

Egregious Inaction: Five Years After *Of Life and Death*

Introduction

In November 1999, the Standing Senate Committee on Social Affairs, Science and Technology was authorized to examine and report upon developments since the release of *Of Life and Death*, the final report of the Special Senate Committee on Euthanasia and Assisted Suicide. In particular, the Committee was authorized to examine:

1. The progress of the implementation of the unanimous recommendations made in the report;
2. Developments in Canada respecting the issues dealt with in the report;
3. Developments in foreign jurisdictions respecting the issues dealt with in the report.¹

A subcommittee to update *Of Life and Death* was therefore established. On February 14, 2000, I participated in the first panel of witnesses before this subcommittee. In light of the subcommittee's mandate, I set myself the following two tasks: first, to update the legal status sections of *Of Life and Death* by reporting on any changes to the legal status and any significant legal events/developments for each of the categories of assisted death; and second, to report on the status of the unanimous and majority legal recommendations made in *Of Life and Death*.

The following report captures the testimony I provided to the Senate Subcommittee. It is divided into five sections: pain control and sedation practices, the withholding and withdrawal of life-sustaining treatment, advance directives, assisted suicide, and euthanasia. Each of these five sections is divided into three subsections: changes in legal status, significant legal events/developments, and the status of the original Senate Committee recommendations.

Pain Control and Sedation Practices

1. Changes in legal status

There have been no changes to the legal status of pain control and sedation practices.

2. Significant legal events/developments

In 1996, Senator Sharon Carstairs introduced a bill designed to clarify the law with respect to pain control and sedation practices and to make it clear that, at least in some circumstances, the provision of potentially life-shortening palliative treatment is legally permitted.² This bill died when the last federal election was called. In 1999, Senator Thérèse Lavoie-Roux introduced a bill with similar intentions. It died with the 1st session of the 36th Parliament.³ Later in 1999, Senator Carstairs introduced another bill again designed to clarify the law with respect to pain control and sedation practices.⁴ This bill is still before the Senate.

3. Status of legal recommendations

Contrary to the unanimous recommendations, Parliament has not amended the *Criminal Code* to clarify the legal status of the provision of potentially life-shortening palliative treatment.

Withholding and Withdrawal of Life-sustaining Treatment

1. Changes in legal status

There have been no changes to the legal status at the federal level. However, there have been some provincial initiatives. For example, the Ontario *Health Care Consent Act, 1996* now provides for a clear statutorily protected right to refuse potentially life-sustaining treatment.⁵

2. Significant legal events/developments

There have been a number of significant events/developments in the area of withholding and withdrawal of potentially life-sustaining treatment. These can be classified as general events/developments and as events/developments of importance to specific groups of individuals.

A. General

The bill introduced by Senator Carstairs in 1996 was designed to clarify the law with respect to the withholding and withdrawal of potentially life-sustaining treatment and make it clear that withholding and withdrawal are, at least in some circumstances, legally permitted.⁶ This bill died when the last federal election was called. Senator Lavoie-Roux's 1999 bill had similar intentions, but it died with the 1st session of the 36th Parliament.⁷ Later in 1999, Senator Carstairs introduced another bill again designed to clarify the law with respect to the withholding and withdrawal of potentially life-sustaining treatment.⁸ This bill is still before the Senate.

B. Immature minors

When the Senate Committee delivered *Of Life and Death*, the common law status of refusals of treatment for immature minors was not clear. Could parents refuse potentially life-sustaining treatment on behalf of their children? In 1995, the Supreme Court of Canada considered this issue in *Sheena B.*⁹ As a result of this case, it is now clear that where withholding and withdrawal of potentially life-sustaining treatment is in the child's best interests, the parents have the authority to refuse the treatment and their refusal must be respected. However, where the treatment is in the child's best interests, then the parental refusal will be overridden by the state.

C. Mature minors

Under the Ontario *Health Care Consent Act*, anyone (regardless of age) able to understand the information relevant to making a health care decision and able to appreciate the reasonably foreseeable consequences of the decision is entitled to have that decision respected.¹⁰ Thus, in Ontario, mature minors now have the statutory right to refuse potentially life-sustaining treatment regardless of

whether the courts or health care providers believe it to be in the minors' best interests.

At first glance, the provisions in the British Columbia *Infants Act* appear similar to those of the Ontario legislation; the consent of a minor appears to be as effective as that of an adult if the minor is capable of understanding the nature and consequences of the treatment decision.¹¹ However, further inspection reveals that this Act provides mature minors with only a limited statutory right. Section 17 limits the right such that consent of a mature minor is necessary and sufficient only where the health care provider believes that the refusal of treatment is in the best interests of the minor.

Recent amendments to the Manitoba *Child and Family Services Act* introduce a mature minor rule with respect to children who have been apprehended under the *Act*. Under the amended *Act*,

the agency shall not authorize medical treatment for children 16 years or older without the consent of the child. The agency may apply to the court to authorize treatment but the court will not do so unless the court is satisfied that the child is not a mature minor.¹²

Several recent cases have also addressed the issue of mature minors. In *Kennett Estate v. Manitoba (Attorney General)*,¹³ the trial judge embraced the principle that a mature minor's consent should generally be respected but could be overridden by the court acting under its *parens patriae* jurisdiction. However, in *Van Mol (Guardian ad litem of) v. Ashmore*, the justices on the British Columbia Court of Appeal appear to be in disagreement with each other over the existence of this *parens patriae* limit on the common law mature minor rule.¹⁴

Thus, since *Of Life and Death*, there has been some legislative and judicial activity in the arena of mature minors. However, there is still little clear guidance to be found in most provincial legislation or in the common law. In particular, it is not yet clear whether minors who understand the nature and consequences of the decision to be made should always have their decisions respected or should have their decisions respected only when what they are seeking to do/not do is actually in their best interests.

D. Incompetent adults without advance directives

It is not yet clear whether minors who understand the nature and consequences of the decision to be made should always have their decisions respected or should have their decisions respected only when what they are seeking to do/not do is actually in their best interests.

Some provincial legislation has addressed the issue of withholding and withdrawal of life-sustaining treatment from incompetent adults without advance directives. For example, the Ontario *Health Care Consent Act, 1996* and the *Substitute Decisions Act* together provide a means to appoint proxies for incompetent persons who did not complete advance directives and to give these proxies the authority to refuse potentially life-sustaining treatment on behalf of the incompetent persons.¹⁵ The legislation sets out the mechanisms and appropriate grounds for decision-making for decisions on behalf of incompetent persons.

One court has also addressed this issue. In October 1997, a Canadian court was asked for the first time to reflect on the issue of potential liability for the removal of life-sustaining treatment from an incompetent adult without an advance directive.¹⁶ R.K. was an 83-year-old man in a persistent vegetative state. His wife initially refused to consent to the removal of life support. The health care providers sought a declaration from the court that life support could be removed and further interventions withheld without the patient's consent and against his surrogate's wishes without "civil, criminal, professional and other legal liability." R.K.'s wife subsequently changed her mind and consented to the removal. However, the court was still asked for a declaration with respect to liability. Justice McDermid found that the withdrawal and withholding of life-sustaining treatment was in the patient's best interests. However, he refused to issue the declaration sought in part because

if what is being sought is a declaration that a physician has a legal right in these circumstances to withdraw life-support from R.K., I am not at all certain that it is a declaration a court should make. Questions such as this, involving as they do complex moral, ethical, religious, and legal issues are best dealt with in a multicultural society by Parliament rather than the courts. They lie essentially within the purview of the legislative branch of government, whose function is to decide upon and enumerate policy, and not within that of the judicial branch.¹⁷

Thus, while there has been some activity since the Senate Committee delivered *Of Life and Death*, the legal status of the withholding or withdrawal of potentially life-sustaining treatment from incompetent adults without advance directives remains unclear.

E. Unilateral withholding or withdrawal ("the futility debate")

In the past few years, two cases that have come forward raise the question of what should happen when surrogate decision-makers want treatment but the health care team believes that treatment would not be in the incompetent person's best interests.

In November 1997, the Court of Appeal in Manitoba decided a case involving a child in a persistent vegetative state.¹⁸ The physicians wished to enter a Do Not Resuscitate (DNR) order on his chart, the parents disagreed, and legal action ensued. The trial judge agreed that a DNR order was in the child's best interests and authorized the placement of the order. On appeal, the Court of Appeal overturned the trial judge's decision to authorize not on the grounds that the DNR order was not in the child's best interests but rather on the grounds that the physicians had the authority to enter it on the child's chart without going to court. Justice Twaddle found, for the court, that consent from the parents of an infant was not necessary for the physician to enter a DNR order on the child's chart. On a broader note, Justice Twaddle wrote:

[N]either consent nor a court order in lieu is required for a medical doctor to issue a non-resuscitation direction where, in his or her judgement, the patient is in a persistent vegetative state. Whether or not such a direction should be issued is a judgement call for the doctor to make having regard to the patient's history and condition and the doctor's evaluation of the hopelessness of the case. The wishes of the patient's family or guardians should be taken into account, but neither their consent nor the approval of a court is required.¹⁹

In the second case, Mr. Sawatzky, an elderly man with Parkinson's disease and numerous other health problems, was a patient in the Riverview Health Centre in Winnipeg. His physician placed a DNR order on his chart without notifying his wife. Mrs. Sawatzky objected to the order and sought an interlocutory injunction to have this order removed from his chart. In November 1998, Justice Beard of the Manitoba Court of Queen's Bench issued an interlocutory injunction ordering the lifting of the DNR order and ordering the parties to seek independent medical opinions and recommending that the parties attempt to resolve the matter out of court.²⁰

Since Justice Beard was hearing a motion for an interlocutory injunction, she did not decide the issue of the legal status of unilateral DNR orders. However, she did

make it quite clear that she believes that the law is unsettled in this arena. She noted that:

Based on the case law to date, the courts have stated that a decision not to provide treatment is exclusively within the purview of the doctor and is not a decision to be made by the courts. Thus, it appears that the courts would not interfere with a medical decision not to provide treatment.²¹

And:

I think that many Canadians would be surprised to learn that a doctor can make a “do not resuscitate” order without the consent of a patient or his or her family, yet that appears to be the current state of the law in Canada, Britain, and the United States.²²

However, she also noted the deficiencies in the case law to date:

[C]ounsel have referred to only three cases in which the facts and issues are at least somewhat closely related to this matter, although even then there are some clear differences. There is only one case from a Canadian court, being the *CFS v. RL and SLH* decisions and that case did not consider either effect of rights under the *Charter of Rights and Freedoms* (the *Charter*) or the *Manitoba Human Rights Code*, CCSM, c. H175.²³

Justice Beard effectively left open the question of what, at trial, would be found to be the legal status of unilateral DNR orders. Before the case got to trial, however, Mr. Sawatzky was transferred to another institution and he subsequently died. It is not yet clear whether the case will proceed despite his death.

These are the only court cases in Canada on the issue of unilateral withholding and withdrawal of potentially life-sustaining treatment. For the present, they can be read as binding precedents only with respect to unilateral DNR orders for persons in Manitoba. However, as highly publicized and controversial cases, they have generated considerable discussion of the issue of unilateral withholding and withdrawal of life-sustaining treatment. Thus, an issue that was lurking in the background in 1995 has very much come to the fore now and is very much in need of attention.

3. Status of legal recommendations

Contrary to the unanimous recommendations in *Of Life and Death*, Parliament has not amended the *Criminal Code* or enacted legislation to explicitly recognize and clarify the circumstances in which the withholding and withdrawal of life-sustaining treatment is legally acceptable.

Advance Directives

1. Changes in legal status

Since the release of *Of Life and Death*, several provinces have moved to introduce advance directives legislation. Seven provinces and one territory have now passed and proclaimed legislation.²⁴ Two provinces have passed but not yet proclaimed legislation.²⁵ One province and two territories still have no legislation.²⁶

2. Significant legal events/developments

There have been no significant legal events/developments apart from the legislative initiatives described above.

3. Status of legal recommendations

As unanimously recommended, some provinces and territories that did not have advance directives legislation have adopted such legislation. However, contrary to the unanimous recommendations, one province and two territories have yet not adopted advance directives legislation and the provinces and territories have not collectively established a protocol to recognize advance directives executed in other provinces and territories.

Assisted Suicide

1. Changes in legal status

There have been no changes to the legal status of assisted suicide.

2. Significant legal events/developments

In October 1995, Mary Fogarty was convicted of assisting in the suicide of a friend. The Crown alleged, and the jury agreed, that Mary Fogarty provided Brenda Barnes, a diabetic, with syringes and insulin and wrote Barnes' suicide note for her. The Crown further alleged that Fogarty assisted with the suicide because she thought (mistakenly) that she stood to benefit from Barnes' \$100,000 life insurance policy. Fogarty claimed that she gave Barnes the syringes so

that she could inject amphetamines and Fogarty also speculated that Barnes took the insulin out of Fogarty's purse. Fogarty admitted writing the suicide note at Barnes' dictation but claimed not to have known it was a suicide note. She was convicted and sentenced to three years probation and 300 hours of community service,²⁷ thus becoming the first person convicted and the first person in over 30 years²⁸ charged under s.241(b) of the *Criminal Code*.²⁹

In June 1996, Dr. Maurice Genereux was charged under s.241(b) of the *Criminal Code* for assisting with the suicide of a patient.³⁰ In May 1997, additional charges were laid and he ultimately faced charges including aiding or abetting suicide and counselling to commit suicide. Dr. Genereux was accused of prescribing drugs to two patients who were HIV positive (one ultimately committed suicide and one attempted suicide). This was the first time that a physician was charged with assisted suicide in Canada. In December 1997, Dr. Genereux pled guilty and became the first physician convicted under s.241(b).³¹

In August 2000, Bert Doerksen will stand trial in Manitoba on a charge of assisting suicide. It is alleged that he helped his ailing 78-year-old wife to commit suicide by carbon monoxide poisoning in the family garage.³²

3. Status of legal recommendations

As recommended by the majority of the Committee, no amendments have been made to the offence of counselling suicide under subsection 241(a) of the *Criminal Code*. In addition, again as recommended by the majority, subsection 241(b) remains intact.

Euthanasia

1. Changes in legal status

There have been no changes to the legal status of euthanasia.

2. Significant legal events/developments

In 1993, Robert Latimer was charged with first degree murder in the death of his daughter. He placed his severely disabled daughter in the cab of his truck and, with the

purpose of alleviating what he believed to be her otherwise unrelievable suffering, asphyxiated her with carbon monoxide. Mr. Latimer was convicted of second degree murder and sentenced to the mandatory minimum life sentence with no possibility of parole for ten years.³³ After he successfully appealed his conviction to the Supreme Court of Canada, the Court ordered a new trial³⁴ on the grounds that the prosecution tampered with the jury by asking Royal Canadian Mounted Police to question

Contrary to the unanimous recommendations, one province and two territories have not yet adopted advance directives legislation and the provinces and territories have not collectively established a protocol to recognize advance directives executed in other provinces and territories.

prospective jurors about their ethical and religious views on euthanasia and abortion. Mr. Latimer was tried again on a charge of second degree murder, convicted, and, despite the mandatory minimum life sentence with no possibility of parole for ten years, was sentenced to two years less a day with one year to be spent in prison and one year

under house arrest. This extraordinary sentence was possible because the trial judge granted Latimer a constitutional exemption from the mandatory minimum sentence on the grounds that such punishment, in the circumstances of this case, would constitute cruel and unusual punishment and thus breach Latimer's s.12 rights under the *Charter*.³⁵ The Saskatchewan Court of Appeal dismissed Latimer's appeal, allowed the Crown's appeal, and imposed the mandatory minimum sentence.³⁶ Latimer was granted leave to appeal to the Supreme Court of Canada³⁷ but his appeal has not yet been heard.

In 1997, Dr. Nancy Morrison was charged with first-degree murder following the death of Paul Mills, a 65-year-old man with cancer of the esophagus. After numerous interventions (including many surgeries), it was determined that nothing more could be done for him. With the consent of the patient's family, all potentially life-sustaining treatment was stopped. Mr. Mills was extubated. Unfortunately, none of the drugs administered appeared to alleviate his suffering; he seemed to be in considerable pain and was gasping for breath. It was alleged that, in response to this situation of unrelievable suffering, Dr. Morrison gave Paul Mills a lethal injection of potassium chloride. Dr. Morrison was released on bail and she returned to a limited practice. At the end of the preliminary hearing, Judge Hughes Randall concluded that "a Jury properly instructed could not convict the accused of the offence charged, any included offence, or any other offence" and discharged Dr. Morrison.³⁸ The Crown sought an order of *certiorari* to quash Judge Randall's decision. However, because this was a review of a decision

at a preliminary inquiry (rather than an appeal), the standard of review was excess of jurisdiction rather than error of law. Thus, while Justice Hamilton found that Judge Hughes had made an error of law, she also found that the error was within his jurisdiction and, therefore, it was not within her powers to grant the application.³⁹ The Crown decided not to appeal Justice Hamilton's decision. This case was therefore closed with respect to criminal proceedings. The College of Physicians and Surgeons then investigated the matter and chose to proceed by way of a letter of reprimand. In March 1999, Dr. Morrison signed the letter (thereby admitting the injection of potassium chloride) and this letter will remain in her file but will not prevent her from practicing in any way.⁴⁰ Thus, the entire case is now closed.

3. Status of legal recommendations

As recommended by the majority of the Committee, non-voluntary and voluntary euthanasia remain criminal offences. As recommended by the entire Committee, involuntary euthanasia remains a criminal offence.

Contrary to the unanimous recommendations, the *Criminal Code* has not been amended to provide for a less severe penalty in cases of voluntary or non-voluntary euthanasia where there is the essential element of compassion or mercy.

Conclusion

In its 1995 report *Of Life and Death*, the Senate Committee on Euthanasia and Assisted Suicide recognized that the legal status of assisted death was both unclear and indefensible. Unfortunately, it is still in need of clarification and law reform.

Consider, first, the need for clarification. The absence of a clear legislative or judicial statement on the withholding and withdrawal of potentially life-sustaining treatment or the provision of potentially life-shortening palliative treatment continues to cause at least six serious harms.

First, under the current system, some people are receiving unwanted treatment because their health care providers do not know whether they will be violating the *Criminal Code* if they do not do everything in their power to sustain life.

Second, patients across the country and even across cities and institutions are getting significantly different treatment

or non-treatment (whether it be removal of a respirator, provision of massive amounts of morphine, or provision of potassium chloride) depending upon the results of the lottery of which health care institution they go to or which health care providers they are assigned. Because there is confusion about the law, some health care providers will not respect any refusals of potentially life-sustaining treatment. Some health care providers will respect

refusals of artificial ventilation but not refusals of artificial hydration and nutrition. Others will respect refusals of all kinds of treatment. Some health care providers will respect refusals of treatment from competent adults but not from surrogate decision-makers for incompetent patients. Others will respect refusals from all decision-makers (whether the competent adult or the proxy). Some health care providers will respect refusals of treatment from terminally ill patients but not from patients who, with the treatment, would have an excellent prognosis. Others will respect refusals from all individuals regardless of diagnosis and prognosis.

Third, some people are not getting adequate pain control because health care providers do not know whether they may legally provide analgesics in doses or ways that may shorten life.⁴¹

Fourth, health care providers are operating under the shadow of the threat of legal liability. It is easy for lawyers to sit in their offices and say "Oh no, withholding and withdrawal of life-sustaining treatment is legal" or "the provision of potentially life-shortening palliative treatment is legal." However, lawyers are not the ones who may be charged (even if not convicted). This shadow harms health care providers by adding stress to their lives. It harms patients too because health care providers may be tempted to practice defensive medicine rather than do that which is in their patient's best interests or is according to their patient's wishes.⁴²

Fifth, law is being made on the backs of individuals who have the resources (financial, emotional, physical) to go to court and challenge the system. Consider, for example, the burden borne by Nancy B. Paralyzed and suffering from Guillain-Barré syndrome, Nancy B. wanted her respirator removed. She had to go to the court system and, with her family, endure a public debate about her right to refuse life-sustaining treatment. She ultimately won the case and, in doing so, helped to establish the right to refuse life-sustaining treatment in Canada.⁴³ However, she paid a significant personal price. Leadership should be

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demonstrated by those with greater resources (of all sorts) including legislators, health care professional organizations, and healthy individuals.

Sixth, law is being made on a case-by-case basis – with all of the limits attendant on such a method of making law. The courts are charged with resolving legal rather than moral issues whereas the legislatures are charged with addressing both legal and moral issues. Courts are constrained by the facts of the case and the abilities and positions of the parties before them, while the legislatures, on the other hand, can canvass far more widely.⁴⁴

In 2000, as in 1995, the legal status of assisted death needs to be clarified in order to stop these harms.

Consider now the need for reform. First, as has become increasingly clear since 1995, instances of assisted suicide and euthanasia receive inconsistent treatment. Canada lacks a standard response to cases involving assisted suicide and euthanasia. Health care providers in two provinces who perform the same acts might be tried for murder in one province yet be allowed to plead guilty to the administration of a noxious substance in another. This is manifestly unfair.⁴⁵ In 2000, as in 1995, law reform is necessary to resolve the inconsistent application of the law.

Second, the administration of justice is still inconsistent with the *Criminal Code*. Euthanasia is clearly murder according to the *Criminal Code* and yet it is being treated as a much lesser crime across the country.⁴⁶ Either euthanasia deserves a punishment less than at least 25 years in jail (in which case, as recommended by the Senate Committee, the *Criminal Code* should be amended to reflect that) or it deserves at least 25 years in jail (in which case the pattern of accepting pleas to much lesser charges should be stopped). The current approach of keeping euthanasia under the homicide provisions of the *Criminal Code* but prosecuting it under the manslaughter or administering a noxious substance provisions is at best confusing and at worst hypocritical.⁴⁷ In 2000, as in 1995, law reform is needed to resolve this confusion/hypocrisy.

Third, under the current system, we continue to fail the dying, their families and friends, as well as health care providers. For example, people are dying in excruciating pain.⁴⁸ People are attempting suicide, failing, and ending up in worse shape than before they attempted suicide.⁴⁹ People are taking desperate steps to help their patients or loved ones and finding themselves facing the potential of imprisonment for life with no possibility of parole for twenty-five years. People are refusing life-sustaining treatment for fear of accepting the treatment offered, finding themselves in a

situation in which they would feel that life is no longer worth living, but not then being allowed to die.

In 1995, the Senate Committee correctly found that the law needed both clarification and reform. Unfortunately, five years later the law still needs both clarification and reform. Therefore, I would argue that the unanimous recommendations made by the Senate Committee should be reissued and anyone with the power to implement them should be called upon to do so. They owe it to all Canadians.

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1. *Senate Journals* (25 November 1999) at 162.
2. Bill S-13, *An Act to amend the Criminal Code (protection of health care providers)*, 2d Sess., 35th Parl., 1996.
3. Bill S-29, *An Act to amend the Criminal Code (Protection of Patients and Health Care Providers)*, 1st Sess., 36th Parl., 1999.
4. Bill S-2, *Medical Decisions Facilitation Act*, 2d Sess., 36th Parl., 1999. The most important provisions of the Act with respect to potentially life-shortening palliative treatment are ss. 2 and 6:
 2. No health care provider is guilty of an offence under the *Criminal Code* by reason only that the health care provider, for the purpose of alleviating the physical pain of a person but not to cause death, administers medication to that person in dosages that might shorten the life of the person.
 - ...
 6. For the purposes of the *Department of Health Act*, the mandate of the Minister of Health to promote and preserve the health of the people of Canada includes (a) coordinating, with provincial authorities and associations of health care professionals, the establishment of national guidelines for the ... controlling of pain, and for palliative care.
5. *Health Care Consent Act, 1996*, S.O. 1996, c. 2 provides that no treatment shall be administered without consent (s.10) and a consent that has been given may be withdrawn at any time (s.14).
6. *Supra* note 2.
7. *Supra* note 3.
8. *Supra* note 4. The most important provisions of this Act for the purposes of the withholding and withdrawal of potentially life-shortening treatment are ss. 3 and 6:
 3. (1) No health care provider is guilty of an offence under the *Criminal Code* by reason only that the health care provider withholds or withdraws life-sustaining medical treatment from a person who has made a request within the meaning of subsection (2) that the

treatment be withheld or withdrawn.

...

6. For the purposes of the Department of Health Act, the mandate of the Minister of Health to promote and preserve the health of the people of Canada includes (a) coordinating, with provincial authorities and associations of health care professionals, the establishment of national guidelines for the withholding and withdrawal of life-sustaining medical treatments,...

...

(c) investigating, researching, and monitoring the frequency with which, and the conditions under which, after the commencement of this Act, life-sustaining medical treatment is withheld or withdrawn.

9. *B.(R.) v. Children's Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315.
10. See s. 4 definition of "capacity", *Health Care Consent Act, 1996*, *supra* note 5.
11. *Infants Act*, R.S.B.C. 1996, c. 223, s.17.
12. *Child and Family Services Amendment Act*, S.M. 1995, c. 23, ss. 25(2) and 25(9).
13. *Kennett Estate v. Manitoba (Attorney-General)*, [1998] M.J. No. 131 (Q.B.), online: QL (MJ).
14. *Van Mol (Guardian ad litem of) v. Ashmore*, [1999] B.C.J. No. 31 (C.A.), online: QL (BCJ). Justice Lambert states an unlimited rule. Justice Huddart expresses support for the limited rule.
15. *Health Care Consent Act, 1996*, *supra* note 5, and *Substitute Decisions Act, 1992*, S.O. 1992, c.30.
16. *London Health Sciences Centre v. R.K. (Guardian ad litem of)*, [1997] O.J. No. 4128 (Gen. Div.), online: QL (OJ).
17. *Ibid.* at para.16-17.
18. *Child and Family Services of Manitoba v. R.L.*, [1997] M.J. No. 568 (C.A.), online: QL (MJ).
19. *Ibid.* at para.17.
20. *Sawatzky v. Riverview Health Centre Inc.*, [1998] M.J. No.506 (Q.B.), online: QL (MJ).
21. *Ibid.* at para. 26.
22. *Ibid.* at para. 5.
23. *Ibid.* at para. 26.
24. *Personal Directives Act*, S.A. 1996, c.P-4.03; *Health Care Directives Act*, S.M. 1992, c. 33; *Advance Health Care Directives Act*, S.N. 1995, c. A-4.1; *Medical Consent Act*, R.S.N.S. 1989, c.279; *Substitute Decisions Act*, *supra* note 15 and *Health Care Consent Act, 1996*, *supra* note 5; Arts. 11, 2130-2185 C.C.Q.; *The Health Care Directives and Substitute Health Care Decision Makers Act*, S.S. 1997, c. H-0.001; and *Health Act*, S.Y. 1989-90, c. 36, s. 45 as am. by S.Y. 1995, c. 8, ss. 19, 20.
25. *Representation Agreement Act*, R.S.B.C. 1996, c. 405 and *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181; *Consent to Treatment and Health Care Directives Act*, S.P.E.I. 1996, c. 10.
26. New Brunswick, Northwest Territories and Nunavut.
27. "Canada's first 'assisted suicide' trial in decades ends in probationary sentence" *Canadian News Bulletins* (November 1 to December 31, 1995), online: Deathnet <<http://www.rights.org/deathnet/open.html>> (date accessed: 28 April 2000).
28. In 1962, three Inuit men were charged and convicted with assisting the suicide of Chief Aleak Kolitalik. There are no official records of this case. However, through interviews with the arresting officer and the crown counsel at trial, it has been reconstructed and is described in A. Mullens, *Timely Death: What We Can Expect and What We Need to Know* (Toronto: Vintage Canada, 1996) at 52-57.
29. "Canada's First Assisted Suicide Charge in 32 Years" *Canadian News Bulletins* (January 1 to January 31, 1995), online: Deathnet <<http://www.rights.org/deathnet/open.html>> (date accessed: 28 April 2000).
30. "Canadian doctor charged with assisting a suicide" *Canadian News Bulletins* (April 1 to May 31, 1996), online: Deathnet <<http://www.rights.org/deathnet/open.html>> (date accessed: 28 April 2000).
31. "Aids doctor faces additional charges" *Canadian News Bulletins* (May 1 to May 31, 1997), online: Deathnet <<http://www.rights.org/deathnet/open.html>> (date accessed: 28 April 2000).
32. "Eighty-year-old man to stand trial for assisted suicide" *Canadian News Bulletins* (January 1 to January 31, 1999), online: Deathnet <http://www.islandnet.com/deathnet/Cnews_9901.html> (date accessed: 28 April 27 2000).
33. *R. v. Latimer* (1995), 126 D.L.R. (4th) 203 (Sask.C.A.).
34. *R. v. Latimer*, [1997] 1 S.C.R. 217.
35. *R. v. Latimer*, [1997] S.J. No. 701 (Q.B.), online: QL (SJ).
36. *R. v. Latimer*, [1998] S.J. No. 731 (C.A.), online: QL (SJ).
37. Leave was granted on May 6, 1999. Supreme Court of Canada, *Bulleting of Proceedings* (7 May 1999) at 711.
38. *R. v. Morrison*, [1998] N.S.J. No. 75 (Prov.Ct.), online: QL (NSJ).
39. *R. v. Morrison*, [1998] N.S.J. No. 441 (S.C.), online: QL (NSJ).

40. Letter dated 25 March 1999 to Dr. Nancy Morrison from Dr. Patricia Pearce, Chair, Investigation Committee “A”, Re: Complaint of Dr. Cameron Little, available from the College of Physicians and Surgeons of Nova Scotia.
41. See testimony before the Special Senate Committee on Euthanasia and Assisted Suicide of Carol Rees from Action Life, Monique Coupal from the Fédération québécoise des centres d’hébergement et de soins de longue durée, and Patricia Rodney. Senate of Canada, *Proceedings of the Senate Special Committee on Euthanasia and Assisted Suicide*, No. 8 (1 June 1994) at 11, No. 32 (17 October 1994) at 39, and No. 15 (27 September 1994) at 129 respectively.
42. As this has already been discussed in the first harm described above, no more will be said about it here.
43. *Nancy B. v. Hôtel-Dieu de Québec* (1982), 86 D.L.R. (4th) 385 (Que. Sup.Ct.).
44. This argument is found in many decisions. See for example Justice Beard’s reasons in *Sawatzky v. Riverview Health Centre Inc.*, *supra* note 20 at para. 5: Those questions raise serious legal, moral, ethical and practical issues on which there is unlikely to ever be complete agreement. ... While the courts may be an appropriate place to start the discussion of these issues in that the courts can clarify the existing state of the law in light of the Charter of Rights and Freedoms, it may be for the government to resolve any moral or ethical questions that remain at the end of the day. The government can ensure a much wider debate including all interested sectors of society, while a court proceeding is, by necessity, relatively narrow and limited even if some interventions are allowed.
45. This lack of fairness was recognized by Justice Noble and contributed to his granting Robert Latimer a constitutional exemption from the mandatory minimum life sentence with no possibility of parole for ten years in *R. v. Latimer*, *supra* note 35.
46. Compare for example *R. v. Mataya* (24 August 1992), Ontario (Ont.Ct. (Gen.Div.)), *R. v. de la Roche* (2 April 1993) Timmins (Ont.Ct. (Gen.Div.)), *R. v. Latimer*, *supra* note 35, *R. v. Myers* (23 December 1994), Halifax (N.S.S.C.), *R. v. Brush*, [1995] O.J. No.656 (Prov.Div.), online: QL (OJ), and *R. v. Morrison*, *supra* note 38.
47. I am not arguing against prosecutorial discretion with respect to charging. Rather, I am arguing against taking prosecutorial discretion to such an extreme that no cases are taken under the provision of the *Criminal Code* under which they *prima facie* belong.
48. See for example the testimony of Thomas Sigurdson, Senate of Canada, *Proceedings of the Senate Special Committee on Euthanasia and Assisted Suicide*, No. 15 (27 September 1994) at 119-23.
49. See for example the testimony of Russell Ogden and Louise Normandin Miller, Senate of Canada, *Proceedings of the Senate Special Committee on Euthanasia and Asssisted Suicide*, No. 14 (26 September 1994) and No. 5 (11 May 1994) respectively.

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