

# End-of-Life Decision Making: Rethinking the Principles of Fundamental Justice in the Context of Emerging Empirical Data

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“And answer made King Arthur, breathing hard:  
'My end draws nigh; 'tis time that I were gone.  
Make broad thy shoulders to receive my weight,  
And bear me to the margin; yet I fear  
My wound hath taken cold; and I shall die.”

Alfred Lord Tennyson - *Morte d'Arthur*

## I. Introduction

More than six years have passed since the decision of the Supreme Court of Canada in the *Rodriguez*<sup>1</sup> case, yet the debate over the legality of euthanasia seems far from over. On the contrary, the upcoming and much anticipated ruling by the highest court in Canada awaited this fall in the *Latimer*<sup>2</sup> case has brought the issue back to the forefront. Indeed, as the *Latimer* case and countless others in the ensuing years have demonstrated, those providing assistance, whether they be family members<sup>3</sup> or health care professionals,<sup>4</sup> do so not only because they deeply believe in the right to self-determination of the terminally ill whom they are responsible for, but also because their own consciences and morality push them to act and to respect the wishes of those they see suffering from incapacitating diseases, such as amyotrophic lateral sclerosis,<sup>5</sup> or from intolerable pain and refractory symptoms which continue to plague a significant number of terminally ill patients.<sup>6</sup>

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<sup>1</sup>*Rodriguez v. B.C.(A.G.)*, [1993] 3 S.C.R. 519 [hereinafter *Rodriguez*].

<sup>2</sup>*R. v. Latimer*, [1995] 8 W.W.R. 609, 126 D.L.R. (4th) 203 (Sask. C.A.) [hereinafter *Latimer*].

<sup>3</sup>In addition to *Latimer*, see e.g. the recent case of eighty-year old Bert Doerksen who assisted in the suicide of his seventy-eight year old wife who had been suffering from arthritis, back problems, heart problems and cancer (Canadian News Bulletins, online: < [http://www.rights.org/deathnet/Cnews\\_9901.html](http://www.rights.org/deathnet/Cnews_9901.html) >).

<sup>4</sup>*R. v. Morrison*, [1998] N.S.J. No. 75 (Prov. Ct.), online: QL.

<sup>5</sup>C. Cassel, “Patient Autonomy as Therapy” in D.W. Mulder, ed., *The Diagnosis and Treatment of Amyotrophic Lateral Sclerosis*, (Boston: Houghton Mifflin, 1980) at 325.

<sup>6</sup>Institute of Medicine, *Approaching Death: Improving Care at the End of Life*, (Washington, DC: National Academy Press, 1997); World Health Organization, *Cancer Pain Relief and Palliative Care* (Geneva: World Health Organization, 1990); R.E. Enck, *The Medical Care of Terminally Ill Cancer Patients*, (Baltimore: Johns Hopkins University Press, 1994); R. Melzack & P. Wall, *The Challenge of Pain*, (London: Penguin Books, 1988); E Scarry, *The Body in Pain*, (New York: Oxford University

Because those providing assistance are merely following their ethical consciences, they feel deeply wronged and outraged when the law, far from being attuned to their exceptional circumstances, treats them as common criminals.<sup>7</sup> As Mr. Latimer has been reported as saying, his daughter's life "was too painful to be bearable [and] it was exactly because he thought so much of her that he did not want her to suffer more."<sup>8</sup> There is cause for concern when the law's rigidity and inability to recognize exceptions to a general rule renders it diametrically opposed to the ethical morality of law abiding citizens.

Meanwhile, in addition to intolerable physical incapacitation, pain and suffering remain a daily reality for thousands of terminally ill, despite recent advances in palliative care and treatment. According to recent data, 56% of outpatients with cancer, 82% of outpatients with AIDS, 50% of hospitalized patients with various diagnoses, and 36% of nursing home residents have inadequate management of pain during the course of their terminal illness.<sup>9</sup> While some of this pain could be stopped by better palliative care, a significant percentage of pain can't be stopped at all.<sup>10</sup> Moreover, between 10% to 50% of patients in programs devoted to palliative care still report significant pain one week before death.<sup>11</sup> In addition to causing physical trauma, severe pain that is not adequately controlled can also lead to psychological and social trauma such as the disruption of daily living, sleep, and social interactions.<sup>12</sup>

When surveying the legal literature on euthanasia, one finds that those in favour of finding assisted suicide to be constitutionally protected tend to focus on individuals, by describing the suffering of terminally ill patients seeking assistance in vivid, heart wrenching detail, while downplaying the potentially adverse consequences of

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Press, 1985).

<sup>7</sup>See e.g. C. Poenisch, "Merian Frederick's Story" (1998) 339 N. E. J. Med 996, where Merian Frederick's daughter, who helped her mother in contacting Dr. Jack Kevorkian, who eventually assisted her suicide, is quoted as saying "[w]e felt like criminals who hadn't committed a crime." See also C. E. Schneider, "At Law: Hard Cases" (1998) 28:2 Hastings Cent. Rep. 24, where Robert Latimer is quoted as saying "my wife mentioned that it's not a crime to cut her [Tracy Latimer's] leg off, not a crime to stick a feeding tube in her stomach, not a crime to let her lay there in pain for another 20 years. I don't think - I don't think you people are being human."

<sup>8</sup>*Ibid.* at 25.

<sup>9</sup>C.S. Cleeland *et al.*, "Pain and its Treatment in Outpatients with Metastatic Cancer" (1994) 330 N. E. J. Med. 592; W. Breitbart *et al.*, "The Undertreatment of Pain in Ambulatory AIDS Patients" (1996) 65 Pain 243; The SUPPORT Principal Investigators, "A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients" (1995) 274 J.A.M.A. 1591; C. Seale & A. Cartwright, *The Year Before Death* (Aldershot, Hants, U.K.: Avebury, 1994).

<sup>10</sup>T.E. Quill & R.V. Brody, "'You Promised Me I Wouldn't Die Like This': A Bad Death as a Medical Emergency" (1995) 155 Arch. Intern. Med. 1250. See also *supra* note 6.

<sup>11</sup>K.M. Foley, "Pain, Physician-Assisted Suicide, and Euthanasia" (1995) 4 Pain Forum 163; N. Coyle *et al.*, "Character of Terminal Illness in the Advanced Cancer Patient" (1990) 5 J. Pain Symptom Manage. 83.

<sup>12</sup>P.J. Vandermaas, J.J.M. van Delden & L. Pijnenborg, *Euthanasia and Other Medical Decisions Concerning the End of Life* (Amsterdam: Elsevier, 1992); R.K. Portenoy, "Pain and Quality of Life: Clinical Issues and Implications for Research" (1990) 4 Oncology 172.

legalization. By contrast, those opposed to finding such a constitutionally protected right to assisted suicide may speak in abstract terms, if at all, of the suffering of these patients, while focussing on the moral or policy justifications for preserving the long-standing rule against the purposeful taking of another's life, even if it be at that person's request.

Legal scholar John Noonan offers an insight into the resolution of this clash of approaches.<sup>13</sup> According to Noonan, "rules" and "persons" are equally essential components of the legal system. Thus, by focussing too rigidly on rules, generally deemed to protect the interests of persons not actually present before the bench, opponents of euthanasia resort to creating a *mask* that hides the humanity and pain of persons who are subjected to such rules. On the other hand, an overly narrow concentration on the particular circumstances of the individuals before the bench, characteristic of many advocates of the legalization of euthanasia, may betray the more general demands of a just social order. In reality, as Noonan argues, rules and persons need not be mutually exclusive. Far from eroding a legal rule, the recognition of an exception enables the rule to maintain its force in the vast majority of cases but also prevents the masking of individual liberties.

After defining the essential concepts employed in the euthanasia debate, this paper will begin by providing a comparative overview of the current law on euthanasia as it exists in various western democracies including Canada, the United States, Australia, and the Netherlands.<sup>14</sup> This will be followed by a synopsis of the empirical data reporting the views of the general public and of medical practitioners on the issue of whether euthanasia should be legalized for competent terminally ill individuals seeking assistance in dying. The majority of this paper will be dedicated to an exploration of the relationship between the concept of fundamental justice and euthanasia.<sup>15</sup> Finally, a series of recommendations will be suggested which, if implemented, would push us towards an approach to end-of-life decision making that is more consistent with the right of individuals to make decisions for themselves according to their own ethics, conscience and convictions.

## II. End-of-Life Decision Making: Defining the Concepts

The term euthanasia has been used in different ways. One way distinguishes passive euthanasia (letting die; the omission of steps which might otherwise sustain life) from active euthanasia (killing; a positive contribution to the acceleration of death). Another way substitutes the term passive euthanasia with termination of

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<sup>13</sup>J. T. Noonan, *Persons and Masks of the Law*, (New York: Farrar, Strauss and Giroux, 1976).

<sup>14</sup>This paper will not address the issue of euthanasia and international law. However, those interested in this topic are invited to see G. Zdenkowski, "The International Covenant on Civil and Political Rights and Euthanasia" (1997) 20 U.N.S.W.L.J. 170 and B. van den Akker, R. Janssens & H. ten Have, "Euthanasia and International Human Rights Law: Prolegomena for an International Debate" (1997) 37 Med. Sci. Law 289.

<sup>15</sup>Since the focus of this paper is the principles of fundamental justice, equality and discrimination issues, as discussed by Chief Justice Lamer in *Rodriguez*, will not be addressed.

life-prolonging treatment while maintaining the label active euthanasia (or simply euthanasia). The advantage of restricting the use of the term euthanasia to its purely active form is the avoidance of semantic confusion in an already confused area of the law.<sup>16</sup>

The termination of life-prolonging treatment can be understood as comprising both the withdrawal of treatment (e.g., disconnecting a respirator) and the withholding of treatment (e.g., a do-not-resuscitate order), both of which are intended to remove inappropriate medical interventions. Euthanasia—which can now be redefined as “a deliberate act undertaken by one person with the intention of ending the life of another person to relieve that person’s suffering where that act is the cause of death”<sup>17</sup>— involves situations of physician-assisted suicide (the prescription or supplying of drugs with the explicit intention of enabling the patient to end his or her own life) and mercy-killing (the administration of drugs such as potassium chloride or morphine with the explicit intention of ending the patient’s life, at the request of the patient).

### III. Current State of the Law: A Comparative Overview

Whereas the termination of life-prolonging treatment is legal in most western democracies, euthanasia is not (see for instance those countries reviewed in table 1). The ethical and legal acceptability of withdrawals and refusals of life-prolonging treatment (including hydration and nutrition) is now so widespread among both opponents and proponents of euthanasia that it is easy to forget that these issues were bitterly contested but a short time ago.<sup>18</sup> For instance, “at one time, patients could legally refuse only certain types of treatment – ‘extraordinary’ but not ‘ordinary’ care, and ‘life-sustaining’ but not ‘life-saving’ treatment. Also, the issue of whether the physician was ‘withholding’ or ‘withdrawing’ treatment was legally significant.”<sup>19</sup>

In fact, it is only over the last decade that a majority of physicians have become comfortable with the idea of respecting their patient’s requests for the withdrawal of life-sustaining treatments. Today, as many as 90% of patients in medical intensive-care units have their life-sustaining treatments withdrawn without

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<sup>16</sup>M.A. Somerville, “Euthanasia by Confusion” (1997) 20 U.N.S.W. L.J. 550.

<sup>17</sup>Report of the Special Senate Committee on Euthanasia and Assisted Suicide, *Of Life and Death* (Ottawa: Ministry of Supply and Services Canada, 1995) at 45.

<sup>18</sup>See e.g. President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions* (Washington, D.C.: U.S. Government Printing Office, 1983) [hereinafter *Deciding to Forego Life-Sustaining Treatment*]. See also M. Solomon, “Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments” (1993) 83 Am. J. Public Health 14.

<sup>19</sup>Editorial, “Physician-Assisted Suicide and the Right to Die with Assistance” (1992) 105 Harv. L Rev. 2021 at 2027 [hereinafter *Physician-Assisted Suicide*]; *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977) [hereinafter *Saikewicz*]; *In Re Conroy*, 486 A.2d 1209 at 1224 (N.J., 1985); *In Re Storar*, 420 N.E.2d 64 (N.Y., 1981), cert. denied, 454 U.S. 858 (1981); *Brophy v. New England Sinai Hospital, Inc.*, 497 N.E.2d 626 (Mass., 1986).

resuscitation<sup>20</sup> – representing a marked increase in respect for and deferral to the autonomous choice of patients over the past decade. In 1999, physicians stopping, or not starting, life-sustaining interventions according to the wishes of their patients has become so routine that guidelines have been established to guide physicians on how to properly withdraw life-sustaining treatments.<sup>21</sup>

**Table 1: Legality of Treatment Refusal and Euthanasia in Various Western Democracies**

Country	Termination of Life-Prolonging Treatment		Euthanasia	
	Withholding	Withdrawing	Physician-Assisted Suicide	Mercy-Killing
Canada	legal	legal	illegal	illegal
United States (excluding the State of Oregon)	legal	legal	illegal	illegal
United States (State of Oregon)	legal	legal	legal	illegal
Australia	legal	legal	illegal	illegal
England	legal	legal	illegal	illegal
Netherlands	legal	legal	legally permissible if guidelines complied with	legally permissible if guidelines complied with

### A. The Law in Canada

In Canada, the rights to self-determination and to autonomous medical decision making underlie the right of patients to demand that treatment, including

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<sup>20</sup>K. Faber-Langendoen, “A Multi-institutional Study of Care Given to Patients Dying in Hospitals: Ethical Practices and Implications” (1996) 156 Arch. Intern. Med. 2130; T.J. Prendergast & J.M. Luce, “Increasing Incidence of Withholding and Withdrawal of Life Support from the Critically Ill” (1997) 155 Am. J. Respir. Crit. Care. Med. 15.

<sup>21</sup>H. Brody *et al.*, “Withdrawing Intensive Life-Sustaining Treatment: Recommendations for Compassionate Clinical Management” (1997) 336 N. E. J. Med. 652.

life-prolonging treatment, be withheld<sup>22</sup> or withdrawn.<sup>23</sup> Failure to disclose to patients the nature of a proposed medical intervention, its gravity, and any material risks attendant upon its performance gives rise to a tort of negligence,<sup>24</sup> while failure to withhold or withdraw treatments in accordance with the patient's wishes gives rise to a tort of battery.<sup>25</sup> In addition to private law protection, public law offers administrative<sup>26</sup> and constitutional<sup>27</sup> protections.

However, the rights to self-determination and to autonomous decision making end where euthanasia begins. Both physician-assisted suicide<sup>28</sup> and mercy-killing<sup>29</sup> are illegal in Canada, the former being punishable as the crime of assisting suicide<sup>30</sup> and the latter, as the crime of murder.<sup>31</sup> No exception exists, including the case of competent terminally ill patients seeking assistance in dying, regardless of their state of physical incapacity or degree of pain and suffering.

## B. The Law in the United States

In the United States, as in Canada, the rights to self-determination and to autonomous medical decision making underlie the right of patients to demand that treatment, including life-prolonging treatment, be withheld or withdrawn.<sup>32</sup> Moreover, at least since the turn of the century,<sup>33</sup> the United States Supreme Court has recognized that a competent person has a constitutionally protected "liberty interest" in refusing unwanted medical treatment.<sup>34</sup> The Supreme Court ruling in

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<sup>22</sup>*Malette v. Shulman* (1990), 67 D.L.R. (4th) 321 (Ont. C.A.) [hereinafter *Malette*]. See also *Walker v. Region 2 Hospital Corp.* (1994), 116 D.L.R. (4th) 477 (N.B. C.A.); *Mulloy v. Sang*, [1935] 1 W.W.R. 714 (Alta. C.A.).

<sup>23</sup>*Nancy B v. Hotel-Dieu de Québec* (1992), 86 D.L.R. (4th) 385 (Que. S.C.). See also *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119; *Nightingale v. Kaplovitch*, [1989] O.J. No. 585 (H.C.), online: QL.

<sup>24</sup>*Reibl v. Hughes*, [1980] 2 S.C.R. 880, 14 C.C.L.T. 1, 114 D.L.R. (3d) 1; *Hopp v. Lepp* (1977), 2 C.C.L.T. 183, 77 D.L.R. (3d) 321.

<sup>25</sup>E.I. Picard & G.B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3d ed. (Scarborough, Ont.: Carswell, 1996) at 107 and 113-115.

<sup>26</sup>See e.g. *Stephen v. College of Physicians & Surgeons (Sask.)* (1991), 95 Sask. L.R. 176 (Q.B.). See also Canadian Medical Association, *Code of Ethics* (1990), s. 5 which states that "a patient has the right to accept or reject any physician and any medical care recommended."

<sup>27</sup>See *Fleming v. Reid* (1991), 82 D.L.R. (4th) 298, 4 O.R. (3d) 74 at 88 (Ont. C.A.) where it was stated that "the common law right to determine what shall be done with one's own body and the constitutional right to security of the person, both of which are founded on the belief in the dignity and autonomy of each individual, can be treated as co-extensive."

<sup>28</sup>*Rodriguez*, *supra* note 1.

<sup>29</sup>*Latimer*, *supra* note 2.

<sup>30</sup>*Criminal Code*, R.S. C. 1985, c. C-46, s. 241.

<sup>31</sup>*Ibid.*, s. 229. See also s. 14 which stipulates that "no person is entitled to consent to have death inflicted upon him ..."

<sup>32</sup>*Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972), cert. denied, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 502 P.2d 1, 9 (Cal. 1972); *Natason v. Kline*, 350 P.2d 1093, 1104 (Kan. 1960).

<sup>33</sup>*Jacobson v. Massachusetts*, 197 U.S. 11, (1905).

<sup>34</sup>*Washington v. Harper*, 494 U.S. 210, 221-22 (1990).

*Cruzan* extended this liberty interest which now includes the right to refuse life-sustaining treatment.<sup>35</sup>

Constitutional protection of the right to terminate life-prolonging treatment does not extend to euthanasia which has more or less consistently been characterized as either murder or manslaughter.<sup>36</sup> However, greater respect for and belief in the right to individual autonomy, as evidenced by the increasing protections accorded to the right to terminate life-prolonging treatment, has recently led some courts and at least one state legislature to protect the right of competent terminally ill patients to choose for themselves whether they desire assistance in dying.

Indeed, two federal Courts of Appeals recently found physician-assisted suicide to be constitutionally protected. They based their findings on the fact that they could find no rational distinction between the now ethically and legally accepted practice of terminating life-prolonging treatment, on the one hand, and the legally unacceptable practice of physician-assisted suicide on the other.<sup>37</sup> Nevertheless, the United States Supreme Court overturned these rulings and unanimously held that there is no constitutional right to physician-assisted suicide.<sup>38</sup> The Supreme Court's ruling represents the current state of the law in all States except Oregon where physician-assisted suicide is currently legal, given that Oregon voters decided by a sixty percent margin to oppose the repeal of the State's *Death with Dignity Act*, which has been in effect since mid-November 1997.<sup>39</sup>

### C. The Law in Australia

The law in Australia is, in essence, identical to that in Canada and the United States: the termination of life-prolonging treatment is legal whereas euthanasia is not.<sup>40</sup> In addition to the existence at common law of a general right to insist on the termination of life-sustaining treatment, explicit codification of this right was attained through legislation in two Australian States (South Australia and Victoria) and two Territories (Australian Capital Territory and Northern Territory).<sup>41</sup>

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<sup>35</sup>*Cruzan v. Director, Missouri Dept. Health*, 497 U.S. 261 (1990). The constitutionally protected liberty interest in refusing unwanted medical treatment was affirmed in *Washington v. Glucksberg*, 117 S.Ct. 2258 (1997).

<sup>36</sup>*State v. Cobb*, 625 P.2d 1133 (Kan 1981); *Aven v. State*, 277 S.W. 1080 (Tex. 1925); *People v. Cleaves*, 280 Cal. Rptr. 146 (Ct. App. 1991).

<sup>37</sup>*Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc); *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996).

<sup>38</sup>*Glucksberg*, *supra* note 35; *Vacco v. Quill*, 117 S.Ct. 2293 (1997) [hereinafter *Vacco*]. The majority did however read in a constitutional right to adequate palliative care, including terminal sedation.

<sup>39</sup>J. Woolfrey, "What Happens Now? Oregon and Physician-Assisted Suicide" (1998) 28:3 *Hastings Cent. Rep.* 9.

<sup>40</sup>P. Quirk, "Euthanasia in the Commonwealth of Australia" (1998) 13 *Issues in Law & Med.* 425; C.J. Ryan & M. Kaye, "Euthanasia in Australia" (1996) 334 *N. E. J. Med.* 326.

<sup>41</sup>S. Chesterman, "Last Rights: Euthanasia, the Sanctity of Life, and the Law in the Netherlands and the Northern Territory of Australia" (1998) 47 *Int. Comp. L. Quart* 362.

Although the Northern Territory of Australia was the first jurisdiction in the world to legalize euthanasia, its *Rights of the Terminally Ill Act 1995*, which had legalized euthanasia from July 1996 to March 1997, was in fact overturned by the Federal Parliament's *Euthanasia Laws Act 1997*. This federal Act empowered Parliament to prevent Australian Territories (Northern Territory, Australian Capital Territory, Norfolk Island) but not Australian States, from legalizing euthanasia.<sup>42</sup> As a result of the *Euthanasia Laws Act*, euthanasia is currently illegal in Australia, and no exception is made for competent terminally ill individuals seeking assistance in dying.<sup>43</sup>

#### D. The Law in the Netherlands

In the Netherlands, while the termination of life-prolonging treatments is legal, both physician-assisted suicide and mercy-killing are formally illegal.<sup>44</sup> However, physicians act within the law so long as they perform euthanasia pursuant to the guidelines established by the Dutch Supreme Court in 1985.<sup>45</sup> Depending on the wishes and medical condition of the patient, these guidelines permit physicians to lawfully conduct either physician-assisted suicide<sup>46</sup> or mercy-killing.<sup>47</sup> The Dutch government has recently put forward a bill that proposes to give legislative recognition to these jurisprudentially developed guidelines.<sup>48</sup>

According to these guidelines, which have evolved over time, the patient must be competent and acting out of his or her own free will, must have made persistent requests to die, and there must be no alternative measures capable of relieving his or her intolerable suffering. Note that these legal guidelines do *not* require that the patient be terminally ill,<sup>49</sup> nor do they require that the patient's intolerable suffering be the result of an underlying physiological disease.<sup>50</sup> The bill purporting to codify these guidelines extends the right to request assistance in dying to minors, including children, so long as they have requested death personally and have the consent of their parents and an independent doctor.<sup>51</sup>

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<sup>42</sup>G. Williams & M. Darke, "Euthanasia Laws and the Australian Constitution" (1997) 20 U.N.S.W.L.J 647.

<sup>43</sup>C. Zinn, "Australian Voluntary Euthanasia Law is Overturned" (1997) 314 Brit. Med. J. 994 [hereinafter "Australian Voluntary Euthanasia"].

<sup>44</sup>E. Borst-Eilers, "Euthanasia in the Netherlands: Brief Historical Review and Present Situation" in R.I. Misbin, ed., *Euthanasia: The Good of the Patient, The Good of Society* (Frederick, Md.: University Publishing, 1992) at 55.

<sup>45</sup>See *Schoonheim* case, Supreme Court, Nederlands Jurisprudentie 1985, No. 106.

<sup>46</sup>See *Kors* case, District Court of Almelo, Nederlands Jurisprudentie 1992, No. 210; *Duintjer* case, Court of Appeal of the Hague, Nederlands Jurisprudentia 1992, No. 457.

<sup>47</sup>See *Admiraal* case, Court of Appeal of the Hague, Nederlands Jurisprudentia 1985, No. 709.

<sup>48</sup>See "The Hague: Dutch Parliament Introduces New Euthanasia Bill" (1999), on-line: DeathNET <[http://www.rights.org/~deathnet/Wnews\\_current.html](http://www.rights.org/~deathnet/Wnews_current.html)> (date accessed: August 19, 1999).

<sup>49</sup>See *Admiraal* case, Court of Appeal of the Hague, Nederlands Jurisprudentie 1985, No. 709.

<sup>50</sup>See *Chabot* case, Supreme Court, Nederlands Jurisprudentie 1994, No.320.

<sup>51</sup>See *supra* note 48.

#### IV. The Democratic Approach: Public and Professional Perspectives Regarding the Legalization of Euthanasia

The Supreme Court of Canada has often stressed the importance of social science evidence, especially in cases that are largely concerned with public policy issues.<sup>52</sup> It therefore seems particularly noteworthy that a majority of each of the general Canadian, American, and Australian adult populations supports the legalization of euthanasia for competent terminally ill patients seeking assistance in dying (see table 2).

##### A. Public and Professional Perspectives in Canada

Recent surveys have found that a majority of the adult Canadian public supports the legalization of euthanasia for competent terminally ill adults seeking assistance in dying. On average, 66% of Canadians are reportedly in favour of legalizing mercy-killing and 55% are in favour of legalizing physician-assisted suicide.<sup>53</sup> Recently, a national Angus Reid poll that did not differentiate between physician-assisted suicide and mercy-killing found that 76% of Canadians support the “right to die” of competent terminally ill patients.<sup>54</sup> This consensus is mirrored amongst the terminally ill themselves. For instance, among terminally ill cancer patients, 65% are in favour of legalizing mercy-killing, and 52% are in favour of legalizing physician-assisted suicide.<sup>55</sup>

Moreover, although the Canadian Medical Association is currently opposed to euthanasia,<sup>56</sup> many of its members have indicated their support for the right of terminally ill patients to seek assistance in death (43%),<sup>57</sup> while others have already

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<sup>52</sup>*RJR-MacDonald v. Attorney-General of Canada*, [1995] 3 S.C.R. 199; *Irwin Toy v. Quebec*, [1989] 1 S.C.R. 927; *R. v. Butler*, [1992] S.C.R. 452; *McKinney v. University of Guelph*, [1990] 3 S.C.R. 229; *Re Eve*, [1986] 2 S.C.R. 388.

<sup>53</sup>P.A. Singer *et al.*, “Public Opinion Regarding End-of-Life Decisions” (1995) 41 Soc. Sci. Med. 1517; M.E. Suarez-Almazor, M. Belzile & E. Bruera, “Euthanasia and Physician-Assisted Suicide: A Comparative Survey of Physicians, Terminally Ill Cancer Patients, and the General Population” (1997) 15 J. Clin. Oncol. 418; S.J. Genuis, S.K. Genuis & W.C. Chang, “Public Attitudes Toward the Right to Die” (1994) 150 C.M.A.J. 701.

<sup>54</sup>National Angus Reid poll, online: <[http://www.angusreid.com/pressrel/euthanasia\\_nov97.html](http://www.angusreid.com/pressrel/euthanasia_nov97.html)>.

<sup>55</sup>Suarez-Almazor, *supra* note 53.

<sup>56</sup>Canadian Medical Association [policy summary], “Physician-Assisted Death” (1995) 152 C.M.A.J. 248.

<sup>57</sup>M.J. Verhoef & T.D. Kinsella, “Alberta Euthanasia Survey: 3-year follow-up” (1996) 155 C.M.A.J. 885; T.D. Kinsella & M.J. Verhoef, “Alberta Euthanasia Survey: 1. Physician’s Opinions About the Morality and Legalization of Active Euthanasia” (1993) 148 C.M.A.J. 1921 [hereinafter *Physician’s Opinions*]. Please note that the authors of the foregoing studies asked physicians whether “it is sometimes right to practice active euthanasia”, and defined active euthanasia as “the intentional termination of the life of a competent human being with a terminal illness, usually by means of an overdose of medication given by a physician or surgeon when requested by the recipient”. Unfortunately this definition does not properly distinguish between mercy-killing and physician-assisted suicide since it does not make clear whether it is the physician or the patient who finally administers the overdose of medication. We have therefore interpreted this definition as describing euthanasia generally and have

indicated that they would be willing to honour the requests of competent terminally ill patients should euthanasia become legal (26%).<sup>58</sup>

**Table 2: Average Percentage of Physicians and Members of the General Adult Population in Canada, the United States and Australia in Favour of Legalizing Euthanasia for the Competent Terminally Ill**

	Canada		United States		Australia	
	Mercy-Killing	PAS	Mercy-Killing	PAS	Mercy-Killing	PAS
General Adult Population	66%	55%	65%	65%	75%	73%
Physicians	43%	43%	54%	60%	33-62%	33-62%

## B. Public and Professional Perspectives in the United States

Surveys in the United States have demonstrated that two-thirds of the American adult population favour the legalization of euthanasia for competent terminally ill patients seeking assistance. On average, 65% of Americans are reportedly in favour of legalizing both mercy-killing and physician-assisted suicide.<sup>59</sup> Support for the legalization of euthanasia can also be found among terminally ill oncology patients (68%),<sup>60</sup> terminally ill AIDS patients (63%),<sup>61</sup> and among patients suffering from amyotrophic lateral sclerosis (56%).<sup>62</sup>

As in Canada, the majority of professional health care associations in the United States are officially opposed to euthanasia.<sup>63</sup> Ironically, a majority of the

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included the data under both mercy-killing and physician-assisted suicide.

<sup>58</sup>P. Wysong, "Doctors Divided on Euthanasia Acceptance" (1996) 32 Med. Post 1, 90; "Physician's Opinions", *ibid.*

<sup>59</sup>D.P. Caddell & R.R. Newton, "Euthanasia: American Attitudes Toward the Physician's Role" (1995) 40 Soc. Sci. Med. 1671; J.G. Bachman *et al.*, "Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia" (1996) 334 N.E.J. Med 303; E.J. Emanuel *et al.*, "Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public" (1996) 347 Lancet 1805 [hereinafter Attitudes and Experiences of Oncology Patients]; R.J. Blendon, U.S. Szalay & R.A. Knox, "Should Physicians Aid Their Patients in Dying? The Public Perspective" (1992) 267 J.A.M.A. 2658.

<sup>60</sup>Attitudes and Experiences of Oncology Patients, *ibid.*

<sup>61</sup>W. Breitbart, B.D. Rosenfeld & S.D. Passik, "Interest in Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients" (1996) 153 Am. J. Psychiatry 238.

<sup>62</sup>L. Ganzini *et al.*, "Attitudes of Patients with Amyotrophic Lateral Sclerosis and their Care Givers Toward Assisted Suicide" (1998) 339 N. E. J. Med 967 [hereinafter "Attitudes of Patients"].

<sup>63</sup>Council on Ethical and Judicial Affairs of the American Medical Association, "Decisions Near the End of Life" (1992) 267 J.A.M.A. 2229; American Geriatrics Society Ethics Committee, "Physician Assisted Suicide and Voluntary Active Euthanasia" (1995) 43 J. Am. Geriatr. Soc 579 [hereinafter "Physician Assisted Suicide"].

members of these associations are in favour of amending the law to permit terminally ill patients to seek assistance in death. On average, 60% of American physicians are reportedly in favour of legalizing physician-assisted suicide and 54% are in favour of legalizing mercy-killing.<sup>64</sup> Moreover, a significant proportion of physicians have indicated their willingness to participate in euthanasia should it be legalized (33-46%).<sup>65</sup> Other studies have shown that many American physicians are already participating in euthanasia for the terminally ill despite its illegality.<sup>66</sup>

Finally, a recent survey of the views of criminal prosecutors found that only 39% would prosecute if confronted with a case of physician-assisted suicide.<sup>67</sup> In addition, when presented with the fictional case of a terminally ill brain tumor patient who is seeking assistance in dying, 67% of the criminal prosecutors believed physician-assisted suicide to be morally correct and 79% would have wanted physician-assisted suicide for themselves had they been in the patient's position.<sup>68</sup>

### C. Public and Professional Perspectives in Australia

A vast proportion of the Australian adult population support the legalization of euthanasia. On average, 75% of Australians are reportedly in favour of legalizing mercy-killing and 73% are in favour of legalizing physician-assisted suicide.<sup>69</sup> As in Canada and the United States, strong support can also be found among the terminally ill – see for instance the overwhelming approval on the part of terminally ill AIDS patients (90%).<sup>70</sup>

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<sup>64</sup>J.S. Cohen *et al.*, "Attitudes Toward Assisted-Suicide and Euthanasia among Physicians in Washington State" (1994) 331 N. E. J. Med. 89 [hereinafter "Physicians in Washington State"]; M.A. Lee *et al.*, "Legalizing Assisted Suicide - Views of Physicians in Oregon" (1996) 334 N. E. J. Med. 310 [hereinafter "Views of Physicians in Oregon"]; L. Ganzini *et al.*, "Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide" (1996) 153 Am J Psychiatry 1469; J.G. Bachman *et al.*, "Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia" (1996) 334 N. E. J. Med. 303.

<sup>65</sup>R.S. Shapiro *et al.*, "Willingness to Perform Euthanasia: A Survey of Physician Attitudes" (1994) 154 Arch Intern Med 575; "Physicians in Washington State", *ibid.*; "Views of Physicians in Oregon," *ibid.*

<sup>66</sup>T.R. Fried *et al.*, "The Limits of Patient Autonomy: Physician Attitudes and Practices Regarding Life-Sustaining Treatments and Euthanasia" (1993) 153 Arch. Intern. Med. 722; E.J. Emanuel *et al.*, "The Practice of Euthanasia and Physician-Assisted Suicide in the United States" (1998) 280 J.A.M.A. 507.

<sup>67</sup>A. Meisel, "Prosecutors and End-of-Life Decision Making" (1999) 159 Arch. Intern. Med. 1089.

<sup>68</sup>*Ibid.*

<sup>69</sup>M. Steinberg *et al.*, "Survey of Approval of Australia's Northern Territory Rights of the Terminally Ill Act" (1997) 349 Lancet 577; M. Steinberg *et al.*, "End-of-Life Decision-Making: Community and Medical Practitioners' Perspectives" (1997) 166 Med. J. Aust. 131; Morgan Research Center. *Finding No.2933: Australians Continue to Support Euthanasia as MPs Discuss Conscience Vote* (Melbourne: Roy Morgan Research Centre, 1996).

<sup>70</sup>B. Tindall *et al.*, "Attitudes to Euthanasia and Assisted Suicide in a Group of Homosexual Men with Advanced HIV Disease" (1993) 6 J. Acquired Immune Deficiency Syndrome 1069.

In addition, a significant proportion of physicians (33-62%)<sup>71</sup> and nurses (50-78%)<sup>72</sup> are in favour of legalizing euthanasia for competent terminally ill adults. In fact, a substantial proportion of nurses would be willing to participate in euthanasia themselves should it be legalized (66%).<sup>73</sup> As in the United States, studies have shown that many Australian physicians are already participating in euthanasia despite its illegality.<sup>74</sup>

## V. End-of-Life Decision Making, Ethics, and Fundamental Justice

### A. Framing the Constitutional Question

Legal theorist James Boyd White has pointed out that judges rendering decisions are not only saying “‘here is how this case should be decided,’ but also ‘here—in this language—is the way this case and similar cases should be talked about. The language I am speaking is the proper language of justice in our culture.’”<sup>75</sup> Indeed, the justices rendering the *Rodriguez* and *Glucksberg* decisions not only paid close attention to their use of language throughout the judgments, but were also careful with their choice of language in framing the constitutional question before them. It is evident from these judgments that language—including choice of vocabulary as well as the language used in framing the nature and scope of the constitutional issues—can have a determinative impact on the outcome of cases.

In *Rodriguez*, the majority framed the constitutional question broadly. Instead of asking whether the constitution protects the right of competent terminally ill patients to seek assistance in dying from the medical community under circumstances of personally unacceptable suffering, circumstances which were in fact reflected in the factual context of that case, they asked whether “*all persons who by reason of disability are unable to commit suicide* have a right under the *Canadian Charter of Rights and Freedoms* to be free from government interference in procuring the assistance of *others* to take their life.”<sup>76</sup> Thus, although Ms.

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<sup>71</sup>H. Kuhse & P. Singer, “Doctor’s Practices and Attitudes Concerning Voluntary Euthanasia” (1988) 148 *Med. J. Aust.* 623; P. Baume & E. O’Malley, “Euthanasia: Attitudes and Practices of Medical Practitioners” (1994) 161 *Med J Australia* 137; I. Wilson, B. Kay & I. Stevens, “General Practitioners and Euthanasia Strong Opinions and Unexpected Views” (1997) 26 *Aust. Fam. Physician* 399.

<sup>72</sup>C. Stevens & R. Hassan, “Nurses and the Management of Death, Dying and Euthanasia” (1994) 20 *Medicine Law* 41; B. Kitchener, “Nurses’ Attitudes to Active Voluntary Euthanasia: A Survey in the Australian Capital Territory” (1998) 22 *Aust. N.Z. J Public Health* 276; H. Kuhse & P. Singer, “Voluntary Euthanasia and the Nurse: An Australian Survey” (1993) 30 *Int. J. Nurs. Stud.* 311.

<sup>73</sup>B.A. Kitchener, “Nurse Characteristics and Attitudes to Active Voluntary Euthanasia: A Survey in the Australian Capital Territory” (1998) 28 *J. Adv. Nurs.* 70.

<sup>74</sup>C. Stevens & R. Hassan, “Management of Death, Dying and Euthanasia: Attitudes and Practices of Medical Practitioners in South Australia” (1994) 20 *J. Med. Ethics* 41.

<sup>75</sup>J.B. White, *Heracles’ Bow: Essays on the Rhetoric and Poetics of the Law* (Madison: University of Wisconsin Press, 1985) at 34.

<sup>76</sup>*Rodriguez*, *supra* note 1 at 581 [emphasis added].

Rodriguez was a competent terminally ill individual who was seeking medical assistance in dying, and not the general assistance of “others,” the majority broadened the scope of the inquiry by omitting certain restrictive words such as “terminally ill”, “competence” and “medical community”.

By contrast to the majority’s use of language, the dissent’s use of language focussed on the particular circumstances and characteristics of Ms. Rodriguez. In her dissenting judgement, McLachlin J. framed the central issue as being the question of whether an exception for competent terminally ill individuals should be carved out of the absolute prohibition against assisted suicide, which would nevertheless continue to apply to the general population.<sup>77</sup>

Similar to the *Rodriguez* majority’s use of language in framing the scope of the constitutional question, the United States Supreme Court in *Glucksberg* reframed—in broader language—the constitutional question that had been enunciated by the courts below. Instead of using restrictive language such as “terminally ill”, “competence” and “medical community”, the court characterized the liberty interest at issue as the “right to commit suicide which itself includes the right to assistance in so doing.”<sup>78</sup> Having framed the question in such an expansive manner, it was easy for the court to demonstrate an enduring opposition to and condemnation of both suicide and assisted suicide and to refuse to carve out an exception for competent terminally ill individuals.

## B. The Principles of Fundamental Justice

Section 7 of the *Canadian Charter of Rights and Freedoms* guarantees the right not to be deprived of life, liberty or security of the person except in accordance with the principles of fundamental justice. In *Rodriguez*, the majority found that an absolute prohibition on assisted suicide deprived Ms. Rodriguez of “autonomy over her person and cause[d] her physical pain and psychological stress in a manner which impinge[d] on the security of her person.”<sup>79</sup> Nevertheless, this violation was held to be in accordance with the principles of fundamental justice. This finding—that an absolute prohibition on assisted suicide does not violate the principles of fundamental justice—lies at the heart of the majority’s decision to effectively deny the right of competent terminally ill patients to seek assistance in dying. For this reason, the majority’s definition and application of the principles of fundamental justice will be thoroughly analysed and discussed.

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<sup>77</sup>*Ibid.* at 628 where McLachlin J. defined the issue as follows: “[o]ur task was the more modest one of determining whether, given the legislative scheme regulating suicide which Parliament has put in place, *the denial to Sue Rodriguez of the ability to end her life is arbitrary and hence amounts to a limit on her security of the person which does not comport with the principles of fundamental justice*” [emphasis added].

<sup>78</sup>*Glucksberg, supra* note 35 at 2260.

<sup>79</sup>*Rodriguez, supra* note 1 at 589.

### 1. Defining Fundamental Justice: A Consensus Among Reasonable People?

According to the majority in *Rodriguez*, the principles of fundamental justice can be defined as principles

upon which there is some *consensus* that they are vital or fundamental to our societal notion of justice.... Principles of fundamental justice must not, however, be so broad as to be no more than *vague generalizations* about what our society considers to be ethical or moral. They must be *capable of being identified* with some precision and *applied* to situations in a manner which yields an understandable result.<sup>80</sup>

The majority further specified that “fundamental” principles are those that have “general acceptance among reasonable people.”<sup>81</sup> Therefore, a principle of fundamental justice requires more than vague generalizations, it requires a general consensus among reasonable people that can be identified and applied.

The societal consensus definition of fundamental justice that was applied by the court in *Rodriguez* is certainly not incompatible with the general definition given to fundamental justice in the great majority of cases in which the issue was considered. In particular, cases such as *Jones*,<sup>82</sup> *Lyons*,<sup>83</sup> *Beare*,<sup>84</sup> *Thompson Newspapers*,<sup>85</sup> *Chiarelli*,<sup>86</sup> *Cunningham*,<sup>87</sup> and *Kindler*,<sup>88</sup> all made use of terms such as “societal interests” or “state interests” in defining the principles of fundamental justice. Under this definition, the role of the judiciary is of balancing between the individual’s right to life, liberty and security of the person and societal or state interests.<sup>89</sup> In *Rodriguez*, the novel nomenclature—societal consensus—introduced into the balancing equation does not alter the nature of fundamental justice as a balancing principle, but rather it is used as a mechanism of validation and legitimization, in this case, of the state interest in protecting the vulnerable. Having thus legitimized the state interest in protecting the vulnerable through the alleged existence of a societal consensus in favour of an absolute prohibition against assisted suicide, the majority proceeded to conclude that the state’s interest outweighed the individual right of Ms. Rodriguez to physician-assisted suicide and to the security of her person.

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<sup>80</sup>*Ibid.* 590-91 [emphasis added].

<sup>81</sup>*Ibid.* at 607.

<sup>82</sup>*Jones v. The Queen*, [1986] 2 S.C.R. 284.

<sup>83</sup>*R. v. Lyons*, [1987] 2 S.C.R. 309.

<sup>84</sup>*R. v. Beare*, [1988] 2 S.C.R. 387 [hereinafter *Beare*].

<sup>85</sup>*Thompson Newspapers v. Canada*, [1990] 1 S.C.R. 425 [hereinafter *Thompson Newspapers*].

<sup>86</sup>*Chiarelli v. Canada (Minister of Employment and Immigration)*, [1992] 1 S.C.R. 711.

<sup>87</sup>*Cunningham v. Canada*, [1993] 2 S.C.R. 143 [hereinafter *Cunningham*].

<sup>88</sup>*Kindler v. Canada (Minister of Justice)*, [1991] 2 S.C.R. 779.

<sup>89</sup>See for instance *Thompson Newspapers*, *supra* note 85 at 583 where L’Heureux-Dubé J. stated that “[f]undamental justice in our Canadian legal tradition...is primarily designed to ensure that a fair balance be struck between the interests of society and those of its citizens.”

Thus, where the state interest can be supported or legitimized by a societal consensus, the state interest will almost undoubtedly be seen as outweighing the individual's right to life, liberty and security of the person. *A contrario*, where societal consensus is in opposition to the state interest (e.g., societal consensus is in support of the right of the *Charter* claimant), the individual's right will presumably be legitimized and seen as outweighing the state interest.

A major problem with defining fundamental justice as a balance between individual and state interests on the one hand, while premising the legitimacy of these interests upon societal consensus on the other, is that the *Charter* claimant's rights become dependent upon the views and opinions of society's majority. The conclusion as to whether the principles of fundamental justice have been breached will depend on whether a societal consensus exists in favour of the individual right or in favour of the state interest. Societal consensus thus becomes the "additional weight" capable of tipping the balancing scale in favour of either the individual right or the state interest depending on whose side of the scale it happens to fall.

This approach is problematic in that it weakens the ability of the *Charter* to operate as a rights-based, counter-majoritarian instrument. Consensus may be an appropriate tool for legislators, whose function it is to weigh public policy options, but it is wholly inappropriate as a definitional element of a legal test, namely the fundamental justice test, the purpose of which is to assess whether an individual right has been violated. To say that a *Charter* right has not been infringed because there exists a consensus among reasonable people that the infringement is justified, nullifies the very ability of the *Charter* to guarantee individual freedoms. Individual rights-bearers are left unprotected against the possibility of "majoritarian malevolence, ignorance or indifference."<sup>90</sup>

Furthermore, the consensus-based balancing approach to fundamental justice makes a section 1 analysis all but redundant, since it shifts the burden of proof to the *Charter* claimant to demonstrate the absence of a valid state interest in order to prove that there has been a violation of fundamental justice. Such a demonstration itself includes the formidable task of proving the absence of a societal consensus in support of the state interest. This formulation of section 7 of the *Charter* is completely at odds with that used in the context of the other *Charter* provisions, where the burden of proving the validity of the state interest rests, as a positive burden, on the State under section 1.<sup>91</sup>

Indeed, as noted by McLachlin J. in *Rodriguez*, "it is not generally appropriate that the complainant be obliged to negate societal interests at the s. 7 stage, where the burden lies upon her, but that the matter be left for s. 1, where the burden lies

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<sup>90</sup>L.E. Weinrib, "The Body and the Body Politic: Assisted Suicide Under The *Canadian Charter of Rights and Freedoms*" (1994) 39 McGill L.J. 618 at 629 [hereinafter "The Body and the Body Politic"].

<sup>91</sup>*R. v. Oakes*, [1986] 1 S.C.R. 103, 26 D.L.R. (4th) 200 [hereinafter *Oakes*].

on the state.”<sup>92</sup> Moreover, this formulation has been criticized as being inconsistent with the purposive approach to *Charter* interpretation outlined in the cases of *Southam*<sup>93</sup> and *Big M Drug Mart*:<sup>94</sup>

[a] purposive interpretation of the rights to life, liberty and security of the person must surely avoid placing a burden on the individual invoking these crucial rights that is so onerous as to have the effect of negating these rights altogether.<sup>95</sup>

A final problem with the current definition of fundamental justice is that, apart from making reference to the notion of societal consensus, it provides little guidance on how to structure the balancing test. To use the words of Chief Justice Lamer in *R. v. Morales*,<sup>96</sup> where he discussed the problems associated with using the term “public interest” to justify infringements of section 7, the current definition of fundamental justice “authorizes a standardless sweep” and is “incapable of framing the legal debate in any meaningful manner or structuring discretion in any way.” The *Oakes* test,<sup>97</sup> in contrast, provides a valuable analytic framework in which individual rights can be balanced against state interests under section 1 of the *Charter*.

## 2. Fundamental Justice and the Basic Tenets of our Legal System

Although the “balancing of interests” definition of fundamental justice was applied by the majority in *Rodriguez*, the Supreme Court of Canada has, on other occasions, adopted a very different approach to the principles of fundamental justice. In *Reference Re Section 94(2) of the Motor Vehicle Act, [re B.C. Motor Vehicle Act]*<sup>98</sup> the first case to address the issue of fundamental justice, a majority of the court subscribed to the following definition: “the principles of fundamental justice are to be found in the basic tenets of our legal system. They do not lie in the realm of general public policy but in the inherent domain of the judiciary as guardian of the justice system.”

Additional cases, such as *Singh*,<sup>99</sup> *Morgentaler*,<sup>100</sup> *Swain*<sup>101</sup> and *Children’s Aid Society of Metropolitan Toronto*,<sup>102</sup> have all applied this definition of fundamental

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<sup>92</sup>*Rodriguez*, *supra* note 1 at 622.

<sup>93</sup>*Hunter v. Southam Inc.*, [1984] 2 S.C.R. 145.

<sup>94</sup>*R. v. Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295.

<sup>95</sup>T.J. Singleton, “The Principles of Fundamental Justice, Societal Interests and Section 1 of the *Charter*” (1995) 74 Can. B. Rev. 446 at 469.

<sup>96</sup>[1992] 3 S.C.R. 711.

<sup>97</sup>*Oakes*, *supra* note 91.

<sup>98</sup>*Reference Re Section 94(2) of the Motor Vehicle Act, R.S.B.C. 1979*, [1985] 2 S.C.R. 486 at 503 [hereinafter *Reference Re Section 94(2) of the Motor Vehicle Act*].

<sup>99</sup>*Singh v. Minister of Employment and Immigration*, [1985] 1 S.C.R. 177 [hereinafter *Singh*].

<sup>100</sup>*R. v. Morgentaler*, [1988] 1 S.C.R. 30 [hereinafter *Morgentaler*].

<sup>101</sup>*R. v. Swain*, [1991] 1 S.C.R. 933, 125 N.R. 1.

<sup>102</sup>*B. (R.) v. Children’s Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315.

justice. This approach to fundamental justice has many advantages as regards the protection of the individual freedoms of the complainant, including: (1) state interests are only considered under section 1 where the burden of proof is on the state; (2) the very existence of the principles of fundamental justice is not predicated or dependent upon societal agreement; and (3) the definition avoids an overly narrow interpretation of section 7 protections, thereby giving the *Charter* greater scope to operate as a rights-protecting instrument. Thus, if the objective of the *Charter* is to effectively guarantee individual freedoms, then clearly the *Re B.C. Motor Vehicle Act* definition of fundamental justice is both analytically superior and more just than its “balancing of interests” counterpart in *Rodriguez*.

According to the *Re B.C. Motor Vehicle Act* definition, a *Charter* claimant must prove two elements under section 7: (1) that a right to life, liberty or security of the person is being violated, and (2) that a basic tenet of our legal system, and hence a principle of fundamental justice, is being infringed. This two-step test was applied by the minority in *Rodriguez* who found that an absolute prohibition on assisted suicide—i.e. without exception for competent terminally ill individuals—violated both the right of Ms. Rodriguez to the security of her person as well as the principles of fundamental justice. The violation of security of the person was characterized as being the breach of Ms. Rodriguez’s right to “personal autonomy,” while the violation of fundamental justice was characterized as being the “arbitrary limitation” on the right of Ms. Rodriguez to “deal with her body as she chooses.” In other words, while the substantive right to personal autonomy was found to be an element of the right to security of the person, the right to procedural fairness, vis-à-vis the substantive right to personal autonomy, was found to be a principle of fundamental justice (a basic tenet of our legal system).

One may query whether the “substantive” common law right to personal autonomy could, in addition to being an element of the right to security of the person, be a principle of fundamental justice. This inquiry is not without foundation. For instance, the principles of fundamental justice not only protect against procedural injustice but against substantive injustice as well.<sup>103</sup> Moreover, the common law has been said to represent one of the “major repositories of the basic tenets of our legal system”<sup>104</sup> and most cases applying the *Re B.C. Motor Vehicle Act* test of fundamental justice have in fact drawn from this repository.

However, if the substantive right to personal autonomy is both an element of the right to security of the person and a principle of fundamental justice, would recourse to this single juridical concept be sufficient to prove both a breach of security of the person and a breach of fundamental justice? Or rather, would distinct juridical concepts need to underlie the breaches? Presumably, the elements of security of the person and fundamental justice require distinct and separate proofs.

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<sup>103</sup>Reference *Re Section 94(2) of the Motor Vehicle Act*, *supra* note 98.

<sup>104</sup>*Beare*, *supra* note 84 at 406.

If it were otherwise, one of the two elements would be rendered redundant. This may be why the minority in *Rodriguez*, having already used the substantive right to personal autonomy in justifying their finding of a breach to security of the person used the separate and distinct right to procedural fairness in justifying their finding of a breach of the principles of fundamental justice.

It is therefore possible that, in addition to being an element of the right to security of the person, the substantive right to personal autonomy is a basic tenet of our legal system. If so, it could be used to justify either a breach to security of the person *or* a breach to the principles of fundamental justice but could not be used as a single justification underlying both breaches.

### 3. Where Should We Look to Find a Consensus?

The argument that has been put forward is that, especially in the case of deeply personal rights, the “basic tenets of our legal system” definition of fundamental justice is both analytically superior and more just than its “balancing of interests” counterpart. Nevertheless, in cases where the consensus-based balancing approach to fundamental justice has been adopted, what becomes determinative to the conclusion of whether a principle of fundamental justice has been violated is whether the existing consensus favours the individual right or the state interest – a question whose answer depends on where we look to find a consensus. For instance, in *Rodriguez*, the majority concluded that there existed a consensus supporting an absolute prohibition against assisted suicide after having reviewed, among other things, legislation existing in various Western democracies.

There are a number of reasons why it may be inappropriate to look outside of Canada when seeking to identify a “consensus.” One reason is that this may undermine Canada’s continuing role as a leader in international human rights.<sup>105</sup> If fundamental justice—a legal principle that lies at the core of Canada’s most important human rights instrument—is defined as a consensus among reasonable people, then such a consensus ought to be drawn from the values held by Canadians, rather than among the practices of foreign legislatures. Otherwise our interpretation of fundamental justice will be ill-suited as a guide for other nations in the realm of international human rights. Conversely, given the remarkable revolution that Canada has undergone in the field of human rights as a result of the entrenchment of its *Charter of Human Rights and Freedoms*,<sup>106</sup> it appears

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<sup>105</sup>Canada should maintain its international role in setting and upholding standards, even if other countries do not immediately follow suit. The Canadian-inspired ban on the use of land mines, which are estimated to kill 20,000 people a year, is a good example of the role Canada has carved out for itself in the realm of international human rights. See for instance B. Wallace, “The Battle to Ban Land Mines: Support Grows for Canada’s Crusade” *Maclean’s* 110:26 (1997) 34.

<sup>106</sup>I. Cotler, “Can the Center Hold? - Federalism and Rights in Canada” in I. Cotler, ed., *Canadian Charter of Rights and Freedoms* [unpublished, archived at McGill University, Faculty of Law, 1998, Law Library Casebook Section]; Chief Justice A. Lamer, “Canada’s Legal Revolution” Canada/Israel Law Conference 1992 [unpublished].

inappropriate for the Canadian judiciary to look to foreign democracies who lack constitutionally-entrenched human rights documents when defining the degree to which the Canadian *Charter* protects the rights of Canadian citizens.

Moreover, if the principles of fundamental justice are in fact principles upon which there is some consensus among reasonable Canadians, then the Canadian consensus data quoted in table 2 supports the view that to violate the right of competent terminally ill individuals to obtain assistance in dying is to breach their security of the person in a manner that is not in accordance with the principles of fundamental justice.

#### 4. Slippery Slopes in Flat Countries: Reviewing the Empirical Data

Having defined the principles of fundamental justice as a balance between individual and state interests, the majority in *Rodriguez* concluded that there was an overriding state interest for two primary reasons: (1) the existence of an alleged consensus in favour of an absolute prohibition against assisted suicide, and (2) the importance of preventing a slippery slope.<sup>107</sup> Having discussed the many problems associated with adopting a consensus-based balancing approach to the principles of fundamental justice, we turn now to the issue of preventing a slippery slope.

In defence of their position, the majority in *Rodriguez* quote heavily from the conclusions of the Law Reform Commission of Canada who, in their Working Paper, had stated that, “[t]he probable reason why legislation has not made an exception for the terminally ill lies in the fear of the excesses or abuses to which liberalization of the existing law would lead.”<sup>108</sup> Moreover, in summarizing the Commission’s conclusions, the majority state that

[T]here is no certainty that abuses can be prevented by anything less than a complete prohibition. Creating an exception for the terminally ill might therefore frustrate the purpose of the legislation of protecting the vulnerable because adequate guidelines to control abuse are difficult or impossible to develop.<sup>109</sup>

The legalization of euthanasia for competent terminally ill individuals could lead to a slippery slope in at least two ways: (1) it could lead to an increasing prevalence of euthanasia among the competent terminally ill over time, and more importantly (2) it could lead to abuses – in particular, the practice of euthanasia without the patient’s explicit consent; as in the case of non-voluntary<sup>110</sup> and

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<sup>107</sup>Interestingly, fear of a slippery slope was also the primary rationale for Australian federal government’s decision to overturn the Northern Territory’s *Rights of the Terminally Ill Act*. See Australian Voluntary Euthanasia, *supra* note 43.

<sup>108</sup>*Rodriguez*, *supra* note 1 at 600.

<sup>109</sup>*Ibid.* at 601.

<sup>110</sup>Where the patient is incompetent to give or withhold consent.

involuntary euthanasia.<sup>111</sup> However, evidence from empirical studies that have quantified the prevalence and abuse of euthanasia in the Netherlands and Australia do *not* support the hypothesis that the legalization of euthanasia for competent terminally ill individuals would lead us down a slippery slope (see table 3).

**Table 3: The Prevalence of Consensual and Non-Consensual Euthanasia in Australia and the Netherlands**

End-of-Life Decision	Australia	Netherlands	
	1995-1996	1990	1995
Mercy-Killing	1.8%	1.7%	2.4%
Physician-Assisted Suicide	0.1%	0.2%	0.2%
Euthanasia Without the Patient's Explicit Consent	3.5%	0.8%	0.7%

First, a comparison of the data acquired in the Netherlands in 1990 with the data collected in the Netherlands in 1995 demonstrates that the prevalence of euthanasia has remained stable over time. In 1990, mercy-killing accounted for approximately 1.7% of all deaths in the Netherlands while physician-assisted suicide accounted for 0.2% of all deaths.<sup>112</sup> These numbers are not statistically different from those representing the incidence of euthanasia in the Netherlands in 1995 – at which time 2.4% of all deaths were the result of mercy-killings and 0.2% were the result of physician-assisted suicide.<sup>113</sup> Second, a comparison of the prevalence of mercy-killing and physician-assisted suicide in the Netherlands (where these practices are lawful so long as physicians follow prescribed guidelines) with that in Australia (where these practices are unlawful) strongly supports the view that a liberalization of existing Canadian law would be unlikely to lead us down a slippery slope. Indeed, while the legal status of consensual euthanasia is different in the Netherlands and Australia, there is no statistical difference in the rates of euthanasia between these two countries.

Third, contrary to the opinion expressed by the Law Reform Commission of Canada, the prevalence of non-consensual euthanasia is not positively correlated with the legal status of consensual euthanasia. On the contrary, in 1995 the prevalence of non-consensual euthanasia was five times greater in Australia (3.5%)

<sup>111</sup>Where the patient is competent, but euthanasia is administered without asking for the patient's explicit consent.

<sup>112</sup>P.J. van der Maas, J.J.M. van Delden & L. Pijnenborg, "Euthanasia and Other Medical Decisions Concerning the End of Life" (1991) 338 *Lancet* 669. See also G. van der Wal *et al.*, "Euthanasia and Assisted-Suicide" (1987) 1 *Fam. Practice* 163.

<sup>113</sup>P.J. van der Maas *et al.*, "Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995" (1996) 335 *N. E. J. Med.* 1699.

than it was in the Netherlands (0.7%).<sup>114</sup> In other words, while non-consensual euthanasia is an unlawful abuse in both the Netherlands and Australia, the prevalence of this abusive practice is far greater in Australia where consensual euthanasia is outlawed than in the Netherlands, where consensual euthanasia is lawful. These results clearly negate the view that the only way to prevent abuses is through an absolute prohibition of consensual euthanasia. Indeed, one commentator has gone so far as saying that the empirical evidence represents

not only a severe blow to one of the most popular standard slippery slope arguments against the legalization of euthanasia. [It] actually support[s] a powerful argument for the legalization of euthanasia.<sup>115</sup>

In short, although the slippery slope argument cannot be disproved with absolute certainty, the empirical evidence to date does not support the assertion that Canada will slide down a slippery slope if it chooses to honour the autonomy rights of competent terminally ill patients by carving out an exception to the complete ban on euthanasia for these individuals. On the contrary, the data actually indicate that the sanctity of life might be better protected, since decriminalization of voluntary euthanasia is correlated with lower numbers of involuntary euthanasia.

Apart from the slippery slope argument, many of those opposed to the legalization of euthanasia for competent terminally ill individuals have been fearful that it will be disproportionately chosen by, or forced upon those patients who are poor, uneducated, uninsured, or fearful of the financial consequences of their illness.<sup>116</sup> Once again, however, the empirical data collected up to date has left these fears largely unsubstantiated. In a recent study on the first year's experience with legalized physician-assisted suicide in Oregon, the authors "found no evidence to support these fears", but rather that those terminally ill patients who requested and made use of physician-assisted suicide were those who had a long-standing belief about the importance of controlling the manner in which they died – that is, those who were primarily concerned about loss of autonomy and/or control of bodily functions.<sup>117</sup>

### 5. The Passive/Active Distinction: A Question of Individual Morality

In their concluding argument about the principles of fundamental justice, in drawing a distinction between the termination of life-prolonging treatment and euthanasia, the majority in *Rodriguez* state that:

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<sup>114</sup>H. Kuhse *et al.*, "End-of-Life Decisions in Australian Medical Practice" (1997) 166 *Med. J. Aust.* 191.

<sup>115</sup>G. Oddie, "The Moral Case for the Legalisation of Voluntary Euthanasia" (1998) 28:1 *Vic. U. of Well. L. Rev.* 207 at 223.

<sup>116</sup>E.D. Pellegrino, "The False Promise of Beneficent Killing" in L.L. Emanuel, ed., *Regulating How We Die* (Cambridge, Mass.: Harvard University Press, 1998) at 71-91; G.J. Annas, "Death by Prescription – the Oregon Initiative" (1994) 331 *New Engl. J. Med.* 1240.

<sup>117</sup>A.E. Chin *et al.*, "Legalized Physician-Assisted Suicide in Oregon – the First Year's Experience" (1999) 340 *New Engl. J. Med.* 5773.

*Regardless of one's personal views* as to whether the distinctions drawn between withdrawal of treatment and palliative care, on the one hand, and assisted suicide on the other are practically compelling, the fact remains that these distinctions are maintained and can be persuasively defended.<sup>118</sup>

Many normative legal and ethical analyses support the majority's position that not only can a distinction between the termination of life prolonging treatment and euthanasia be drawn, but further that it should be applied regardless of the personal views of those who are compelled to live, despite intolerable pain and suffering, according to this moral postulate.<sup>119</sup> In essence, those who advocate that there is a moral distinction between active and passive euthanasia are advocating this position not only for themselves but for everyone else.

Other legal and ethical analyses claim the absence of a moral distinction between the termination of life prolonging treatment and euthanasia.<sup>120</sup> According to this view, it is the decision to hasten a patient's death that is the crucial factor, and not the method used to do so. Once the decision has been made by the patient to hasten her own death, the morally correct action is that which eases the patient from life to death in the most merciful way possible.

Everyone would undoubtedly agree that if a competent terminally ill patient wishes, be it for personal, religious, moral, family or other reasons, to remain alive, despite the fact that his or her body is in unremitting pain, it is that patient's moral right to do so; neither the attending physician nor society as a whole can substitute their own moral conception of relief of suffering at the end of life for the patient's moral beliefs in order to demand that the patient accept euthanasia. Conversely, based on the same reasoning, if a competent terminally ill patient is experiencing personally unacceptable suffering and wishes to die a painless death, it is that patient's moral right to do so. What is controlling is the voluntary wish of the competent terminally ill individual,<sup>121</sup> not the moral beliefs and opinions of others

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<sup>118</sup>Rodriguez, *supra* note 1 at 607-8 [emphasis added].

<sup>119</sup>*Deciding to Forego Life-Sustaining Treatment*, *supra* note 18; T.L. Beauchamp & J.F. Childress, *Principles of Biomedical Ethics*, 3rd ed. (New York: Oxford University Press, 1994); Council on Scientific Affairs, American Medical Association, "Good Care of the Dying Patient" (1996) 275 J.A.M.A. 474.

<sup>120</sup>J. Rachels, "Active and Passive Euthanasia" (1975) 292 N. E. J. Med. 78; J. Rachels, *The End of Life: Euthanasia and Morality* (Oxford: Oxford University Press, 1986); P.D. Hopkins, "Why Does Removing Machines Count as 'Passive Euthanasia'" (1997) 27:3 Hastings Cent. Rep. 29; "Physician-Assisted Suicide", *supra* note 63.

<sup>121</sup>D. Orentlicher, "The Legalization of Physician Assisted Suicide" (1996) 335 N. E. J. Med. 663; M.A. Drickamer, M.A. Lee & L. Ganzini, "Practical Issues in Physician-Assisted Suicide" (1997) 126 Ann. Intern. Med. 146; M. Angell, "The Supreme Court and Physician-Assisted Suicide: The Ultimate Right" (1997) 336 N. E. J. Med. 50; T.E. Quill, B. Lo & D.W. Brock, "Palliative Options of Last Resort. A Comparison of Voluntary Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia" (1997) 278 J.A.M.A. 2099.

concerning ethical distinctions between euthanasia and the termination of life prolonging treatment.

Euthanasia, like the termination of life prolonging treatment, is a question of individual morality. In the final analysis, it is for the patient, and only the patient, to decide how and when to end his or her life.<sup>122</sup>

## VI. Recommendations and Conclusion

Individual rights require special protection by the judiciary, protection which in the case of euthanasia has not yet been forthcoming.<sup>123</sup> In contrast to its approach in other contexts,<sup>124</sup> the Supreme Court of Canada has not treated the terminally ill as individual rights-bearers and as members of a society that promotes the equal dignity of all of its members.

Nevertheless, both the Canadian and the American Supreme Courts opened the door to a reformulation of the law when they reserved a role for the legislative organs of government regarding the future lawfulness of assisted suicide.<sup>125</sup> Indeed, although neither of the Courts would go so far as to guarantee that statutes amending the absolute prohibition against assisted suicide would necessarily be upheld as constitutional, they did broadly hint that they would tolerate government experimentation in a democratic society.<sup>126</sup> Such an approach is consistent with that

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<sup>122</sup>It goes without saying that the attending physician need not assist a patient in dying if such assistance would be contrary to the physician's own moral convictions. See generally A.S. Brett & L.B. McCullough, "When Patients Request Specific Interventions: Defining the Limits of the Physician's Obligation" (1986) 315 N. E. J. Med. 1347; T.E. Quill & C.K. Cassel, "Nonabandonment: A Central Obligation for Physicians" (1995) 122 Ann. Intern. Med. 368. In such circumstances the physician's only obligation would be to refer the patient to a colleague who is willing to practice euthanasia.

<sup>123</sup>It is of note that since the handing down of the *Rodriguez* decision, the composition of the Bench of the Supreme Court of Canada has undergone a significant change. Two of the majority members of the bench (Sopinka and LaForest JJ.), who were opposed to the right of competent terminally ill individuals to assisted suicide, have since been replaced by two new justices (Bastarache and Binnie JJ.). In addition, two of the four dissenting members of the bench (Lamer CJC and Cory J.), who supported the right to assisted suicide were also replaced (by Lebel and Arbour JJ. respectively). Although it is difficult to determine a priori whether these compositional changes would lead to a different result should the issue arise again, it is plausible that the new Bench would line up quite differently on this issue, particularly given certain recent decisions that indicate a shift of the Court toward a more progressive, rights-sensitive approach: see e.g. *Arsenault-Cameron v. Prince Edward Island* [2000] S.C.J. No. 1 (S.C.C.), online: QL (SCJ); *M. v. H.* [1999] 2 S.C.R. 3; *R. v. Marshall* (1999), 177 D.L.R. (4<sup>th</sup>) 513.

<sup>124</sup>In other cases the Court has gone to great lengths in trying to conceptualize the claim from the perspective of the rights bearer, see *Singh*, *supra* note 99; *R. v. Vaillancourt*, [1987] 2 S.C.R. 636; *Morgentaler*, *supra* note 100; *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143.

<sup>125</sup>Although the courts upheld the assisted suicide statutes, they nevertheless opened up a channel of communication between themselves and their respective legislatures in recognition of the high-policy content of end-of-life decision making. See P.W. Hogg & A.A. Bushell, "The Charter Dialogue Between Courts and Legislatures" (1997) 35 Osgoode Hall L.J. 75 at 104.

<sup>126</sup>See e.g. Justice Sopinka's statement in *Rodriguez*, *supra* note 1 at 614 that "in dealing with this 'contentious' and 'morally laden' issue, Parliament must be accorded some flexibility." See also Justice O'Connor's observation in *Vacco*, *supra* note 38 that "[s]tates are presently undertaking extensive and

advocated by Mr. Justice Oliver Wendell Holmes some three quarters of a century ago:

There is nothing that I more deprecate than the use of the Fourteenth Amendment beyond the absolute compulsion of its words to prevent the making of *social experiments that an important part of the community desires*, in the insulated chambers afforded by the several states, even though the experiments may seem futile or even noxious to me and to those whose judgment I most respect....<sup>127</sup>

A number of amendments to the current law are possible. The broadest possible change would be to strike down the absolute prohibition and legalize euthanasia for all Canadians. However, given the obvious risks of abuse in permitting compassionate killing in the absence of any control and supervision, this suggestion is unlikely to be accepted. Another possibility, which has been endorsed by both the Law Reform Commission of Canada<sup>128</sup> and the Special Senate Committee on Euthanasia and Assisted Suicide,<sup>129</sup> would be to amend the criminal code to provide for less severe penalties where the motive is one of compassion and not malice. One way to accomplish this would be to reduce the grading of the offense from murder to manslaughter,<sup>130</sup> an offense that does not carry a mandatory minimum sentence. Although manslaughter offers the possibility of a reduced or non-existent sentence, the difficulty with this approach is that physicians who participate in euthanasia at the voluntary request of their patients will still be faced with court proceedings as well as a criminal record. This outcome is incompatible with the fundamental premise that physicians are morally blameless given that they are merely respecting the voluntary wishes of their patients who are exercising their right to euthanasia according to their own individual ethic.

A more favourable solution would be to legalize euthanasia only for certain categories of individuals (e.g., competent terminally ill individuals) in certain restricted settings (e.g., licensed health care facilities) and only according to certain prescribed guidelines. Many guidelines and safeguards have already been proposed

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serious evaluation of physician-assisted suicide.... In such circumstances, the...challenging task of crafting appropriate procedures for safeguarding...liberty interests is entrusted to the 'laboratory' of states."

<sup>127</sup>*Truax v. Corrigan*, 257 U.S. 312 (1921) in R.A. Posner, *The Essential Holmes* (Chicago: University of Chicago Press, 1992) at 311 [emphasis added].

<sup>128</sup>Law Reform Commission of Canada, *Working Paper 28: Euthanasia, Aiding Suicide and Cessation of Treatment* (Ottawa: Minister of Supply and Services, 1982).

<sup>129</sup>The Report of the Special Senate Committee on Euthanasia and Assisted Suicide, *Of Life and Death* (Ottawa: Minister of Supply and Services, 1995) at 88, where it was recommended that "the *Criminal Code* be amended to provide for a less severe penalty in cases where there is the essential element of compassion or mercy."

<sup>130</sup>See B. Sniderman, "The Latimer Mercy-Killing Case: A Ruminant on Crime and Punishment" (1997) 5 Health L.J. 1.

for the regulation of euthanasia.<sup>131</sup> These guidelines generally require that (1) palliative care options be available but insufficient to relieve personally unacceptable suffering, (2) the practice of euthanasia be subjected to a heightened standard of informed consent, (3) there must be diagnostic (clearly ascertainable disease) and prognostic (how long the patient has to live) clarity, (4) physicians willing to honour patient requests for euthanasia must obtain an independent second opinion, and that (5) accountability must be guaranteed through an explicit process of documentation, reporting, and review.

This solution will not solve all hard cases. For one, neither Mr. Latimer nor his daughter would have immediately and directly benefited from this solution. Indeed, the objective of this paper was to present a case for the legalization of active euthanasia in the context of competent, terminally-ill patients in a medical setting. None of these factors are present in the *Latimer* case. It certainly was not our purpose to provide the key to answering the troubling question with which the Supreme Court of Canada finds itself seized in that case. Nevertheless, we would simply take this opportunity to point out that, despite the absence of a clear precedent in Canadian law, both American and British courts have developed doctrines by which an incompetent person is granted the same rights as a competent patient to obtain the termination of life-prolonging treatment.<sup>132</sup> Underpinning this case law is the notion that both competent and incompetent individuals must be afforded the same right regarding the termination of inappropriate treatment, because “the value of human dignity extends to both.”<sup>133</sup>

If our courts grant to competent individuals a right to euthanasia, as we have suggested in this paper, and then extend that right to incompetent individuals (as we presume is the law regarding termination of life-prolonging treatment), then we

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<sup>131</sup>C.H. Baron, *et al.*, “Statute: A Model State Act to Authorize and Regulate Physician-Assisted Suicide” (1996) 33:1 *Harvard J. Legislation* 1. See also T.E. Quill, C.K. Cassel & D.E. Meier, “Care of the Hopelessly Ill: Proposed Criteria for Physician-Assisted Suicide” (1992) 327 *N. E. J. Med.* 1380; H. Brody, “Assisted Death” (1992) 327 *N. E. J. Med.* 1384; F.G. Miller *et al.*, “Regulating Physician-Assisted Death” (1994) 331 *N. E. J. Med.* 119. In addition, see the safeguards proposed by Chief Justice Lamer in *Rodriguez*, *supra* note 1 at 579.

<sup>132</sup>In the U.K., the courts defer to the discretion of medical professionals to withdraw treatment in cases where “life-prolonging treatment is properly regarded as being, in medical terms, useless” while reserving their *parens patrie* power to ensure that the best interests of children are indeed respected: see for instance *Airedale v. Bland* [1993] 1 All E.R. 821 (H.L.). In the U.S., the courts have invoked the “doctrine of substituted judgement,” whereby a “proxy”, e.g., a close family member, legal guardian, a judge, etc., is entitled to determine, by virtue of a legal fiction, what an incompetent patient would have decided, were she able to: see *e.g.* in *In re Quinlan*, 355 A.2d 647 (N.J. Sup. Ct. 1976), where the court allowed the father of a permanently unconscious patient to exercise her constitutional right of privacy to refuse life-prolonging treatment. See also, *Saikewicz* *supra* note 19 where the court determined that a probate judge was the appropriate authority for exercising the “substituted judgement” of the patient, in conjunction with testimony from family members, medical practitioners, legal guardians, etc. Note that we exclude from the category of incompetent individuals the case of advanced directives by an unconscious patient who clearly expressed her will regarding medical treatment prior to her becoming incompetent, as was the case in the Canadian decision of *Malette*, *supra* note 22.

<sup>133</sup>*Saikewicz*, *ibid.* at 427.

would propose that certain additional safeguards to the guidelines recommended above be adopted, notably the requirement that a family member or other legal guardian requesting active euthanasia for an incompetent individual obtain specific court authorization.<sup>134</sup> Courts would be expected to engage the assistance of expert testimony by medical professionals and would be responsible for ensuring that the patient's best interests were respected at all times. Had Mr. Latimer had a court to turn to, as do the families of suffering, incompetent individuals in the U.K. and the U.S., for example, perhaps he would not have taken the law into his own hands, as he felt he was compelled to.

In the meantime, as regards competent terminally ill patients at least, the legal solution advocated here strikes a balance between two important legal objectives: that of advancing the state interest in protecting the vulnerable through black letter rules and that of guaranteeing the protection of certain other vulnerable individuals, namely the competent terminally ill who wish to die, by carving out a right to assistance from these black letter rules, in recognition of their particular circumstances. In short, the law of murder and assisted suicide would continue to apply as a general rule to the "many who are not now knowingly in the last days of life and who do not know when and how they will die", but an exception would be carved out of this general rule for the "few who face imminent death and personally unacceptable suffering."<sup>135</sup> In this way, terminally ill individuals who do desire assistance in dying will not be left to suffer behind a legal *mask* of indifference but will be able to make decisions for themselves, out of their own faith, conscience, and convictions.

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<sup>134</sup>This was in fact the approach advocated in *Saikewicz* for the withdrawal of life-prolonging treatment, where the court reasoned that a judge, and *only* a judge, was entitled to exercise the substituted judgement on behalf of the incompetent patient since "such questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created", *ibid.* at 435. We would simply extend this reasoning to the case of active euthanasia.

<sup>135</sup>The Body and the Body Politic, *supra* note 90.