THE SEARCH FOR A MODEL SYSTEM WHICH BALANCES FREEDOM AND RESPECT FOR END OF LIFE DECISIONS AND STRICT REGULATION TO PROTECT THE VULNERABLE FROM ABUSE

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A thesis submitted in conformity with the requirements for the degree of Masters of Law

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Masters of Law
Faculty of Law
University of Toronto
2010

Abstract

This thesis proposes a model for legalized Physician-Assisted Suicide [PAS] for adoption into Canadian legislation. The basis of this model is one which respects the individual freedom to make end-of-life decisions free from state interference. The research herein supports the provisions contained in Oregon legislation where PAS has been legalized on the basis that the Oregon model is consistent with the guarantees afforded under s.7 of the Charter of Rights and Freedoms. Oregon maintains strict regulatory barriers which protect against the threat of abuse which the Supreme Court reasoned in Rodriguez outweighed her s.7 rights to autonomy. This thesis will engage in the theories of Ronald Dworkin who supports the preservation of the sanctity of human life which Sopinka J. held prevailed over s. 7 violations in Rodriguez and seeks a model which respects individual freedom without compromising that sanctity or value of life.

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Chapter 1 Introduction to End of Life Decisions

Part one of this thesis addresses the arguments for and against Physician-Assisted Suicide (PAS) drawing from the three main decisions in U.S., U.K., and Canadian case law. Part two analyses the sanctity of life and the right to make autonomous decisions over one’s body arguments and part three supports Oregon law where PAS has been regulated in cases where certain conditions have been met and concludes with a proposed model for adoption into Canadian legislation similar to that of Oregon and the proposed Bill C-384.

PAS is distinguishable from euthanasia since PAS requires the assistance of a doctor at the patient’s request and with the patient’s informed consent. It is differentiated from euthanasia which is described by Ronald Dworkin as ‘killing out of kindness’. Euthanasia involves involuntarily killing a patient in the absence of informed consent. This thesis deals with Physician-Assisted suicide only.

Those opposing the legalization of PAS argue that human life has sanctity and value worth preserving and legalizing PAS compromises that value and sanctity, throwing open the floodgates to abuse, in particular among the aging and disabled. The arguments herein support embracing and respecting the right to autonomy, human dignity and bodily

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integrity and seek to grant the freedom to choose PAS. While there are strong arguments for a ban on PAS, case law in both the United States and Canada provide a compelling rebuttal against the contention that vulnerable people are at risk.

The effect of legalizing Physician-Assisted Suicide is to allow a patient to enlist the assistance of a physician to administer drugs which will intentionally bring about the patient’s death without the physician being prosecuted for murder. It is a controversial debate which has brought about a wide range of arguments ranging from advocacy for its acceptance into legislation (based on fundamental liberty and constitutional rights) to a blanket prohibition based on a detached objection of the state to preserve the sanctity and value of life. This idea of a detached obligation on the state to protect the lives of its people is one Dworkin explores in Life’s Dominion which will be further explored in part III.

This debate has been approached with great caution by courts and legislators since the right to life is one of the most fundamental of rights guaranteed in the Canadian Charter of Rights and Freedoms. The right to life, the freedom to make choices over one’s body and the right to autonomy and bodily integrity are guaranteed under s.7 of the Charter which provides:

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5 Dworkin, Life’s Dominion at 117.
Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.\(^7\)

Section 7 seeks to achieve a balance between liberty rights and protection from abuse. This thesis seeks a model which conforms to s.7 and allows a patient to make choices about death during their terminal illness while protecting the vulnerable from abuse. It can be argued that in guaranteeing the right to life, liberty and security of the person under s. 7 the Charter is also guaranteeing the freedom and privacy to make decisions and choices concerning one’s life and body including the time and manner of death. Each individual should be granted the right to die in a manner they consider to be respectful to their life and given the opportunity to choose not to endure a painful or degrading death. This idea is in conformity with the theories Ronald Dworkin puts forward in Life’s Dominion. Dworkin puts forth the argument that life has a value in itself which is worth protecting but even he allows for exceptions to the argument where death may be more appropriate, he submits that:

Making someone die in a way that others approve, but he believes is a horrifying contradiction of his life, is a devastating, odious form of tyranny.\(^8\)

This submission of Dworkin conforms to the goals behind the s.7 and s.12, provisions which Rodriguez based her arguments on in her fight to lawfully avail of PAS.\(^9\)

\(^7\) Ibid s.7.
\(^8\) Dworkin, Life’s Dominion at 217.
\(^9\) Society
may think it appropriate to prohibit PAS however Dworkin claims that under certain circumstances a prohibition can force a person to die a painful death if they are suffering from a terminal illness. This was the case in British Columbia v. Rodriguez, a case which was ultimately unsuccessful in the Supreme Court of Canada. The research enclosed herein suggests that there is not enough evidence to support a blanket prohibition on PAS since the individual’s right to autonomy outweigh a direct state interference in freedom rights. A ban on PAS is a direct violation and interference in the right to choose whether one dies peacefully or painfully, slowly losing all bodily functions and dignity.

This thesis supports the theory that it is morally wrong to force a terminally ill patient to continue living when treatment is futile and the patient themselves no longer places value on their life and no longer wish to continue living because they are terminally ill. This specifically refers to cases where the patient would commit suicide if their illness did not incapacitate them from doing so unaided.

Living with a terminal illness in itself has been argued that it constitutes a form of torture, an argument rejected by the Supreme Court in Rodriguez. The terminal illness creates an incapacity which prohibits the patient from committing suicide unaided thus; a prohibition on PAS under these circumstances is a direct state interference since the person cannot relieve themselves from their suffering as a non-terminal person can

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9 S.7 guarantees life liberty and the security of the person while s.12 protects against cruel and unusual punishment, Rodriguez argued both sections were violated by a PAS prohibition [see note 40].
through suicide. Chief Justice Rehnquist supported this theory in *Cruzan v Director, Missouri Department of Health*¹¹; Rehnquist believed that Nancy Cruzan’s constitutional right to die arose out of the right not to be forced to be medicated, rather than a right to die. It is a remarkable slant on the debate. The debate centers on not forcing someone to suffer rather than supporting them in a premature death. I agree with Rehnquist C.J. that there is a moral injustice in a society which forces terminally ill patients to endure pain and suffering against their will.

¹¹ 110 S. Ct. 2841 (1990) at 2859 [Cruzan]. Nancy Cruzan was in a persistent vegetative state. Her parents petitioned to the court for the removal of her feeding tube which was initially denied based on a lack of evidence to support that that was what Nancy herself would have wanted. The Missouri Court upheld the standard in the Due Process Clause of the 14th Amendment which states allows a competent person to refuse life sustaining treatment. The court looked for unambiguous evidence from her parents supporting that this was what she would have wanted and the issue in the case was whether a petition could be granted in the absence of such evidence and the court upheld the Missouri decision. The petition was finally granted by the Supreme Court when her parents produced further evidence that she would have wanted life sustaining treatment withdrawn under such circumstances. The decision was based on what the patient would have wanted.
Chapter II Arguments against Physician-Assisted Suicide

In order to properly analyse the PAS debate it is necessary to put forward the arguments both for and against the legalization of assisted suicide.

1) It is argued that Physician-Assisted suicide is contrary to medical ethics & the medical profession.

The medical profession is based on the assumption that doctors heal the sick and traditional views do not include the support for the infliction of harm. This may be true for active euthanasia but is not true for Physician-Assisted Suicide. While it is undisputed that the primary obligation of a doctor is to heal the sick, this obligation is not absolute. Healing the sick does not allow a physician to disregard a patient’s wishes. If a patient does not want to be treated based on the fact that treatment will merely prolong their illness and death is imminent they should be given the opportunity to live the remainder of their healthy life. To be forced to endure the remainder of one’s life suffering with a deteriorating terminal illness seems unjust for the following reason; no doctor has the right to force a terminal illness on a patient when the patient could be relieved of their suffering at a time they can control and sometimes people want to take control of the remainder of their lives rather than their illness taking control of them.

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12 Ibid at 1206.
Under a system which is heavily regulated, it is possible to respect the decisions and wishes of terminally ill patient’s’ who wish to avail of PAS and protect the vulnerable from abuse, such a system in my opinion cultivates a respect in society for doctors and patients alike. It is only when abuse is present that the medical profession loses respect and thus, society’s faith in doctor’s decreases. This can be overcome through heavy regulation and reporting of PAS cases. Kamm comes up with a logical way of reasoning why a physician should be allowed to assist in a suicide without being prosecuted for homicide which does not contravene medical ethics; first, she says a physician may relieve pain. Relieving pain is part of his duty as a doctor and does not violate any professional ethics. Second, a physician may induce pain if the pain is for a better good and if it will help the patient to get better. The third step in Kamm’s moral reasoning is: when faced with two morally problematic ‘evils’ and death is the lesser ‘evil’ then it is morally permissible to choose death.\(^\text{13}\) Thus, when death is the lesser evil, and when the intention is to relieve pain, it is in fact permissible.\(^\text{14}\) Kamm goes as far as justifying her reasoning with the ‘duty argument’. The ‘duty argument’ relies on death being the lesser evil and thus, as a healer of the sick, a physician has a duty to take whatever measures necessary to relieve pain even if that means death. When death is the lesser evil it is morally permissible to treat death as we would treat other evils such as prescribing

\(^{13}\) This was affirmed by the House of Lords in Re A (Children) (Conjoined twins) 4 All E.R. 961, the court approved the surgical separation with the knowledge that one twin would die. Lord Justice Brown applied the defence of necessity in his reasoning for supporting the separation per Ward L.J. at 63 (See R. v. Dudley & Stephens [1884] 14 QBD 273 DC).

marijuana for medicinal purposes. When death is imminent and the patient is in pain a doctor has a duty to relieve the pain in whatever way possible. Rodriguez was unsuccessful in her attempt to lawfully induce death where it was, in her view, preferable to the pain of her illness and imminent loss of dignity.

2) Those against Physician-Assisted Suicide claim that it is an abuse of the physician-patient trust.

The physician-patient relationship is built on a foundation of trust and confidentiality. It may be argued that aiding a person in taking his or her life is an abuse of that trust which undermines the close relationship which has formed. However, the contrary is true. If a patient seeks out information on how to commit suicide effectively and safely, it is their doctor whom they can speak openly and honestly to about their illness, the consequences of treatment and the side effects. The patient can trust their physician to give them correct and accurate information.

A blanket prohibition forces people who are terminally ill to seek out information from other unreliable sources like the internet. The danger in this is that external information can be unreliable, posted online by people not qualified to give an opinion on such matters as suicide. An example of this is abortion. In Ireland, where abortion is strictly prohibited it was written into legislation that physicians could distribute information
regarding abortions abroad.\textsuperscript{15} Prior to this, it was widely known that Irish women went to England for abortions. However, there were a number of underground abortions in Ireland and England in the past which were not performed by physicians and in some cases led to infertility or severe bleeding leading to death. Thus, misguided information is damaging and potentially increases the suffering. In states where assisted-suicide has been regulated, safeguards are in place to protect the vulnerable. A blanket ban in any area promotes a black market, which must not be ignored or avoided. A system which advocates PAS must ensure that assistance is provided only by licenced physicians. Terminally ill patients put their faith in their doctor to be upfront about what lies ahead in the future and what they can expect during the last days of their illness. U.S. Supreme Court Justice Stevens accepts that there would be no breach of doctor-patient trust if a patient was to seek the help of the family doctor and he is of the view that it would not harm the relationship.\textsuperscript{16}

3) There is a fear that terminally ill patients will be persuaded by the financial burden of healthcare & palliative care and for altruistic reasons coerced into premature death against their wishes.

It is argued by those against PAS that the financial burden of palliative and hospice care can lead to undue coercion or duress on a patient to agree to physician-assisted suicide

\textsuperscript{15} \textit{Attorney General v. X} [1992] 1 I.R. 1 led to the Fourteenth Amendment to the Constitution of Ireland lifting a ban on the distribution of information within the state about abortion services in foreign countries.

before they are ready to die. This is a real and substantive argument in the U.S. where there is no established public health care infrastructure to care for the terminally ill, and healthcare expenses fall on the patient and their family. However, this thesis seeks a model which would be practical for implementation into Canadian legislation and the ‘financial burden of healthcare’ argument is not a substantial risk since there is a better established public healthcare system in Canada for Canadians and permanent residents in Canada than in the U.S.

It was reported in 2009 that 98.7% of those who choose to obtain a prescription in Oregon under the *Death with Dignity Act*\(^\text{17}\) had some form of private healthcare insurance.\(^\text{18}\) This evidence rebuts the argument that vulnerable people like the aged or disabled would be coerced into choosing to die based on financial pressures of healthcare of the terminally ill.\(^\text{19}\) This argument is a greater issue in the United States where there is no public health care infrastructure to support the cost of palliative care, an effective public healthcare system like OHIP\(^\text{20}\) can eliminate and at the very least least ameliorate this issue.\(^\text{21}\)

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\(^\text{20}\) Ontario Health Insurance Plan, Health insurance in Canada is delegated on a provincial basis from as per the Canada Health Act R.S.C., c. C-6. Essentially under the program, each person whom qualifies for OHIP can access emergency care and can visit any doctor for free. The program is funded from federal and provincial taxes and is open to permanent residents and Canadian citizens.

\(^\text{21}\) Canada Health Act, R.S.C., c. C-6.
4) The legalization of Physician-Assisted Suicide would lead Canada down the Slippery Slope to Active Passive Euthanasia in the future.

The slippery slope argument claims that if we legalize physician-assisted suicide we open the floodgates to abuse in the future. It is an argument which claims that regulation becomes diluted to the point that we will eventually kill off the handicapped, the poor, the elderly and the terminally ill. The slippery slope argument suggests that in legalizing PAS slowly the boundary separating PAS from passive euthanasia will become hazy to the point that it also becomes legal and acceptable in society.\(^{22}\) An example of this is Nazi Germany where disabled children could be killed with the consent of their Guardian. Racial cleansing moved in and quickly the consent of the Guardian became none existent.

However this fear has not materialized in states where PAS is legalized. In Oregon, where PAS has been legal for over a decade, regulation has not become illusory. The practice is strictly controlled and meticulously monitored. Further, it is reported that approximately two thirds of the people who obtain prescriptions actually use them. This indicates that PAS is a decision people take very seriously and it has not been abused.\(^{23}\) The laws surrounding PAS remain due to awareness of the slippery slope argument combined and strict control and regulation surrounding Death with Dignity prescriptions.


For the terminally ill, the prospect of dying and the fear of the unknown can be the biggest instigator in seeking out PAS. Some individuals who are terminally ill view a Death with Dignity prescription as an insurance policy which provides them with comfort during their illness. They are consoled with the knowledge that they can use the prescription if they need to at a time when they choose. This can be attributed to why only two thirds of patients who obtain prescriptions for PAS actually use them in Oregon. Some terminally ill people merely want comfort during their illness which they find in having a prescription. The prescription alleviates some of the fear of the unknown.

5) It is argued that Assisted Suicide is murder.

PAS is distinguishable from suicide, since death is brought about with the help of another and not by oneself like suicide. The request for help originates voluntarily from the patient themselves and the want to die originates from suffering caused by the terminal illness. The House of Lords confirmed in Airedale NHS Trust v. Bland that a ‘positive act’ differed from an omission and the courts thus justified prohibiting the former (assisted suicide) and not the latter (withdrawal of life-sustaining treatment) on the basis of that distinction, even though both cases would result in the death of the patient.24 In Airedale, the House of Lords authorised the withdrawal of life-sustaining treatment from a seventeen year old teenager who had been one of the victims of the Hillsborough

24 [1993] 2 W.L.R. [Airdale].
As a result of the tragedy Anthony Bland was in a persistent vegetative state [PVS] and medical treatment was futile. Although the issue was not of active euthanasia, the courts made the distinction between withdrawal of lifesaving treatment and euthanasia but failed to address a situation where the request to cut life short came from the patient themselves;

[The law] forbids the taking of active measures to cut short the life of a terminally ill patient.\(^\text{26}\)

In the above extract Lord Keith describes active euthanasia which is involuntary, like murder but assisted suicide is voluntary, with full disclosure and informed consent from the patient which I argue makes PAS permissible and euthanasia unlawful. PAS is a practice which is much more respectful to the person’s life and needs and when practiced correctly is free from abuse and coercion. The House of Lords permitted the lawful withdrawal of life sustaining treatment in \textit{Airedale} on the basis that withdrawal of life-sustaining treatment differed from taking an active measure to cut short Bland’s life since it was an ‘omission’, distinguishable from a ‘positive act’.

There is a distinction between taking someone’s life without consent, whether by an omission or otherwise and aiding a terminally ill patient in their request to end their own

\(^{25}\) The Hillsborough disaster involved a crush in a football stadium during a match. A build up from traffic congestion and control on entrances meant when the turnstiles were open they were not big enough to allow all fans go in at once and people were crushed. The death toll reached 96 after Antony Bland’s respirator was removed. 76 of the victims were 30 years or younger and it remains the most controversial of disasters in English football history which was renowned for crushes and hooliganism since the 1960s.

\(^{26}\) \textit{Ibid} per Lord Keith at 362.
life. They must not be categorized as the same. The distinction lies in the patient’s request to hasten death. The *Airedale* decision demonstrates a slow move toward an ease in the regulation in the U.K. however the Rodriguez case which will be examined later shows a more reluctant approach by the Canadian courts.

Assisted suicide is not murder since the person who seeks assistance in committing suicide no longer places value on their life. The prospect of their life may be one lacking in quality and full of pain and suffering due to terminal illness. Their illness is ‘a means to an end’ and rather than living they are waiting to die since in many cases treatment is futile.

As a consequence of terminal illness the patient no longer experiences the same enjoyment or value from life as they did before they became ill. The value they once placed on life has diminished and they no longer wish to continue to suffer. Like withdrawal of life-sustaining treatment it arises not from a wish to die but from a wish not to suffer. Chief Justice Rehnquist in writing for the majority in *Cruzan* submitted that there was a clear distinction between PAS and withdrawal of life which justified the state’s differential treatment of the two; everyone may refuse treatment however, no one may assist in a suicide. This is where the distinction lies. This thesis is not about whether one has the right to assist in a suicide but rather - one has the right to request the aid of a physician without the physician being prosecuted for homicide. This thesis

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27 *Cruzan* *per* Rehnquist C.J.
argues that in the presence of patient consent, the absence of malicious intent extinguishes any basis for a homicide conviction and validates the assistance requested of the physician.

Traditional academic research advocating a blanket prohibition has focused on the negative connotations of PAS and the position the physician faces when the debate should focus on the patient and their desires. Lamer C.J., in Rodriguez, felt that a complete prohibition was too severe an action for the state to take to achieve the objective of protection from abuse.\(^{28}\) McLachlin J. in her dissenting opinion submitted that these fears about abuse could be easily dealt with under existing provisions in the Criminal Code.\(^ {29}\) Lamer C.J. set out ‘guidelines’ he would follow in order to repeal s.241(b) including that terminally ill patients apply for a court order in order to lawfully avail of PAS.\(^ {30}\) Many jurisdictions like Oregon successfully use court orders and other restrictions and regulations to successfully monitor the practice.

In the New Jersey case *re Quinlan* the physician refused to withdraw life sustaining treatment from Quinlan in the absence of a Court Order.\(^ {31}\) Quinlan collapsed at a party having consumed a large amount of alcohol, aspirin and barbiturates. Her condition was diagnosed as futile, thus her parents sought the removal of life-saving treatment. They


\(^{29}\) R.S.C. 1985, c. C-4. See note 28 per McLachlin J. dissenting at p.8

\(^{30}\) Supra note Lamer C.J. dissenting put forward a constitutional exemption for Rodriguez and others in her case on application to the court for a Court Order provided certain conditions were met, the conditions were similar to that proposed by McEachern J. in the Supreme Court of British Columbia, at p.73.

petitioned to the court to compel the hospital to remove life-sustaining treatment. The removal was authorized in the absence of patient consent. Such cases are distinguishable since Physician-Assisted Suicide allows for the patient to express their own wishes and give consent to administer lethal drugs. On a comparable level, McLachlin J. failed to recognize any distinction between refusal of treatment and assisted suicide. If cases like *Bland* and *Quinlan* can be justified in the absence of informed consent, why do we stigmatise and ban PAS in instances where patient consent is possible? This thesis argues that if withdrawal of life-sustaining treatment can be legal, then on a comparable level PAS is justifiable where requested by the patient since it has already been legalized and reasoned by the court that withdrawal of life is lawful. The distinction between withdrawal of life and PAS is mere timing and consent. Withdrawal of life and PAS both result in death with the aid of a physician. However in PAS cases, the request originates with the patient. For that reason it seems more reasonable to advocate PAS before withdrawal of life since withdrawal of life is open to much more abuse. All of the arguments for and against PAS are applicable to withdrawal of life including protection of the vulnerable, threat of coercion from family members, public policy, pro-life etc. At the end of the day the patient’s wishes should, at the very least, be considered by the physician and if not supported, then the patient should be referred to a physician who will support them in their last days.
Chapter III Arguments Supporting Physician Assisted Suicide

The Physician-Assisted Suicide debate makes three assumptions which differentiate it from cases of ‘active euthanasia’ or ‘withdrawal of life-sustaining treatment’. PAS assumes;

(i) the patient is terminally ill;
(ii) the patient is in unbearable pain and suffering; and
(iii) The patient has explicitly expressed a desire to end his life and seeks help in doing so at such a time in the future as they are unable to commit suicide unaided due to their incurable illness.

These three assumptions are absent in ‘withdrawal of life sustaining treatment’ cases. Canada, the U.S. and the U.K. have acknowledged the legality of withdrawal of life but refuse to legalize assisted suicide. This paper argues that it is more appropriate to legalize PAS since it conforms to the right to autonomy, bodily integrity and human dignity which are guaranteed by s.7.
1. A Prohibition on PAS violates the Right to Autonomy.

In *re Quinlan*\(^{32}\) the New Jersey Supreme Court recognized the right to privacy as protected by the American Constitution. The arguments in the Quinlan case were universal and similar to those made by Rodriguez in the Supreme Court of Canada.\(^{33}\) The treating physician and the hospital refused to withdraw life support and Quinlan’s parents successfully petitioned to the courts to compel the withdrawal of life saving treatment.

The New Jersey Supreme Court ruled that such an act would not constitute homicide since it was distinguishable as an ‘omission’ from a ‘positive action’ which would lead to the death of another.\(^{34}\) It was argued that the right to privacy included a right to die with dignity and the right to refuse life-saving treatment. This is an argument rejected by Sopinka J. in *Rodriguez*.\(^{35}\) The right to privacy was established in *Roe v. Wade*\(^{36}\) in which privacy was a basis for freedom from “state intrusion or coercion, whether by government or by society at large”.\(^{37}\) This argument can be applied herein. The right to autonomy, bodily integrity and the freedoms inherent in those rights should be unencumbered by State intrusion. Imposing a ban on assisted suicide is a direct State

\(^{32}\) 355 A.2d 647 (N.J.), 429 U.S. 922 (1976), [Quinlan].


\(^{35}\) Rodriguez at 99.

\(^{36}\) 410 U.S. 113 (1973), [Roe v. Wade].

\(^{37}\) Gerald B. Cope, Jr., “To be let Alone: Florida’s Proposed Right of Privacy”, (1978) 6 Fla. St. U. L. Rev. 671. See Roe v. Wade, 410 U.S. 113 (1973) and Griswold v. Connecticut, 381 U.S. 479 (1965). Griswold asserted the constitutional right to privacy, prior to this Connecticut had a ban on contraceptives, subsequently the ban was lifted on the basis that it violated a right to marital privacy guaranteed by the Constitution.
interference on freedom rights. While *Cruzan* rejected the *Roe v. Wade* privacy argument as a basis for death with dignity, *Casey v. Planned Parenthood* made arguments for fundamental and constitutional rights to liberty and autonomy. Planned Parenthood argued that the requirement of spousal consent, consent for minors, 24 hour waiting periods and reporting requirements in abortion cases infringed women’s liberty rights guaranteed under the 14th Amendment. A similar parallel can be drawn from the State interference in PAS. The Court in *Casey* ruled that marital consent was an infringement on privacy; however, the other requirements were justifiably constitutional. Inherent in the right to autonomy is the privacy to make autonomous decisions, free from intrusion or interference from the State. This right should be extended to include the right to lawfully request the aid of a doctor in committing suicide.

2. **PAS Respects the Right to Human Dignity and Bodily Integrity over one’s body**

In many cases a loss of human dignity will arise out of terminal illness. Rodriguez claimed that the pain, suffering and psychological torture of her disease violated her s.7 rights guaranteeing her right to life and security of the person and a prohibition on PAS violated s.12 of the Charter based on the reasoning that the suffering she endured due to

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38 *Supra* note 5.
39 505 U.S. 833 (1992)
her disease constituted cruel and unusual punishment.\textsuperscript{40} While this was rejected by the Supreme Court, this thesis supports Rodriguez’s claim and rejects the reasoning of Sopinka J.

The body belongs to the patient, it is therefore the patient’s right to determine how they wish to treat it, whether with artificial drugs or treatment to prolong the disease or otherwise. It is also within the patient’s determination to choose to end their life at a time when they are still able to enjoy life. They can lawfully do this by committing suicide when they are well and able to do so unaided. However, they may wish to end their life at a time when they are unable to cope with the illness and its side effects and many times this is at a stage when they are physically unable to do this unaided.

Some people loathe the thought of being remembered as terminally ill, unable to eat, swallow, talk and (in severe cases) breathe unaided. This was the life Sue Rodriguez, sought to avoid in \textit{Rodriguez v. British Columbia}.\textsuperscript{41} Sue Rodriguez was 42 years old, married, with an eight year old son. She was diagnosed with a degenerative disease and a life expectancy of between two and fourteen months. She did not want to be remembered by her family as being in a vegetative state. Due to her disease she would die from choking, suffocation or pneumonia. She wished to end her life with the aid of a physician at an unidentified time in the future when life became too unbearable to go on.


\textsuperscript{41} \textit{Ibid.}
Respecting a patient’s right to autonomy or human dignity was recognized in *McKay v. Bergstedt*. Bergstedt had made an explicit express desire to end his own life by the removal of his respirator. Bergstedt was the victim of a swimming accident and required the constant care and attention of his father. His father was terminally ill and he did not wish to be cared for by anyone else after his father’s death. The Supreme Court of Nevada held that Bergstedt had the right to refuse treatment and to request to withhold the ventilator knowing that it would bring about in his death. The Bergstedt case was a PAS case under the veil of withdrawal of treatment. He was on life sustaining treatment which he wished to withdraw. However, he was unable to withdraw treatment without external aid. It would appear from this decision that the U.S. courts are slowly moving towards adoption of PAS.

The U.S. courts (like Canadian courts) are prepared to authorize the withdrawal of life support to a mentally incompetent patient; however a higher standard is needed to authorize PAS in a mentally competent patient. This seems unfair. In *Superintendent of Belchertown State School v. Saikewicz* the patient was a 67 year old man suffering from leukaemia. He was incompetent and unable to communicate his desires. The appropriate treatment was chemotherapy. This involves killing the cancer cells and the treatment results in normal cells being killed off, thus the patient immediately becomes sicker, suffers various side effects - anaemia, bladder irritation, depressed bone marrow,

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weakness and becomes susceptible to infection. The judge held that such treatment requires cooperation from the patient, which Saikweicz was unable to provide due to his lack of mental capacity. Based on Saikweicz’s age the probability of a remission was between 30-40%. Considering his lack of competency and cooperation, the side effects of the treatment and the probable success of chemotherapy the judge held no treatment should be administered. Based on a balance of probabilities, the negative effects outweighed the benefits of chemotherapy. Saikweicz’s best interests were not served in forcing medical treatment on him. In many cases, the best interests of the patient are served by ending their life and not by continued treatment. If we apply the rights guaranteed under s.7 to Saikweicz’s case then the individual would be granted the freedom to choose, in Saikweicz’s case he was unable to openly exercise his s.7 rights and thus the courts decided correctly in not allowing state interference in his medical care without his consent. If the court had of taken the position that the courts and state had a detached or derivative interest in preserving life and to allow an individual die prematurely would be wrong then it would have ruled to enforce chemotherapy on Saikweicz.
3. The Right to Life, Liberty and Security of the Person as an argument affirming the right to PAS [s. 7]

The reasoning in *Rodriguez* decision centered around the rights guaranteed under s.7 of the *Charter*, the analysis was two pronged and addressed; first, whether s. 7 was violated and second, whether such a violation could be saved by s. 1.

Rodriguez sought to control the time and manner of her death based on her s. 7 rights. Justice Sopinka held that while there was a violation of Rodriguez’s’ s. 7 rights which was caused directly by the provisions in s. 241(b), the ban fell within in the interests of fundamental justice and therefore refused to grant Rodriguez a constitutional exemption enabling her to avail of PAS lawfully. Justice Sopinka submitted that the suffering caused by the ban was the psychological and emotional stress of not knowing when she was going to die rather than the fact that she could not commit suicide. Justice Sopinka held that while s. 7 afforded the rights of life, liberty and security of the person:

> These interests cannot be divorced from the sanctity of life, which is the third value protected by s. 7. Even when death appears imminent, seeking to control the manner and timing of one's death constitutes a conscious choice of death over life.\(^{46}\)

\(^{44}\) *Per Factum of Rodriguez* at 2 para. 4.
\(^{45}\) *Rodriguez* at 78.
\(^{46}\) *Rodriguez* at 3.
Even if the court accepted Rodriguez’s argument that her interests were violated and she
should be granted a constitutional exemption, she was still choosing death over life, and
traditional societal values protect life and do not advocate or accept self-infliction in any
way.\textsuperscript{47} This is an over generalization. While it may be argued that the ban is in the best
interests of society, it was not necessarily in the best interests of Rodriguez.

\textit{Rodriguez} claimed that the prohibition in s. 241(b) criminalizing assisted suicide violated
her liberty and security interests as protected under s. 7. The intentions behind s. 7 were
to grant the right to make personal and autonomous decisions free from state intervention.
The s. 241(b) prohibition is an example of a direct state intervention on the individual’s
ability to exercise autonomous decisions over one’s body. A s. 7 violation could be valid
if it is consistent with the principles of fundamental justice. Rodriguez argued that the
violation was not consistent with the principles of fundamental justice since the provision
was over-inclusive and not the least invasive way of achieving the means behind the
objective of s. 241(b) which was to safeguard against abuse.\textsuperscript{48} Her needs could have been
met by a constitutional exemption and the safeguards could have been put in place using
a system under which PAS applicants must apply for a court order and decisions are
based on a case to case basis. Justice Sopinka refused to accept that this would be a less
intrusive means of achieving the objective of s. 241(b) and protecting Rodriguez’s s. 7
rights.

\textsuperscript{47} Rodriguez at 81.
\textsuperscript{48} Rodriguez at 55.
Sopinka J. noted that the goal of s. 241(b) was to ensure that the aged, disabled, terminally ill and generally vulnerable people would not be manipulated or coerced into a premature death against their will. Justice Sopinka also sought to avoid the slippery slope argument whereby active euthanasia would surface as a result of legalized PAS. These are all valid concerns however Lamer C.J., dissenting came up with conditions to put in place to safeguard against such abuses and I argue in the presence of such safeguards the violation cannot be saved by s. 1 and the ban is over inclusive.

In addressing whether Rodriguez had the right to make such autonomous decisions privately Sopinka referred to No. 10083/82, R. v. United Kingdom, July 4, 1983 in which the European Commission of Human Rights held that assisted suicide under s.2 of the Suicide Act 1961 was not included in the right to privacy as guaranteed by Article 8 and the Right to Freedom of Expression guaranteed by Article 10 of the Convention for the Protection of Human Rights and Fundamental Freedoms based on societal interest in protecting sanctity and human life.

The majority looked at the case from the viewpoint of society and not from the individual viewpoint of Rodriguez and thus, based his reasons on the fact that society views life as inviolable, intrinsic and sacred and thus he refused to recognize disregarding the

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49 Rodriguez at 8
50 Rodriguez at 99.
protection of life and granting a constitutional exemption which would allow her bring about her own death.

[S]ecurity of the person, by nature, cannot encompass a right to take action that will end one’s life as security of the person is intrinsically concerned with the well-being of the living person. This argument focuses on the generally held and deeply rooted belief in our society that human life is sacred and inviolable to mean that life is seen to have a deep intrinsic value of its own.

Rodriguez argued that her case should be looked on in light of justice and not societal interest. It was certain that due to Rodriguez’s’ illness death would come about through pneumonia, suffocation or choking and while palliative care is available to ease the symptoms she worried that palliative care would not cure her emotional distress. She argued that death was inevitable and the stress of knowing that death was imminent further intensified her emotional distress. However, Sopinka J. disagreed, he reasoned that death was imminent for us all, what was distressing to her was the knowledge that she could not control the time of death.

In reaction to the argument that it was lawful to administer palliative care which sometimes induces death, Sopinka J. accepted that but recognized a distinction between palliative care and assisted suicide. He used a means-end balancing test to reach his decision. The end objective was to safeguard from the fear that elderly and disabled people would be abused under a system where PAS was lawful and did not want Canada
to go down the slippery slope that Holland have gone down, whereby PAS would be legalized in Canada and slowly active euthanasia would come to be widely practiced.
Ronald Dworkin, in his book *Life’s Dominion* argues that human life is sacred and as a society, we place value on the sacredness of human life.\(^{51}\) Dworkin’s reasoning stems from the belief that human life is valuable. If we accept this as absolute, we cannot support abortion or assisted suicide, unless we accept it, save for certain circumstances which in my opinion undermines the validity of the argument.\(^{52}\) Dworkin asserts that human life has subjective value.\(^{53}\) This subjective value arises from the value society places on life; “something is subjectively valuable if someone else desires it”.\(^{54}\) Dworkin refers to life as “sacred” and “inviolable” and points out that some things are incrementally valuable - the more there is the better. This cannot be said for life. Human life is sacred regardless of the quantity of it.\(^{55}\)

Dworkin claims that the intrinsic value present in life is inherent in its sacredness. This value stems from life being independently valuable whether people desire it or not.\(^{56}\) Dworkin uses a Rembrandt painting as an analogy to illustrate this theory. Regardless of whether or not anybody wants to view a Rembrandt painting, if it was destroyed it would

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\(^{52}\) Dworkin: *Life’s Dominion* at 70.

\(^{53}\) Ibid at 70.

\(^{54}\) Ibid at 71.

\(^{55}\) Ibid at 70.

\(^{56}\) Ibid at 71 “something is intrinsically valuable if its value is independent of what people want or desire”.
be a bad thing. This analogy is used to draw a parallel on the argument that whether or not human life is wanted by others it is a bad thing to destroy it.

Dworkin goes further and submits that life in itself has both subjective and objective value. Destroying life kills the objective value of life since it kills the potential of that life and everything it could have achieved or become.

Dworkin explains that entities can acquire value through their history or association.\textsuperscript{57} Therefore, entities acquire value from past achievements, merits and what they have given back to society:

\begin{quote}
...[The w]aste of life is often greater and more tragic because of what has already happened in the past. The death of an adolescent girl is worse than the death of an infant girl because the adolescent’s death frustrates the investments she and others have made in her life.\textsuperscript{58}
\end{quote}

If we are to accept this argument then the closer to old age we get, the more we achieve. Physician-Assisted Suicide would therefore amount to a frustration of those achievements.

Dworkin agrees that in certain circumstances killing can be justified, for example when two lives are in conflict with one another. Dworkin goes even further submitting that society has an obligation to respect the choices of others;

\textsuperscript{57} Dworkin: \textit{Life’s Dominion} at 74.  
\textsuperscript{58} Dworkin: \textit{Life’s Dominion} at 211.
…[A] decent society…will allow and ask its citizens to make the most central, personality defining judgments about their own lives for themselves.  

This is at the heart of the argument. Society should respect the privacy and choices of others. Inherent in this statement is Dworkin’s central argument in Life’s Dominion that the State has no right to interfere in these rights. Dworkin identifies a number of misperceptions in the ‘right to life’ and ‘right to autonomy over one’s body’ debate. He explores these concepts in Life’s Dominion with regard to assisted suicide and abortion. The misperceptions he identifies derive from the different ways we view the value and sanctity of life. The first set of assumptions assumes that killing in itself is wrong, regardless of the circumstances, whether this be as a result of an abortion or through assisted suicide. This set of values assumes that all life is valuable whether it is a foetus or an old man and morally it is wrong for anyone to interfere in this, this assumes that life is a gift from god and we have no place in the frustration of life. This he calls the ‘derivative objection to abortion’.  

Someone who believes in the derivative objection believes that all life regardless of its age has value and interests in living which the state should protect. This is the position taken by Sopinka J. in Rodriguez. Sopinka J. sought to protect life through the s.241(b) prohibition, the minority disagreed with his reasoning and submitted that a prohibition was an interference in an individuals rights and that protection from abuse could have been achieved by less severe means than the s.241(b)

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60 Dworkin, Life’s Dominion at p11.
prohibition. The second misperception identified by Dworkin assumes that abortion is morally wrong and that life has intrinsic value but someone who agrees with Dworkin’s assertion believes that the government has ‘detached grounds’ for prohibiting abortion based on life’s intrinsic value. Dworkin uses the Cruzan case to distinguish the difference between derivative and detached grounds.\textsuperscript{61} The Missouri Supreme court held that they could keep Nancy Cruzan alive, against her parents’ wishes and against evidence supporting Nancy’s wishes not to be sustained in a persistent vegetative state. The court based its decision on the fact that it was a bad thing when anyone dies prematurely or deliberately even if that was against their own interests.\textsuperscript{62} Scalia J. held that the state had an interest in preventing the deaths of its citizens even if they thought that they had a right to die and that decision did not depend on the patient’s own wishes. This thesis disagrees with this on the basis that disregarding an individual’s own interests and wishes is a blanket contravention of their s.7 rights and the state has an obligation, at the very least to consider a patient’s wishes on application for a Court Order for an assisted suicide or withdrawal of treatment.

If we agree with Scalia J.’s opinion then in the interests of preservation of life and the governments detached interest in life we should criminalize suicide on the basis that it frustrates the value of life and is necessary to preserve life. Based on Scalia J. and Dworkin we can justify this on the basis that it is not always necessary to take into account a person’s own wishes. While suicide has been decriminalized, assisted-suicide

\textsuperscript{61} Cruzan see note 11.
\textsuperscript{62} Dworkin, Life’s Dominion, at p12.
carries a sanction. Rodriguez claimed that in decriminalizing suicide and criminalizing assisted suicide she was placed at a disadvantage based on her illness and disability which infringed her autonomy and equality rights. She argued that the s. 241 prohibition violated her right to equality on the basis that her illness disabled her from committing suicide. This is a widely supported argument and was accepted by Sopinka J. however it was held that the violation was saved by the Limitations clause of s.1. of the Charter.

Justice Dickson in *R v. Big M Drug Mart* acknowledged the necessity of a society which recognizes an individual’s freedom to express themselves based on a model ‘free’ society, whether that be based on religion or otherwise;

...[A] truly free society...can accommodate a wide variety of beliefs, diversity of tastes and pursuits, customs and codes of conduct. A free society is one which aims at equality with respect to the enjoyment of fundamental freedoms and I say this without any reliance upon s.15 of the *Charter*.

PAS recognizes the individual’s right to choose to make their own decisions when faced with a terminal illness. This decision will vary from person to person since each individual will place a different weight on moral and religious beliefs and past experiences. As an example, Big M Drug Mart was charged with trading on a Sunday

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63 R.S.C., 1985, c. C-46, s.241; R.S., 1985, c. 27 (1st Supp.), s.7. s. 241 prohibits aiding and abetting a suicide.
contrary to the *Lord’s Day Act 1906*66 which prohibited carrying out business on Sundays.67 The legalization was struck down as unconstitutional since it infringed the right to freedom of conscience and religion and such a secular religious based restriction was unlawful. This decision demonstrates the notion that people should be granted the freedom to make decisions of personal and intimate nature, like PAS which is an intimate decision. Thus, support for PAS will vary based on an individual’s religious and moral beliefs. Rather than support PAS, this thesis seeks to support the freedom to choose whether or not to avail of PAS when faced with a terminal illness.

Freedom rights are the most fundamental rights guaranteed by the Charter. In attacking the constitutionality of enforcing the continuation of Cruzan’s life sustaining treatment, Stevens J. dissenting, submitted that not granting a person the freedom to choose the time and manner of their death was a violation of the sanctity of their life based on the fact that different people value different qualities of life. They have the freedom to choose the quality of life they have and the freedom to choose if they wish to continue to live as they are or to commit suicide and end their suffering. This is the freedom individuals have if not incapacitated from a terminal illness.68 The value of life will vary depending on the enjoyment of life and the ability one has to enjoy life. Stevens J. submitted that ‘in [his] view, the Constitution requires the state to care for Nancy Cruzan’s life in a way that

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67 Supra note 64.
respected her own best interests.69 Canadian courts respected this notion of ‘patient autonomy and best interests’ in Nancy B. v. Hotel Dieu de Québec. Does this name need QCA??70 when they authorized the removal of a respirator from a patient whose treatment was futile.

Nancy B was informed that her disease would result in the loss of full motor nerves and treatment was futile. She applied to the court for removal of her respirator. I argue that in terms of terminally ill patients there is little difference between a patient on chemotherapy drugs to treat their disease and a patient in a persistent vegetative state on a respirator, both are terminally ill, both receiving treatment which may prolong the illness but is ultimately futile. On face value there is little distinction separating them. They are both going to die, however at law the distinction means one patient suffers unbearable pain and suffering until their disease kills them and the other patient may be set free from the machine keeping them alive and escape the pain and suffering. The difference is in control of suffering and the patient controls the time of death as opposed to the disease controlling the patient.

69 Cruzan per Stevens J. dissenting.
70 Nancy B. v. Hotel-Dieu de Québec et al. (1992), 86 D.L.R. (4th) 385 (Québec Superior Court).
Chapter V Autonomy as a Right to PAS

This thesis takes the position that life, regardless of where it originates from, is the person’s own possession and thus they have the right to decide how their body should be treated and how to live their life. Thus, a person is not trapped in their own body and should be allowed to decide whether life is too unbearable to continue living when faced with a terminal illness which incapacitates them.

*Re Conroy* claims autonomous decisions require clear communication and knowledge of the patient’s desires and wishes. This is problematic for PVS patients who cannot articulate their desires and wishes for treatment. In numerous PVS cases withdrawal of life support with the intention of hastening death has been approved by the courts, yet courts are still reluctant to allow PAS in the presence of informed consent.

*Conroy* identifies two types of tests. The first test is the ‘limited objective test’ which allows treatment to be withdrawn when there is some proof that the patient would have rejected the treatment. The second test is the ‘pure objective test’ which weighs up the

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71 98 N.J. at 342 n.1, 486 A.2d 1209 (1985).
73 Cruzan and Airdale ruled this.
74 *Supra* note 71.
benefits and burdens in the absence of knowledge of the patients desires. This is an individualized test which assesses what the patient may have wanted.\textsuperscript{75}

The problem here lies in respecting autonomy and deciphering what a reasonable person would have wanted, which may not necessarily be what the particular patient would want. Should we subject everyone to a reasonable standard regarding such intimate decisions or should such decisions be explored on a subjective basis consistent with liberty interests? This thesis suggests not. In implementing an objective test in which each patient decides for themselves at a time when they are competent to do so appears to align with the freedom rights laid down in the Charter. This paper supports a system based on this reasoning.

The problem with a pure objective test based system is how to be certain that relatives ‘know’ what their loved one would have wanted? Family opinions may be distorted by financial burdens or biased interests. For example, in the U.S. the burden of palliative care may lay on patient’s relatives who cannot afford it. A solution to this problem is to let the patient decide for themselves and not involve the family in the decision making process, thus eliminating the possibility of external influences on the decision and to discuss PAS with the patient at an earlier stage when they are coherent and able to express their wishes for the future.

\textsuperscript{75} Supra note 71.
Chapter VI The Right to Life and Freedom of Choice in a Canadian Context

Canadian law prohibits any act which intends to end the life of another under s. 14 of the Criminal Code;

No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.\textsuperscript{76}

Mercy killings and assisted-suicides are unlawful in Canada, the leading Canadian case in the area which this thesis will draw from is \textit{Rodriguez v. British Columbia}.\textsuperscript{77}

Canadian law goes further into prohibiting assisted suicide under s.241 of the Criminal Code which expressly prohibits aiding suicide in the context of which it is considered in this paper:

\begin{quote}
241. Everyone who
(a) counsels a person to commit suicide, or
(b) aids or abets a person to commit suicide,
Whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.\textsuperscript{78}
\end{quote}

\textsuperscript{76} R.S.C., 1985, c. C-46.
\textsuperscript{78} R.S.C., 1985, c. C-46, s.241; R.S., 1985, c. 27 (1\textsuperscript{st} Supp.), s.7.
This provision of the Criminal Code imposes a hefty maximum sentence on PAS. Rodriguez argued that the ban in itself constituted cruel and unusual punishment under s.12 of the Charter. Taking from arguments made by Rodriguez and from R. v. Smith79 there may be an argument that the mandatory sentence in itself constitutes cruel and unusual punishment. The fourteen year punishment in itself seems excessive in addition to disciplinary proceedings from the Medical Council for assisting in a suicide.

Section 241(b) as a safeguard from abuse

Section 241 was challenged in Rodriguez v. British Columbia.80 Rodriguez sought an order declaring s.241(b) of the Criminal Code invalid.81 The Supreme Court of Canada upheld the constitutionality of s.241 on the basis that section 241 was intended to protect the rights of vulnerable people similar to Rodriguez. The court accepted it had a duty to protect vulnerable people who were at risk from premature death when they do not truly desire it. Rodriguez claimed the prohibition on assisted suicide violated her liberty rights guaranteed under s.7:

Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.  

Section 7 grants life, liberty and security of the person, thus, it can be inferred that one should have the freedom to choose how to live their life and what to do with it, free from state interference. Rodriguez did not wish to continue living based on the quality of life she was faced with. She wanted to commit suicide and end her pain and suffering, she did not want to lose her dignity and bodily integrity which was imminent. Rodriguez argued that she was discriminated against on the basis that her terminal illness placed her in the category of ‘disabled’ or ‘handicapped’ which contradicted her right to be treated equally since if she were not ill she could commit suicide lawfully:

[W]ery individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Rodriguez argued that her disability amounted to discrimination under s.15 since suicide has been decriminalized. She wished to end her suffering at a time when the pain became too unbearable to continue living. If Rodriguez committed suicide she would not be penalized however if she sought assistance in committing suicide from her doctor or

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83 Suicide is decriminalized, had Rodriguez committed suicide she would not have been subject to a criminal sanction. See Wayne R. LaFave & Austin W. Scott, Jr, *Substantive Criminal Law* §7.8 at246 (1986), Catherine D. Shaffer, “Criminal Liability for Assisted Suicide”, (1986), 86 Colum. L. Rev. 348 at 350.
84 Ibid.
husband, they would be criminally charged and penalized. This argument failed since it was the only means of achieving the objective and was thus saved under the Limitations Clause. Cory J. dissenting submitted that the right to die was a protected right under s.7.\textsuperscript{85} Thus, it was held that the criminal ban on suicide was not unconstitutional since it fell within the Limitations Clause of s.1.

Sopinka J. in writing for the majority rejected the s.15 argument. For the purposes of his reasoning he assumed that Rodriguez had been discriminated upon under s.15. The next step in Sopinka J.’s methodology was to ascertain whether discrimination under s.15 could be saved by the Limitations Clause in s.1 of the \textit{Charter}.\textsuperscript{86} He accepted that the ban on assisted suicide infringed on Rodriguez’s right to security of the person and that infringement was a significant source of psychological stress to Rodriguez but he submitted that a breach was valid under the Limitations Clause.

Sopinka J. reasoned that a ban on PAS, while it violated Rodriguez’s s.15 rights, was valid on the basis that the s. 241(b) safeguards protected persons over whom others may wish to control for the reasons set out in part I of this thesis. He held that an exception to s.241(b) which would permit Rodriguez to lawfully avail of assisted suicide would lend support to passive euthanasia and even if there was an exception for terminally ill patients, there would be no guarantee that it would be limited to those who genuinely

\textsuperscript{85} \textit{Supra} note 1. \textit{See} note 33.

\textsuperscript{86} Section 1 reads: The \textit{Canadian Charter of Rights and Freedoms} guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society. \textit{Supra} note 1.
wished to die themselves free from outside influence or coercion. Sopinka J. considered the safeguard of s.241(b) to be necessary and the ban was thus justifiable under s.1 on this basis. In response to the guidelines proposed by Lamer C.J, Sopinka J. held that the guidelines were vague and unenforceable in parts.

In response to her s.12 argument that the prohibition caused psychological stress which along with the effects of the disease constituted cruel and unusual punishment, he held that such suffering did not fall within the meaning of s.12 and rejected her argument on these grounds. The argument turned on the meaning of ‘treatment’ rather than the meaning of ‘cruel and unusual’. The ‘ban’ itself which was imposed by s.241 (b) did not fall within the meaning of ‘treatment’ as intended in the s.12 protection. The court compared the ban to castration of sex offenders and lobotomy and drew from R. v. Smith in its decision. Lamer C.J. in R. v. Smith struck down the mandatory 7 year sentence for drug importation. Smith arrived in Canada via Bolivia in possession of 7 ounces of cocaine. The mandatory sentence under the Narcotics Control Act was challenged on the basis that it violated s.12 of the Charter and was ultimately successful. While the 7 year sentence achieved the effect of deterrence of drug trafficking into Canada it was grossly disproportionate to the offence Smith committed and under s.1 the provision was struck down. In Rodriguez, Lamer C.J. felt that the ban in itself did not constitute cruel and unusual punishment within the meaning of s.12 as it did in R. v. Smith.

[1987] 1 S.C.R. 1045.:
C.R.C., c. 1041. See note 1.
Chapter VII The Constitutional Liberty Right to P.A.S.

Under the 14th Amendment to the United States Constitution

The 9th and 2nd Circuit Courts in the U.S. recognized a constitutional right to Physician-Assisted suicide in Washington v. Glucksberg and Vacco v. Quill. The Second Circuit Court considered PAS to be on a par with withdrawal of life sustaining treatment. The Ninth Circuit Court saw little distinction between the patient and the physician administering the drug. People assume it turns on moral reasoning but the issue runs deeper than that. “We must not let PAS be a ‘quick, cost effective way of ending serious, complex problems’ ”. The Ninth Circuit Court saw little distinction between the patient and physician administering the drug. The basic argument of Dworkin

[A] decent society … will allow and ask its citizens to make the most central, personality defining judgments about their own lives for themselves.

This is central to this thesis and it is a theory closely related to the dissenting opinions of McLachlin J. and Lamer C.J. in Rodriguez. Rather than advocating a system which
encourages suicide in moments where people are faced with fear and the challenges of a terminal illness, this thesis seeks to advocate a system which embraces individual freedom and the guarantees of s.7 which respects the decisions of an individual concerning their own body regardless of whether we are in agreement with that decision or practice. In short, it is less about suicide and more about allowing the person decide what happens to their body, free from state interference. In prohibiting assisted suicide the state is directly interfering in the rights of the citizen. This is a theory Dworkin develops in Life’s Dominion. He agrees that life and death decisions should be free from state intrusion. For example, abortion is less about killing and more about respecting the woman’s right to choose what happens to her body and respecting her autonomy and bodily integrity. There is an over-focus on death in the PAS debate and those against it argue it is murder. The debate is more about respecting the freedom to choose than about killing and we, as a society, have a duty to respect the decisions of others whether we think it is a frustration of human life or an insult is irrelevant on an individual level. On a collective level, rather than judge, we merely have a duty to protect against abuse and ensure the system runs accordingly.

Rehnquist C. J. submitted in *Cruzan*\(^96\) that the constitutional right to die arose from the right not to have medication forced on you rather than a right to autonomy over one’s body.\(^97\) He made a valid distinction between the ‘withdrawal of life saving treatment’ and ‘assisted-suicide’ remarking that everyone has the right to refuse treatment but no one


had the right to assist in a suicide. While I accept this, I submit that no one has a right to assist in a suicide but everyone has a right to request medical aid in committing their own suicide when they are terminally ill. This does not mean there is any obligation on a physician to accept the request. It is not unlawful to solicit help and in my opinion, help should come only from a doctor who is medically capable of helping safely. Rehnquist C.J.’s analysis comes down to causation and intent and thus he rejects the notion that any fundamental liberty interest lay within the Due Process Clause of the Fourteenth Amendment. Cruzan recognized the liberty interest in assisted-suicide which existed for competent people. In dissenting Stevens J. in Cruzan saw little distinction between withdrawal of treatment and hastening death. Empirical evidence shows that 22,500 Dutch deaths arise out of non-treatment decisions while 3,700 arise from physician-assisted suicide and euthanasia. Thus, the evidence suggests people exercise autonomy in different ways and many choose to withdraw from treatment or to forgo treatment in order to bring about a natural death and there is no evidence of abuse of the process or lax regulation resulting in higher numbers of deaths.

98 Supra note 97 at 790. Rehnquist C.J. acknowledged the difference between the facts of Cruzan and Washington, one was a passive and the other an active action toward hastening death. Rehnquist recognized that while many rights are protected under the Due Process Clause, it did not automatically mean all liberty rights and autonomous decisions were protected under the Clause. See John Keown “No Constitutional Right to Physician Assisted Suicide?”, 56:3 Cam. L. J. 506 (1997).
99 U.S.Const. amend. XIV §1.
100 Supra note 97.
101 Supra note 96.
The subject is approached with caution by courts. The House of Lords approved withdrawal of life support in the United Kingdom in *Airedale NHS v. Bland*. In contrast, in the *Cruzan* case, the lower courts recognized the federal and constitutional right to the removal of life sustaining treatment for a patient in a persistent vegetative state. However, the Missouri Supreme Court reversed the lower court’s decision claiming that since Nancy Cruzan was in a permanent vegetative state, she was unable to make any judgment as to withdrawal from treatment; it was in the federal courts that withdrawal of life sustaining treatment was finally approved. The courts appear to be stricter on PAS than withdrawal of life cases.

Courts appear to be slowly moving toward a system which recognizes the right to choose death when faced with a terminal illness or in cases where treatment is futile. Chief Justice Rothstein in *Compassion in Dying* submitted that the ‘due process clause’ as interpreted in *Planned Parenthood v. Casey* protected personal decisions involving an individual dignity and autonomy. Rothstein C.J. recognized the right to the withdrawal of life saving treatment as per *Cruzan*. Rothstein C.J. submitted that the statute prohibiting physician-assisted suicide violated the Equal Protection Clause since it discriminated against terminally ill people who could not commit suicide unaided. In

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103 [1993] 1 All ER 821 HL.
108 *Supra* note 106 at 199. See note 104 at 1462-66.
her view the decision in *Cruzan*\(^{109}\) supported the argument that the right to die was a right inherent in the ‘due process’ liberty interest.\(^{110}\) Minor J. in *Quill v. Vacco*\(^{111}\) refused to acknowledge a distinction between the withdrawal of life sustaining treatment and Physician-Assisted Suicide which would justify the legalization of one and not the other. Both PAS and the withdrawal of treatment in circumstances like in *Cruzan*, hasten death at the hands of a physician.\(^{112}\) The court held in *Quill* that the state had an obligation and duty to protect all citizens which did not constitute grounds for distinguishing between terminal patients requesting withdrawal of treatment and non-terminal patients requesting physician-assisted suicide.\(^{113}\) Cory J. dissenting in Rodriguez found no distinction between the refusal of treatment and PAS which justified the unequal treatment of one and not the other.

\(^{109}\) *Supra* note 107.

\(^{110}\) *Supra* note 106.

\(^{111}\) 80 F. 3d 716 (2d Cir. 1996).

\(^{112}\) *Supra* note 106 at 202.

\(^{113}\) *Ibid.*
In 1997, Oregon became the first state to legalize Physician-Assisted Suicide and still remains the only state in the United States in which it is legalized despite unsuccessful attempts at reform in the states of California and Washington.\footnote{Death with Dignity Act 1997.} Evidence shows that in Oregon physicians follow the regulations which have been put in place.\footnote{Supra note 115 at 336.} There is no evidence from reports that the system has been abused in the manner described by Sopinka J. in Rodriguez or that any of the patients who availed of Death with Dignity did so involuntarily.

While it is evident that the law will recognize a right to die, it is still reluctant to recognize any positive action which leads to death. Other countries have not legalized PAS, even though it remains permissible to prescribe large doses of pain relievers with the knowledge that the dosage will hasten death.\footnote{Supra note 115.} Liberal countries where this is permissible include; Switzerland, Denmark, Germany, Finland and the United Kingdom.\footnote{Supra note 115 at 336.} In rejecting the guidelines submitted by Lamer C.J., Sopinka J. claimed that they were open to abuse and not as concrete as those imposed by the proposed Bills put
forward in California and Washington. In countries where PAS has been regulated, including Oregon, the governments have focused on regulation and channelled efforts into well-developed palliative care and hospice treatment.

Oregon legislation has imposed the following requirements to lawfully obtain a lethal prescription under the *Death with Dignity Act*;

1. The patient must be an Oregon resident.
2. The patient must be diagnosed with an incurable disease.
3. The disease must be diagnosed as terminal with a probable life expectancy of six months or less
4. The patient is required to make two oral and one written request and there must be fifteen days between the first and second request to be eligible.
5. The patient must be mentally competent to make such request.

There was an attempt to legalize PAS in both Washington State and California which were unsuccessful. *Washington v. Gluckberg* argued the right to assisted-suicide fell under the Fourteenth Amendment Due Process Clause since it was a liberty interest. Section one of the Fourteenth Amendment states;

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118 Initiative 119.
Again, to reiterate, the debate turns on the interference of the state in an individual’s freedom rights rather than protection of the vulnerable or public policy issues of PAS. Gluckberg was a physician who used the Due Process Clause of the Fourteenth Amendment to challenge the constitutionality of the law\textsuperscript{121} on the basis that assisted suicide was a liberty interest protected under the Fourteenth Amendment and thus the provision of the \textit{Natural Death Act 1979}\textsuperscript{122} which prohibited assisted suicide was unconstitutional. The case went to the Supreme Court and the court assessed whether the protection offered under the Fourteenth Amendment extended to assisted-suicide.

The Ninth Circuit Court of Appeals held that the ban was a violation of the Fourteenth Amendment, that decision was subsequently overturned in the Supreme Court by Rehnquist C.J.

The Death with Dignity legislation was challenged again by the \textit{Ashcroft Directive} in 2001.\textsuperscript{123} Attorney General Ashcroft during his term in the Bush Administration attempted to suspend the licence of any physician who prescribed lethal drugs for the purposes of

\textsuperscript{120} U.S.Const. amend. XIV §1.
\textsuperscript{121} \textit{Ibid.}
\textsuperscript{122} [1979 c §112 1,] Chapter 70.122 RCW.
suicide on the basis that it was prohibited by the *Controlled Substances Act*. The attempt was ultimately unsuccessful. Under the *Controlled Substances Act* the Attorney General was granted the right to suspend the licence of a physician suspected of supplying prescriptions contrary to the general interest of the public. Ashcroft believed that PAS was against the interests of the public and attempted to interfere in the provisions in the Death with Dignity Act through the power granted to him under the *Controlled Substances Act*. This power allowed the government to interfere in regulation generally reserved to State law. The attempt was ultimately unsuccessful.

**Bill C-384**

There was an attempt in Canada to introduce a Bill *Death with Dignity Act* similar to the Oregon one by Francine Lalonde MP in May 2009. Lalonde had introduced an identical Bill in June 2008 and a similar Bill in 2005, all of which were unsuccessful. The Bill was defeated in the House of Commons: 228 votes to 59 (75% voted against the Bill). The Bill is similar to Oregon’s *Death with Dignity Act*; it amends s. 222 of the Criminal Code which penalizes homicide and s. 241(b) which regulates aiding and abetting suicide. The Bill amends s. 14 of the Criminal Code which states that no person can consent to have death perpetrated on them by another person to include exceptions under

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124 21 USC Sec. 801 01/22/02  
125 *Ibid*  
127 *Supra* note 63.  
128 *Supra* note 63.
s. 222 and s. 241(b). Section 222 would be amended to include the exception of an adult over 18 years of age suffering from a terminal illness that is in severe pain. The provision includes regulations and restrictions on the availability of PAS under s. 241(b). Section 241(b) would be amended to include the following exception:

(2) A medical practitioner is not guilty of an offence under this Act by reason only that he or she aids a person to commit suicide with dignity, if

(a) The person who commits suicide meets the conditions set out in paragraph 222(7) (a); and
(b) The medical practitioner meets the conditions set out in paragraph 222(7) (b).

(3) For the purposes of paragraph (2), “medical practitioner” means a person duly qualified by provincial law to practice medicine.129

The exception includes such restrictions and conditions similar to Oregon’s Death with Dignity Act, however, unlike Oregon law, the provision is not restricted to Canadian citizens. It is unclear whether it would be restricted to permanent residents as is the case in Oregon or whether it would be open to people from other jurisdictions traveling across the border as is the case in Switzerland. The Bill is in conformity with the arguments set forth in this thesis however it was unsuccessful in the House of Commons; it is unclear whether if it were put to the people in a referendum the outcome would be the same.

Lorraine Weinrib advocates that legislators address the PAS debate with a view to respecting individual autonomous decisions with respect to end-of-life decisions and disregard that legislators base their reasoning on abstract ideals of the sanctity and value

129 http://www2.parl.gc.ca/HousePublications/Publication.aspx?Docid=3895681&file=4
of life and a societal ideal.\textsuperscript{130} This is contrary to the majority’s view in Rodriguez. The majority advocate a system which conforms to society’s generalized view of the sanctity of life. The majority go so far as recognizing a right to refuse treatment by a competent person and withdraw treatment of an incompetent patient, all of which result in the same outcome – death, however the majority would not go so far as to recognize a right to assisted-suicide.\textsuperscript{131}


\textsuperscript{131} \textit{Ibid} at 3.
Conclusion

In conclusion, Oregon has constructed a system which respects the rights guaranteed under s. 7, rights which this thesis argues are violated by a ban on PAS. It has implemented a system stricter than that of Lamer C.J. or Bill C-384. Oregon legislation achieves a balance between respecting the right to autonomy and human dignity and regulation to prevent abuse of the vulnerable, aged and disabled.

The success of the Oregon system suggests that freedom rights need not be sacrificed and it is possible to choose the timing and manner of one’s death, meanwhile maintaining strict regulatory control in the area. This could be achieved in Canada by following guidelines similar to those implemented under Oregon law. The restrictions brought in under Oregon legislation are a suitable base to follow since they strike a balance between respecting ‘end of life’ choices and protection of the vulnerable.

It is imperative not to lose sight of the vulnerable people the Rodriguez decision seeks to protect when attempting to achieve respect for end of life choices. The slippery slope argument is a real and substantial danger which should be addressed through strict monitoring and control of assisted suicide laws. Jack Kevorkian and his ‘euthanasia device’ is a prime example of how PAS can be abused. The controversial Kevorkian
should be distinguished from cases like *Quill*\textsuperscript{132} since Kevorkian neither did he know the patients previous to the assisted suicide request nor were they terminally ill. This is a clear abuse of the respect which this thesis seeks to advocate. In contrast, *Quill* had a relationship with his patient; he advised her where to find information on how to commit suicide and then wrote her a prescription which she took some months later. The courts held that Quill’s patient had the right to die with assistance however Kevorkian’s patients did not have the same right and the state was under a duty to protect such vulnerable people from abuse. The State’s duty to protect Quill’s patient was diluted since she was mentally competent to make the decision to terminate her own life herself.\textsuperscript{133} *Compassion for Dying* supports the direct involvement of a physician which would provide the safeguards necessary to protect against abuse.\textsuperscript{134}

As has been noted in the arguments herein, the House of Lords, the U.S. Supreme Court and the Supreme Court of Canada have acknowledged the legality of withdrawal of life support in an incompetent person. I argue that the case for a competent person is stronger since they can consent to physician-assisted suicide and I believe that this is inherent in our right to autonomy, our right to life and the right to choose to live that life with a terminal illness. My arguments claim that this category of people are unfairly discriminated against since mentally incompetent people can have their death hastened in the absence of informed consent by committing suicide and we as a society have a duty to


\textsuperscript{134} Supra note 104. See Breezer J. dissenting.
respect the individuals freedom and liberty to choose not to live the remainder of their life with a terminal illness.

Using guidelines based on Oregon’s *Death with Dignity Act* there is no reason why people like Rodriguez cannot have their wishes respected meanwhile maintaining the duties and obligations necessary to protect the vulnerable and the weak. I seek a system which respects value and sanctity of life and embraces the individual liberty to treat one’s body in accordance to one’s own belief whether that be based on religion or otherwise.

I put forward the conditions imposed under the Oregon legislation and those submitted by Lamer C.J. in *Rodriguez* in defence of the concerns raised by Sopinka J. and with the purpose of safeguarding those who are vulnerable and susceptible to coercion and manipulation in end-of-life decisions.