ASSISTED SUICIDE AND THE NOTION OF AUTONOMY

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Objections to the criminal prohibition against euthanasia and assisted suicide are commonly framed in a number of ways, including the perceived threat to vulnerable persons (slippery slope), the sanctity of life, an affirmation of the proper role of the physician in the clinical relationship or the anomaly that is seen to be created by the legality of suicide and refusals of life-sustaining treatment. A different type of objection is proposed which focuses on the limits to autonomous decision-making which typically accompany suicidal intentions.

It is argued that a criminal prohibition against assisted suicide is justified by doubts about the state of the suicidal individual's understanding, freedom from coercive influences and ability to rationally evaluate his or her situation. While the law may not view one's own suicide as helpfully dealt with by the criminal law, the participation of another, in lending assistance to a suicide, is an appropriate object of criminal sanction. It is conceivable that one contemplating suicide could both make this decision in an adequately autonomous way and also require assistance. However, the difficulties inherent in determining whether a particular suicidal decision is sufficiently autonomous, coupled with its grave and irrevocable consequences, justify a general criminal ban on acts which promote the suicide of another. Decriminalizing such assistance would threaten to abandon suicidal persons to their own potentially inadequate capacity for self-determination at an especially vulnerable time, inviting tragic and irretrievable mistakes.

Les personnes qui sont en faveur de la prohibition criminelle de l'euthanasie et du suicide assisté invoquent plusieurs arguments, dont la menace que la décriminalisation présenterait pour les personnes vulnérables (l'argument du doigt dans l'engrenage), le caractère sacré de la vie, l'affirmation du rôle que devrait jouer le médecin dans le cadre de la relation médecin/patient ou l'anomalie que l'on semble créer en légalisant le suicide et le refus de recevoir un traitement essentiel à la vie. On avance un autre type d'argument qui est axé sur les limites de l'autonomie décisionnelle de la personne qui a des intentions suicidaires.

Certaines personnes prétendent que la prohibition criminelle du suicide assisté est justifiée en raison des doutes que l'on peut entretenir quant à la faculté de comprendre de la personne suicidaire, au fait qu'elle soit libre de toutes contraintes et à sa capacité d'évaluer sa situation de façon rationnelle. Bien que le droit criminel ne règle pas de manière adéquate la question du suicide, la participation d'une tierce personne qui en aide une autre à se suicider fait à juste titre l'objet d'une sanction criminelle. On peut concevoir qu'une personne qui envisage de se suicider prenne cette décision de façon tout à fait autonome et ait aussi besoin d'aide. Cependant, les difficultés inhérentes à la détermination de la question de savoir si une décision de suicide est prise de façon suffisamment autonome, ainsi que les conséquences graves et irrévocables de cette décision, justifient une interdiction générale des actes qui encouragent le suicide d'une autre personne. En décriminalisant l'aide au suicide, on risque de laisser les personnes suicidaires à leur propre capacité de disposer librement d'elles-mêmes, qui pourrait bien être inadéquate, à un moment où elles sont particulièrement vulnérables, et de provoquer ainsi des erreurs tragiques et irréparables.

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TABLE OF CONTENTS

I. INTRODUCTION 3

A. *Assisted Suicide and Active Voluntary Euthanasia* 5
B. *A Right to Die?* 5

II. AUTONOMY IN LIFE-ENDING DECISIONS 7

A. *Refusal of Life-Sustaining Treatment* 7
B. *Suicide* 12

III. ARGUMENTS AGAINST ASSISTED SUICIDE 12

A. *The Sanctity of Life* 13
B. *Risk of Abuse and "Slippery Slope"* 13
C. *The Role of the Medical Profession* 16
D. *The Patient Has a Skewed Appreciation of His or Her Own Situation* 17
E. *Refusing Life-Sustaining Treatment is Morally Distinct from Suicide* 17
F. *Killing is Morally Distinct from Letting Die* 19
G. *Conclusion About These Objections to Assisted Suicide* 20

IV. THE NOTION OF AUTONOMY 20

A. *Autonomous Decisions as Informed* 20
B. *Autonomous Decisions as Voluntary* 21
C. *Autonomous Decisions as Directed toward One's Own Ends* 21
D. *Autonomous Decisions as Rational* 21
E. *Other Constraints on Autonomous Decision-Making* 22
F. *The Medicalization of Assisted Suicide* 23

V. AN ARGUMENT AGAINST DECRIMINALIZATION OF ASSISTED SUICIDE 24

A. *The Argument* 24
B. *Objections to the Argument — Initial Remarks* 26
C. *Objections to the Argument — Compassion* 27
D. *Objections to the Argument — Autonomy* 28
E. *Objections to the Argument — Cases Where Decisions Are Sufficiently Autonomous* 29
F. *Objections to the Argument — Applicability to Refusals of Life-Sustaining Treatment* 30

VI. CONCLUSION 30

I. INTRODUCTION

Autonomy is a core value of the law and ethics of health care. The power to make decisions for oneself — to retain control of one's own destiny — is central to a meaningful sense of self. The ability to make conscious choices based upon reflection — the capacity to transform oneself in accordance with an active will — is arguably a uniquely human endeavour. For this reason, we prize the exercise of autonomy. Autonomy is self-rule; it is personal liberty itself. After all, should the competent adult not make important life decisions for himself or herself? The vital role which autonomy plays in our common law tradition was proclaimed in 1891 by Mr. Justice Gray, of the United States Supreme Court:

> No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.[1]

In the realm of medicine too, autonomy is a cherished value:[2]

> The primary goal of health care in general is to maximize each patient's well-being. However, merely acting in a patient's best interests without recognizing the individual as the pivotal decisionmaker would fail to respect each person's interest in self-determination — the capacity to form, revise, and pursue his or her own plans for life. Self-determination has both an instrumental value in achieving subjectively defined well-being and an intrinsic value as an element of personal worth and integrity.[3]

Medical autonomy is commonly contrasted with a physician's paternalistic beneficence. Medical paternalism, simply speaking, is the view that the health care treatment which a patient should be given is a medical decision and, accordingly, the doctor, who is trained in medicine, is the natural person to make that decision. Beauchamp and Childress characterize paternalism (the beneficence model) as grounded in "the professional's obligatory beneficence. The physician's primary obligation is to act for the patient's medical benefit, not to promote autonomous decisionmaking."[4] In its extreme, the patient's views about his or her medical treatment are not relevant as the patient is not trained to formulate medical judgements and is perhaps involved too personally to make the dispassionate and reasoned assessment required. In addition, disclosing diagnoses to a patient, particularly diagnoses of serious illnesses, will unnecessarily upset the patient and possibly reduce his or her ability or will to fight on — he or she may give up hope. Furthermore, the patient's judgement may be thought to be skewed by an unreasoning denial of the reality of the situation or the awakening of unrealistic hopes.

In recent times, such strong forms of medical paternalism have fallen into disrepute. It is now widely accepted that decisions concerning one's medical care are not medical

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1 *Union Pacific Railway Company* v. *Botsford*, 141 U.S. 250 at 251 (1891).

2 T.L. Beauchamp and J.F. Childress devote an entire chapter to a consideration of the principle of autonomy in their seminal work, *Principles of Biomedical Ethics*, 4th ed. (New York: Oxford University Press, 1994) at 120-88.

3 *Deciding to Forgo Life-Sustaining Treatment*, Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research (Washington, D.C.: U.S. Government Printing Office, March 1983) at 26. [hereinafter the *President's Commission*]

4 Beauchamp and Childress, *supra* note 2 at 272.

decisions, but are personal ones, rightly to be made by the patient. While medical information concerning diagnosis, prognosis, risks and potential benefits of available medical treatments are important to help a patient make medical decisions, it is the *patient's* values and goals that are determinative. Respect for such values and goals naturally leads to respect for a patient's autonomous decision-making. The detached assessment and advice of the physician, while providing valuable background information, should not determine a patient's course of treatment. The emotions, desires, hopes and goals of the patient are of overriding importance in making a decision which will reflect his or her concept of a meaningful life.

As to the concern that the patient's judgement may be clouded by despair or a hopeless view of the situation, patients are generally not such tender flowers as this objection may presume. Patients need to know the reality of their own medical condition so that they and their families can make plans, arrangements and decisions about their own future. It is demeaning and untrue to suppose that patients are unable to cope with medical information and to make their own decisions on the basis of such information, even when the medical condition is serious. Finally, there is substantial agreement that an understanding of one's own medical condition and the ability ultimately to be in control of one's own treatment is empowering and in fact may improve healing and recovery.[5]

In this paper I examine the notion of autonomy in the context of life-ending decisions for competent persons. In particular, I will examine refusals of life-sustaining treatment, suicide, assisted suicide and active voluntary euthanasia. I will attempt to show that while the law exhibits a strong presumption in favour of permitting individuals to make autonomous choices to commit or attempt suicide and to refuse even life-preserving medical treatment, the choice of assisted suicide or euthanasia is not accorded this respect. If it is permissible to kill oneself, why is it impermissible to ask that another assist with the project? Why is it that although respecting the competent, voluntary request that life-sustaining treatment be withheld[6] or withdrawn[7] is typically a legal obligation, respecting the request to assist a competent, voluntary suicide is a crime? Are we failing to acknowledge a person's right of autonomy in prohibiting assisted suicide and euthanasia?

I will argue that, if we understand autonomy in its usual, straightforward, non-contextual way, then it, together with a reasonably well developed sense of compassion, justifies the decriminalization of assisted suicide, so long as safeguards are put in place to ensure the voluntariness and persistence of the request. However, this is not a totally satisfactory response. Such decriminalization is still troubling in a way that is not well defined, but which does not seem to be captured by the standard objections. It will be the point of this paper to attempt to give expression to these residual doubts. In order to make this argument, however, it will be necessary first to canvas some initial matters.

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[5] However, the view that medical ethical choices can be analysed in terms of a finite set of overarching principles seems too simplistic, and indeed has itself fallen into some disfavour. Nevertheless, whatever the meta-ethical status of autonomy, it is clear that it gives expression to a value of great importance.

[6] See *Malette* v. *Shulman* (1990), 72 O.R. (2d) 417, 47 D.L.R. (4th) 18 (C.A.) [hereinafter *Malette* cited to O.R.].

[7] *Nancy B.* v. *Hotel Dieu de Québec* (1992), 86 D.L.R. (4th) 385 (Que. Sup. Ct.) [hereinafter *Nancy B.*].

A. *Assisted Suicide and Active Voluntary Euthanasia*

Assisted suicide describes a situation where a person provides the means of committing suicide to another who freely and consensually uses such means to bring about their own death. Voluntary active euthanasia is the deliberate killing of another, with the other's consent and at the other's request, in furtherance of the other's intention to die. In an act of assisted suicide, it is the person who intends to die that directly performs the life-ending act. Assisted suicide is clearly prohibited in Canada,[8] in most states of the U.S.[9] and elsewhere.[10] Voluntary active euthanasia may be distinguished from assisted suicide in that the life-ending act is performed by another. There is also no question that voluntary active euthanasia is a crime in Canada,[11] the U.S.[12] and elsewhere, typically the crime of murder. There may or may not be important ethical differences between acts of assisted suicide and euthanasia.[13] However, for the purposes of this paper I will consider them together and use the term "assisted suicide" to refer to either. The relevant element present in each is that ultimately both are acts in furtherance of a freely consented and intended suicide. Assisted suicide and voluntary active euthanasia are nothing more than different kinds of acts of suicide with the assistance of another, and both are unlawful in Canada.

B. *A Right to Die?*

The exercise of autonomy is associated with one's personal liberty or freedom — the power to act in accordance with one's own will. More precisely, the exercise of autonomy may be seen as the authority to make voluntary and informed choices about oneself and one's life, for reasons which are one's own. Personal autonomy, at least as protection of bodily integrity,[14] is clearly accepted to be a right,[15] albeit one which is not

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[8] *Criminal Code*, R.S.C. 1985, c. C-46, s. 241(b). The Supreme Court of Canada, in a five to four decision, upheld the constitutional validity of s. 241(b) in *Rodriguez* v. *B.C. (A.G.)*, [1993] 3 S.C.R. 519, 107 D.L.R. (4th) 342, [1993] 7 W.W.R. 641 [hereinafter *Rodriguez* cited to S.C.R.]. For an account of the *Rodriguez* decision, see B.M. Dickens, "When Terminally Ill Patients Request Death: Assisted Suicide before Canadian Courts" (1994) 10:2 *Journal of Palliative Care* 52.

[9] U.S. state laws prohibiting assisted suicide are briefly described, for example, in J. Reno, "A Little Help from my Friends: The Legal Status of Assisted Suicide" (1992) 25 Creighton L. Rev. 1151 especially the Appendix at 1175-83; and in C. Schaffer, "Criminal Liability for Assisting Suicide" (1986) 86 Colum. L. Rev. 348.

[10] Sopinka, J., in *Rodriguez*, *supra* note 8 at 601-05, canvasses the laws prohibiting assisted suicide in a number of countries.

[11] In Canada, active euthanasia is culpable homicide (*Criminal Code*, *supra* note 8 s. 222(5)) and is arguably always (at least on a plain reading of the statute) first degree murder (ss. 229(a) and 231(2)), since the killing is planned and deliberate. S. 14 provides that the consent of the "victim" is not a defence.

[12] L.O. Gostin, "Drawing a Line Between Killing and Letting Die: The Law, and Law Reform, on Medically Assisted Dying" (1993) 21 *The Journal of Law, Medicine and Ethics* 94; and D. Hirsch, "Euthanasia: Is It Murder or Mercy Killing? A Comparison of the Criminal Laws in the United States, the Netherlands and Switzerland" (1990) 12 Loy. L.A. Int'l & Comp. L.J. 821 at 833-35.

[13] For example, D.W. Brock, in "Voluntary Active Euthanasia" (1992) 22 *Hastings Center Report* 10, argues that there is no relevant moral distinction between assisted suicide and euthanasia.

[14] See *R.* v. *Morgentaler*, [1988] 1 S.C.R. 30, 44 D.L.R. (4th) 385.

[15] Protected in Canada under the s. 7 right to liberty and security of the person in the *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada*

absolute.[16] A "right of autonomy" in the context of life-ending decisions has been the subject of much discussion. I will argue that very little about the right of autonomy is as straightforward as it appears, and that talk of rights, while not wholly inappropriate, is not so central to these questions as might be supposed.

Initially then, it is worth saying something about rights in this context. Much of the discourse surrounding assisted suicide has focused on the issue of whether the individual has a "right" to die. In particular, it is urged that, in order to justify assisted suicide, it must be shown that (a) individuals have the *right* to attempt or commit suicide, together with the further *right* to enlist the assistance of another in so doing, and (b) such other person has the *right* to offer such assistance. A substantial literature, primarily in the U.S., has arisen both denying[17] and championing[18] the existence of constitutionally protected rights of this kind.

However, it may be that this project is unnecessary for those wishing to justify a law permitting assisted suicide. Section 241(b) of the *Criminal Code*, which forbids aiding and abetting suicide, or the laws which make euthanasia murder, could be repealed or modified to permit assisting suicide when certain guidelines are met, without acknowledging a right to die. From the fact that attempting or committing suicide are not criminally prohibited under Canadian law, we cannot conclude that Canadians have a "right" to commit or attempt suicide. The fact that something is permitted does not in itself make the doing of it a right. However, just as we do not need a "right" to attempt suicide in order to be free of criminal sanction if we attempt suicide, we do not necessarily need a "right" to die in order to escape criminal sanction for assisting suicide. It would be enough if there was, as in the case of suicide, no legal prohibition. At the risk of over-simplifying, if it is not against the law, it is permissible.

It is true that courts, when called upon to strike down legislation based upon a violation of the *Charter*,[19] must find a right or rights which are violated. However, this is only because of the particular role of the judiciary. Parliament is under no compulsion to find a right to die or a right to assisted suicide in order to repeal or amend the present law concerning assisted suicide. Further, Parliament is really the most appropriate decision-making body to make or amend laws concerning this type of politically sensitive and emotionally charged issue. This is true for at least two reasons.

First, the elected Parliament has the democratic legitimacy and accountability to make such decisions. It is arguably more responsive to the needs and wishes of the

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Act 1982 (U.K.), 1982, c. 11 [hereinafter the *Charter*]. See *Rodriguez, supra* note 8; and *Fleming* v. *Reid* (1991), 4 O.R. (3d) 74, 82 D.L.R. (4th) 298 (C.A.) [hereinafter *Fleming* cited to O.R.].

[16] Canadian courts have found limits to the right of autonomy in either the *Charter* s. 7 "principles of fundamental justice" or in s. 1 as a "reasonable limit imposed by law". See *Rodriguez, supra* note 8.

[17] In Canada, Sopinka, J., in *Rodriguez, supra* note 8 at 597-98, denied a general right to suicide. In the U.S. context, see for example R.A. Destro "The Scope of the Fourteenth Amendment Liberty Interest: Does the Constitution Encompass a Right to Define Oneself Out of Existence?" 10 *Issues in Law & Medicine* 183; T.J. Marzen, "'Out, Out Brief Candle': Constitutionally Prescribed Suicide for the Terminally Ill" (1994) 21 Hastings Const. L.Q. 799; Y. Kamisar, "Are Laws Against Assisted Suicide Unconstitutional?" (1993) 23:3 *Hastings Center Report* 32; and L.R. Kass, "Is There a Right to Die?" (1993) 23:1 *Hastings Center Report* 34.

[18] R.A. Sedler, "The Constitution and Hastening Inevitable Death" (1993) 23:5 *Hastings Center Report* 20; and E.A. Gifford, "*Artes Moriendi*: Active Euthanasia and the Art of Dying" (1993) 40 UCLA L. Rev. 1545 at 1575-85.

[19] *Supra* note 15.

people and, in any event, is ultimately answerable to them. Within its jurisdiction, it is clearly Parliament's role to legislate. The courts, at least in the constitutional arena, quite properly are given the task only of ensuring that Parliament acts within its jurisdiction. Second, courts are restricted in their decision-making deliberations, in general, to upholding, quashing or "reading-down" legislation which is already in existence. Although courts have, on occasion, granted themselves considerable latitude in shaping remedies to reflect the rights and interests they find in the *Charter* and elsewhere, the exercise of their decision-making discretion is proscribed by the existing legislation and the terms of the *Charter*. Parliament is under far less restraint. It can initiate legislation in the terms which it sees fit. Subject of course to the *Charter*[20] and to the limits of its jurisdiction, it can grant powers and create obligations which it finds to be in the best interests of the country. Admittedly, the courts are not limited to the same extent by the political pressures which appear to constrain the elected Parliament in controversial and personally sensitive matters. Nevertheless, the fact remains that Parliament is the most appropriate source of new law in this area, if action is warranted. Parliament need not find a right to die in order to act.

II. Autonomy in Life-Ending Decisions

A. *Refusal of Life-Sustaining Treatment*

Decisions to require the withholding or withdrawing of life-sustaining medical treatment are, with limited exceptions, accepted as legitimately within the power of the individual. This power has its genesis in the common law concerning the inviolability of the individual's person. This tradition is expressed, for example, by Mr. Justice Cardozo, writing for the New York Court of Appeals in 1914:

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.[21]

In Canada and elsewhere, these principles have given rise to a right of informed consent to medical treatment. That is, subject to an exception for medical emergencies, no physician may treat a person without his or her informed consent to such treatment. If medical treatment is administered in the absence of consent, an action lies against the physician in battery.[22] If consent is given but is insufficiently informed, an action lies against the physician in negligence.[23] While health care workers and academic commentators have noted the clinical reality that physicians and hospitals continue to do a very poor job of adequately and sensitively informing patients as to the risks and benefits of proposed and alternative treatments,[24] the Supreme Court in *Hopp* v. *Lepp*,[25]

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[20] Which may, under certain circumstances, be overridden by the "notwithstanding clause" found in the *Charter*, s. 33.

[21] *Schloendorff* v. *Society of New York Hospital*, 105 N.E. 92 at 93 (N.Y. Ct. App. 1914).

[22] *Malette*, *supra* note 6.

[23] *Reibl* v. *Hughes*, [1980] 2 S.C.R. 880, 114 D.L.R. (3d) 1; and *Videto* v. *Kennedy* (1981), 33 O.R. (2d) 497, 125 D.L.R. (3d) 127 (C.A.).

[24] See for example J. Katz, *The Silent World of Doctor and Patient* (New York: Free Press, 1984) at 26; and B.M. Dickens, "Decision-Making in Terminal Care: The Days of One's Life and the Life of One's Days" (1986-1987) 51 Sask. L. Rev. 1.

[25] [1980] 2 S.C.R. 192, 112 D.L.R. (3d) 67.

Reibl v. *Hughes*[26] and *Ciarlariello* v. *Schacter*[27] has confirmed and refined the physician's obligations to a patient in this regard. The natural corollary of a right to informed consent is a right to refuse consent, which right, even in the case of life-preserving treatments, is firmly entrenched.

In *B.C. (A.G.)* v. *Astaforoff*[28] the British Columbia Court of Appeal ruled that prison authorities have no duty to force feed an inmate engaged in a hunger strike, even though the inmate's clear intention was to starve herself to death. While this decision may be seen as having limited application, since it did not decide whether prison authorities would have been *permitted* to force feed the prisoner, the case is significant in light of the acknowledged duty on behalf of the prison authorities to care for those in their charge.

In *Malette* v. *Shulman*,[29] the plaintiff, Mrs. Malette, having been involved in a car accident, arrived at the hospital unconscious and, in the opinion of the emergency physician, in urgent need of a life-saving blood transfusion. Mrs. Malette was carrying a signed card, identifying her as a Jehovah's Witness and demanding that no blood or blood products be administered to her. Notwithstanding this card, Dr. Shulman did administer a blood transfusion, possibly thereby saving her life. Mrs. Malette successfully sued the physician and was awarded $20,000 in damages for battery.[30] The Ontario Court of Appeal upheld the award. Mr. Justice Robins writes:

> The right of self-determination which underlies the doctrine of informed consent also obviously encompasses the right to refuse medical treatment. A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternate form of treatment, even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community. Regardless of the doctor's opinion, it is the patient who has the final say on whether to undergo the treatment.[31]

The Ontario Court of Appeal faced a similar issue in *Fleming* v. *Reid*.[32] In that case, two involuntary, incompetent psychiatric patients sued to enforce their right to refuse the administration of certain neuroleptic drugs, judged by their treating psychiatrist to be necessary to minimize psychotic episodes. While competent, the patients had clearly expressed their wish not to be given these drugs which, it was agreed, can have significant and unpredictable harmful side effects. Mr. Justice Robins again wrote for the Court of Appeal affirming that competent adults have the right to be free from unwanted medical treatment. These patients had the power, in anticipation of incapacity, to specify in advance their refusal of consent to a particular medical treatment. Provisions of the Ontario *Mental Health Act*[33] granting physicians the power to administer such drugs, against the wishes of the patient, if deemed to be in the patient's

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26 *Supra* note 23.

27 [1993] 2 S.C.R. 119, 100 D.L.R. (4th) 609.

28 (1983), 54 B.C.L.R. 309, [1984] 4 W.W.R. 385 (C.A.).

29 *Supra* note 6.

30 The trial decision of Donelly, J. is reported at (1987), 63 O.R. (2d) 243, 47 D.L.R. (4th) 18 (H.C.J.).

31 *Malette, supra* note 6 at 424.

32 *Supra* note 15.

33 R.S.O. 1980, c. 262.

best interests,[34] were found to be contrary to the liberty and security of the person guarantees found in section 7 of the *Charter*.[35]

> With very limited exceptions, every person's body is considered inviolate, and, accordingly, every competent adult has the right to be free from unwanted medical treatment. The fact that serious risks or consequence may result from a refusal of medical treatment does not vitiate the right of medical self-determination.[36]

Although the treatment refused was not life-preserving treatment, the court was not hesitant to express this right broadly:

> The patient's right to forgo treatment, in the absence of some overriding societal interest, is paramount to the doctor's obligation to provide medical care. This right must be honoured, even though the treatment may be beneficial or necessary to preserve the patient's life or health, and regardless of how ill-advised the patient's decision may appear to others.[37]

Two cases from the Québec Superior Court brought these issues into sharper focus. In *Nancy B.* v. *Hotel-Dieu de Québec*,[38] Nancy B. was a competent young woman permanently disabled by an extreme form of Guillain Barré Syndrome, an irreversible neurological disorder rendering her incapable of unassisted breathing and virtually incapable of independent movement. She applied to the court seeking an injunction requiring the hospital, upon her request, to discontinue mechanical ventilation, without which she would surely die. The Court, noting that the request was freely given and informed, held that she "*is entitled to require that the respiratory support treatment being given her cease.*"[39] The court held further that no crime is committed in so doing. The terms of any apparently applicable prohibition found in the *Criminal Code* must be read in light of the common and civil law right to refuse treatment, and the relevant provisions of the Québec *Civil Code*. The law could not intend that a patient has a right to refuse treatment and at the same time that a physician could be legally liable for giving effect to that right. According to Mr. Justice Dufour, such legislative intent would "*result in absurdities*".[40]

Just a few weeks after the *Nancy B.* decision, Mr. Justice Rouleau, again of the Québec Superior Court, agreed in *Manoir de la Pointe Bleue (1978) Inc.* v. *Corbeil*[41] that a quadriplegic resident of a long-term care institution should be permitted to die by starvation, upon his request, and without criminal sanction against the institution or its staff. While the *Nancy B.* and *Corbeil* cases were decided under applicable provisions of the Québec *Civil Code*, it is a fair guess that the general principles enunciated are

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34 *Ibid.* s. 35(2)(b)(ii) and s. 35a as am. by S.O. 1987, c. 37, s. 12.
35 *Fleming, supra* note 15 at 87-96.
36 *Ibid.* at 85.
37 *Ibid.* at 86.
38 *Nancy B., supra* note 7.
39 *Ibid.* at 392.
40 *Ibid.* at 394.
41 [1992] R.J.Q. 712 (Sup. Ct.) [hereinafter *Corbeil*].

applicable throughout the country and that such litigation elsewhere would have yielded similar results.[42] The situation appears to be the same in England.[43]

U.S. case law has also typically upheld a patient's power to refuse life-sustaining treatment, even where such a decision is made on the patient's behalf by an appropriate substitute decision-maker. The ground-breaking case was the *Matter of Quinlan.*[44] In that case, the father of 21-year-old Karen Ann Quinlan, in a coma diagnosed to be permanent, sought the power to discontinue extraordinary life-sustaining procedures. The Court recognized Quinlan's right to choose to terminate non-cognitive existence as an expression of her right to privacy.[45] The court held further that her father could give effect to this right on her behalf.

The 1984 case of *Bartling* v. *Superior Court*[46] found that a competent adult person has the constitutionally protected right of privacy to have life-sustaining treatment withdrawn. Although Mr. Bartling, who suffered from a myriad of maladies including emphysema, chronic respiratory failure, arteriosclerosis, abdominal aneurysm and malignant tumour of the lung, died prior to the court hearing, he would have had the right to be disconnected from the ventilator.

More recently, in a California case, Elizabeth Bouvia was a quadriplegic who suffered from severe cerebral palsy and crippling arthritis, and was permanently bedridden. She successfully sued to have a nasogastric feeding tube, inserted and maintained against her will, removed, even though the tube did not cause her great physical discomfort and she was not terminally ill. Ms Bouvia could make that decision even though the medical evidence indicated that she would ultimately die as a result and that the treatment consisted only of nourishment and hydration.

> The right to refuse medical treatment is basic and fundamental. It is recognized as a part of the right of privacy protected by both the state and federal constitutions...[i]ts exercise requires no one's approval. It is not merely one vote subject to being overridden by medical opinion.[47]

U.S. courts have upheld the privacy right to refuse life-preserving medical treatments in *Superintendent of Belchertown State School* v. *Saikewicz*,[48] *Matter of Conroy*[49] and in the U.S. Supreme Court case of *Cruzan* v. *Director, Missouri Dept. of Health*[50] on the basis that withdrawal of treatment is what the patient would have chosen, if competent. This right is based both on the right of privacy and the right not to be treated in the absence of informed consent. In *Cruzan*, the Court also found a constitutionally protected liberty interest in refusing unwanted medical treatment in the 14th Amendment due process guarantee. It recognized however that the state has a legitimate interest in

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[42] See B. Dickens, "Medically Assisted Death: *Nancy B.* v. *Hotel-Dieu de Québec*" (1993) 38 McGill L.J. 1053.

[43] *In Re T*, [1992] 3 W.L.R. 782 (C.A.).

[44] 355 A.2d 647 (N.J. S.C. 1976).

[45] On the right to privacy as personal autonomy, see *Griswold* v. *Connecticut*, 381 U.S. 479 (1965).

[46] 209 Cal. Rptr. 220 (Ct. App. 1984) [hereinafter *Bartling*].

[47] *Bouvia* v. *Superior Court*, 225 Cal. Rptr. 297 at 301 (Ct. App. 1986) [hereinafter *Bouvia*].

[48] 370 N.E.2d 417 (Mass. 1977) [hereinafter *Saikewicz*].

[49] 486 A.2d 1209 (N.J.S.C. 1985) [hereinafter *Conroy*].

[50] 110 S. Ct. 2841, 497 U.S. 261 (1990) [hereinafter *Cruzan*].

the protection and preservation of human life and may require, in the case of an incompetent patient, that "clear and convincing" evidence exist of the patient's wishes.

Notwithstanding the weight of these decisions, no Canadian, American or British[51] court has been prepared to find an absolute right to refuse life-sustaining treatment. Courts are careful not to generalize this power to all cases. Such a right must in every case be balanced against competing social values which are not clearly defined but are described variously as preserving life, protecting others, safeguarding the integrity of the medical profession, and discouraging suicide. However, when a person is suffering from a debilitating, incurable, neurological disease (*Nancy B.* or *Bouvia*), has strong religious views with respect to the treatment (*Malette*) or has become a quadriplegic (*Corbeil*), courts have found that the patient's right to refuse treatment overrides these societal interests. In *Malette*, the court writes:

> In sum, it is my view that the principal interest asserted by Mrs. Malette in this case — the interest in the freedom to reject, or refuse to consent to, intrusions of her bodily integrity — outweighs the interest of the state in the preservation of life and health and the protection of the integrity of the medical profession. While the right to decline medical treatment is not absolute or unqualified, those state interests are not in themselves sufficiently compelling to justify forcing a patient to submit to non-consensual invasions of her person.[52]

So, while the right to refuse treatment is acknowledged to have limits, courts have not provided much illumination as to how those limits are to be balanced against the right to refuse life-sustaining treatment.

The one recent Canadian case (of which I am aware) which held that an individual's right to refuse life-saving treatment was overridden by the state's interest in preserving life was the 1984 Québec Superior Court decision in *Canada (P.G.)* v. *Hopital Notre Dame et Niemiec*.[53] In this case, Mr. Niemiec was a competent adult and illegal immigrant detained by Canadian authorities awaiting deportation. He had swallowed a piece of wire and refused all medical treatment to remove the wire. He refused also to eat, claiming to prefer death to deportation. The court authorized the hospital to feed Mr. Niemiec and treat him surgically, finding that he had no right to refuse treatment in this case. The court overrode his right to refuse treatment on the basis of the societal interest in preserving his life. It is not clear whether the *Niemiec* decision has been overridden by the later *Nancy B.* and *Corbeil* cases, but it seems that courts may be prepared to override the right to refuse treatment in less sympathetic or less dire circumstances.[54]

In the United Kingdom, courts have similarly upheld the individual's right to refuse life-sustaining treatments. However, there too the right is subject to limits. For example, in *In Re S.*[55] the court ordered a caesarian section birth, which the mother had refused on religious grounds, on the basis of medical opinion that the lives of both the mother and the child were threatened.

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[51] For example, see *Airedale N.H.S. Trust* v. *Bland*, [1993] 2 W.L.R. 316 (H.L.).

[52] *Malette*, *supra* note 6 at 430.

[53] [1984] C.S. 426 [hereinafter *Niemiec*].

[54] For a discussion of the *Niemiec* case, see J. Gilmour, "Withholding and Withdrawing Life Support from Adults at Common Law" (1993) 31 Osgoode Hall L.J. 473 at 489, 495-98.

[55] [1992] 3 W.L.R. 806.

Nevertheless, while not absolute, there is a strong presumption that one may refuse any medical treatment and that such presumption will be overborne by courts only in extraordinary cases.

> To summarize, where the patient is competent, courts appear increasingly willing to give effect to the familiar proposition that common law medical treatment cases cite and recite: every human being of adult years and sound mind has the right to determine what shall be done with his or her own body.[56]

B. *Suicide*

Until 1972, suicide and attempted suicide were prohibited in Canada by the *Criminal Code*.[57] Accordingly, one may now, as an expression of one's autonomy, attempt suicide without fear of criminal reprisal. It is not necessary that we find, in such decriminalization, the creation or acknowledgement of a "right" to suicide. There may or may not be such a right in Canada. It was sufficient that Parliament, in its democratic, legislative function, was prepared to allow Canadians to attempt or commit suicide without criminal sanction. It may have been that Parliament collectively decided that suicide is acceptable for those who wish it. It may have been that Parliament collectively decided that suicide is a mental health problem and not a criminal law problem. It may have been finally that Parliament saw that it had no business interfering with the choices of citizens in this area. Whatever the reason, there is presently no public sentiment in favour of reimposing criminal sanctions for suicide or attempted suicide. Canadians are prepared to accept that personal choice or autonomy can extend to overtly and directly self-destructive behaviour.

Given this very strong legal and ethical presumption in favour of personal autonomy, even in choices involving one's own death, why is it that assisted suicide and active euthanasia for competent, consenting individuals are crimes in Canada? In each case, the intention of the person is to die and the decision is freely and competently made. Glanville Williams saw euthanasia as ultimately a matter of "the liberty of the individual", that is of autonomy, in an early modern defence of euthanasia.[58]

> If the law were to remove its ban on euthanasia, the effect would merely be to leave this subject to the individual conscience. This proposal would... be easy to defend, as restoring personal liberty in a field in which men differ on the question of conscience.[59]

III. Arguments Against Assisted Suicide

If refusals of life-sustaining treatments and assisted suicide are varieties of suicide, on what basis is assisted suicide prohibited where, in general, suicide and refusals of life-sustaining treatment are not? I will examine four broad arguments commonly raised against assisted suicide and two others which purport to show that there is a moral distinction between refusing life-sustaining treatment and assisted suicide. The arguments which I here briefly describe have been presented, analysed and challenged countless

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[56] Gilmour, *supra* note 54 at 499.

[57] The law against suicide and attempted suicide was repealed by the *Criminal Law Amendment Act, 1972*, S.C. 1972, c. 13, s. 16.

[58] G. Williams, *The Sanctity of Life and the Criminal Law* (New York: Knopf, 1957) at 346.

[59] *Ibid.* at 341.

times in the euthanasia literature. There are, of course, many others.[60] I have found them to be unpersuasive, broadly speaking, for the reasons indicated below. These arguments are presented, however, not to give them rigorous treatment, but rather in order to point out certain of their features which will be of assistance in developing an argument which is, in my view, more successful.

A. *The Sanctity of Life*

It is said that permitting assisted suicide violates the sanctity of life. That life is accorded something close to absolute deference is deeply rooted in our common law tradition and in our intuitive moral sense. Assisted suicide involves taking an active part in the killing of an innocent life. Accordingly, it is urged, we rightly forbid assisted suicide. Some have argued that any self-destructive act is wrong since it is equally wrong for one to kill oneself — an innocent person.[61] In short, human life is so valuable that it must be protected even if the bearer of that life no longer wishes it.

As tempting as this argument is, it fails, I think, for at least two reasons. First, if the sanctity of life were sufficient objection to assisted suicide, then it should also be sufficient against unassisted suicide and refusals of life-sustaining treatment. For, these too result in the termination of life. Further, as McLachlin, J. points out in her dissenting opinion in the *Rodriguez* case, not all instances of killing render one criminally liable under Canadian law:

> Thus there is no absolute rule that causing or assisting in the death of another is criminally wrong. Criminal culpability depends on the circumstances in which the death is brought about or assisted. The law has long recognized that if there is a valid justification for bringing about someone's death, the person who does so will not be held criminally responsible.[62]

Second, and perhaps more fundamentally, while human life is no doubt of enormous value, the argument is not thereby completed. While life is supremely valuable, it must be valuable, not in the abstract, but *for* something or *to* someone. If the life in question is an unwanted burden to the person who is living that life, does the value or sanctity of life in the abstract justify requiring its continuation? Why would the state's interest in maintaining life override the interest of the individual for whom this life is a burden and who wishes to dispose of it? The sanctity of life is acknowledged to be of overwhelming value to society when chosen, but its value in the particular case is not so clearly seen when it offers only suffering.

B. *Risk of Abuse and "Slippery Slope"*

In *Rodriguez*, Mr. Justice Sopinka, writing for a five to four majority, identifies the risk of abuse as being the fundamental difficulty about decriminalizing assisted suicide.[63] In that case, Sue Rodriguez, who was afflicted with amyotrophic lateral

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[60] A quite thorough canvass of these objections is undertaken by H.T. Engelhardt Jr., "Death by Free Choice: Modern Variations on an Antique Theme" in B. Brody, ed., *Suicide and Euthanasia* (Dordrecht, The Netherlands: Kluwer Academic, 1989) 251 and by D.W. Brock, *supra* note 13.

[61] H. Arkes "Once More Into the Breach: The Right to Die — Again" (1992) 8:3 *Issues in Law & Medicine* 317.

[62] *Rodriguez*, *supra* note 8 at 623.

[63] *Ibid.* at 599-601.

sclerosis (Lou Gehrig's disease) applied to court for a declaration that she be permitted to receive assistance in dying and that a physician affording such assistance be free from criminal prosecution. Under section 241(b) of the *Criminal Code*, anyone who "aids or abets" another in an attempted suicide, whether successful or not, is guilty of an indictable criminal offence and is liable to imprisonment for up to 14 years. According to the court, while this provision does deprive one of the *Charter* section 7 right of liberty or security of the person, such deprivation is in accordance with the principles of fundamental justice[64] and is anyway saved by the fact that the risk of abuse of vulnerable persons provides a reasonable limit under section 1 of the *Charter*.[65]

The concern appears to be that the weak and the vulnerable may be pressured into accepting assistance in dying by selfish, thoughtless or unscrupulous heirs, family members, or even health care professionals. Sopinka, J., writes:

> Section 241(b) has as its purpose the protection of the vulnerable who might be induced in moments of weakness to commit suicide. This purpose is grounded in the state interest in protecting life and reflects the policy of the state that human life should not be depreciated by allowing life to be taken.[66]

Yale Kamisar, in reply to Glanville Williams' argument noted earlier,[67] responds:

> Williams champions the 'personal liberty' of the dying to die painlessly. I am more concerned about the life and liberty of those who would needlessly be killed in the process or who would irrationally choose to partake of the process.[68]

The concern here is that a decision to commit assisted suicide will not be truly free. The risk of abuse of the vulnerable can be seen as a species of so-called "slippery slope" objection. Such arguments attempt to show that although permitting assisted suicide, with appropriate safeguards, would not be in itself harmful, the result of allowing assisted suicide would be that other, more objectionable, practices would arise.[69] Slippery slope arguments can be seen generally as being of two types.

The first type urges that a rule permitting assisted suicide would open the door to people attempting other, illegitimate practices not permitted by the rule. While it might be conceded that assisted suicide should be permitted in some instances, that is, when a decision is free, consensual and fully informed, this rule will provide a screen for those who would exert certain types of pressures upon an older or weaker person to "choose" assisted suicide where they would not otherwise.

The second type of slippery slope argument is that establishing a rule permitting assisted suicide, even restricted to certain circumstances, will lead over time to the establishment of more and more lenient and objectionable rules concerning assisted suicide. It may be the first step of many towards expanding assisted suicide to, for example, people who are incapable of giving consent, people who create an "unacceptable"

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[64] *Ibid.* at 583-608.

[65] *Ibid.* at 613-15.

[66] *Ibid.* at 595.

[67] *Supra* note 58.

[68] Y. Kamisar, "Euthanasia Legislation: Some Non-Religious Objections" in A.B. Downing, ed., *Euthanasia and the Right to Death* (London: Peter Owen, 1969) 85 at 88. Prof. Williams responds to Kamisar in "Euthanasia Legislation: A Rejoinder to the Non-Religious Objections" in Downing, *op. cit.*, 134.

[69] For example, see Gifford, *supra* note 18 at 1558-74.

drain on health care resources, or people who happen to be old or infirm and are no longer "productive" members of society or of their families.

Arguments alleging that the weak and vulnerable may be abused and similar slippery slope arguments are difficult to analyse.[70] They involve essentially factual claims being made about the probable or possible consequences of permitting assisted suicide. Both the prediction and its denial are speculative — not satisfactorily provable or refutable. However, as the argument is put, there seems to be a great deal at stake. If taking a modest single step toward giving people, even under certain safeguards, access to assisted suicide will ultimately result in their lives being ended without their informed, voluntary intention to die, the objection would be very powerful.

While it cannot be said with certainty that such dire consequences will not follow from a rule permitting assisted suicide in limited circumstances, a couple of things can be said. First, there is something to the view that permitting suicide and refusals of life-sustaining treatment might also carry the risk of abuse and a journey down a slippery slope. Margaret Battin wonders,

> Would choices of euthanasia be more or less abused than, say, choices of high risk surgery or choices to withhold or withdraw life-sustaining treatment? After all, any of these choices can lead to death, not only choices about euthanasia.[71]

Subtle or not-so-subtle pressures might be brought to bear on the person encouraging unassisted suicides or the discontinuation of needed medical treatment which may be every bit as effective and manipulative. Again, as expressions of personal autonomy, we are prepared to permit unassisted suicide and refusals of care even given the possibility that abuse may be present.

More importantly, it seems to me that the fear of abuse is overstated. There is no reason to suppose that the guidelines or safeguards that may be established for assisted suicide cannot be effective in ensuring that such decisions are freely taken. As the case law indicates, there are virtually no safeguards to ensure that a decision to refuse life-sustaining treatment is fully informed, considered and voluntary. Judicial or administrative review of assisted suicide (as suggested, for example, by Chief Justice Lamer in *Rodriguez*[72]) need not be unduly onerous. While the experience of the Netherlands[73] is somewhat mixed, evidence of serious abuse has not been presented.[74] Finally, as

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[70] M. Battin, in "Voluntary Euthanasia and the Risks of Abuse: Can We Learn Anything from the Netherlands?" (1992) 20 *Law Medicine & Health Care* 133, discusses different types of possible abuses that may occur as well as the types of safeguards which may be effective to prevent them.

[71] *Ibid.* at 135.

[72] *Supra* note 8 at 579-80.

[73] The experience of the Netherlands is significant because, although euthanasia is strictly illegal, the administrative policy is not to prosecute physicians who commit euthanasia in accordance with certain prescribed guidelines. M.P. Battin, in "Assisted Suicide: Can We Learn from Germany?" (1992) 22:2 *Hastings Center Report* 44, suggests that since assisted suicide is not unlawful in Germany, and in fact is fairly well accepted so long as physicians are *not* involved, it provides a helpful model for considering the decriminalization of assisted suicide elsewhere.

[74] On September 10, 1991, the Dutch Committee to Investigate the Medical Practice concerning Euthanasia, chaired by the Attorney General of the Supreme Court, Prof. J. Remmelink published its report (the "Remmelink Study"). For analysis of its findings, see R. Fenigsen, "The Report of the Dutch Government Committee on Euthanasia" (1991) 7:3 *Issues in Law Medicine* 339; and J.J.M. van Delden, L. Pijnenborg and P.J. van der Maas, "The Remmelink Study: Two Years Later" (1993) 23:6 *Hastings Center Report* 24.

McLachlin, J., points out, "assisting" suicide where consent is lacking or improperly obtained would remain punishable as culpable homicide. Counselling suicide also would remain a crime under *Criminal Code* section 241(a).[75]

C. *The Role of the Medical Profession*

Another common objection to assisted suicide focuses on the role of the physician, or of the health care professions generally. It is argued that the doctor's role is to heal, "or at least, do no harm".[76] The Council on Ethical and Judicial Affairs of the American Medical Association describes physicians' obligations as follows: "Physicians are healers of disease and injury, preservers of life, and relievers of suffering." Further, "Physician-assisted suicide, like euthanasia, is contrary to the prohibition against using the tools of medicine to cause a patient's death."[77] It has been urged also that permitting assisted suicide would desensitize doctors to killing, destroy physicians' moral credibility, subvert society's faith in physicians and generally make life more difficult for physicians whether they agree or refuse to assist.[78] Nancy Dickey adds:

> Besides threatening one of the basic underpinnings of the profession, allowing physicians to kill — even with patient consent — threatens the patient's trust, the belief that the physician is there for the well-being of the patient and not to make judgements about the quality of one's life and therefore the value of continuing that life.[79]

However, I am not convinced that the role of the physician and the essential relationship between doctor and patient, together with the goals of medicine, are sufficient to outweigh the importance of the patient's autonomous life-ending choice. Again, would not the same objection apply to refusals of life-sustaining treatment? If assisted suicide undermines the norms of the medical profession, why do such refusals not do so as well? In addition, although concerns about risk of abuse tend to creep into these objections,[80] it is by no means clear that permitting assisted suicide in particular cases would be destructive to the goals of medicine and the nature of the relationships involved. It is doubtful that the twin virtues of respect for autonomy and compassion for the patient are less important than the somewhat abstract values identified by this objection.

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[75] *Rodriguez, supra* note 8 at 627.

[76] D.W. Amundsen, "The Physician's Obligation to Prolong Life: A Medical Duty without Classical Roots" in R.M. Veatch, ed., *Cross Cultural Perspectives in Medical Ethics: Readings* (Boston: Jones and Bartlett, 1989) 248, challenges the view that physicians have a classically-rooted duty to prolong life. Indeed, he attempts to show that, under ancient Greek and Roman law, assisting suicide would not be a crime and, in these cultures, would, in fact, be accepted by most (although not all) physicians.

[77] "Decisions Near the End of Life" (1992) 267 *Journal of the American Medical Association* 2229 at 2230, 2233.

[78] A.J. Dangelantonio, "Physician-Assisted Suicide: The Legal and Practical Contours" (1993) 4:1 *Risk — Issues in Health and Safety* 55.

[79] "Euthanasia: A Concept Whose Time Has Come?" (1993) 8:4 *Issues in Law & Medicine* 521 at 524.

[80] See E.P. Pellegrino, "Doctors Must Not Kill" in R.I. Misbin, ed., *Euthanasia: The Good of the Patient, the Good of Society* (Frederick, Maryland: University Publishing Group, 1992) 27; and response by F. Abrams, "The Quality of Mercy: An Examination of The Proposition 'Doctors Must Not Kill'" in Misbin, *op. cit.*, 43.

D. *The Patient Has a Skewed Appreciation of His or Her Own Situation*

It is argued further that requests for assisted suicide are very often not fully informed, in the sense that the person does not fully appreciate the possibilities of physical or emotional/psychological recovery. It might be, for example, that a person contemplating assisted suicide is suffering from a major but treatable psychiatric illness, perhaps a serious depression. In the person's despair, he or she does not see that certain drugs, counselling and other emotional support may be successful in lifting the depression, if not entirely, then at least to the point where life becomes, for the person, worth living.[81] Even leaving depressive illness aside, it may be that, because of acute suffering (which a suicidal person would commonly have), the person is not seeing clearly the possibility that his or her life may take a more positive turn and that optimism may be rewarded. Many stories are told of suicidal individuals who wish desperately to die but who later are grateful that their wish was not granted. It is undoubtedly true that some or even most people who wish to die have an unrealistically negative view of their future prospects for a contented and fulfilling life.

Note again that precisely the same objection may be raised against suicide and refusing life-sustaining treatment. Acknowledging that suicidal feelings may be based on misconceptions about a person's situation, at the end of the day are we prepared to say that the individual may not decide for himself or herself? Ultimately, who is to decide whether a mistake is being made? Despair or major depression may confound the judgement of persons facing those decisions, yet, at least within the realm of criminal law, such decisions are left to them. If we are prepared to permit those who are suicidal and those contemplating refusing life-sustaining treatment ultimately to exercise their own autonomy in making such choices, the situation with an assisted suicide should be no different.

While this argument, as expressed, fails to provide a convincing attack on assisted suicide, it carries within it an essential truth about the suffering and suicidal, from which a more satisfying argument arises. This argument will be addressed further on.

E. *Refusing Life-Sustaining Treatment is Morally Distinct from Suicide*

This argument and the next attempt to show that assisted suicide is morally different than a refusal of life-sustaining treatment by focusing on differences in the intentions of the persons involved. First, from the standpoint of the person wishing to be released from suffering, Canadian[82] and U.S.[83] courts have consistently distinguished cases of refusing life-sustaining treatment from suicide on the basis that the patient does not die from the act of withdrawing or withholding treatment, but rather dies from the underlying illness or disease. On a practical level, if such refusal is suicide, then a physician who withdraws or withholds such treatment may be committing assisted suicide, a crime in Canada and in most other jurisdictions. This would be a problematic result inasmuch as it would render meaningless the clear right of a patient to refuse such treatment. It would be a right which the criminal law forbids the physician to respect. If

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[81] Y. Conwell and E. Caine, "Rational Suicide and the Right to Die" (1991) 325 *New England Journal of Medicine* 1100.

[82] For example, see *Rodriguez, supra* note 8 at 606 (Sopinka, J.).

[83] For example, *Satz* v. *Perlmutter*, 362 S.2d. 160 at 162-63 (Fla. Ct. App. 1978); *Saikewicz, supra* note 48 at 426; and *Bartling, supra* note 46 at 225.

there is a moral distinction between refusing life-sustaining treatment and suicide, there must be a distinction between acceding to a refusal of life-sustaining treatment and assisting suicide.

For example, in the *Nancy B.* case, in characterizing Nancy B.'s decision to refuse treatment, the court writes:

> I would however add that homicide and suicide are not natural deaths, whereas in the present case, if the plaintiff's death takes place after the respiratory support treatment is stopped at her request, it would be the result of nature taking its course.[84]

The U.S. cases have tended to agree. Describing the situation of Elizabeth Bouvia, Mr. Justice Beach of the California Court of Appeals notes:

> As a consequence of her changed condition, it is clear she has now merely resigned herself to accept an earlier death, if necessary, rather than live by feedings forced upon her by means of a nasogastric tube. Her decision to allow nature to take its course is not equivalent to an election to commit suicide with real parties aiding and abetting therein.[85]

In *Conroy*, the Court argues that,

> ...rejecting her artificial means of feeding would not constitute attempted suicide, as the decision would probably be based on a wish to be free of medical intervention rather than a specific intent to die, and her death would result, if at all, from her underlying medical condition, which included her inability to swallow.[86]

However, with respect, for legal and ethical purposes, this amounts to a semantic quibble. In essence, a free, informed and consensual refusal of life-preserving treatment will usually amount to an act of suicide. Any suicide involves a choice, for the individual, between death and the individual's present existence taking into account the possibilities which the individual sees for a future life. That Elizabeth Bouvia's action is described as the acceptance of an earlier death, and not as a desire to die, does not change the essential intention motivating her decision. Any suicide results in an earlier death. The fact that Bouvia happened to have (a) an illness which would kill her in the absence of life-sustaining treatment, and (b) a common law right to refuse treatment, does not together alter the basic psychological fact that the point of her decision was her own death. In such cases it is absurd to suggest that a preference to allow nature to take its course is relevantly different than an intention to die. If the life available to the individual were or could be different, then certainly that person might not decide to die. However, the person who commits suicide, like the person who refuses life-sustaining treatment, forms an intention based upon the choices which they see available to them. Where the intention is to die and the individual goes about accomplishing the realization of that intention, it is not morally different from suicide.

Admittedly, those who refuse life-preserving medical treatment for religious reasons (as in *Malette*) likely do not wish to die. These are special cases. However, in the other cases here discussed, the refusals of treatment amount to a species of suicide. This means that the criminal status of assisted suicide cannot be sustained on the basis

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[84] *Nancy B., supra* note 7 at 394.

[85] *Bouvia, supra* note 47 at 306.

[86] *Supra* note 49 at 1226.

that there is a relevant moral distinction between suicide and refusing life-sustaining treatment.[87]

F. *Killing is Morally Distinct from Letting Die*

The distinction between respecting a refusal of life-sustaining treatment on the one hand and assisting suicide on the other is often defended by drawing a moral distinction between omissions and acts. The attempt is to fashion a morally relevant distinction by examining the actions of the person acceding to the request of the suffering person. After all, the moral acceptability of the patient's decision is not so much in issue as that of the suicide assister. The argument is that refusing treatment, when such a treatment would sustain the life of a person, amounts to letting them die. Assisting with a suicide, particularly active euthanasia, is, of course, killing or participating in killing. Allowing to die in these circumstances is ethically acceptable while killing is always wrong.[88]

The moral relevance of this distinction has been challenged, I think, with considerable success.[89] First of all, conceptually the distinction is difficult to draw. For example, is disconnecting a patient from a ventilator an act or an omission? The doctor does something active, but the activity is to withdraw a previous intervention, without which the patient would likely have died anyway. Even if such conceptual difficulties are answerable, it is plain that in either case the result which is expected to follow from the act or the omission, that is, the death of the patient, is foreseen and intended. This is the key. We assume that the person who assists a suicide intends the death which ensues. The morally relevant question is whether the physician (or other person) who withholds or withdraws life-sustaining treatment also intends the death. The common response is that the physician foresees but does not intend the death.

While it is beyond the scope of this paper to examine this question deeply, I accept that, where death ensues, withholding or withdrawing treatment cannot helpfully be characterized as a foreseen but unintended consequence. In general, a foreseen but unintended consequence is the by-product of a separate, truly intended consequence. In the case of a refusal of treatment, there is no *other* meaningful consequence of which death is a by-product. In addition, a foreseen but unintended consequence of an act is regretted by the actor, who would take such steps as are possible to reduce or avoid the unintended consequence, if that were possible. Seen in this way, the death of the patient is not a foreseen but unintended consequence of the withdrawal of treatment because the person withdrawing the treatment would not act at all if he or she knew the death would *not* result. Accordingly, while a great deal more could be said on this matter, I am content that the acts/omissions distinction is not morally relevant in this regard.[90]

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[87] B. Dickens, *supra* note 42, argues that in this case a distinction may helpfully be drawn at least for legal purposes.

[88] See the *President's Commission*, *supra* note 3 at 65-68.

[89] See, for example, the exchange between J. Rachels, in "Active and Passive Euthanasia" (1975) 292 *New England Journal of Medicine* 78, and T.L. Beauchamp, "A Reply to Rachels on Active and Passive Euthanasia" in T.L. Beauchamp and S. Perlin, eds., *Ethical Issues in Death and Dying* (Englewood Cliffs, N.J.: Prentice-Hall, 1978) 246; Gifford, *supra* note 18 at 1550-58: and also "Physician-Assisted Suicide and the Right to Die with Assistance" (1992) 105 Harv. L. Rev. 2021.

[90] For a discussion of the distinction between an intended effect and a foreseen but unintended effect see the *President's Commission*, *supra* note 3 at 77-82.

G. *Conclusion About These Objections to Assisted Suicide*

On the quite reasonable assumption that effective and appropriate guidelines can be established and enforced, the widely discussed objections to assisted suicide are not convincing. On the basis of these objections we are given no reason to prohibit assisted suicide while permitting suicide and refusals of life-sustaining treatment. Our right of autonomy seems to apply to assisted suicide in much the same way. Powell and Cohen put the matter quite succinctly:

> Our commitment to the principles of an individual's right to control her own body, privacy, and liberty should lead us to approach the issue of a right to die with a commitment to respect the autonomy of the individual who is involved. Adopting this approach... mean[s] that, after appropriate safeguards are put in place to ensure that individual autonomy is being respected, the individual's choice must be regarded as paramount.[91]

This analysis is tempting. Respect for the individual entails respect for the individual's choices. However, there remains something troubling about this response which requires exploration. The difficulty is that this analysis seems too straightforward to reflect the real situation of real people considering suicide. Arising out of this concern, I think that a case can be made against the practice of assisted suicide. This case depends upon the supposition that an overly simplistic notion of autonomy has heretofore been applied to the analysis of assisted suicide. Accordingly, the notion of autonomy itself must be re-examined.

IV. The Notion of Autonomy

What does it mean to say that decision-making is autonomous? Ideally, autonomous decision-making is free and voluntary, reasonably informed and rationally directed at the fulfilment of one's own goals and values.[92] It will be seen at once, however, that fully informed, non-coerced decision-making, in rational furtherance of one's own goals, is an ideal which is never fully realized.

A. *Autonomous Decisions as Informed*

While it is important that autonomous decision-making be informed, obviously one can never be fully informed in the sense of having an appreciation of all information relevant to such decision-making. We can only know to an imperfect degree the feelings, thoughts, wishes, and motivations of ourselves, much less of others. Nevertheless, these are virtually always important to our decision-making. In any event, we can never know perfectly, and we often know not at all, what will be the result of proposed or alternative courses of action. We cannot know the future.

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[91] J.A. Powell and A.S. Cohen, "The Right to Die" (1993) 10 *Issues in Law & Medicine* 169 at 177.

[92] James Childress sees the two essential features of autonomy as (1) acting freely and (2) deliberating rationally. See "Autonomy" in R.M. Veatch, *supra* note 76, 233. B.L. Miller, in "Autonomy & the Refusal of Lifesaving Treatment" (1981) 11:4 *Hastings Center Report* 22 at 24-25, finds four senses of autonomy: autonomy as free action, autonomy as authenticity, autonomy as effective deliberation and autonomy as moral reflection.

B. *Autonomous Decisions as Voluntary*

Further, while decision-making could not be described as autonomous if not voluntary, that is, free of coercion and undue influence, totally free decisions are never possible. Decision-making will always be affected by the feelings, wishes and dependencies of others and their influence on our own fears and hopes. We will always be affected, either subtly or blatantly, by social values and power relationships. Our will is continually swayed, to some extent, by the expectations, needs and responses of others. These forces continually drive us to make choices which we would not otherwise make.

C. *Autonomous Decisions as Directed toward One's Own Ends*

In order to be autonomous, decision-making must be rationally directed toward the achievement of one's own ends—it is about oneself. However, it should be immediately clear that no decision is made purely about oneself. Others are always affected and the interests of others are almost always taken into account in making so-called autonomous decisions. One's own ends are inextricably caught up with the goals and the welfare of others, family members, friends, colleagues and other members of one's community. It is perfectly sensible to say that we can make the ends of others our own; for example, we can make the happiness and prosperity of a child an important motivation in our own life. Nevertheless, we should see that autonomy cannot be divorced from the relationships, dependencies and emotional claims of others. This is to say that autonomy is not simply about oneself. Autonomy cannot claim to be *independent* self-rule.

A notion of autonomy which takes seriously the importance of relationships in decision-making is reflected in a care-based ethic.[93] Leslie Bender argues for a care-based approach to autonomy:

> In a care-based ethic, individual autonomy is a *process* nurtured in webs of relationships and responsibilities instead of a static condition pre-existing them. Whereas the ideological basis of a rights-based ethic rests on an assumption of equally empowered, independent people, an ethic of care recognizes that many relationships contain dependencies between differently empowered people—parents and children, caregivers and mentally or physically impaired people, teachers and students, doctors and patients, and at times lovers and friends... Self-governing in an ethic of care does not mean governing alone by abstract reasoning and distant observations, but means choosing options with respect to responsibilities, relationships, conversations, and dialogues with others.[94]

D. *Autonomous Decisions as Rational*

It seems important that autonomous decisions be *rationally* directed at the satisfaction of our ends. If so, however, it ignores that the exercise of decision-making

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[93] For example, C. Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Cambridge: Harvard University Press, 1982), especially c. 3, "Concepts of Self and Morality", at 64-105; and S. Sherwin, *No Longer Patient* (Philadelphia: Temple University Press, 1992), especially c. 4, "Toward a Feminist Ethics of Health Care", at 76-95.

[94] L. Bender, "A Feminist Analysis of Physician-Assisted Dying and Voluntary Active Euthanasia" (1992) 59 Tenn. L. Rev. 519 at 536-37.

is based, to varying degrees, on non-rational or even irrational factors. Emotions, passions and fantasies are important forces motivating our decisions and actions. Indeed, decision-making would be less than fully human if purely rational. Further, we make choices not only on the basis of conscious motives, but based also on sub-conscious fears, desires and passions. Autonomy describes the making of conscious choices for our own reasons. The element of conscious choice is important because it is doubtful that a choice can be truly free if it is motivated, in part, by factors of which we are unaware.

E. *Other Constraints on Autonomous Decision-Making*

All of this is simply to point out that autonomy is a much more complex notion than it initially appears. The value of living autonomously is the value of being in control of oneself or one's life, or acting with self-determination. Clearly, autonomy is, by its very nature, constrained in the above ways. In fact, autonomous decision-making is limited in a number of other ways as well. For example, our ability to act autonomously is limited by the law-making power of the state which proscribes and regulates our actions in innumerable ways. In addition, we may quite reasonably give to others at least regions of our autonomous decision-making. For example, we allow lawyers, accountants, plumbers, automobile mechanics and others to make decisions about our affairs, within their expertise, usually subject to our determination of the ultimate goals. Renouncing decision-making authority over some aspects of our lives compromises autonomy, but may result in better decisions.

Or, we may have autonomy taken from us by fraud, coercion or by being deprived of full information about a decision. Medical paternalism can be seen as an example of patients being denied autonomy by being denied reasonable information concerning their own condition. Finally, we can renounce our autonomy by giving ourselves over to fate. It might happen that self-determination becomes too onerous, tiresome, or unfulfilling and we deliver ourselves into the hands of fate and permit our life to unfold as it will.

Autonomy, then, is not a decision-making power which we possess non-contextually, dispassionately and independent of our relationships with others. Rather, autonomy is a *capacity* to make informed, non-coerced decisions rationally in furtherance of one's own ends, but which capacity is never fully realizable. If self-determination is the ability to act freely, without coercion and for one's own ends, then autonomy can be seen only as the capacity for self-determination, which may be realized to a greater or lesser degree. The characterization of autonomy as a capacity for self-determination has been suggested by Jay Katz, who describes it as follows:

> Psychological autonomy refers to the extent and limits of a person's capacities to reflect and make choices inherent in the psychological nature of human beings....[Ideally, though such an ideal is unattainable] with an awareness of the internal and external influences and reasons that they would wish to accept.[95]

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[95] *Supra* note 24 at 111.

F. *The Medicalization of Assisted Suicide*

The exercise of autonomy, that is, acting in a fully self-determined way, is further compromised by what Michael Burgess has termed the "medicalization" of dying.

> "Medicalization"... describe[s] a social process in which behavior, that was not understood to be relevant to medical concerns, is constructed as a medical problem.[96]

The idea is that dying is increasingly becoming a medical issue to be dealt with in accordance with the so-called "medical model". The process of dying is seen in terms of the illness, diseases and underlying medical conditions that threaten life. The goal of the medical model is to defeat such illnesses by scientific, medical means. Success is measured by cure, relief of suffering or continued life. However, the converse is also true. A failure of the physicians' science, that is the inability to cure and restore health, translates into failure. As serious disease and the process of dying become increasingly medicalized, patients may begin to feel such failure acutely. If they cannot be restored to health, not only has the medical science failed, but they have failed.

The decriminalization of assisted suicide would have the effect of increasing its medicalization in the context of the suffering, serious illness or process of dying which a suicidal person is, almost certainly, experiencing. If medicine's failure becomes, to some extent, that of the patient, then autonomous decision-making is surely undermined. Such medicalization has the additional effect of diverting attention and resources away from comforting, consoling and providing emotional support to the patient.

> [T]he promotion of a medical or healthcare response may result in a reduction of attention to, and funding for the remaining social or personal problems. This problem has been discussed in the area of caring for the elderly, where the presence of medical services is accompanied by a reduction in available social services.[97]

The goal focuses on defeating the disease or illness rather than providing comfort and emotional support to a suffering human being. Less attention to the patient's emotional needs will surely render the patient more likely to choose death than otherwise. Reduced attention to emotional needs undermines voluntariness. Decriminalizing assisted suicide would compromise the individual's capacity to make autonomous choice because one's will to live cannot but be affected by a sense of failure coupled with increased emotional suffering and dependence.

Institutionalizing assisted suicide may also produce coercive pressures on someone contemplating suicide by seeming to cheapen the value of their own life. If assisting suicide becomes an acceptable response to serious, even terminal illness, the patient himself or herself may see life as less worth living. The acceptance of assisted suicide might teach the lesson that life with a disability or with a serious illness is a burden, both to the patient and to the family, friends and health care workers surrounding the patient. The institutionalization and medicalization of assisted suicide may contribute to a patient seeing assisted suicide as a way of lightening that burden for others.[98]

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[96] M.M. Burgess, "The Medicalization of Dying" (1993) 18 *Journal of Medicine and Philosophy* 269 at 270.

[97] *Ibid.* at 275.

[98] See the *President's Commission, supra* note 3 at 91-118, for a further discussion of the limits to autonomy in a health care setting.

> Patients who are enfeebled by disease and devoid of hope may choose assisted suicide not because they are really tired of life but because they think others are tired of them. Some patients, moreover, may feel an obligation to choose death to spare their families the emotional and financial burden of their care. Other patients may succumb to the repeated signals from society that it would prefer to spend its limited resources on other compelling needs.[99]

How autonomous can decision-making be in this physical, psychological and emotional condition?

V. An Argument Against Decriminalization of Assisted Suicide

A. *The Argument*

If we accept that autonomy is a capacity which can be exercised by individuals only to varying degrees, a more persuasive reason for a prohibition against assisted suicide is suggested. The time when one contemplates suicide, or assisted suicide, is certainly one of despair and often a time when one is the victim of an apparently unendurable, incurable or terminal illness. It is often associated with great pain and physical discomfort but also with emotional and psychological suffering. The uncertainties, fears and confusions about the nature and future course of one's medical condition, coupled with the condition of dependence on family, friends and even strangers must attenuate very substantially one's capacity to autonomous decision-making. Given this compromised decision-making capacity, and in light of the very substantial dependence of the person contemplating assisted suicide, others — the community of the person, including health care workers — must take greater responsibility for the person, at least to a limited extent.

Consider that *Criminal Code* section 241(b) (which prohibits aiding or abetting suicide) does not restrict, except indirectly, the behaviour of the person contemplating suicide. It is the assistor that is criminally liable.[100] In such a situation, I suggest that autonomy is almost inevitably compromised in respect of all of the factors found to be essential to autonomous decision-making. Information about the medical condition and the possible future courses of life is typically badly wanting, even notwithstanding the best efforts of the medical team. The dependent condition and uncertainties about one's own feelings, fears and needs coupled with those of others, makes a mockery of voluntariness. Considered reflection must be very difficult and unreliable in these circumstances. Taking the situation as a whole, we cannot be satisfied that a person's assisted suicide really is in accordance with their own values and goals. We are not sure that the assisted suicide is really the choice that would have been made if the person realistically appreciated the range of options open to him or her. According to the *President's Commission*:

> A patient's choice is binding when it is selected freely — that is, when the patient can decide in accord with his or her own values and goals.[101]

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[99] D. Orentlicher, "Physician Participation in Assisted Suicide" (1989) 262 *Journal of the American Medical Association* 1844 at 1845.

[100] Although it might be argued that the person attempting assisted suicide, if unsuccessful, may be criminally liable as a party to the offense of the person giving the assistance.

[101] *Supra* note 3 at 45.

This is precisely the question — whether we can be satisfied that the patient can in fact "decide in accord with his or her own values and goals" — that we cannot confidently answer. Bruce Miller has termed this aspect of autonomy, "autonomy as authenticity" and describes it as "...an action... consistent with the person's attitudes, values, dispositions, and life plans."[102] In this sense, we are unsure whether the suicide is an authentic exercise of autonomy, given the stresses, fears, confusions and hopeless feelings that tend to accompany the consideration of a decision to die.

However, it may not be necessary that the law determine whether suicide is an authentic exercise of autonomy. It may be enough that the law requires that others refrain from lending assistance. If there is uncertainty about the individual's autonomous capacity, is it not sensible to require that others, if they are to be involved, err on the side of life? There may be no law against suicide or attempted suicide because, as a matter of criminal law, it makes no sense to punish that individual. What would be the point? Laws permitting the refusal of life-sustaining treatment arise from a different source— from the inviolability of the individual's body and the law of battery. The criminal law can, however, helpfully deter others from acceding too easily to the self-destructive request of one contemplating suicide who almost certainly has a questionable degree of self-determination. If we could be certain that a person requesting assistance in dying has sufficient capacity for autonomous decision-making, then respecting his or her decision may be unobjectionable. The person would be making an informed decision rationally in accordance with his or her own goals and values. But, if cases of such certainty are either non-existent or extremely rare, then the criminal law may quite properly proscribe all such assistance.

Leslie Bender has suggested that the justifications for drawing a legal and ethical distinction between killing (euthanasia and assisted suicide), which is not permissible; and letting die (acceding to a refusal of life-sustaining treatment), which is permissible:

> ...are legitimate only if we agree with three underlying assumptions: 1) laws and ethical principles must be designed for the "bad actors"; 2) each line must be firmly set to prevent a precipitous decline down the proverbial slippery slope; and 3) truly bad actors are in fact deterred by laws. I am unpersuaded by each.[103]

The defence of assisted suicide laws which I propose does not depend upon predictions that decriminalization of assisted suicide will lead to other, unintended and unacceptable practices. This is not a slippery slope argument. Neither does this defence arise from a concern that a person weak and vulnerable may be subject to abuse as a result. It is not designed to answer a problem of "bad actors". This defence is content to accept the good will and loving care which the vast majority of friends, family and health care workers wish to offer persons contemplating their own death.

Note also that this argument against assisted suicide acknowledges our visceral feelings about the importance of life. The argument does not proclaim that the patient's life must be protected even if the patient him or herself finds that life is a burden. This defence does not seek to protect life as a value in the abstract, but seeks to protect people from making a certain type of irrevocable, life-ending decision which they might not otherwise make. It reflects our uncertainty, when a suffering fellow human being

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[102] Miller, *supra* note 92 at 24.

[103] *Supra* note 94 at 532.

reaches out to us requesting assistance with suicide, as to whether in fact that person is really choosing death in a sufficiently autonomous way. It acknowledges life's importance by erring on the side of life at a time when autonomous decision-making is likely severely compromised and the capacity therefore doubtful. Where is the value of autonomy if, through it, one is left alone to make an irretrievable decision at what may be a time of confusion, despair and dependence?

Note also that this argument reflects society's widely held view that the role of doctors and other health care professionals is to *protect* the patient's life and well-being. Again, however, it is important to see that this argument does not say that physicians should protect the patient's life despite his or her fully autonomous decision to choose death. It does question the degree of autonomy which may be exercised by such a person and chooses life, since the answer is uncertain. Finally, this argument does not assume that people who are suffering are incompetent. The issue is not whether the patient has the capacity to understand and appreciate his or her medical condition. Rather, it guards against the possibility that, in the exercise of the patient's understanding and appreciation, the patient might be mistaken in making a choice which is in fact not the choice he or she would make if autonomous decision-making capacity was adequately present.

Legalizing assisted suicide may have the effect of discouraging what should be encouraged, that is, the development and application of improved palliative and comfort care for the suffering. If assisted suicide is an acceptable response to extreme suffering, it is an easier response than providing appropriate analgesia, emotional support and personal comfort to the suicidal. Greater emphasis on comforting and relieving the pain and suffering of a suicidal person clearly reduces the likelihood of that person choosing death. The autonomous decision-making of that person is affected by the treatment he or she receives from those providing care. Less pain and suffering and more comfort will surely tend to translate into a stronger choice for life.

B. *Objections to the Argument — Initial Remarks*

Assisted suicide is commonly defended on two broad grounds. The first defence of assisted suicide is based on compassion. Glanville Williams describes this justification for voluntary euthanasia as the prevention of cruelty:

> Much as men differ in their ethical assessments, all agree that cruelty is an evil—the only difference of opinion arising in what is meant by cruelty. Those who plead for the legalization of euthanasia think that it is cruel to allow a human being to linger for months in the last stages of agony, weakness and decay, and to refuse him his demand for merciful release.[104]

In short, we have an obligation of beneficence to permit a suffering person to be at last relieved of such a burden. Accordingly, when a person is suffering, and when they freely and voluntarily desire it, assistance may be offered to their suicide. Mr. Justice Cory, writing in dissent of the *Rodriguez* decision, is of the view that:

> State prohibitions that would force a dreadful, painful death on a rational but incapacitated terminally ill patient are an affront to human dignity.[105]

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[104] Williams, *supra* note 68 at 134.

[105] *Supra* note 8 at 630.

The second defence is that assisted suicide expresses respect for the individual's exercise of autonomy. Even the majority in the *Rodriguez*[106] case agreed that a prohibition against assisted suicide deprived Sue Rodriguez of autonomy of her person (although such deprivation was held to be in accordance with principles of fundamental justice). Madame Justice McLachlin wrote,

> Security of the person has an element of personal autonomy, protecting the dignity and privacy of individuals with respect to decisions concerning their own body.[107]

There are good reasons why a person contemplating suicide would wish to have assistance. First, their illness or some other disability may have rendered them unable to commit suicide unassisted. In addition, the availability of assisted suicide may permit someone with a deteriorating condition to delay their suicide until life becomes utterly a burden, a time which may be after their body has reached the point that unassisted suicide is no longer possible. For example, Sue Rodriguez argued that she may be 'forced' to commit suicide earlier than she wished to avoid being trapped by a physical inability to commit suicide at a later time. Second, a person committing suicide might reasonably wish to have the help of a doctor, to ensure that death is pain-free, comfortable and certain; or the company of friends or family members at this significant time. As it is, the presence of others at a suicide exposes them to the risk of prosecution for "aiding and abetting" the suicide.

If autonomy and compassion are two important grounds for supporting assisted suicide, it will not be surprising that these values also present challenges to my argument.

C. *Objections to the Argument — Compassion*

A serious objection, then, to this proposed defence of assisted suicide is that in refusing to assist someone's suicide we are failing to act compassionately towards a suffering human being. If the pain and torment of life has become too great for a person, whatever the state of their autonomous decision-making capacity, is it not better that that person's wish to die be respected? It may be that a person contemplating assisted suicide is often labouring under reduced autonomous capacity, and so may be mistaken about whether death, even by their own terms, is preferable. Clearly, however, death will sometimes in fact *be* preferable. The denial of assistance to those persons can be seen as unkind in the extreme. For example, there appears to be fairly widespread public sympathy for the plight of Sue Rodriguez, and a belief that it was not wrong for her to be given assistance with her suicide (if that is in fact what happened).

The difficulty with this objection is that if the argument casts sufficient doubt upon the individual's autonomous decision-making capacity as to justify forbearance in assisting suicide, then the moral force of the concern about compassion either disappears or is profoundly reduced. While respect for autonomy *and* compassion may together constitute an arguable defence of assisted suicide, compassion by itself is not sufficient. For, if we are not satisfied that a competent person genuinely and autonomously wishes to die, sympathy for that person's condition does not alone provide adequate justification.

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[106] *Ibid.* at 584-89.

[107] *Ibid.* at 618.

Compassion is perhaps a necessary, but definitely not a sufficient, condition to a defence of assisted suicide. Accordingly, at least when dealing with a competent suffering person, an ethically sound decision to assist their suicide will depend on that suicide being autonomously chosen. We are back to a consideration of the autonomous quality of the person's decision.

However, of course compassionate treatment of the person contemplating suicide is very important. This objection points eloquently to the need for family members, physicians, counsellors and others providing emotional support to those contemplating assisted suicide to be sensitive to how the sadness and despair of suicidal persons may affect their ability to appreciate the possibilities as well as the torments of their life.

D. *Objections to the Argument — Autonomy*

It may be said that the requirement that a suffering person be denied assisted suicide is a paternalistic affront to that person's autonomy. That is, even granting that in the normal case a person contemplating suicide and requiring assistance may have compromised capacity for autonomous decision-making, it is not clear on what basis society can substitute its decision for that of the individual. What justifies the paternalistic intervention of another? After all, even if the suicidal person *is* making a mistake, is it not *their* mistake to make? It may be that in requiring that no assistance be lent to suicidal persons, some degree of paternalism is implied. So be it. But in fact I believe that if there is paternalism involved in this suggestion, then it is only of a particular kind which is, in the circumstances, not objectionable.

I have noted that autonomous decision-making is "about oneself" without analysing just what this means. While the issue is complex, we might mean one of (at least) two things. First, we might mean that we are entitled to make decisions about what is done with or to our own bodies. That is, who can touch us, what drugs are to be administered to us, what surgical procedures may be performed upon us. This may be seen as autonomy of bodily integrity. Other decisions associated with autonomy do not involve our bodily integrity, but may be seen as regarding what is more fundamentally "about oneself", that is, it describes the decision-making power to shape the course of our present and future lives. The question is, how do we see ourselves — what choices are we to make about the way our future is to be? It is important to note that autonomy, even in a medical setting, is not simply about what is to be done with one's body. It is also about what is to be done with the rest of one's life — what sort of life one wishes for oneself — at least to the extent that is within the control of the individual.[108]

In this light, refusing to assist a person's suicide is a refusal to respect that person's immediate bodily integrity, that is, autonomy in the first sense. We refuse to lend assistance to individuals doing what they wish with their body, that is to kill it. If the individual dies, then autonomy in this second sense becomes moot. Autonomy as the ability to choose for oneself what one's future life will be like is the sense in which, I propose, we are uncertain as to whether our refusal promotes or frustrates the individual's autonomy. This is precisely because we do not know whether death is really the choice by the individual, in their pain, suffering and dependence, which will promote his or her "true" goals and values.

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[108] This distinction was suggested by Professor Alta Charlo at a talk given at the University of Toronto, Faculty of Law, on November 16, 1994.

The requirement to refrain from assisting does not arise out of society's or others' judgement as to the best interests of the person. Rather, it acknowledges that autonomous decision-making is not free of context. The nature and quality of our relationships, dependencies, confusions and fears are an integral and unavoidable aspect of our decision-making. Our decisions will necessarily change if our relationships change, our dependencies become acknowledged and accepted, our fears diminish, or our condition is better understood. These are all things over which the community of a person (family, friends, health care workers) has substantial control. Given the interrelations and interdependence of human life, can we abandon a suffering member of our community to make a decision of this magnitude at a time when they have perhaps the least ability to make it well? Even granting that a mistake (if it be one) is for the suicidal person, and no one else, to make, it does not follow that others must be legally entitled to render assistance. The person himself or herself is permitted to commit suicide, but others may be required, given the uncertainty as to whether a horrible mistake is being made, to resolve such uncertainty in favour of continued life.

E. *Objections to the Argument — Cases Where Decisions Are Sufficiently Autonomous*

Admittedly, there seem to be some cases where a request for assisted suicide is made with an adequately realized autonomy. In such cases, in theory, no principled reason has been advanced to show that lending assistance would be wrong or should be illegal. For example, people like Sue Rodriguez may have made a decision to commit suicide in a tolerably autonomous way. Anyway, if she did not, certainly many others have and will continue to do so. For those people, a rule against assisted suicide creates a formidable burden. The difficulty remains that there appears to be no satisfactory way of refining the rule to permit assistance only to those whose decision-making is truly reflective of their own goals and values. That being the case, the law is justified in prohibiting all such assistance, since no more sophisticated means have been found to isolate different types of cases.

Hopefully, this will be a problem for a relatively small number of persons. It is not suggested that suicide be recriminalized, so unassisted suicide remains an option for those who genuinely have chosen death, and are able. Of course, this is not a happy option for a couple of reasons. First, as we have noted, a person in that situation may wish not to be alone. So long as assisted suicide is a crime, anyone accompanying a suicide risks prosecution. More importantly, some terminal patients will wish to choose death, but only after living for so long as it is bearable. This may be beyond the time when unassisted suicide is possible for them. If it can be shown that significant numbers of people commit suicide sooner, because they will be unable to have assisted suicide later, the criminal status of assisted suicide may have to be reconsidered. However, I do not believe this to be the case. In any event, it is suggested that the benefits of its prohibition outweigh its harms.

The response that those who are able can commit unassisted suicide without criminal sanction is troublesome for another reason. That is, it has the effect of discriminating against the seriously disabled. This, of course, was one of the arguments raised by Sue Rodriguez, that the criminal prohibition of assisted suicide discriminates against those with disabilities, contrary to section 15 of the *Charter*.

The legal response to this objection was made by the *Rodriguez* majority, which found that, whether or not *Criminal Code* section 241(b) contravenes section 15 of the

Charter, it is saved by section 1 as a reasonable limit imposed by law. McLachlin, writing in dissent for herself and another (L'Heureux-Dubé) found no section 15 violation. Only Chief Justice Lamer and Justice Cory found a *Charter* violation on this basis. The majority held that any discrimination would be justified by the legitimate legislative purpose of protecting the weak and vulnerable from abuse. The parallel legal and ethical justification for overriding any discriminatory effect arising out of the argument against assisted suicide here proposed, relies on the protection of those whose diminished capacity for autonomy may cause them to make a terrible mistake. Unless some other way is found of distinguishing between those the rule seeks to protect and those not in need of protection, the law is justified in enforcing a general rule.

F. *Objections to the Argument—Applicability to Refusals of Life-Sustaining Treatment*

One final point may be made about this proposal, which may or may not be seen as an objection to it. I have argued that the moral relevance of the killing/letting die distinction is suspect. If this is so, the moral status of a person who complies with a refusal of life-sustaining treatment and that of a person who complies with a request to assist suicide are the same. If my proposal is correct and a criminal prohibition against assisting suicide is justified, are we then committed to the view that refusals of life-sustaining treatment ought also to be prohibited? When confronted with a patient wishing to have treatment withheld or withdrawn, is that patient not also likely deciding with reduced autonomous capacity? Therefore, ought we not to err on the side of life?

Even if the killing/letting die distinction is not morally relevant, it may be that the law of battery creates a legal difference. Doubts about the capacity of a person to exercise autonomous decision-making may lead us to require the refusal of assistance in suicide. But, the common law rule that patients are entitled to refuse treatment, under pain of liability for battery, overrides this consideration. If I am correct however that a person contemplating suicide is in a poor position to make an autonomous life-ending decision, perhaps the law of battery ought to give way to the protection of life. Without reaching a conclusion about this, it may be reasonable to suppose that the right to refuse treatment ought to be similarly restrained.

> To continue to address those issues as if they are, should be, or even could be resolved merely by elaboration of and deference to an individual 'right to die' would be to continue to apply a flawed paradigm. Decisions to withdraw treatment are not purely autonomous. At the very least, they are decisions in which individual choice is accompanied by social choice, a social choice which... requires confronting in some way the momentous decision of when, if ever, a life has no value.[109]

VI. Conclusion

I have attempted to show that, while not a perfect solution, the prohibition against assisted suicide amounts to an appropriate, and perhaps more caring response to a suicidal patient, family member or friend. Autonomy is an important human and bioethical value, but it is neither straightforward nor absolute. The objection to assisted suicide defended here is life-affirming and reflects our caution about helping someone

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[109] D.L. Beschle, "Autonomous Decisionmaking and Social Choice: Examining the 'Right to Die'" (1988) 77 Ky. L.J. 319 at 357.

execute a serious and irrevocable decision, when the circumstances of that decision cast doubt upon its authenticity.

I think too that this objection reflects more accurately the troubling nature of allowing assisted suicide. The nagging doubt which accompanies a consideration of this question is not (at least for me) a concern that people will come, significantly often, to abuse those in their care. Some abuse is possible (people are, no doubt, capable of almost anything), but not enough to justify overriding the authentic autonomous wishes of one who is deeply suffering. Nor is it that life, as an abstract concept, is too valuable ever to be renounced or sacrificed. I am prepared to accept that life can ethically and sensibly be renounced in some circumstances. I do not accept that, in principle, and in these types of situations, killing is morally worse than letting die.

The concern which gives me pause is that the suicidal person may be making a terrible mistake in judging that, even on his or her own terms, the values, goals and meaning of his or her life are truly no longer attainable. If a person is mistaken in this way, assisting that person would also be a tragic mistake, and would, in fact, be disregarding the person's authentic autonomy. Unless it has a reliable way of knowing when such a tragic mistake is or is not being made, the law is justified in proscribing assistance with suicide generally. The solution is not ideal, and does create some hardship. We have some reason to suppose that the alternative may be worse.