One per cent thought it should always be punished.
Physicians must also report their actions to the municipal coroner. The new legislation will not substantively change the present due care requirements. It recognizes the validity of euthanasia declarations (advance directives). Physicians can act on the directive unless they have good reason not to. Persons as young as sixteen years old can request voluntary euthanasia and assisted suicide as long as their parents participate in the decisionmaking process. Children between the ages of twelve and sixteen can also request the procedures, but the consent of their parents or guardians is required. Review committees will continue to conduct investigations, but only have to refer cases to the prosecutor when they deem it necessary to do so. The legislation received the support of the Social-Democratic, Liberal-Democratic, and Liberal coalition government, but was opposed by three small right-wing religious parties and the Christian-Democratic Party. On 10 April 2001, the Dutch Senate passed the bill and it is anticipated that it will go into force in autumn 2001.

V. NORMATIVE JUSTIFICATION OF VOLUNTARY EUTHANASIA AND ASSISTED SUICIDE IN CANADA

A number of positions have been advanced in favour of, and in opposition to, the legalization of voluntary euthanasia and assisted suicide. Some of the more compelling arguments will be examined in detail below with particular attention being paid to the Canadian situation.

A. The Rodriguez "Consensus"

The majority in Rodriguez interpreted such things as the prohibition of voluntary euthanasia and assisted suicide in foreign jurisdictions and the official positions of medical associations as

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111 "Review of Cases," supra note 101; and "Bill Passed," supra note 108.
112 "Review of Cases," ibid.
113 Janssen, supra note 103.
114 The vote was 46-28: Minister of Justice of The Netherlands, "Bill for Testing Requests for Euthanasia and Help with Suicide Passed by Dutch Parliament" (2001), online: Department of Justice <http://www.minjust.nl:8080/c_actual/persber/pb0715.htm> (date accessed: 28 May 2001).
115 Rodriguez, supra note 26.
evidence that there is a consensus that the practices should not be permitted.\textsuperscript{116} This approach is problematic for various reasons. The weight to be given to an alleged consensus when formulating or amending public policy and the law should be cautiously assessed.\textsuperscript{117} As well, the courts should not use the purported consensus in foreign jurisdictions to define the extent to which the rights of Canadians are protected by the \textit{Charter}.\textsuperscript{118} Instead, if consensus is to be utilized, then it should be informed by the Canadian experience.\textsuperscript{119} If one examines the results of the public and physician opinion polls listed above, then the consensus arrived at in \textit{Rodriguez} is anything but accurate. Rather, sentiment appears to significantly favour law reform. Moreover, the recent legislative development in Oregon throws the entire “prohibition—therefore-consensus” argument into question. However, a consensus alone does not necessarily justify permitting voluntary euthanasia and assisted suicide. The \textit{Charter} protects the rights and freedoms of all Canadians (minorities included)\textsuperscript{120} and a consensus is merely one factor that needs to be taken into account.

B. Killing Versus Letting Die

There has been much controversy surrounding the distinction between “killing” and “letting die.” Roughly, the argument for maintaining the distinction is as follows: withdrawing or withholding life-sustaining treatment constitutes an omission, not a positive act; death is caused by the underlying disease, not by the omission nor by the administration of a lethal substance; thus, the doctor does not kill, but lets the patient die.\textsuperscript{121} As a result, culpability differs. Each claim will be dealt with in turn.

Withholding treatment is obviously an omission and Lord

\textsuperscript{116} \textit{Ibid.} at 601-608, 612-15.

\textsuperscript{117} E.W. Keyserlingk, “Assisted Suicide, Causality and the Supreme Court of Canada (Case Comment)” (1994) 39 McGill L.J. 708 at 715.

\textsuperscript{118} “Fundamental Justice,” \textit{supra} note 54 at 250-51.

\textsuperscript{119} \textit{Ibid.}

\textsuperscript{120} See, for example, the provisions pertaining to fundamental freedoms, equality rights, and minority language educational rights in \textit{Charter, supra} note 29, ss. 2, 15, 23.

\textsuperscript{121} B. Sneiderman, “The Case of Nancy B: A Criminal Law and Social Policy Perspective” (1993) 1 Health L.J. 25 at 28-29 [hereinafter “The Case of Nancy B”].
Browne-Wilkinson in *Airedale*,\(^\text{122}\) articulated why withdrawing treatment can also be classified as such:

The positive act of removing the nasogastric tube presents more difficulty. It is undoubtedly a positive act, similar to switching off a ventilator in the case of a patient whose life is being sustained by artificial ventilation. But in my judgement in neither case should the act be classified as positive, since to do so would be to introduce intolerably fine distinctions. If, instead of removing the nasogastric tube, it was left in place but no further nutrients were provided for the tube to convey to the patient's stomach, that would not be an act of commission. Again, as has been pointed out ... if the switching off of a ventilator were to be classified as a positive act, exactly the same result can be achieved by installing a time-clock which requires to be reset every 12 hours: the failure to reset the machine could not be classified as a positive act.

This line of reasoning reflects the difficulties in reconciling the acts/omissions doctrine with acceptable medical practice. Yet, if one concedes that, in some circumstances, withdrawing treatment should be classified as an omission, then the procedure can be distinguished from voluntary euthanasia and assisted suicide since these practices involve positive acts.

It has been asserted that the cause of death when treatment is withheld or withdrawn is the underlying disease; nature simply takes its course.\(^\text{123}\) It is hard to envision though, that withdrawing life-sustaining treatment does not fall within the ambit of legal causation, especially when the withdrawal is contrary to the patient's wishes.\(^\text{124}\) Legal causality in this area is based on policy considerations: whether consent has been given, whether treatment is futile,\(^\text{125}\) and who is withdrawing the treatment. Nonetheless, voluntary euthanasia and assisted suicide do involve the administration of substances that undoubtedly cause death. Additionally, it can be argued that the act of giving a lethal substance to a patient invokes different feelings on behalf of the facilitator.\(^\text{126}\)

Intent can also serve to differentiate other end-of-life decisions


\(^{125}\) Keyserlingk, *supra* note 117 at 712.

from voluntary euthanasia and assisted suicide; that is, with regard to the latter procedures, the primary intent of the facilitator is to kill.\textsuperscript{127} In \textit{Rodriguez}, Justice Sopinka reiterated that such distinctions form the basis of Canadian criminal law.\textsuperscript{128} However, other end-of-life decisions also involve subjective foresight of death and a person should not simply avoid responsibility by turning one's attention to one effect as opposed to another.\textsuperscript{129}

Do the above distinctions serve to isolate voluntary euthanasia and assisted suicide from other end-of-life decisions and as a result, justify prohibition? The matter is further obscured when one considers common medical practice regarding the withdrawal of life-sustaining treatment in Canada. In a case involving the withdrawal of a respirator, the Québec Superior Court permitted the physician to ask the hospital for any "necessary assistance" in such circumstances "so that everything can take place in a manner respecting the dignity of the plaintiff."\textsuperscript{130} In a medical disciplinary hearing in Ontario in 1995, the committee heard testimony from three expert witnesses:

They testified that, once the decision is made to withdraw life-support by removing the intra-tracheal tube, it is the attending physician's duty to do everything necessary to keep the patient comfortable and prevent suffering. Morphine is the drug of choice and should be given in doses to relieve feelings of suffocation and anxiety that would otherwise occur ... the physician should err on the side of giving too much rather than not enough, to ensure that this goal is reached...whether morphine administration hastens death while relieving suffering, in a situation where death is imminent and inevitable, is immaterial.\textsuperscript{131}

The contrast between killing and letting die is far from being crystal clear. All of the aforementioned end-of-life decisions involve the inevitable death of the patient and the facilitator's subjective foresight of that outcome. Moreover, many of the distinctions are circumstantially dependent. For example, withdrawing treatment would certainly be classified as a positive act if it were not consensual and involved a malefactor. Additionally, legal causation in the context of withdrawing treatment is contingent upon consent. If a dying patient had the potential to live for quite some time, desired to do so, and a physician withdrew life-sustaining treatment despite the patient's wishes, then

\textsuperscript{127} Ibid.
\textsuperscript{128} \textit{Rodriguez}, \textit{supra} note 26 at 607.
\textsuperscript{129} \textit{Singer}, \textit{supra} note 2 at 209-10.
\textsuperscript{130} \textit{Nancy B.}, \textit{supra} note 24 at 395.
\textsuperscript{131} \textit{Re de la Rocha}, [1995] O.C.P.S.D. No. 6 at para. 29, online: QL (OCPS) [hereinafter \textit{de la Rocha}].
surely the underlying disease could not be held out to be the legal cause of death. As well, the feelings invoked on behalf of a facilitator that administers a lethal substance need not be interpreted in a negative manner; facilitators should perceive their actions as providing appropriate care for their patients.

Although it is possible to maintain certain distinctions between voluntary euthanasia or assisted suicide and other end-of-life decisions in some situations, the above discussion supports the contention that the procedures differ in degree and not in kind. Furthermore, such differences are not determinative of whether prohibition is warranted. Justice McLachlin (as she was then), dissenting, in Rodriguez, held that if a justification is established, it does not matter whether the assistance to end life is passive (withdrawing treatment) or active (providing the necessary means). It is necessary to look elsewhere in order to decide whether the prohibition of voluntary euthanasia and assisted suicide can be justified.

C. The Sanctity of Life

It is commonly argued that human life is sacred and inalienable. The majority in Rodriguez accepted this proposition. Human life is well protected under Canadian law and there is little doubt that its value should be enthusiastically revered. However, the strength of the argument needs to be evaluated. As previously indicated, Canadians are free to terminate their own lives if they so wish. With regard to the killing of others, Justice Sopinka, in Rodriguez, asserted that participating in the death of another is inherently “morally and legally wrong.” However, Justice McLachlin stated that people are not necessarily criminally sanctioned when their omissions result in another's death. Those under a legal obligation to provide the necessaries of life are not criminally liable when a lawful excuse is established, such as the incapacity to provide or the consent of the person who dies. A person who kills in self-defence is not culpable either. Thus, the legal rule that killing is wrong is not absolute. Culpability is dependent upon the

132 Rodriguez, supra note 26 at 624.
133 Otlowski, supra note 38 at 21.
134 Rodriguez, supra note 26 at 595-96.
135 Ibid. at 601.
circumstances and whether a valid justification can be made out. As far as morality is concerned, it can be argued that causing a person's death is morally wrong when it is unauthorized, unjustified, and deprives a person of benefits that would otherwise have been afforded. No moral wrong exists when these elements are absent. As a result, the contention that killing is inherently wrong is highly debatable.

The "sanctity of life" argument is further called into question when one considers that Canadians can refuse life-sustaining treatment and have it withdrawn. Doctors can also withhold futile treatment and the administration of palliative care that has the effect of shortening life is medically accepted practice in Canada. Moreover, the argument cannot be viewed in the abstract. Life must be valuable to someone or for something: "[t]he sanctity of life is acknowledged to be of overwhelming value to society when chosen, but its value in the particular case is not so clearly seen when it offers only suffering." The "sanctity of life" argument is by no means devoid of merit, but it does not serve as an adequate justification for the continued prohibition of voluntary euthanasia and assisted suicide.

D. The Right to Die?

There may or may not be a "right" to die in Canada. As it stands, a person can, without fear of criminal punishment, express one's autonomy and end her or his life. There has not been a push for the re-criminalization of suicide in Canada. People also have much control over other end-of-life decisions. Thus, Canadians apparently accept that the notion of autonomy or personal choice extends to self-destructive behaviour. Whether a general "right to die" exists and just what that entails (a positive or negative right) is open to debate. Regardless, it is not necessary to find such a right in order to justify voluntary euthanasia and assisted suicide.

136 Ibid. at 623-24.


139 Ibid. at 12.
E. The Integrity of the Medical Profession

As mentioned above, the American Medical Association considers assisted suicide to be at odds with the traditional role of the physician as “healer” and the state has an interest in protecting the honour of the medical profession. Additionally, it is argued that allowing physician-assisted suicide “would desensitize doctors to killing, destroy physicians’ moral credibility, subvert society’s faith in physicians and generally make life more difficult for physicians whether they agree or refuse to assist.” However, Justice Stevens, in Glucksberg, acknowledged that a physician's refusal to administer medication that renders death dignified and tolerable could contradict the physician’s role as healer. The dying patient may view a physician’s refusal to hasten death as a rejection, abandonment, or a declaration of inappropriate paternalistic authority. Complying with a patient’s request for physician-assisted suicide would not harm the doctor-patient relationship. Moreover, there is already tension between the traditional role of physicians and contemporary reality; doctors engage in practices that shorten life, such as withdrawing or withholding life-sustaining treatment and terminal sedation. The “medical integrity” objection and the concerns above should also apply to these practices. Yet, as previously mentioned, these practices have been accepted in Canada to the extent that there has been a push to recognize the legality of these common medical procedures through legislation. Furthermore, palliative care in Canada has recently been at the forefront of political discussion. The Standing Senate Committee on Social Affairs, Science and Technology, following up on the 1995 Senate report on euthanasia and assisted suicide, concluded, among other things, that: “Each person is entitled to die in relative comfort, as free as possible from physical, emotional, psychosocial, and spiritual distress. Each Canadian is entitled to access skilled, compassionate, and respectful care at the end of their life.

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140 Glucksberg, supra note 72 at 731, 748-94.
141 DuVal, supra note 138 at 16.
142 Glucksberg, supra note 72 at 748-49.
143 Ibid.
144 DuVal, supra note 138 at 16.
145 Bill S-2, supra note 44.
Euthanasia and Assisted Suicide

life." Consistent with this view, there comes a time in the doctor-patient relationship when the physician’s role is no longer curative, but transforms into one that involves comforting. Death is an inevitable part of life and medical care should address the event appropriately. The basic ethical principles espoused by the Canadian Medical Association (CMA) provide for compassionate end-of-life care. The CMA’s Code of Ethics does not explicitly mention euthanasia or assisted suicide, but “has traditionally been interpreted as opposing these practices.” The continued prohibition of voluntary euthanasia and physician-assisted suicide on the grounds that there is a need to protect the medical profession’s integrity is not persuasive.

F. Quality Palliative Care is not the Solution

It can be argued that adequate palliative care can reduce or eliminate requests for euthanasia and assisted suicide. According to some, the lack of palliative care services underscores the push for assisted suicide in Canada. In some cases, palliative care may inhibit or end one’s desire to die. However, this is not true in all cases. For example, Justice Stevens, in Glucksberg, referred to sources that assert that such care is not always effective because pain becomes more difficult to treat as death draws near. Additionally, inadequate pain management is not necessarily the prime concern of dying patients. A study of the characteristics of those that died under Oregon's DDA in 1998 and 1999 revealed that patients were very much concerned about


end-of-life issues unrelated to pain.\textsuperscript{151} Furthermore, a Canadian study of 126 patients indicated that they were most anxious about the following: avoiding inappropriate prolongation of dying (61.1 per cent), strengthening relationships with loved ones (38.9 per cent), achieving a sense of control (38.1 per cent), relieving burden (38.1 per cent), receiving adequate symptom and pain management (22.2 per cent).\textsuperscript{152}

There is often more behind a request for death than the alleviation of pain. Admittedly, palliative care encompasses more than just pain control and can be of assistance in other areas that might influence an end-of-life decision. But this does not directly challenge the permissibility of voluntary euthanasia or assisted suicide; these practices are independently justifiable. Palliative care, and voluntary euthanasia and assisted suicide, can be conceptualized as legitimate alternatives on the health care continuum, not as dichotomies.\textsuperscript{153} Comprehensive care for the dying should be adopted in Canada.

G. Autonomy and Beneficence

The right to refuse life-sustaining treatment or have it withdrawn in Canada is premised on the notion of autonomy. The Standing Senate Committee on Social Affairs, Science and Technology stated that, in general, the principles of autonomy, beneficence, and justice guide ethical discussions concerning end-of-life care:

Autonomy generally encompasses self-determination, personal liberty and freedom of choice. Justice refers to the overall question of fairness, of equitable distribution of scarce resources. Beneficence seeks to ensure that any intervention is for the benefit of the patient and not for experimental, economic, or other reasons. The trend is away from an ethic of prolonging life at all costs and toward an ethic that emphasizes the quality of life and of dying.\textsuperscript{154}

\textsuperscript{151} "Suicide in Oregon," supra note 81 at 603: While the families of nineteen patients indicated that physical suffering was quite a concern to those dying (53 per cent), the physicians of all forty-three patients identified the following concerns; burden on family, friends, or other care-givers (21 per cent); loss of autonomy (79 per cent); inability to participate in enjoyable activities (77 per cent); losing control over bodily functions (58 per cent); inadequate pain control (21 per cent).


\textsuperscript{154} End-of-Life Care, supra note 146 at Part I.
The principles of autonomy (explicitly mentioned) and beneficence (implicit in the discussions involving suffering) were extensively examined in the Rodriguez decision and, according to the dissent, justified assistance in dying. Additionally, beneficence and autonomy underscore the CMA’s code of ethics. These principles are the driving force behind the push for palliative care in Canada and, when taken together, can justify voluntary euthanasia and assisted suicide as well. When people make voluntary and informed decisions that continuing life is not to their benefit, they should be free (with qualification) to seek assistance so that they can end their lives in a compassionate and acceptable manner. However, there are some objections to this assertion.

There is some concern that permitting “death with dignity” will spread the message that disabled life is not worth living. But the same criticism can be levied against the practice of withdrawing and withholding of life-sustaining treatment, yet the total devaluation of disabled lives has not resulted. Most severely disabled persons do not consider themselves as being “better off dead.” However, commitment to autonomy demands that such persons’ wishes be respected whether they decide to live or reject treatment. If a disabled person desires death, is not receiving life-sustaining treatment, and is unable to take his/her own life, then the principles of autonomy and beneficence support permitting voluntary euthanasia or assisted suicide in such a case. A fear of what might occur in the future should not override individual choices to end suffering in the present.

Various attempts have also been made to undermine the notion that autonomous decisionmaking is possible in the “terminally ill” context. First, there is concern that treatable depression is related to the desire to die in terminally ill patients and that proper treatment can reverse such feelings. Recognizing and treating endogenous

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155 Rodriguez, supra note 26.
158 “The Case of Nancy B,” supra note 121 at 37-38.
depression is an ongoing problem for medical practitioners. Although depression is not uniformly present in dying patients, it has been argued that severe depression casts serious doubt on whether an individual’s request is well-reasoned, because depression “is an intrinsic part of the disease.” However, not all depressive conditions affect the decisionmaking process. As a result, autonomy is not necessarily undermined.

Second, it has been contended that some psychologists are not qualified to conduct mental competency assessments, that the degree of confidence based on single evaluations is very low, and that these limitations may adversely affect free choice. Nonetheless, such assessments are made daily, in a variety of important contexts, and their validity is not seriously questioned. Furthermore, this objection, as well as the first, does not directly challenge the notion of autonomous decisionmaking. Rather, it highlights the need for legislative safeguarding to reasonably ensure that autonomous decisionmaking will be realized.

Third, it has been argued that autonomous decisionmaking that is “fully informed, non-coerced ... in rational furtherance of one’s own goals, is an ideal which is never fully realized.” For this reason, even voluntary euthanasia should not be permitted. The stylized argument for this conclusion is as follows: decisions are always subject to external influences. Due to the extreme circumstances, the autonomy of an incurably or terminally ill patient is seriously compromised. In such cases, the person desiring death may be making a terrible mistake. There are no satisfactory means of identifying these cases. Therefore, an absolute prohibition on assisted suicide is justified in order to prevent disregarding a person’s “authentic autonomy.” Implicit in the argument is the premise that terminally ill individuals who exercise a

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164 Singer, supra note 2 at 196-97.

165 DuVal, supra note 138 at 20.

166 Ibid. at 20-22, 29, 30-31.
reasonable degree of autonomy do not generally request death. Thus, a request is evidence of a lack of autonomy and assistance should not be given. The argument also requires one to accept that totally autonomous decisions cannot be made, especially by the terminally ill. As a result, any argument from autonomy that advocates voluntary euthanasia or assisted suicide for the terminally ill automatically fails. However, decisions are always made within a context and the fact that they are made in difficult circumstances does not render them non-autonomous. The dismissal of terminally ill patients' autonomous decisionmaking ability in the above manner is paternalistic. Moreover, autonomous capacity is not generally an issue in the context of refusing or withdrawing life-sustaining treatment and it should not be questioned simply because a person is asking for assistance in dying. Furthermore and again, this argument emphasizes the need for caution in drafting legislation that protects against abuse and does little to undermine the notion of autonomy. With the above discussion in mind, the combined principles of autonomy and beneficence provide the foundation necessary to support the permissibility of voluntary euthanasia and assisted suicide in Canada.

H. Slippery Slopes

By far, the most common argument used to oppose voluntary euthanasia and assisted suicide takes the form of the slippery slope. Slippery slope arguments usually entail that an alleged action, although acceptable in the circumstances, would set off a disastrous set of subsequent events. Thus, the initial step should not be taken. These types of arguments present analytical difficulties in the voluntary euthanasia and assisted suicide context because: "[t]hey involve essentially factual claims being made about ... probable or possible consequences ... [b]oth the prediction and its denial are speculative—not satisfactorily provable of refutable." Nevertheless, the arguments cannot be taken lightly due to the seriousness of the allegations.

It has been argued that permitting voluntary euthanasia and assisted suicide could lead to an increase in the prevalence of the

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167 See, for example, T. Govier, A Practical Study of Argument, 2nd ed. (Belmont, Calif.: Wadsworth, 1988) at 388.
168 DuVal, supra note 138 at 15.
practices. This may or may not be the case. After all, most people cherish life and fight to survive. Increased medical technology and better end-of-life care should also help prevent the practices from reaching epidemic proportions. But even if the incidents of voluntary euthanasia and assisted suicide were to increase, that would not necessarily be an unfavourable outcome. The practice of voluntary euthanasia may be more humane than other permissible end-of-life procedures as it can lead to less suffering.

Permitting voluntary euthanasia and assisted suicide could also lead to abuses. For example, the vulnerable could be coerced into asking for the procedures. The Ontario Law Reform Commission employed this reasoning to justify assisted suicide but not voluntary euthanasia. The Commission stated that active participation negates much of the potential for abuse that could occur when someone else administers a lethal substance. This argument is unconvincing. It is not difficult to imagine a situation where a person has been persuaded to ask for assisted suicide. More importantly, the same criticism can be levelled against the practices of withholding, withdrawing, and refusing life-sustaining treatment. It can be argued that these practices are even more susceptible to abuse in light of advance directive legislation and proxy decisionmaking ability, yet, there has not been a push to prohibit these practices. The assertion that abuses, such as the coercion of the vulnerable, might occur if voluntary euthanasia and assisted suicide are permitted stresses the need for enacting stringent legislative safeguards, not maintaining a blanket prohibition.

It has additionally been alleged that permitting the practices could lead to non-voluntary and involuntary euthanasia. These latter forms of euthanasia categorically differ from voluntary euthanasia in that they do not involve voluntariness and explicit requests. Thus, in the logical sense, the argument fails. Nonetheless, the argument is continually made and those opposed to voluntary euthanasia and


171 Rodriguez, supra note 26 at 581-601; “Fundamental Justice,” supra note 54 at 251-52.

172 Gilmour, supra note 42 at 258.


assisted suicide point to the situation in the Netherlands for evidence that this slide and other abuses have occurred in reality.175 This claim greatly fortifies the position of those opposed to lifting the prohibition and is arguably the most significant obstacle that proponents of change have to face.

I. Summary and Conclusion

The previous discussion lends support to the following propositions. First, there is a general sentiment that the laws prohibiting voluntary euthanasia and assisted suicide in Canada are in need of change. Second, while it is possible to maintain some distinctions between voluntary euthanasia or assisted suicide and other end-of-life practices, the procedures differ in degree and not in kind. Third, the "sanctity of life" is not an absolute value. Patients and physicians currently have much control over end-of-life matters in Canada. As a result, the argument that human life is inviolable and inalienable fails to justify the continued prohibition of voluntary euthanasia and assisted suicide. Fourth, the practices do not pose a threat to the medical profession's integrity. Fifth, comprehensive care for the dying should include not only palliative care, but also voluntary euthanasia and assisted suicide. Sixth, the twin principles of autonomy and beneficence provide the foundation for permitting the procedures in Canada. Finally, although slippery slope arguments can generally be dismissed, they do raise some legitimate concerns. If allowing voluntary euthanasia and assisted suicide inevitably leads to non-voluntary or involuntary euthanasia and/or widespread abuse, then continued prohibition is warranted; the evidence must be examined.

VI. THE NORMATIVE QUESTION MARK: THE SLIPPERY SLOPE

Allegations that voluntary euthanasia and assisted suicide lead to non-voluntary and involuntary euthanasia as well as other abuses abound. The goings-on in the Netherlands are used to substantiate such claims. The validity of these claims will be examined below. The extent

175 See, for example, Keown, ibid. at 407-48; Rodriguez, supra note 26 at 603-604; Glucksberg, supra note 72 at 734-35; and T. Lemmens, “Legalizing Euthanasia” (1995) 2 Can. HIV/AIDS Pol'y Newsl. 7 at 8-9.
to which voluntary euthanasia and assisted suicide are being practiced, and whether similar criticisms can be levelled against the state of affairs in other countries, will also be discussed.

A. The Netherlands

Dutch jurisprudence suggests that the situation in the Netherlands is far from being trouble-free. However, the empirical evidence must be examined in order to provide an accurate account of the overall situation. Unfortunately, reliable and valid research in the Netherlands did not exist before 1990. In 1991, the state-authorized Remmelink Commission delivered its national report on euthanasia and other end-of-life decisions. The Commission conducted three separate studies and ensured confidentiality. The "physician interview" (PI) study entailed in-depth interviews with 405 physicians. The "death certificate" (DC) study was based on a stratified sample of 7,000 deaths. The physicians that participated in the PI study answered questionnaires concerning their actions in the subsequent six months; this was referred to as the "prospective" study. A number of medical decisions concerning the end-of-life were examined. With regard to euthanasia, the Commission adopted the definition accepted in the Netherlands: "the purposeful acting to terminate life by a person other than the person concerned upon request of the latter." Thus, only voluntary euthanasia is classified as euthanasia in the Netherlands. Assisted suicide was defined as "the purposeful assisting of the person concerned to terminate life upon request of the latter." Life-terminating acts

176 Assistance was given in questionable circumstances and/or in breach of the established guidelines in the Kors, Duintjer, and Chabot cases. For a detailed case analysis see: "Patient Autonomy," supra note 95 at 393-405. It has been argued that accepting a suicide plea from a patient with psychiatric problems is simply poor psychiatry: "Seduced by Death," supra note 159 at 164. Technically, the Dutch have also condoned the practice of non-voluntary euthanasia as the Prins and Kadijk cases did not involve the request of the infants involved. For more details see: Euthanasia and Law, supra note 97 at 83-84, 341-51; Approximately fifteen severely disabled infants are euthanized every year in the Netherlands: Euthanasia and Law, supra note 97 at 230.

177 Euthanasia and Law, ibid at 202; "Changes in Dutch Opinions," supra note 102.

178 Euthanasia and Law, ibid. at 77-79.

179 "Special Issue," supra note 6 at 13; P.J. van der Maas et al., "Euthanasia and Other Medical Decisions Concerning the End of Life" (1991) 338 Lancet 669 at 669-70 [hereinafter "Other Medical Decisions"].

180 "Special Issue," ibid. at 23.

181 Ibid.
without the patient's explicit request (LAWER) entailed "acts" such as the administration of drugs (withdrawing treatment not included) and a non-explicit request (no request at all or vague remarks). LAWER includes non-voluntary and involuntary euthanasia as defined in this paper. The results of the PI study were weighted so as to enable extrapolation. In 1995, the PI and DC studies were duplicated. The following table offers a detailed comparison of the studies findings:

**TABLE 1**

The incidence of euthanasia and assisted suicide in the Netherlands*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Phys. Interview (PI) Study</th>
<th>Death Cert. (DC) Study</th>
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<tbody>
<tr>
<td>Explicit requests for VE** or AS***</td>
<td>8,900</td>
<td>9,700</td>
</tr>
<tr>
<td>VE: % of deaths (number)</td>
<td>1.8 (2,300)</td>
<td>2.4 (3,200)</td>
</tr>
<tr>
<td>PAS****: % of deaths (number)</td>
<td>0.3 (400)</td>
<td>0.4 (500)</td>
</tr>
<tr>
<td>LAWER: % of deaths</td>
<td>no data</td>
<td>0.7 (900)</td>
</tr>
</tbody>
</table>

* percentages are based on total number of deaths in the Netherlands: 128,786 (1990); 135,546 (1995), numbers have been rounded; ** VE-voluntary euthanasia; *** AS-assisted suicide; **** PAS-physician-assisted suicide.


183 "Other Medical Decisions," supra note 179 at 670.


185 Ibid. Based on the figures contained in Table 1.
Although a great number of requests for voluntary euthanasia and assisted suicide are made, relatively few are granted. It is generally agreed upon that the best estimates for voluntary euthanasia equalled 1.8 per cent (2,300) and 2.4 per cent (3,200) in 1990 and 1995, respectively. For both years, the agreed upon total for assisted suicide is 0.3 per cent (400). With regard to LAYER, the figure for 1990 is 0.8 per cent (1,000) and 0.7 per cent (900) for 1995. However, commentators rightly point out that opioids given with the intention to end life (not included in the above analysis) should be added to the number of deaths that occurred without an explicit request: 1 per cent (1,300) in 1990; 1.4 per cent (1,900) in 1995. Thus, estimated deaths caused by active physician intervention total 5,000 (3.9 per cent) in 1990 and 6,400 (4.7 per cent) in 1995.

In the 1990 study, 54 per cent of physicians indicated that they had performed voluntary euthanasia or assisted suicide at some time and 34 per cent had not but could conceive of doing so. In 1995, the corresponding figures were 53 per cent and 35 per cent, respectively. In 1990, 54 per cent of the physicians surveyed stated that circumstances exist where a doctor should raise voluntary euthanasia as a possibility with the patient. There is a concern that the voluntariness of a request...
can be compromised by such a suggestion. In all cases of voluntary euthanasia, assisted suicide, and LAWER in 1990, the doctor initiated the discussion 21 per cent of the time. In voluntary euthanasia and assisted suicide cases only, the doctor initiated the discussion 12 per cent and 15 per cent of the time for 1990 and 1995, respectively. While such instances are infrequent, they occur nonetheless and voluntariness must be questioned in at least some cases.

Reported cases of physician-assisted death increased from 486 in 1990 to 1,466 in 1995. In light of the estimates of voluntary euthanasia and assisted suicide, the notification rate increased from approximately 18 per cent to 41 per cent. Only two cases of physician-assisted death without the explicit request of the patient in 1990 and three cases in 1995 were reported. Thus, while the situation is improving, reporting rates are low and this is extremely troubling.

According to the Pi study in 1990, the patients had good insight into the disease and prognosis in all of the voluntary euthanasia and assisted suicide cases. There were no alternatives 79 per cent of the time. In 17 per cent of the cases, alternatives were available but the patient no longer wanted them. Four per cent of the voluntary euthanasia and assisted suicide cases did not involve an explicit request. Similarly, 6 per cent of the cases did not involve a repeated request. Eighty-four per cent of the physicians consulted with colleagues and only 60 per cent kept written records. The DC study in 1995 revealed that 100 per cent of voluntary euthanasia and assisted suicide cases involved an explicit request; however, 3 per cent of the patients were not competent. Of all voluntary euthanasia and assisted suicide cases, 4 per cent were discussed with no one. A comparison between the most recent reported and unreported cases in 1990 and 1995 indicated that, as far as the satisfaction of the substantive requirements was concerned, no differences existed. However, procedural requirements showed a decrease in cases not discussed with colleagues in 1995 (11 per cent)

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194 “Special Issue,” supra note 6 at 50.

195 “End of Life in The Netherlands,” supra note 184 at 1704: 83 per cent were discussed with a colleague, 33 per cent with a nurse, and 70 per cent with relatives or others (more than one answer was possible).
compared to 1990 (16 per cent). Written reports were also more available in 1995: 81 per cent of the cases as opposed to 60 per cent of the cases in 1990. Another report on the 1990/1995 data indicated that a physician administered some or all of the medication in 91 per cent of the voluntary euthanasia cases, and a nurse or person other than the physician or nurse did so 5 per cent of the time. While 72 per cent of the doctors interviewed remained present until death, a physician was not present at all in 2 per cent of the cases. With regard to assisted suicide, only 52 per cent of the cases involved the continuous presence of a physician and the absentee rate was 10 per cent.

With regard to LAWER, the PI study in 1990 indicated that 27 per cent of the respondents had performed such an act at some time and 32 per cent have never done so but could conceive of doing so. The corresponding figures for 1995 were 23 per cent and 32 per cent, respectively. Of the most recent cases in 1990, patients were totally able to make a decision 14 per cent of the time and there were alternatives in 8 per cent of the cases. In 1995, there was no explicit request but the issue was discussed or a wish was stated in 52 per cent of the cases. In the remaining 48 per cent of the cases, the decision was not discussed and there was no previous wish. Of all cases in 1995, 21 per cent involved competent patients and 5 per cent were discussed with no one. LAWER is of great concern as such cases can be treated as non-voluntary or involuntary euthanasia.

The information above indicates that there are problems in the Netherlands. Many of the substantive and procedural requirements listed in Part IV are not being adhered to. The majority of the cases are not being reported. Additionally, Dutch physicians are participating in non-voluntary and quite possibly, involuntary euthanasia. Given the abundance of data, it is not difficult to understand why the situation in the Netherlands draws so much attention. Since there was no reliable research before 1990, however, it is unclear whether the voluntary

196 van der Wal, supra note 193 at 1708.
198 “Special Issue,” supra note 6 at 58: 41 per cent would never do so.
199 “End of Life in The Netherlands,” supra note 184 at 1701: 45 per cent would never do so.
200 “Special Issue,” supra note 6 at 61-62. Patients were not totally able to make a decision in 11 per cent of the cases and totally unable 75 per cent of the time.
201 “End of Life in The Netherlands,” supra note 184 at 1704.
euthanasia and assisted suicide rates have substantially increased. Thus, there is no evidence of the presence of a slippery slope. Furthermore, while some abuses are occurring, it is far from certain that the situation is out of control or that the cause of any problems is related to the permissibility of voluntary euthanasia and assisted suicide. Before commentators point their fingers at the Dutch sliding down the slippery slope, these critics might do well to look at the goings-on in their own countries.

B. Australia

Research on end-of-life decisions in Australia is rather plentiful and quite enlightening. In a study of 943 Australian nurses reported in 1993, 218 stated that they had been asked by a doctor to participate in euthanasia, and 85 per cent complied with the request. Additionally, sixteen nurses, without having been approached by a doctor, granted a patient's request for euthanasia. In a survey published in 1994, 52 per cent of the 278 Australian nurses sampled took active measures in order to bring about a patient's death, frequently without a request to do so from the patient or his/her family. Another 1994 report indicated that 47 per cent of the Southern Australian physicians sampled received a request for assisted death or euthanasia at some time and that 19 per cent had participated in the practices. In a 1995 paper delivered at an Australian HIV conference, 18 per cent (forty one) of the doctors surveyed had participated in assisted suicide. These physicians had received 438 requests. Surprisingly, four people who received assistance were healthy. Evidently, Australian doctors and nurses are participating in acts of euthanasia and assisted suicide, sometimes in extremely dubious circumstances.

In 1996, a study was conducted that largely duplicated the

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204 D. A. Asch, "The Role of Critical Care Nurses in Euthanasia and Assisted Suicide" (1996) 334 New Eng. J. Med. 1374 at 1374 [hereinafter "Critical Care Nurses"].
"prospective study" in the Netherlands. Of the 800 physicians that made medical decisions concerning the end of life (MDEL), 3.2 per cent (twenty six) reported engaging in euthanasia or assisted suicide. Of these, 100 per cent involved an explicit request but 4 per cent did not involve a competent patient. In 12 per cent of the cases, the decision was discussed with no one. With regard to life-terminating acts without the patient's explicit request (LAWER), 6.4 per cent (fifty one) of physicians reported having done so. Of these, 31 per cent reported that there was no explicit request, no wish expressed, and no discussion of the action with the patient. Moreover, 6 per cent of the physicians engaging in LAWER indicated that the action was neither requested nor discussed with the patient and the patient was competent. Sixteen percent of the physicians discussed the decision with absolutely no one. The study also estimated the percentage of total deaths due to MDEL in Australia. The results were compared to those of the Netherlands in 1995. The rates of death in Australia during 1995 resulting from acts of euthanasia (1.8 per cent) and physician-assisted suicide (0.1 per cent) were slightly lower than those in the Netherlands (2.4 per cent and 0.2 per cent, respectively). However, the LAWER rate was substantially higher: 3.5 per cent in Australia as compared to 0.7 per cent in the Netherlands. This information indicates that incidents of assisted suicide and voluntary, non-voluntary, and involuntary euthanasia are occurring in Australia. The situation definitely invites "Dutch-like" criticism, especially with regard to LAWER.

C. The United States

Assisted suicide and euthanasia (save perhaps for involuntary euthanasia) are practiced in the United States. Retired pathologist, Dr. Jack Kevorkian, had no qualms about openly performing dozens of so called "medicides." But much also goes on behind closed doors. In 1995, 53 per cent of 117 doctors working with HIV patients in the San Francisco Bay Area admitted to granting an assisted-suicide request on

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208 Ibid. at 193-94.


at least one occasion to a patient suffering from AIDS.\textsuperscript{211} The results of a 1996 survey involving 852 critical care nurses showed that 16 per cent had participated in an act of euthanasia or assisted suicide at least once during their careers, 65 per cent doing so three times or less, and 5 per cent doing so twenty or more times.\textsuperscript{212} In that same year, over 1,900 American physicians completed surveys on euthanasia and assisted suicide.\textsuperscript{213} The results indicated that 18.3 per cent and 11.1 per cent received a request for assisted suicide or a lethal injection, respectively. Of the entire sample, 3.3 per cent had written a prescription conducive to suicide and 4.7 per cent had administered a lethal injection. The patient characteristics of the most recent cases of euthanasia or assisted suicide (eighty one) showed that assisted suicide cases involved: a patient request (95 per cent), an explicit request (75 per cent), a repeated request (51 per cent), twelve or more years of education (93 per cent), a second opinion (less than 1 per cent), and cancer (70 per cent). Cases of euthanasia involved: a patient request (39 per cent), an explicit request (21 per cent), a repeated request (53 per cent), twelve or more years of education (83 per cent), a second opinion (32 per cent), and cancer (23 per cent).\textsuperscript{214}

A study published in 1998 was conducted in order to determine whether American physicians were adhering to the proposed safeguards for euthanasia and physician-assisted suicide.\textsuperscript{215} Of the 355 oncologist respondents, 15.8 per cent (fifty six) admitted to participating in one of the practices. The results of in-depth interviews with thirty-eight of the fifty-six oncologists revealed that 5.3 per cent reported administering lethal injections, 73.7 per cent prescribed medication knowing the patient would commit suicide, and 21.1 per cent engaged in both procedures. Cancers were the most common underlying conditions.\textsuperscript{216} In 78.9 per cent of the cases, the patient initiated the request and 63.2 per cent of the time it was repeated. Cases were only discussed with other

\begin{enumerate}
\item \textsuperscript{211} L.R. Slome \textit{et al.}, "Physician-Assisted Suicide and Patients with Human Immunodeficiency Virus Disease" (1997) 336 New Eng. J. Med. 417 at 419.
\item \textsuperscript{212} "Critical Care Nurses," \textit{supra} note 204 at 1375. Not all of the reported cases of euthanasia were performed pursuant to requests or with the knowledge of family members, surrogates, or the patients themselves.
\item \textsuperscript{213} Meier, \textit{supra} note 86 at 1194.
\item \textsuperscript{214} \textit{Ibid.} at 1197.
\item \textsuperscript{216} \textit{Ibid.} at 509.
\end{enumerate}
doctors 39.5 per cent of the time.\textsuperscript{217}

A study released in the year 2000 revealed that of the 152 United States oncologists sampled, 48 per cent received requests for euthanasia or assisted suicide. None performed euthanasia, 7 per cent (eleven) engaged in assisted suicide, and 2 per cent (three) ended life without a request. The most frequent diagnosis was cancer, and cases were only discussed with other physicians 8 per cent of the time.\textsuperscript{218} The results of a comparative study of those that died under Oregon’s DDA in 1998 (sixteen) and 1999 (twenty seven) was also published in 2000.\textsuperscript{219} The median age of those assisted was seventy and seventy-one in 1998 and 1999, respectively. High school and college graduates comprised 81 per cent of those aided in 1998 and 92 per cent in 1999. The most common underlying illness was cancer in both years. At the time of request in 1998, 67 per cent were enrolled in a hospice program. The corresponding figure for 1999 was 44 per cent. Immediately before death, 73 per cent (1998) and 78 per cent (1999) of those receiving assistance were enrolled in such programs. All of the persons in 1999 were insured and 6 per cent (one) in 1998 were not.\textsuperscript{220}

A number of propositions may be drawn from this information. The notion that vulnerable persons/groups, such as the uneducated, the uninsured, and the disabled (the most common underlying condition being cancer) will end up requesting assisted suicide (in light of the DDA research) or euthanasia, is highly questionable. Hospice and palliative care do not necessarily eliminate a person’s desire to die. Moreover, assisted suicide, voluntary and non-voluntary euthanasia, and quite probably involuntary euthanasia, are being practiced in America, both within and outside the medical context. Violations of proposed guidelines are also occurring. American critics of the Dutch experience should consider being a little more attentive to their own situation.

D. Canada

Research on voluntary euthanasia and assisted suicide in Canada is quite scarce, but what little does exist is illuminating. A small study in

\textsuperscript{217} Ibid. at 510.


\textsuperscript{219} “Suicide in Oregon,”\textit{ supra} note 81.

\textsuperscript{220} Ibid. at 600.
1992-1993 indicated that respondents from various professional backgrounds participated in the deaths of thirty-four persons with AIDS and one afflicted with cancer.\(^{221}\) The results of an Alberta survey published in 1993 revealed that, of the 1391 physician respondents, 19 per cent had received at least one request for euthanasia.\(^{222}\) Of all respondents, 33 per cent stated that they would not report a colleague who had engaged in euthanasia to anyone.\(^{223}\) Unfortunately, the survey did not ascertain whether doctors had actually participated in the practice. A minor study reported in 1996 revealed that at least eleven persons assisted in twenty-five AIDS-related deaths.\(^{224}\) Another small study involving Canadian nurses in AIDS care was published in 1998 and indicated that 22.2 per cent (ten) of forty-four respondents received patient requests for voluntary euthanasia. The corresponding figure for assisted suicide was 11.1 per cent (five) of forty-two respondents. Of the total nurses responding (forty-five), 57.8 per cent (twenty-six) stated that physicians perform voluntary euthanasia and assisted suicide and 28.9 per cent (thirteen) stated that nurses do likewise.\(^{225}\)

Further insight as to the occurrences of euthanasia and assisted suicide in Canada can be attained through an examination of criminal trials and non-criminal hearings. In 1941, an Alberta couple was acquitted of killing their two-year-old son who suffered from cancer; he was asphyxiated with carbon monoxide.\(^{226}\) In 1991, a physician administered a lethal dose of morphine to two elderly patients and was not criminally charged. In that same year, a nurse gave a lethal injection to a seventy-eight-year-old patient. He was convicted of administering a noxious substance, received three years' probation, a suspended


sentence, and was prohibited from ever practicing nursing. In 1992, it was reported that a Montréal doctor administered a lethal injection to an AIDS patient. The matter was not pursued as the Québec College of Physicians advised against prosecution. In 1993, a doctor was convicted of administering a noxious substance (potassium chloride) to a cancer patient that had been removed from a ventilator. He received a suspended sentence and three years probation. In 1994, Sue Rodriguez apparently died with the help of a physician and to this day, the doctor remains anonymous. In 1993, Robert Latimer was charged with second-degree murder for asphyxiating his daughter with carbon monoxide; she had severe cerebral palsy. Several years later, after a prolonged court battle, Latimer's conviction and sentence were upheld by the Supreme Court of Canada. In 1995, an eighty-one-year-old woman helped her ill husband commit suicide and attempted to take her own life. She pleaded guilty to manslaughter and received eighteen months probation. In 1996, Dr. Nancy Morrison administered potassium chloride to a patient after he had been removed from a respirator. The judge at the preliminary inquiry held that there was insufficient evidence to commit Dr. Morrison to stand trial for first-degree murder. The Crown application to quash the decision was dismissed in 1998. In 1999, the Court of Appeal of Ontario dismissed

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227 The cases of Dr. Peter Graff and Scott Mataya cited in Ogden, supra note 221 at 20-24.


229 de la Rocha, supra note 131.


231 Latimer was initially convicted of second-degree murder in 1994. Latimer appealed the decision to the Saskatchewan Court of Appeal, but his appeal was dismissed: R. v. Latimer, [1995] 8 W.W.R. 609. However, Latimer’s conviction was quashed and a new trial was ordered by the Supreme Court of Canada when it was ascertained that the prosecutor interviewed potential jurors regarding their views on subjects of significance in the case: R. v. Latimer, [1997] S.C.R. 217. At his second trial, Latimer was once again convicted for second-degree murder; however, Justice Noble, the trial judge, granted Latimer a constitutional exemption from the mandatory minimum sentence and instead sentenced Latimer to one year of imprisonment and one year on probation. The Crown appealed the decision to grant a constitutional exemption and Latimer appealed his conviction to the Saskatchewan Court of Appeal. The court dismissed Latimer's appeal and allowed the Crown's appeal from the decision to grant a constitutional exemption: R. v. Latimer (1998), [1999] 6 W.W.R. 118 (1997). Latimer appealed his conviction and sentence to the Supreme Court of Canada. The Court dismissed Latimer's appeal and upheld Latimer's conviction for second-degree murder and the accompanying mandatory minimum sentence of ten years: R. v. Latimer, [2001] S.C.J. No. 1, online: QL (SCI).


the appeal of a doctor who pled guilty to two counts of aiding suicide after he prescribed lethal doses of Seconal to two HIV patients who were not suffering from AIDS. The trial judge imposed sentences of incarceration for two years less a day and three years probation to be served concurrently. In July of 2000, the Manitoba Crown stayed charges against Bert Doerkson, eighty-one, for assisting in his cancer-stricken wife's suicide.

This information suggests several things. The courts have dealt with many cases leniently. Little is known about the frequency of voluntary euthanasia and assisted suicide in the medical context and more research is necessary. But the material does verify that incidents of voluntary and non-voluntary euthanasia, and assisted suicide, are occurring in Canada. In light of the more extensive research from other countries, it might well be surmised that involuntary euthanasia within the medical context is being practiced here also.

E. Summary and Conclusion

The situation in the Netherlands is far from perfect. Assisted suicide, voluntary and non-voluntary euthanasia, and quite possibly, involuntary euthanasia are practiced, often in questionable circumstances. Many of the substantive and procedural requirements are also violated. By acknowledging the existence of such practices, the Dutch have invited criticism. Although euthanasia and assisted suicide are prohibited elsewhere, they are practiced nevertheless. Whatever one might think of the Dutch approach, it is speculation to conclude that a slippery slope exists or that the slide is already complete in the Netherlands. Since there is no reliable research in the Netherlands before 1990, the claim that "permissibility" necessarily entails "slippery slopes" cannot be established. The research emerging from Oregon casts further doubt on such a claim. This is not to say that permitting the practices will not lead to problems; the potential is real. It does not follow, however, that adequate safeguards cannot be developed.

234 R. v. Genereux (1999), 44 O.R. (3d) 339. Both the Crown and the accused appealed sentence. Leave was granted to both parties, but the court of appeal dismissed both appeals.

elsewhere because the situation in the Netherlands is problematic. A different approach is necessary.

VII. PRACTICAL MEASURES

Arguably, too much medical and judicial discretion, a *post hoc* reporting procedure, and a lack of legislative input, has given rise to the current state of affairs in the Netherlands. In Canada, Parliament has declined and still refuses to deal with the continued prohibition of voluntary euthanasia and assisted suicide, preferring instead that the courts consider the issue. Canadian and American case law suggests that the topic warrants a political response. Justice Souter, in *Glucksberg*, explained why the matter is best left for legislators: “[n]ot only do they have more flexible mechanisms for factfinding than the Judiciary, but their mechanisms include the power to experiment, moving forward and pulling back as facts emerge within their own jurisdictions.” Although the drafting of adequate legislation may be a cumbersome task, it is possible. Foreign schemes, such as the *DDA*, *ROTTI*, and the Dutch requirements are highly instructive. What follows is a proposal of what voluntary euthanasia and assisted suicide legislation in Canada should include.

A. Proposed Legislation

First of all, the title of an Act should attempt to convey what lies at the foundation of the legislation. For example, the “Voluntary and Compassionate Death Act” might appropriately characterize Canadian legislation. The Act would include a preamble to the following effect: Nothing in this Act shall be construed so as to permit the practices of non-voluntary or involuntary euthanasia. It would also include a suitable definition section and a residency provision. The Act would permit the practice of both voluntary euthanasia and assisted suicide in the medical context. It can be argued, however, that assisted suicide is preferable for

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237 *Rodriguez*, supra note 26; *Brush*, supra note 232; and *Glucksberg*, supra note 72 at 788.
238 *Glucksberg*, ibid.
239 *DDA*, supra note 77.
240 *ROTTI*, supra note 59.
a number of reasons. First, it minimizes the involvement of third parties. Second, persons should not ask others to do what they can do for themselves. Third, assisted suicide decreases the risk of traumatizing another party. Additionally, it increases the patient’s involvement and stresses the voluntariness and genuineness of the request. Finally, it might also ease the consciences of those that assist. Nonetheless, given the similarity between voluntary euthanasia and assisted suicide, and the justifiability of each, voluntary euthanasia must also be permitted. Forcing life on those physically unable to complete the act would be cruel since they have, potentially, years of agony to experience as compared to one who is “knocking on death’s door.” As well, such policy does not adequately respect the principles of autonomy and beneficence. Moreover, if problems are experienced during an assisted suicide, then medical staff might need to intervene. Permitting voluntary euthanasia would also help to insulate the legislation from a constitutional challenge pursuant to section 15 of the Charter.

As opposed to the post hoc reporting procedures in all of the jurisdictions mentioned above, a system of pre-authorization should be in place. Such a procedure would ensure predictability in the law. Applications would be submitted to a provincial panel for approval. The panel could include permanent and rotating positions for: a medical ethicist; a palliative care specialist; a psychologist; a lawyer; a social worker; a coroner’s representative; a specialist with experience relevant to the specific case; a criminologist, sociologist, or other academic with a background in the humanities; a nurse; a patient advocate. Such a panel would be in a better position than a court to evaluate the legitimacy of individual cases. Although the application process would

241 Otlowski, supra note 38 at 465-66.
243 Ibid.
244 Otlowski, supra note 38 at 466.
245 See, for example, Rodriguez, supra note 26.
246 A system of pre-authorization was also suggested by Gilmour, supra note 42 at 257-58; and T.O. Nielsen, “Guidelines for Legalized Euthanasia in Canada: A Proposal” (1998) 31:7 Annals, Royal College of Physicians and Surgeons of Canada 314 at 317 [hereinafter “Guidelines for Canada”].
247 Regional ethics committees were suggested by “Guidelines for Canada,” ibid.
248 Ibid.
249 Ibid.
detract from patient autonomy, the procedure strikes an appropriate balance between absolute prohibition and unqualified respect for autonomy. The number of members on a given panel should be no less than five, in order to ensure a balanced appraisal. Majority opinion would be decisive. A national committee could monitor provincial decisions, direct research (integral to such a legislative scheme) and report its findings, and suggest whether adjustments are in order.

A written application for assistance in dying would have to be filed by the patient. Where a patient is physically unable to sign an application, a proxy signor would be allowed to do so. Given the gravity/finality of the practices, restricting eligibility to those eighteen years of age and older would be acceptable. The patient would have to be competent and all applicants would be required to submit to mental status assessments. Since the Act would not permit non-voluntary or involuntary euthanasia, patients would have to be competent immediately before the procedure is initiated. As a consequence, requests cannot be premised on advance directives or on decisions made by proxies. The patient would have to be informed of all the relevant medical facts. The request would have to be voluntary; not coerced or economically influenced. The request must be repeated in order to account for any variability involved in the desire to die. There would also be a mandatory waiting period between the making of requests and the performance of the procedures. The patient would have the right to rescind the request at any time, in any manner.

The practices of voluntary euthanasia and assisted suicide would be limited to instances where pain and suffering is reasonably unacceptable to the individual. Reasonable alternatives would also need to be explored. Thus, assessments of suffering and health care alternatives would be based on a mixed subjective/objective model: a balanced approach. With regard to alternative care, the more intrusive the procedure, the more reasonable it would be to refuse it. Ample weight should be given to the principles of autonomy and beneficence at all times. Suffering would need to stem from an irreversible

252 Otlowski, supra note 38 at 479.
physiologically based condition. A “Schedule of Medical Conditions” would outline the eligible medical conditions and corresponding time limitations within which the procedures could be performed. For example, amyotrophic lateral sclerosis (ALS), AIDS, various types of cancer, and total physical incapacity could have tailored time limitations of six months, one year, or none at all. The medical profession (including nurses), in conjunction with the legal community, would determine these time limits in order to account for all of the medical issues and legal ramifications. Such a schedule would eliminate ambiguities, provide for flexibility, and ensure that amendments are debatable and occur in the open. In cases of total physical incapacity when death is not imminent, patients would have to consult with a patient advocate. Given the length of life shortening involved, this further requirement would be justified.

An applicant would have to be examined by two physicians that verify the above requirements have been met. The physicians and the psychologist would have to submit independent reports, not simply sign another’s assessment. This would guard against abuse and promote accountability. Someone with palliative care experience would have to consult with the patient. A physician would be entitled to introduce the options of voluntary euthanasia and assisted suicide; they would be legitimate alternatives and should be openly discussed. Second opinions and mental assessments would ensure that such suggestions do not unduly affect the decisionmaking process.

The medical profession would determine the appropriate drugs to be utilized and establish a procedure of acceptable administration. Persons eligible to give assistance would not be limited to physicians. A qualified nurse, in the presence of a physician, could carry out the procedure as long as the established standards of practice are adhered to. This would allow for the maximization of medical personnel autonomy and ensure adequate procedural availability. A physician would be required to remain present until the individual died. The procedure would be performed in front of witnesses in order to provide a check on abuse and error. One of the witnesses would have to be unrelated to the patient and could not stand to gain from the death. The practices would not have to be performed in a medical setting; rather, they could be carried out at the homes of people choosing to die in more comfortable surroundings. No medical professional would be required to perform either procedure. There would be no need to impose new

254 It should be remembered that unassisted suicide is an option for a person suffering from a non-somatically based condition where there is a wish to die.

255 Otlowski, supra note 38 at 491.
criminal penalties, as the Code, 1985\textsuperscript{256} provisions would remain in force. However, since the courts tend to treat physicians leniently, minimum three to six month suspensions of medical licences might accompany violations.\textsuperscript{257} The Act would also delineate its effect on the construction of contracts, wills, statutes, and annuity and insurance policies.\textsuperscript{258}

VIII. CONCLUSION

Autonomy underscores the right of Canadians to have life-sustaining treatment withheld or withdrawn. Together, the principles of autonomy and beneficence propel Canadian palliative care policy, the CMA's Code of Ethics, and informed the Rodriguez decision. These principles provide the foundation for justifying voluntary euthanasia and assisted suicide. When people make voluntary and informed decisions that the continuation of life is not to their benefit, they should be free, with qualification, to seek assistance in order to end their lives in a compassionate and acceptable manner. Withdrawing and withholding life-sustaining treatment and administering palliative care that has the effect of shortening life, differ from voluntary euthanasia and assisted suicide only in degree, not in kind. All of these practices can be viewed as legitimate exceptions to the principle of the "sanctity of life."

While slippery slope arguments raise some serious concerns, they can ultimately be dismissed. Admittedly, there are risks with the Dutch model due to the possibility of a slippery slope. However, the other countries discussed have not adequately explored what is transpiring in their own back yards. They are open to many of the same criticisms given that euthanasia and assisted suicide are being practiced in these countries. There is evidence of cause for concern in the Netherlands, but the evidence is insufficient to warrent a blanket prohibition in Canada. Too much medical and judicial discretion, a post hoc reporting procedure, and a lack of legislative input has given rise to the Dutch status quo. A different approach, such as the one delineated above, would prevent abuses from occurring and maintain the prohibition of non-voluntary and involuntary euthanasia. The experience in Oregon supports the assertion that similar legislation is feasible. Public opinion strongly supports legislative reform, as does much of the Canadian

\textsuperscript{256} Code, 1985, supra note 12.

\textsuperscript{257} "Guidelines for Canada," supra note 246 at 317.

\textsuperscript{258} See, for example: DDA, supra note 77 at § 127.870, s. 3.12, § 127.875, s. 3.13, § 127.880, s. 3.14; and ROTTI, SUPRA NOTE 59, ss. 16, 18, 19, 20.
medical community. Consequently, since legislators are in the best position to deal with these issues, change in the existing law should be accomplished by the government, not the judiciary.