Mémoire de VieCanada à l`Endroit de la Commission Spéciale sur la Question de Mourir dans la Dignité

RÉSUMÉ GÉNÉRAL

- VieCanada préconise la dignité pour tous, avec préoccupation particulière pour les personnes vulnérables.
- Nous voulons surtout mettre l`accent sur les questions légales et morales associées à l`euthanasie et au suicide assisté.
- La vie et la mort ont davantage rapport à l`interdépendance qu`à l`autonomie.
- L`accès aux soins palliatifs est limité au Québec, tout comme ailleurs au Canada.
- Il est prématuré de légaliser l`euthanasie avant d`avoir accès aisément aux soins palliatifs.
- Notre sondage Environics a démontré que les Québécois sont ambivalents sur l`euthanasie. 73% sont préoccupés par l'impact négatif de la légalisation sur les personnes vulnérables.
- Le caractère sacré de la vie est une valeur fondamentale. Cette valeur a un sens non-religieux.
- Légaliser l`euthanasie et le suicide assisté serait franchir un Rubicon morale et juridique, mettant à risque la vie de personnes vulnérables.
- La décriminalisation du suicide n'est pas une base pour sa légalisation.
- La Hollande démontre la pente glissante où l'euthanasie est acceptée. L'expérience néerlandaise devrait donner à réfléchir au Québec.
- Le cœur du point de vue favorable à l'euthanasie semble être l'idée que parfois la vie n`est plus digne d'être vécue. Ce concept est dangereux pour la société et ne peut être adopté.
- Les propositions visant à légaliser l'euthanasie pour les malades chroniques - qui ne sont pas mourants - illustrent bien la pente glissante.
- La légalisation aurait un impact négatif sérieux sur les personnes âgées au Québec: (1) La flambée des coûts des soins de santé créerait une pression pour l'euthanasie. (2) Le problème de l`abus des aînés augmenterait. (3) Les aînés seraient confrontés à des pressions psychologiques pour mettre fin à leur vie.
- Les personnes handicapées sont déjà affectées par les stéréotypes sociaux négatifs. La légalisation nuirait à l'image ces personnes handicapées et aurait un potentiel sérieux d`abus.
- La légalisation impliquerait l'acceptation sociale du suicide et porterait atteinte à la prévention du suicide.
- Dans l'Oregon les garanties pour protéger les malades en phase terminale qui demandent le suicide assisté sont apparemment contournées. L`Oregon n'offre pas un bon modèle pour le Québec.
- L`argument principal de Jocelyn Downie en faveur de la légalisation est que les médecins causent déjà la mort de leurs patients - effectivement en les tuant - chaque fois qu`ils retiennent ou retirent des traitements de survie. Cet argument est vicié, enracinée dans une explication d`éthique erronée.
- Les lignes directrices de poursuites judiciaires, comme celles introduites en Angleterre, équivalent à changer la loi par la «porte d`en arrière». La Commission doit résister à cette approche.
- La légalisation peut effectivement porter atteinte aux valeurs de dignité et d'autonomie.
- Nous implorons la Commission de rejeter toute forme d’approbation sociale de l’euthanasie et du suicide assisté.

Brief to the Select Committee

on Dying with Dignity

National Assembly of Québec

LifeCanada

July 14, 2010

Introduction

We thank the Committee for this opportunity to share our views on this most important topic, one that touches the lives of Quebecers in a personal way.

LifeCanada advocates for the dignity of everyone's life, with special concern about the most vulnerable members of the community. That includes the dying, the chronically ill, the elderly, and persons with disability. As an organization our vision is to establish the value of human life in the hearts and minds of Canadians; we pursue that vision through public education.

We appreciate that the Committee has stated it wants an "open debate" about dying with dignity, and that in its deliberations "all points of view" are welcome. In submitting our views, we respectfully ask that they will be considered on their own merits, without reference to positions we may hold on other subjects.

While we realize the Committee will examine dying in a broad sense, we wish to focus our attention primarily on moral and legal issues related to euthanasia and assisted suicide. While there is much in the Committee's Consultation Document that is helpful for public discussion, we find one footnote problematic. In the section on *What the Words Mean*, note 2 mentions the qualifiers "voluntary", "involuntary" and "nonvoluntary" in describing euthanasia and says "their use is out of date." With respect, these terms are still current in the literature[1] and seem necessary to distinguish between acts where the patient consents and acts where no consent is given. We trust the Committee will agree that those distinctions are not irrelevant.

One final important point: In what we say herein about "legalization", our remarks apply not only to statutory and court changes in the current law, but also to other potential forms of public sanction along the lines put forward this year by the Director of Public Prosecutions in the

United Kingdom (Consultation Document, p. 36). We comment later on this type of approach.

Living and Dying: About Interdependence More than Autonomy

Human experience reveals that living and dying both are more about interdependence than independence and autonomy. Proposals for legalization which emphasize the principle of autonomy tend to miss this larger picture.

So much in living and dying is beyond our control; this is simply the nature of human existence. As we approach death, or experience chronic illness or serious disability, we rely on others more. In many ways, we die with dignity to the extent we receive compassion and care from others.

Though there is an existential sense in which we each die alone, our death normally takes place amid a network of family, friends and care givers. Our life and our death touches others. This interpersonal reality was well captured in John Donne's classic poem, "No Man Is an Island:"

Each man's death diminishes me,
because I am involved in mankind
and therefore never send to know
for whom the bell tolls
it tolls for thee.

While suicide is something of an exercise autonomy, families where this occurs are deeply affected. Assisted suicide and voluntary euthanasia are even less about autonomy, because another person is by definition involved in these acts. When these persons who either assist or directly bring about death are family members, physicians, nurses, or other care givers, the social dimension must be considered.

For example, if physicians are involved in killing their patients, is there not a profound

impact on the individual physician? And does it not affect the very definition of what it means to be a doctor? Society must also decide: Do we really want physicians to be involved in killing their patients? Would it not undermine the trust (interdependence) between patients and doctors?

Care of the Dying and Euthanasia

The impetus for legalizing assisted suicide and euthanasia usually arises in the first instance from a consideration of the human suffering often associated with terminal illness, notably cancer. In recent decades our society has made major advances in the care of the dying through the availability of palliative care and highly effective pain management techniques. However, as the Consultation Documents notes, access to good palliative care is still short of what it should be in Québec, above all for those with incurable illnesses besides cancer.

According to a reliable authority, "There are at least 70% of Canadians who do not have access to palliative care. And when then there is access, it is not equitable."[2] Similarly, effective pain management is often not readily available.[3]

Medical experience shows that palliative care and pain management can often alleviate patient demand for assisted suicide and euthanasia. Senator Sharon Carstairs, who has done tremendous work in this area for the federal government,[4] has stated it is premature to legalize euthanasia before palliative care is readily available to dying Canadians. We find wisdom in that caution.

Adding note of caution comes from palliative care specialists who believe legalized euthanasia could reduce the incentive to expand palliative care and pain control research.[5]

Palliative or terminal sedation are ethical options to mitigate suffering, though less than

ideal because of the ways they impair / negate consciousness.[6] We expect that more research will yield better, more humane results in time.

There no need to kill the patient in order to kill the pain.

Opinion Poll: The Ambivalence of Quebecers

Various opinion polls have reported a high level of support for legalized euthanasia among Quebecers. Such polls, however, do not capture the full picture of how Quebecers feel. They do not indicate how ambivalent they really are about euthanasia, how concerned they are that if euthanasia is legalized the lives of the most vulnerable in the community will be put at risk.

However, in 2009 our organization carried out an Environics poll that did capture the larger picture. Similar to other polls, it found that 75% of Quebecers agree with legalized euthanasia under some circumstances (specifically, when the patient consents). However, it also found that 73% of the Quebec population are concerned, that if euthanasia (with consent) is legalized, sick, disabled or elderly persons would be euthanized *without their consent*. In addition, 65% were concerned that the elderly would feel pressured to accept euthanasia in order to reduce health care costs.[7] In most cases the very same people who say they support legalization are concerned about its negative impact on the most vulnerable. Quebecers are thus more ambivalent about euthanasia than is usually recognized.

Very revealing as well is the fact that concern about the negative impact is higher among Quebecers than other Canadians.[8] This suggests that Quebecers are more concerned than other Canadians about the most vulnerable members of the community. Policy makers would be well

advised to take this into account as they consider the wisdom of legal changes.

The Sacredness of Life: A Non-Religious Argument

We believe in the sacredness of human life and recommend it as a core value indispensable to the well-being of society. This value has long been enshrined in Canadian society and law.[9] In the Supreme Court of Canada's decision in the Sue Rodriguez case concerning assisted suicide, Justice Sopinka, writing for the majority, referred approvingly to the "sanctity of life" principle and noted that it gave rise to "the policy of the state that human life should not be depreciated by allowing life to be taken."[10]

In upholding the Criminal Code provision against assisted suicide, the majority said its purpose was "the protection of the vulnerable," and noted that purpose was grounded in the sacredness of life principle.[11]

We wish, however, to make two important points about the sacredness of life principle: (1) this value can have a secular, not just religious, meaning and it is this non-religious meaning we propose in the argument herein. As explained by the Law Reform Commission, that secular meaning has to do with a basic intuition - accessible to everyone - that life is precious and worthy of respect and protection.[12] This kind of non-religious meaning was expressly adopted by the *Rodriguez* majority and employed in its decision. Justice Sopinka described it in terms of "the intrinsic value of human life" and "the inherent dignity of every human being."[13]

(2) Our advocacy of this value does not preclude recognition of other core values needed for a civilized society, and these notably include autonomy and dignity.[14]. We recognize that the issues of euthanasia and assisted suicide engage all three core values mentioned.

In general our society has judged that, in the event of conflict among the core values, the sacredness of life trumps the others in the case of killing someone. Thus autonomy gives way in s. 14 of the Criminal Code which prohibits someone from consenting to have death inflicted upon them.

Now our society has allowed certain exceptions to the ban against killing. These include killing in a just war, in self-defense, or in a peace officer's line of duty. Jocelyn Downie argues that legalized euthanasia and assisted suicide would just be other allowable exceptions, justified by the values of autonomy and dignity.[15] But we contend that to allow these particular exceptions would be to cross a moral and legal Rubicon that Downie fails to recognize.

None of the exceptions noted above entail killing an innocent civilian. Euthanasia and assisted suicide differ in that respect. To allow them thus would alter our law, public policy and collective identity in a fundamental way.

In the *Rodriguez* decision, Justice Sopinka referred in effect to the Rubicon against killing innocent civilians when he stated that "the active participation by one individual in the death of another is intrinsically morally and legally wrong."[16] In our view, to cross that Rubicon would be most unwise.

The reason is not simply that a ban against killing innocent civilians is ethically and legally sound in itself. As the court's majority also noted, "Given the concerns about abuse and the great difficulty of creating appropriate safeguards, the blanket prohibition on assisted suicide is not arbitrary or unfair."[17] Even in the face of a heartrending case like Ms. Rodriguez who had a most debilitating disease (ALS), the court feared that if were to set a new precedent, the lives of the vulnerable would be placed at risk.

The wisdom of that fear - in essence, the slippery slope argument - we try to explain more below.

An Objection: The Decriminalizaton of Suicide

Here we wish to address an objection that Jocelyn Downie might make to our crossing the Rubicon argument. She would probably say we've already crossed that river when Canada decriminalized attempted suicide. For she maintains, with Chief Justice Lamer in his minority opinion in *Rodriguez*, that that legal change implied society's *approval* of suicide.[18] For the law to then allow someone to obtain help in ending their own life (assisted suicide) or to consent to someone else ending the life of the one consenting (euthanasia, in a voluntary sense), would accordingly be on the same side of the river, so to speak.

We disagree. With the *Rodriguez* majority, we hold that the decriminalization of attempted suicide did not imply approval of suicide, only the recognition that such attempts were better prevented through other social means.[19] Our society has never been comfortable with the practice of suicide, as demonstrated by our widespread suicide prevention programs. While people may sympathize with some cases of suicide, institutionally we have thusfar not crossed the Rubicon of sanctioned intentional causation of death involving innocent civilians.[20]

The Slippery Slope?

We must define what we mean by "slippery slope." We mean the tendency, once euthanasia or assisted suicide is legalized - or otherwise sanctioned by public authorities (e.g. via prosecution guidelines) - under a narrow set of circumstances to gradually expand to include more and more cases originally unintended, and to do so whether as a result of an abuse of the

legal rules or an ever expanding change in those rules. The net result of this tendency is a steady rise in the euthanasia rate and / or a steadily widening circle of patient categories affected.

We submit that Holland offers the best case study for whether this phenomenon exists, because of its lengthy experience with state-allowed euthanasia. Other jurisdictions, such as Belgium, the U.S. State of Oregon, and Switzerland, are less instructive because of their considerably shorter experience.[21]

One authority on suicide has characterized the Dutch experience this way:

> The country has moved from euthanasia for terminally ill patients to euthanasia for those who are chronically ill, from euthanasia for physical illness to euthanasia for psychological distress, and from voluntary euthanasia to nonvoluntary and involuntary euthanasia.[22]

This trajectory of expanding categories of patients has come about primarily through a succession of precedent-setting court cases which preceded formal legalization (2002). It has been well chronicled and is acknowledged by proponents of legalization.[23] Legalization, which provided for euthanasia patients as young as 12 (with parental consent), has been followed by acceptance of the 2003 Groningen Protocol for euthanizing disabled infants.[24]

While significant underreporting of figures is widely acknowledged,[25] it appears the past few years have seen a steady rise in euthanasia cases: from 1923 in 2006 to 2120 in 2007 to 2331 in 2008 to approximately 2500 in 2009.[26]

The above figures are for deaths with explicit patient consent (voluntary euthanasia), since the Dutch government does not technically classify deaths induced by physicians without consent (nonvoluntary or involuntary euthanasia) as “euthanasia.”[27] Nevertheless government studies have revealed a significant number of such deaths: approximately 1,000 per year in 1990

and 1995.[28] In many cases Dutch physicians have not adhered to the guidelines set up originally to allow only for voluntary euthanasia.

The conclusion seems clear: Holland has indeed demonstrated a slippery slope in its experience with euthanasia. There has been a steady expansion in patient categories affected. The numbers appear to be on the rise. And a serious problem of *de facto* euthanasia outside accepted guidelines has arisen. Meanwhile, Belgium, which legalized euthanasia in 2002, has shown similar tendencies as Holland.[29]

The Dutch experience should give Québec great pause about accepting any form of euthanasia or assisted suicide. If allowed initially only for some narrow cases, over time it will tend to prove most difficult to restrict it. If accepted initially only with patient consent, it will eventually likely be carried out without it, partly on the basis of an equality argument: if euthanasia is an acceptable form of medical treatment to relieve suffering, why should the non-competent (e.g. small children, the mentally disabled) be deprived of it?

The heart of the pro-euthanasia viewpoint seems to be the notion that life is sometimes no longer worth living.[30] and in that case it is expendable. The problem, according to one Dutch observer, is that "...when you start to admit that killing is a solution to one problem, you will have many more problems tomorrow for which killing may also be a solution"[31] Is this the direction that Québec wishes to move?

What should concern us is that the ultimate impact of the slippery slope phenomenon is upon the most vulnerable members of society: small children, the elderly, the mentally challenged, those with other disabilities, those weakened by chronic illness, etc. As a Québec bioethicist stated to the Senate Committee on Euthanasia,

> It would be difficult for a society to withstand long the pressures - once voluntary euthanasia is accepted - to move on and to give euthanasia to those whose lives seem to have no sense, no purpose, no worth in the eyes of others.[32]

Impact on the Chronically Ill

We find it illustrative of the slippery slope that whereas discussion of euthanasia normally begin with a focus on those who are dying, attention soon shifts to those who are not yet dying - such as the chronically ill. Thus contemporary legalization projects, such as the *Euthanasia Act* of Belgium (passed, 2002) and Bill C-384 (defeated 2010, 40th Parliament of Canada)[33] typically include the chronically ill.

We find it troubling that society might, through legalization, adopt the idea that the lives of some chronically ill persons are not worth living. Is there not a danger that the dignity of *all* persons with chronic illness would thereby be reduced in the popular mind?

We certainly are not indifferent to the suffering or care needs of persons with chronic illness. With continued medical progress in treating disease and improvements in our health care system, much can be done to alleviate their suffering and thereby affirm their dignity in a positive way.

On the other hand, if euthanasia or assisted suicide is legalized for such people along with some set of guidelines, it seems to us that some level of abuse if likely. For example, persons without such illness sometimes have a more negative outlook on the illness than those who have the condition. Those with the illness may find themselves being pressured against their will to consider procured death as a reasonable option.

Impact on the Elderly

We are very concerned that legalization would have a seriously negative impact on the elderly population in Québec. There are several reasons.

1. **Health care costs**. Québec's population is aging. We hear anecdotally from our supporters that the Quebec health care system is already struggling to adequately provide for the needs of the elderly. As the proportion of seniors rises, so will health care costs. It is said that half of the costs incurred by the health care system for the average person are from the last six months of life.[34] . If euthanasia is legalized, will there not be a tremendous temptation to reduce costs by steering the elderly to an early demise? As the Canadian Nurses Association stated to the Senate Committee,

> No public policy on euthanasia would ever be proposed on the basis of saving money, but, once such a policy were in place, who can say that financial concerns would not become a consideration within facilities and agencies or even within families.[35]

It seems to us, then, that the 65% of Quebecers who, in the Environics poll cited above, expressed concern about the elderly being pressured to accept euthanasia (once legalized) have reason to worry.

2. Elder Abuse. Our society is becoming more aware of the serious problem of elder abuse. The federal government recognizes this problem, and estimates that 4-10% of elderly persons experience one or more forms of physical, psychological or financial abuse.[36]

The elderly sometimes are at the same time frail, demanding and dependent upon others. This can create a recipe for abuse. The elderly person abused is sometimes isolated and afraid to report the abuse. A surprising level of abuse happens at the hands of family members or other care givers. The misuse of a senior's financial resources is one of the most common problems.

If euthanasia and / or assisted suicide become socially sanctioned, would not many of

those in positions of power and inclined to abuse the elderly be tempted to arrange an early death, whether honestly or dishonestly, perhaps to eliminate a burden they feel or to gain financial advantage? We can easily imagine abusers pressuring the elderly to accept “a peaceful end” or themselves deciding that a senior with dementia no longer has a life worth living. It seems naive to expect that this would not happen.

3. **Psychological Pressures**. The elderly are naturally susceptible to certain psychological pressures that legalized euthanasia could exacerbate with tragic results.

> Loss of control, concern over being able to financially pay for the support required to continue living, and the fear of becoming burden to family members are internal pressures that can affect an individual’s desire for euthanasia and assisted suicide.[37]

A leading legalization advocate does not deny the risk of the elderly from being negatively impacted.[38] Is this a risk Québecers feel comfortable to take?

Impact on Persons with Disabilities

The experiences of persons with disability, time and again, show that they are often victims of an unfair bias that a great percentage of society holds, namely that their lives involve intolerable suffering and that, in some cases, are not worth living. As the Council of Canadians with Disabilities has stated, ‘I would rather be dead that live with a disability,’ is a sentiment often heard from people without disabilities.

> Such a comment rests on an incorrect assumption that the quality of life is poor when you have a disability. Incorrect assumptions about quality of life have the power to trigger responses that harm people with disabilities.[39]

If persons with disabilities already struggle with negative stereotypes and resultant harm to them, how much more would they face if society sanctions procured death for them? Thus the

Council

> opposes any government action to decriminalize assisted suicide because of the serious potential for abuse and the negative image of people with disabilities that would be produced if people with disabilities are killed with state sanction.[40]

Disabled people already face serious challenges when it comes to the issue of medical treatment. Their common experience is that they are less likely to receive treatments that non-disabled Canadians would be given without question. The prospect of legalizing euthanasia and physician assisted suicide becomes very concerning. There seems little doubt that if that prospect becomes reality a disproportionate number of disabled Canadians would receive death as a 'medical treatment' instead of the commitment to life to which they are entitled.

That persons with disabilities do not presently enjoy the same protections of their lives that people without disabilities do is made strikingly clear when one examines instances where parents have killed or attempted to kill their disabled children. Judicial decisions and public opinion have favoured lenient sentences that would never have been condoned for cases where the children did not have disabilities. These cases serve as a clear indication that even now the lives of disabled persons are less valued and less protected. The impact that legalization would have truly alarms many people with disabilities and their advocates.

The Council of Canadians with Disabilities has intervened in many important cases involving deaths of disabled people at the hands of doctors or family members. In the Tracy Latimer case, they argued that Tracy's disability not be seen as a mitigating factor in her murder. They were dismayed at the outpouring of sympathy for Tracy's father and the fact that his sentence was reduced to a charge of 2nd degree murder despite evidence that it was a pre-meditated act.

Our society has made great strides in making people with disabilities feel more welcome and included. Is there not a real danger than legalization and its slippery slope would end up as a tragic step backward?

> *Had euthanasia or "assisted suicide" been legal I would have missed the best years of my life. And no one would ever have known that the future held such good times, and that the doctors were wrong in thinking I didn't have long to live*. – Michael Wenham, author of *My Donkey Body*, diagnosed in 2002 with degenerative Motor Neurone Disease

Impact on Suicide Rate

Were assisted suicide and euthanasia to be legalized, it is hard to see how it would not signal a paradigm shift in society's approach to suicide itself. If we legalize *assisted* suicide, for instance, how can we maintain suicide is unacceptable? It is not hard to imagine suicide prevention programs falling by the wayside, as we shift more and more to autonomy ideals associated with assisted suicide advocacy such as, "it's your body and your right."

Suicide counsellors could become loathe to impose any negative views on clients. What would the net effect of **non**-prevention be among vulnerable populations like troubled youth and indigent First Nations people? Those are troubling prospects.

Oregon: Model or Concern?

Physician assisted suicide was legalized in Oregon in 1997, for terminally ill patients with an expected six months to live. According to the law, an individual must be 18 years of age, capable of making the decision, and voluntarily express his or her wish to die.

As various commentators have noted, the Oregon experience is difficult to assess, because of the way information on assisted suicide cases is collected and reported by the administering

agency. Nevertheless serious concerns have been raised about the way the law is working. According to several case studies and other research reported in the *Michigan Law Review*, "seemingly reasonable safeguards for the care and protection of terminally ill patients written into the Oregon law are being circumvented."[41]

> The problem lies primarily with the Oregon Public Health Division, which is charged with monitoring the law. OPHD does not collect the information it would need to effectively monitor the law and in its actions and publications acts as a defender of the law rather than as the protector of the welfare of terminally ill patients.[42]

One specific concern is that depressed patients have not been adequately referred for mental health evaluation, despite the law's requirement. According to one of the researchers, in general "two thirds of patients requesting assistance with suicide have been shown to be depressed."[43] Yet from 1998-2005 only 13% of Oregon patients requesting assisted suicide were referred for evaluation, and in 2006 only 4% did so.[44] And in 2007 there were no referrals at all for psychiatric consultation![45]

It seems Oregonians are being improperly dispatched to death.

Especially troubling is the case of Barbara Wagner. Wagner was an indigent resident of Oregon who had lung cancer. The Oregon Health Plan refused to pay for a drug to possibly prolong her life but indicated they would pay for her assisted suicide instead. Unable to afford the drug, she was effectively steered toward suicide.[46] "To say to someone, we'll pay for you to live, but not pay for you to live, it's cruel. I get angry," Wagner commented.[47]

Oregon hardly seems like a model for Québec to emulate.

An Objection: Nontreatment Decisions Kill

An important objection to the case against legalization that we have tried to make comes

from those who argue essentially: the legalization of euthanasia and assisted suicide does not represent a radical change for Québec and Canada, society has already accepted foundational changes with respect to intentional causing death. Legalization, therefore, is only a matter of being consistent with the changes we as a society have already accepted.

This precisely is the position of one of Canada's leading proponents of legalization, Jocelyn Downie. In her book on the subject, her central thesis is that decisions to withhold or withdraw life-sustaining medical treatment, as well as the administration of standard analgesics used in palliative care which make shorten life, physicians are *already intentionally causing the death of their patients*, and this is well accepted legally and socially, based on various court cases and the evolution of standard medical practice.[48] She maintains the guiding principle of autonomy that justifies these acts is the same in the cases of voluntary euthanasia and assisted suicide.[49] In other words, there is a moral equivalence among all these different acts. In short, Downie implies that *doctors are already killing their patients in Canada*, under public sanction. Hence, it might be said, legalization crosses no Rubicon and should logically be accepted.

This is a bold and seductive argument. But it is deeply flawed, rooted in an erroneous ethical account of the acts compared.

The notion that nontreatment decisions kill is not new. Its academic pedigree dates especially from a famous, highly controversial essay by James Rachels. The assertion has been vigorously rejected by numerous authorities.[50] Nevertheless it continues to be propounded by some, and has previously surfaced in the Canadian debate.[51]

Those who take issue with this view (and implicitly with Downie's position) state that decisions to withhold or withdraw life-sustaining treatment are fundamentally different kinds of

moral action from homicide. The essential difference has to do with what is chosen or intended in each case. In nontreatment cases, the treatment is, as a rule, withheld or withdrawn because it is judged not to be useful to the patient, or is refused by the patient because it is a burden upon him or her. In making such decisions, death may well be foreseen but is not directly intended. On the other hand, in a homicidal act, such as the administration of a lethal injection for euthanasia, death is directly intended.

Thus *allowing* someone to die and *making* them die are not simply morally equivalent [52]

Similarly, in the case of administering analgesics in palliative care, the intent is to alleviate pain, even though the unintended side effect may be to shorten life. Contrary to what Downie asserts, no death is caused.

It is true that, in certain circumstances, nontreatment can be homicidal.[53] For instance, if a doctor arbitrarily withdraws a respirator from a patient who wants it and temporarily needs it in order to breathe, and the patient dies as a result, the doctor may be said to have caused the death. Not only ethically is it homicide, legally it could result in a charge of homicide as well.[54]

But such limited circumstances are not what Downie has in mind. Her view, rather, is that *any* act of withholding or withdrawing life-sustaining treatment where death is foreseen involves the causation of death and is tantamount to homicide. This is where she treads on shaky ground. Certainly there is no consensus among ethicists that doctors effectively are killing their patients every time they stop life support.

On the other hand, Justice Sopinka was on solid ground in the *Rodriguez* decision when he wrote that (1) “distinctions drawn between withdrawal of treatment and palliative care, on the one hand, and assisted suicide on the other ...can be persuasively defended;”[55] (2) palliative care and

assisted suicide differ in intent - in the former it is "to ease pain" whereas in the latter it is "undeniably to cause death."[56] He also wisely pointed out that "distinctions based upon intent are important, and form the basis of our criminal law."[57]

Jocelyn Downie's thesis does not hold water. Doctors are not killers in their normal everyday duties of caring for the dying. Would not they and the public be astonished by such an accusation? Were the Committee to accept Ms. Downie's argument, that in effect is the accusation it would also be making.

Our society has *not yet* crossed the Rubicon. It has not yet authorized its doctors to kill their patients.

Changing the Law by the "Back Door"

For public officials interested in changing the law's prohibitions against euthanasia and assisted suicide, but who feel that such a change may not yet be politically opportune or possible, it may be tempting to make administrative changes that effectively remove those prohibitions for some people. Such is the case with the previously mentioned new prosecution guidelines introduced in the United Kingdom, whereby assisted suicides may not be prosecuted if there is evidence the assistance was based on compassion, etc.

This type of implied public sanction of a prohibited act is sometimes referred to, aptly in our view, as changing the law by the "back door." We are troubled by this type of approach. It seems to override the fundamental difference between making the law and administering it, thus undermining the rule of law. It also negates the principle of equality before the law, by giving some people an exemption from the prohibition that binds others.

We urge the Committee not to endorse an end-run around the law.

Closing Notes on Dignity and Autonomy

The debate over legalization involves a conflict among core values in our society, such as the sacredness of life, autonomy and dignity. But it is wrong to assume that the conflict is simply between the sanctity of life on the one side and autonomy and dignity on the other.

First of all, there is much that can be done to alleviate demand for assisted suicide and euthanasia that is consistent with all three values yet without entailing procured death. For many people who suffer, the provision of palliative care, pain management, the treatment of depression, and other forms of care respects autonomy, affirms dignity and supports the value of life.

Secondly, social acceptance of euthanasia and assisted suicide can be contrary to autonomy and dignity. When competent patients are pressured to accept an arranged death (like Barbara Wagner), and when non-consenting patients are put to death based on someone else's evaluation that their life is not worth living (like Tracy Latimer), autonomy is hardly affirmed.

And when someone's life is ended, based on the notion that it was no longer worth living, dignity is sacrificed in a certain way, even if the death is voluntary. For if the worth of one's life is conditional rather than unconditional, i.e. if it is based on certain conditions being fulfilled - e.g. being in control, having good health, an absence of suffering, etc., then the dignity of the human person is relative and transitory, rather than inherent and enduring. And when the idea goes abroad that some lives are not worth living, it can endanger the lives of many vulnerable people.[58] Which is contrary to their human dignity.

Conclusion

We were very troubled by a prominent Québec physician's reported comment that "Death can be an appropriate care in certain circumstances."[59] We hope this comment does not prove to be an omen of what the future health care system will be like. As the Committee considers the questions before it, we suggest it be mindful of the poet's warning: "*Death, once invited in, leaves its muddy footprints everywhere.*"

We urge the Committee to reject any form of social approval of euthanasia and assisted suicide. We wish the Committee well in its deliberations.

ENDNOTES

1. E.g. Senate of Canada, *Of Life or Death*: Report of the Special Senate Committee on Euthanasia and Assisted Suicide, June 1995, 14; Jocelyn Downie, *Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada* (Toronto: University of Toronto Press, 2004), see especially 106-120.
2. The Hon. Sharon Carstairs, PC, Senate of Canada, *Raising the Bar: A Roadmap for the Future of Palliative Care in Canada*, June 2010, 3.
3. Senate, *Of Life or Death*, 25
4. See n. 2.
5. Senate, *Of Life or Death*, 59.
6. They are ethical provided high dosages of analgesics are not used with the aim of advancing death.
7. LifeCanada, News Release "Poll: Canadians Conflicted about Legal Euthanasia," www.lifecanada.org, 2 November 2009.
8. The Environics poll indicated 70% of Canadians were concerned about sick, disabled or elderly persons being euthanized without consent; 56% of Canadians were concerned that the elderly would feel pressured to accept euthanasia in order to reduce health care costs. Ibid.
9. See Law Reform Commission of Canada, Study Paper *Sanctity of Life or Quality of Life* (1979), 4.
10. *Rodriguez v. British Columbia (Attorney-General)* 3 SCR (1993) 519, Sopinka J., LaForest, Gonthier, Iacobucci, Major JJ.(concurring) at 34.
11. Ibid.
12. *Sanctity of Life or Quality of Life*, 17-18.
13. *Rodriguez*, at 14.
14. Justice Sopinka refers to all three. *Rodriguez*, see especially at 35. See also Downie, 49-61.
15. Downie, 100-101, 77.
16. *Rodriguez*, at 47.
17. Ibid., at 60.
18. Downie, 136.
19. *Rodriguez*, at 40. See also Downie, 135.
20. *Notes:* (1) We deal below with the question of whether the withholding or withdrawal of life-sustaining treatment intentionally causes death, and argue that the assertion it always does so is incorrect. (2) Many Canadians, ourselves included, would say Canada's legal permissiveness on abortion indicates acceptance of the intentional death of innocent human beings. The fact remains that institutionally Canada does not consider abortion as the taking of a

human life: see Criminal Code, s. 223. In terms of its institutional framework - which undeniably shapes the life of the country - the Rubicon has still not been crossed.

21. We do comment on Oregon below, and make brief mention of Belgium: see n. 29.

22. Herbert Hendin, MD, *Seduced by Death: Doctors, Patients and Assisted Suicide* (New York: Norton, 1998), 135.

23. See Downie's account of case law, ibid., 119-126.

24. E. Verhagen and P.J.J. Sauer, "The Groningen Protocol - Euthanasia in Severely Ill Newborns," *New England Journal of Medicine* 10 March 2005, 959-962.

25. See Downie, 119.

26. Euthanasia Prevention Coalition, *Newsletter* September 2009, 4; *Newsletter* January 2010, 3 citing *Dutch News* 3 Jan. 2010. The figures do not include assisted suicides, which are reported to be about 400 a year.

27. For Hendin, quoted above, and for our purposes here, "nonvoluntary" refers to instances where a patient is unable to consent, e.g. an infant; "involuntary" refers to instances where the patient is competent and able to consent, but does not do so. See Hendin, 91-92.

28. Hendin, 139, citing the Remmelink Commission reports for those years.

29. A *Canadian Medical Associaton Journal* study of one region of Belgium showed that 32% of euthanasia deaths were without explicit consent, despite that being a legal requirement. K. Chambaere et al., "Physician Assisted Death under the Euthanasia Law of Belgium," *CMAJ* 15 June 2010, 895-901.

30. Downie grounds her legalization proposals in this concept, e.g. "What matters is whether the individual believes his or her life to be no longer worth living," 77.

31. Cited in Downie, 110.

32. David Roy, cited in Senate, *Of Life or Death*, 80.

33. Bill 384: An Act to amend the Criminal Code (right to die with dignity).

34. Margaret Somerville, "When Is Euthanasia Justified?" *Globe & Mail* 15 March 2010.

35. Senate, *Of Life or Death*, 80.

36. See www.seniors.gc.ca

37. Council on Aging, cited in Senate, *Of Life or Death*, 60.

38. Downie, 106, 131-132.

39. Submission to Parliamentary Committee on Palliative and Compassionate Care, House of Commons, 16 June 2010.

40. Ibid.

41. Herbert Hendin and Kathleen Foley, "Physician-Assisted Suicide in Oregon: A Medical Perspective," *Michigan Law Review*, June 2008, 1613-39 at 1613.

42. Ibid.

43. Herbert Hendin, Letter to the Editor, 343 *New England Journal of Medicine*, 13 July 2000.

44. Hendin and Foley, 1622.

45. *American Medical News*, 12 May 2008.

46. Margaret Datiles, "A Price on Your Head," *Washington Times* 2 Nov. 2008.

47. Cited in Euthanasia Prevention Coalition, *Newsletter* Summer 2008.

48. Jocelyn Downie, *Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada* (Toronto: University of Toronto Press, 2004).

49. See especially 45, 68, 77, 87, 133-139.

50. For the Rachels essay, and articles on the debate, see James Rachels, *The End of Life: Euthanasia and Morality* (Oxford: Oxford University Press, 1986), 88-150. For an overview see also New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994), 110-113. For a convincing argument why Rachels was wrong, see Joseph M. Boyle, "On Killing and Letting Die," *New Scholasticism* 51 (1977), 433-52.

51. See the view of the minority on the Senate Euthanasia Committee that favored legalized euthanasia. Senate, *Of Life or Death*, 87.

52. For a reliable account of the ethical distinctions involved, see Luke Gormally, ed., *Euthanasia, Clinical Practice and the Law,* (London: Linacre Center for Health Care Ethics, 1994) 37-50.

53. Thus, allowing to die and making die *sometimes* are morally equivalent. Delineating those circumstances is beyond the scope of this brief. For a helpful explanation, see Gormally, ibid.

54. See Criminal Code, ss. 222, 224.
55. *Rodriguez*, at 58.
56. Ibid., at 57.
57. Ibid.
58. See comments of Council of Canadians with Disabilities above.
58. Dr. Yves Robert, cited in “Death can be an appropriate treatment,” *The New Freeman* 13 Nov. 2009.