**Killing as Kindness: The Problem of Dealing with Suffering and Death in Secular Society**

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1. **Introduction**

Recently, courts have been equating suffering to the loss of dignity and vice versa. They define dignity as requiring that persons have control over what happens to them and, consequently, also equate a loss of autonomy and self-determination with the loss of dignity. This approach is consistent with American physician Eric Cassel’s definition of suffering as having a sense of one’s own disintegration and a loss of control over what happens to one. Often, claims with regard to what respect for a person’s dignity and autonomy requires are framed as respect for a right to choice. In short, allowing “choice” regarding what happens to oneself is put forward as the remedy for a loss of dignity and an appropriate means to relieve suffering.

At present, physician-assisted suicide and euthanasia are the most prominent and contentious issues in relation to which maintaining a person’s dignity, relieving suffering, and the proper approach of the law in dealing with suffering are relevant considerations. The law already seeks to uphold or restore dignity by giving terminally ill, suffering persons who want to die control over the treatments they receive. Requirements for informed consent — which from the perspective of giving control over treatment to the patient can be characterized as a “suffering reduction mechanism” — and rights to refuse life-prolonging treatment are examples. However, pro-euthanasia advocates argue that the necessary and only sufficient control of suffering is to be able to choose death.

Pro-euthanasia advocates see euthanasia principally as a way to relieve people’s suffering. They view suffering as the greatest evil and the relief of it as trumping almost all other values — respect for individual autonomy is the major exception. One of the challenges in responding to this argument in the euthanasia debate is that it’s not easy to give meaning to suffering other than through religion, which was the way many people dealt with suffering in the past. But today, many people are not religious. When suffering cannot be given any worth or meaning and a person does not believe that there is anything inherently wrong — that is, unethical — in inflicting death on a suffering person, at least on a suffering person who requests death and gives informed consent to it, it is very difficult to convince them that legalizing euthanasia is a bad idea.

Considering how we should respond to suffering, especially as a society, also raises the philosophical claim that it is not the job or proper role of medicine or the law to relieve all suffering and that in trying to do so physicians and law-makers are unjustifiably crossing boundaries that should be respected. And that leads to the question: How, then, does and should the law deal with suffering? First, let’s look at how some law students view it.

2. **How Suffering is Perceived**

I used to teach a course, “Ethics, Law, Science and Society”, to upper year and graduate law students at McGill University and one of the topics we discussed was euthanasia. I’ve researched euthanasia, physician-assisted suicide, the ethics and law of palliative care and pain relief treatment, decision-making at the end of life, and related topics for nearly three decades and published a 433-page book, *Death Talk: The case against euthanasia and physician-assisted suicide*. Yet, I came away from the class feeling that I had completely failed to communicate to most of my students what the problems with legalizing euthanasia were — that I was hitting a steel wall. This was not due to any ill will on their part; rather, they seemed not to see euthanasia as raising major problems — at least any beyond preventing its abuse — a reaction I found very worrying.

So, I emailed my students explaining I felt “that I had not done a good job in presenting the euthanasia debate […] [and] decided to see if I could work out why not by writing about it.” I attached an early draft of my article setting out my thoughts in that regard and asked for comments; I received several, very thoughtful replies.

One student explained that she thought I was giving far too much weight to concerns about how legalizing euthanasia would harm the community and
our shared values, especially that of respect for life, and too little to individuals’ rights to autonomy and self-
determination, and to euthanasia as a way to relieve
people’s suffering.

She emphasized that individuals’ rights have
been given priority in contemporary society, and they
should also prevail in relation to death. Moreover,
legalizing euthanasia was consistent with other changes
in society, such as respect for women and access to
abortion, she said.

I had suggested in my article that, among other causes
of the move to legalize euthanasia, the vast exposure to
death that we are subjected to in both current-affairs and
entertainment programs might have overwhelmed our
sensitivity to the awesomeness of death and, likewise, of
inflicting it. But another one of my students responded,
“If anything, I think many of our reactions come not
from an overexposure to death, but from an aversion to
suffering, and an unwillingness or hesitancy to prolong
pain.”

The Carter case shows a trial judge, Justice
Lynn Smith of the British Columbia Supreme Court,
articulating in great detail both the same approach
as the students took and the reasoning on which they
based their approach. She ruled that prohibiting
physician-assisted suicide is unconstitutional, because
it is necessary medical treatment for the relief of the
suffering of people with disabilities who are unable
to commit suicide without assistance. The British
Columbia Court of Appeal overruled Justice Smith’s
judgment on the grounds that it was contrary to the then
binding precedent of the Supreme Court of Canada’s
ruling in the Rodriguez case, in which a narrow
majority held that Canada’s Criminal Code prohibition
of assisted suicide was constitutional. The plaintiffs in
Carter appealed to the Supreme Court of Canada,
which overruled its previous precedent in Rodriguez
and allowed the appeal, relying on and strongly endorsing
Justice Smith’s findings of both law and fact.

In the analysis of the Carter case that follows,
numbers in square brackets referencing a court’s holding
refer to paragraphs in the Supreme Court of Canada’s
judgment while those in round brackets to paragraphs
in the trial court’s — that is, Justice Lynn Smith’s —
judgment.

3. The Carter Case

At 355 pages containing 137,000 plus words,
the trial judgment of Justice Smith in Carter is rightly
described as a tome. But it is one with groundbreaking
impact for Canadian society, because the Supreme
Court of Canada has upheld it on appeal. Leaving aside
abortion, it constituted the crossing of the thousands-of-
years old line-in-the-sand that we must not intentionally
kill another human being (the only exceptions being
where that is the only way to save human life, as in
justified self-defence) or help them to kill themselves.

In striking down the prohibition of assisted suicide
in section 241(b) of the Canadian Criminal Code as
unconstitutional, Justice Smith took the first step in
legalizing physician-assisted suicide (the physician
supplies the patient with the means to commit suicide
intending that they do so) in Canada and, where the
person is incapable of committing suicide because of
physical disability, euthanasia (the physician administers
a lethal injection). One of the plaintiffs in the Carter
case, Gloria Taylor, a woman suffering from ALS
(Lou Gehrig’s disease), wanted to have a physician
assist her in committing suicide at a time and a place
of her choosing. Justice Smith legitimized and granted
Ms. Taylor’s wish. Ms. Taylor subsequently died of
natural causes. The Supreme Court of Canada relied
heavily on the trial judgment in reaching its conclusion
that an absolute prohibition on “physician assisted
dying” breaches the Canadian Charter of Rights and
 Freedoms. Without meaning any disrespect, one could
say the Supreme Court hid behind the skirts of the trial
judge, especially with regard to questions of fact. Given
this heavy reliance, the trial judgment merits close
analysis.

Read as a whole, Justice Smith’s judgment
gives a strong impression that she is far from neutral
about physician-assisted suicide and euthanasia,
but, rather, favours these interventions in certain
circumstances. In particular, with respect, the judgment
seems to give undue weight to the evidence of
witnesses in favour of legalizing physician-assisted
suicide, while massively devaluing that of those who
oppose it. But the Supreme Court of Canada found the
contrary: “The trial judge’s findings were based on an
exhaustive review of the extensive record before her”.
However, the Supreme Court at its hearing refused
to allow the admission of evidence which would have
corrected this imbalance in Justice Smith’s assessment
of the evidence. Moreover, the trial judge’s
emphasis on the relief of suffering — the words “suffer”
and “suffering” appear 212 times in her judgment
— gives rise to what appear to be philosophical and
social biases being imposed by her upon the wealth of
evidence submitted by both parties.

Thus, one can question Justice Smith’s conclusions that
physician-assisted suicide is not inherently unethical;
that the availability of legalized physician-assisted
suicide is necessary “medical treatment” for some
people; and the very lengthy legal justification she constructs to allow her to implement her rulings to these effects. That justification was largely based on a selective application of Charter jurisprudence and was established by distinguishing the precedent set by the Supreme Court of Canada in Rodriguez, which found the prohibition of assisted suicide constitutional in a fact situation very similar to Ms. Taylor’s.

A majority of the Court of Appeal of British Columbia overruled Justice Smith by holding that Rodriguez applied. But the Supreme Court of Canada reinstated Justice Smith’s finding that she was not bound by Rodriguez on two bases: since that case (1) the law had changed and (2) there were new facts. Regarding the change in the law, after agreeing with Justice Smith that the absolute prohibition of assisted suicide by the Criminal Code breached all section 7 Charter rights – life, liberty and security of the person – the Supreme Court ruled that she was also correct that the test for compliance “with the principles of fundamental justice” that s. 7 allows to render such breaches constitutional had changed. It now required that, to be constitutionally valid, legislation must not be overbroad, that is, not breach the rights of people who do not fall within the legislature’s object in enacting the legislation:

[Rodriguez] did not apply the principle of overbreadth as it is currently understood, but instead asked whether the prohibition [of assisted suicide] was “arbitrary or unfair in that it is unrelated to the state’s interest in protecting the vulnerable, and that it lacks a foundation in the legal tradition and societal beliefs which are said to be represented by the prohibition” […]. By contrast, the law on overbreadth, now explicitly recognized as a principle of fundamental justice, asks whether the law interferes with some conduct that has no connection to the law’s objectives […]. This different question may lead to a different answer. [46]

And, with regard to the change in the facts:
The matrix of legislative and social facts in this case also differed from the evidence before the Court in Rodriguez. The majority in Rodriguez relied on evidence of (1) the widespread acceptance of a moral or ethical distinction between passive and active euthanasia. [47]

In Carter, the Supreme Court ruled that distinction was no longer accepted.

I will now examine, in more detail, some of the issues raised in Carter and how the Supreme Court endorsed the way in which Justice Smith dealt with them.

i) The primary goal of prohibiting physician-assisted suicide

Central to both the trial and Supreme Court judgments in Carter is whether protecting vulnerable people is the only purpose of the prohibition of physician-assisted suicide. Justice Smith rejects the Attorney General of Canada’s argument that the purposes are broader, including upholding respect for human life and the integrity of the medical profession, and “preventing negative messages about the value of human life, particularly the value of the lives of individuals with disabilities” (1187). Likewise, the Supreme Court of Canada rejects the Attorney General of Canada’s argument

…that the object of the prohibition [of assisted suicide] should also be defined more broadly as simply “the preservation of life”.[75] […]

Section 241 (b) is not directed at preserving life, or even at preventing suicide — attempted suicide is no longer a crime. […] The direct target of the measure is the narrow goal of preventing vulnerable persons from being induced to commit suicide at a time of weakness. [78]

The Supreme Court also held that rights to refuse life-support treatment, including artificial hydration and nutrition, show that there is no overriding goal of “the preservation of life” [66]. That is correct, but this goal or object should have been argued as maintaining “respect for life,” including at the societal level, and emphasis should have been placed on the argument that there is a difference-in-kind, not just a difference-in-degree, between justifiably allowing someone to die of natural causes and killing them with a lethal injection or helping them to kill themselves. Both the trial judge and the Supreme Court expressly rejected this distinction.

If the prohibition of assisted suicide were meant to uphold “respect for human life” in general at the societal level, then in all probability it would not, in stark contrast to these rulings, be found to be unconstitutional on the grounds on which both courts relied, which focused very strongly on individuals’ rights. Justice Smith ruled, and the Supreme Court agreed, that the prohibition was overbroad because of its harmful impact on people with disabilities, such as Ms.
Taylor, who want to commit suicide but need assistance to do so, in that it was absolute, with no exceptions for people such as Ms. Taylor. Consequently, the prohibition impaired her section 7 Charter rights to “life, liberty and security of the person” more than was necessary for the state to achieve its legitimate goal of protecting vulnerable people. In other words, limiting the goal of the prohibition on assisted suicide to the protection of “vulnerable people” is essential to the reasoning that the prohibition is unconstitutional, because it is overbroad.

This ruling raises the issue of whether Parliament should include in any legislation it passes to implement the Supreme Court’s decision, as the court invited it to do, a provision that the object of the legislation is also to uphold respect for human life at both the individual and societal levels. I would strongly recommend that it do so, as even if completely banning physician-assisted suicide is not possible without using the Charter’s section 33 “notwithstanding clause,” this would enable Parliament to severely restrict access to assisted suicide.

In light of the object identified for the prohibition of assisted suicide, it is not surprising that Justice Smith’s conclusions, and those of the Supreme Court, do not give substantial weight to institutional or societal protections or needs, but are focused principally at the individual level and giving individuals’ claims priority, which in Ms. Taylor’s case was her claim of a right to access assisted suicide for the relief of suffering. In other words, they accept an individual’s suffering as the principal justification for euthanasia and that its presence means an individual’s request for “assisted death” trumps other claims and considerations. Here’s how the Supreme Court opens its judgment:

It is a crime in Canada to assist another person in ending her own life. As a result, people who are grievously and irremediably ill cannot seek a physician’s assistance in dying and may be condemned to a life of severe and intolerable suffering. A person facing this prospect has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. The choice is cruel. [1] (Emphasis added)

The last four words tell us what the decision will be. And the Supreme Court turns to the stories of individuals’ suffering and difficult deaths to support this outcome:

The stories in the affidavits vary in their details: some witnesses described the progression of degenerative illnesses like motor neuron diseases or Huntington’s disease, while others described the agony of treatment and the fear of a gruesome death from advanced-stage cancer. Yet running through the evidence of all the witnesses is a constant theme — that they suffer from the knowledge that they lack the ability to bring a peaceful end to their lives at a time and in a manner of their own choosing.

We must listen to and take into account such stories, but they are not all that we need to hear and to take into account.

There is also a paradox here. The focus is on individuals’ suffering and, hence, vulnerability. This focus, which is meant to protect vulnerable people, is being used to place them at risk from assisted suicide by legitimizing it. The same reversal of an initial protective goal has occurred with the concept of quality of life. Initially “quality of life” was developed as a concept intended to protect and promote life through the argument that everyone had a right to the resources, especially healthcare resources, needed to maintain an acceptable “quality of life.” Now the concept is often used to achieve the exact opposite outcome, namely, that a person’s “quality of life” is so poor that they are better off dead or, at the least, do not merit the expenditure of resources needed to keep them alive.

Having decided that the ban on assisted suicide is intended primarily to protect vulnerable persons, Justice Smith then concludes, and the Supreme Court agrees, that an absolute ban on it is not necessary to implement that goal and, moreover, that an absolute ban infringes Ms. Taylor’s Charter rights as a disabled, suffering person, and, by extension, those of other and similarly situated “vulnerable persons”:

In this case, I have found that the infringement [of the Charter] arises from the preclusion of physically disabled persons who are grievously ill and experiencing intractable suffering from ending their lives. Thus, it is the absolute nature of the prohibition against assisted suicide that requires justification, not the prohibition overall. In other words, the real question is whether the defendants have demonstrated justification for criminalizing the rendering of assistance in suicide to persons such as Gloria Taylor. (1171) (Emphasis added)

In reaching this conclusion, Justice Smith takes into account Ms. Taylor’s own views that she does not need protection from assisted suicide as helping to establish that she does not. In other words, the judge gives priority to the value of individual autonomy in relation to a decision to commit suicide to avoid
suffering. She rules that a safeguarded exception should be allowed and sets out the conditions for such an exception. Justice Smith envisions that the cases in which physician-assisted suicide or euthanasia is acceptable will be rare. But it is important to note that the method for accessing these interventions she sets out in her exception is broad and without the safeguards that might assure its application only in very restricted cases. Exactly the same observations are true of the Supreme Court’s ruling in this regard.

Because it is so unusual, and especially because the Supreme Court adopted it, I wish to note here how Justice Smith interprets the right to life enshrined in s. 7 of the Charter: It [i.e. Rodriguez] leaves open whether the legislation [the prohibition on assisted suicide in section 241(b) of the Criminal Code] infringes Ms. Taylor’s right to life. (13)

To say the least, this is a novel way to construct a breach of Ms. Taylor’s Charter right to life. In effect, this reasoning converts the right to life to a right to death by physician-assisted suicide or euthanasia. The Supreme Court endorsed this approach as follows:

[...] We do not agree that the existential formulation of the right to life requires an absolute prohibition on assistance in dying, or that individuals cannot “waive” their right to life. This would create a “duty to live”, rather than a “right to life”, and would call into question the legality of any consent to the withdrawal or refusal of lifesaving or life-sustaining treatment. The sanctity of life is one of our most fundamental societal values. Section 7 is rooted in a profound respect for the value of human life. But s.7 also encompasses life, liberty and security of the person during the passage to death. It is for this reason that the sanctity of life “is no longer seen to require that all human life be preserved at all costs” [...] And it is for this reason that the law has come to recognize that, in certain circumstances, an individual’s choice about the end of her life is entitled to respect. [63]

It merits noting the lengthy reasoning the Supreme Court uses here to reach its conclusion that “an individual’s choice about the end of her life is entitled to respect”: it has eight separate steps. But as mentioned previously, while it is correct “that all human life [need not] be preserved at all costs,” that does not mean that it can be intentionally taken. Not preserving human life and intentionally taking it are not commensurable and are not the same ethically or legally. Provided it can be justified in any given circumstance, not preserving life can be ethical and legal; intentionally taking life has never been such, except when it is the only reasonable way to save innocent human life, as in self defence.

With respect to who the suffering persons are who may have access to physician-assisted suicide, in speaking about palliative care services in British Columbia, Justice Smith refers to “the end-of-life population” (692). She does not define this term, which in the Royal Society of Canada Expert Panel Report on End of Life Decision Making encompasses a continuum beginning with a serious diagnosis or injury. This expansion of a term that traditionally is used for those in the last days or weeks of life to all with chronic conditions resulting from illness and injury presages precisely the dangerous expansion along a “slippery slope” from the “limited” exception the judge proposes. Likewise, the Supreme Court did not require a person to be terminally ill to have access to “physician assisted death.”

There is something chilling about Justice Smith’s construction of an “end-of-life population” that is not present when we speak of “dying people,” “vulnerable people,” “terminally ill people” or, even, “the terminally ill.” First, we do not know to whom it refers. But, if, as seems plausible, Justice Smith has accepted the approach of The Royal Society Expert Panel report, to which the Supreme Court also refers with approval [7], it may encompass all individuals with a serious diagnosis or injury that might be fatal in the course of time. And, of course, it is notoriously difficult to predict with any certainty the timing of death in relation to even obviously terminal illnesses for which no clinical treatment is possible. 18

Just as troubling is the dropping of the word “people” or “person.” It is dehumanizing, depersonalizing, and allows easier dis-identification from the person or people concerned. The “end-of-life population” is a term that marks off the people labeled as such from the general population. They become “them,” in contrast to the “rest of us.” It brings to mind Susan Sontag’s metaphor of the two “kingdoms,” the kingdom of the well and the kingdom of the sick but, if physician-assisted suicide or euthanasia
Killing as Kindness

were legalized, with even more alienating and frightening connotations: “Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.”19 Justice Smith’s depersonalized and undefined generalization of an “end-of-life population” also brings to mind the dystopic world imagined by P. D. James in her novel The Children of Men in which elderly persons’ duty to die is enacted through a form of mass suicide called the Quietus (quiet us).20 And this disposal of fragile persons through a “duty to die” was famously argued as policy by Colorado Governor Richard Lamm in the 1980s21 as well as by, in a modified form, ethicist and Hastings Center Fellow Daniel Callahan in the 1990s.22

The point, yet again, is that despite the promise of very restricted relaxation of the current legal prohibitions protecting persons, implicit in Justice Smith’s decision is the invitation to expand physician-assisted death to many people not dying, but diagnosed with a serious illness or disabled or, simply, suffering. The same is probably even truer with respect to the Supreme Court’s ruling:

Section 241 (b) and s. 14 of the Criminal Code unjustifiably infringe s. 7 of the Charter and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. [147]

The Supreme Court explicitly requires that informed consent to “physician-assisted death” (physician-assisted suicide and euthanasia) be obtained. But that is not possible unless all reasonable alternatives to the proposed “treatment” are offered.23 This means that fully adequate palliative care must be available before a patient’s consent to “physician-assisted death” would be valid. We know, however, that only 16 to 30 percent of Canadians who need palliative care have access to it, which is appalling.24 We also know that many patients who ask for euthanasia change their minds when given good palliative care.25 And, because the Canadian Medical Association was proposed as one of the main advisers to the government about the steps it should now take in response to the Carter judgment, it’s immensely worrying that in their factum as an intervener before the Supreme Court of Canada, they expressly said that the unavailability of palliative care should not be a reason to refuse “physician-assisted death”.

ii) Suicide is not a crime

Justice Smith focuses on the Canadian Parliament’s repeal of the suicide and attempted suicide offences in 1972 and accepts, as she is bound to do by the precedent established by the Supreme Court of Canada in Rodriguez,26 that this was not done to give a personal choice to die priority. She states:

As to the objective underlying Parliament’s repeal […] the majority [in Rodriguez] held that the objective was not to recognize a consensus that the autonomy interest of those who might wish to kill themselves is paramount to the state interest in protecting the lives of citizens; rather, it was to recognize that attempted suicide did not mandate a legal remedy. (926)In the same vein, the Supreme Court notes that

[s]ection 241(b) is not directed at preserving life, or even at preventing suicide — attempted suicide is no longer a crime. [78]

With respect, I would explain the matter differently: the crimes were abolished to try to save the lives of suicidal people. It was hoped that if they were not threatened with the possibility of being charged with a criminal offence in seeking medical help to treat suicidal ideation, they and their families would be more likely to seek such assistance.

In coming to her conclusions about the acceptability of legally permitted assisted suicide, throughout the judgment Justice Smith relies heavily on the fact that it is not a crime to commit or attempt to commit suicide, and asks, why then is it a crime to assist it? She opines:

[T]he law does not prohibit suicide (15).

[…] The plaintiffs […] argue that there is no ethical distinction between the laws that permit suicide and those that prohibit physician-assisted suicide. (176)

[…] What is the difference between suicide and assisted suicide that justifies making the one lawful and the other a crime, that justifies allowing some this choice, while denying it to others? (1010)

The answer is, as explained above, that decriminalizing suicide and attempted suicide is intended to protect life; decriminalizing assisted suicide does the opposite. We try to prevent suicide and, importantly, there is no right to commit suicide. If there were such a right, we would
have a duty not to treat people who attempt suicide, in order to try to save their lives, and to let them die.

The difference between suicide and physician-assisted suicide is fundamental. Suicide is a solitary act we may try to prevent, but which is carried out by the individual, usually in despair. Physician-assisted suicide is a social act in which medical personnel licensed and compensated by the state are involved in the termination of the life of a person with the approval of the state. It asks not that we attempt to preserve life, the normal role of medicine and the state, but that we accept and act communally upon a person’s judgment that his or her life is unworthy of continuance. It is to see the infliction of death as an ethical, appropriate and justified response to suffering. This is exactly the message that those trying to prevent suicide want to negate totally.

Assisted suicide thus involves a separate ethical enquiry that distinguishes it from suicide, an enquiry which is not undertaken in either the trial or Supreme Court judgments: this is the ethics of society’s and a physician’s complicity in helping a person to kill themselves. Legalized physician-assisted suicide involves both these forms of complicity: society is complicit in legalizing the procedure and a physician, licensed by society and, in Canada, compensated by it, is complicit in carrying it out.

For this reason the value of respect for life, especially at the societal level of respect for human life in general, is differently impacted by assisted suicide as compared with suicide. The former contravenes this value, particularly at the societal level, in a way that the latter does not.

Justice Smith relied on the dissenting judgment of Chief Justice Lamer of the Supreme Court of Canada in Rodriguez to find that

[...] s. 241(b) of the Criminal Code creates an inequality by preventing persons physically unable to end their lives from having the option to choose suicide, while other members of the public have that option. He [Chief Justice Lamer] found that the inequality is imposed because of a physical disability, a personal characteristic among the grounds of discrimination listed in s. 15(1) [of the Charter]. He concluded, at 549-50, that the inequality constitutes a burden or disadvantage since it limits the ability of persons who are subject to the inequality to take and act upon fundamental decisions regarding their lives and persons; for them, “the principle of self-determination has been limited”. Differing from the majority, he found that the infringement of s. 15 was not justified under s. 1 [of the Charter].

But Justice Smith fails to mention that in order to rule to this effect the Chief Justice recognized a right to choose to commit suicide. The way in which the Chief Justice’s ruling is summarized in the headnote to Rodriguez throws a different light on the passage from his judgment upon which Justice Smith relies:

This inequality—the deprivation of the right to choose suicide—may be characterized as a burden or disadvantage, since it limits the ability of those who are subject to this inequality to take and act upon fundamental decisions regarding their lives and persons. (Emphasis added)

Does such a right mean that we would have correlative obligations not to prevent people making that choice? Certainly, hospital emergency rooms and healthcare professionals faced with a patient who has attempted suicide do not, at present, act on that basis. And psychiatrists who fail to take reasonable care that their patients do not commit suicide, including by failing to order their involuntary hospitalization in order to prevent them committing suicide, can be liable for medical malpractice (negligence), unprofessional conduct (they lose their medical licenses), and, even criminal negligence in extreme cases.

The Supreme Court avoided addressing the issue of discrimination. In responding to the question, “Does the Prohibition on Assisted Suicide Violate Section 15 of the Charter?” it ruled:

Having concluded that the prohibition of assisted suicide violates s. 7, it is unnecessary to consider this question. [93]

iii) Weighting the evidence disproportionately

Consistent with focusing on the risks and harms to individuals, the vast majority of the evidence to which Justice Smith gives credibility is empirical. Correlatively, she dismisses or gives short shrift to evidence she labels as non-empirical, which includes evidence of risks and harms to existential realities such as important shared societal values. In fact, the word “empirical” appears with great frequency in the judgment—28 times in all. (It is paired with the words studies, research, evidence, knowledge, data, foundation, work, proof, and precision.) Suffering can be empirically established, although the evidence that demonstrates it is largely subjective. In Carter it was introduced in evidence by witnesses who described either their own circumstances of illness and disability, and explained why they wanted the option of physician-
assisted suicide to be available, or those of loved ones, who had also wanted that option. The Supreme Court emphasizes this evidence, focusing on individual cases and the suffering they manifest, starting with Gloria Taylor’s situation [12] and continuing by referring to witnesses’ descriptions of horrible diseases and suffering, the agony of treatment and the fear of a gruesome death [14]. As mentioned previously, at the very beginning of its judgment, the Supreme Court summarizes how it sees the situation of these people:

A person facing this prospect has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. The choice is cruel. [1]

In contrast to the weight she gives to the plaintiffs’ evidence, Justice Smith dismisses or gives little weight to most of the defendants’ expert witnesses’ testimony on the ground that it’s not empirically based (see, for example, such references by the judge to the evidence of Dr. Jose Pereira, Baroness Ilora Finlay, and Dr. Herbert Hendin (664)). The problem here is that many of the risks and harms of legalized physician-assisted suicide and euthanasia, at levels other than the individual one, are metaphysical risks and harms (to values, beliefs, attitudes, norms and so on) and not physical risks and harms. The former are not necessarily assessable through empirical research, especially those that will occur in the future. The strong emphasis on empirical evidence, to the exclusion of other valid and accepted research methodologies, means that what can’t be measured or counted is treated as unimportant or ignored.

That said, there are also serious risks of legalized physician-assisted death, particularly its abuse, especially with regard to vulnerable people, which can and have been empirically established in jurisdictions that allow it. Justice Smith gives little weight to the evidence of these abuses. The Supreme Court allowed the Attorney General of Canada to present an affidavit from one expert witness providing testimony about such abuses in Belgium, but refused to admit further evidence that would have corrected Justice Smith’s factual errors in this regard. Indeed, as mentioned previously, the Supreme Court affirmed her findings of fact.

The Supreme Court’s refusal is consistent with the rules governing appeals, namely that evidence that was available at the time of trial and not presented cannot be introduced on appeal; that there must be great deference to a trial court’s findings of fact; and that appeals must be on questions of law, not fact. However, with respect, Justice Smith’s findings on the basis of the evidence before her in regard to abuses of euthanasia in the Netherlands and Belgium and its ongoing expansion in those countries to more and more people in more and more situations were so manifestly wrong that I would have hoped that the Supreme Court justices would have wanted to ensure that the evidence on which they based their decision was as accurate as possible. The question of whether legalizing euthanasia leads to its abuse is such a critical issue in the decision of whether to legalize it, and legalizing it is such a landmark change for Canadian society’s collective values and for medical practice, that it is imperative that the evidence on which such a decision is based is correct, complete, and accurately interpreted. With respect, I do not believe that is true of Justice Smith’s findings which the Supreme Court endorsed. Indeed, in my respectful opinion, many of those findings are clearly wrong.

In summary, almost all of Justice Smith’s analysis, in particular of the risks and benefits of physician-assisted suicide, is at the level of the individual suffering patient who wants physician-assisted suicide. By focusing her analysis at this level and treating empirical evidence as the only relevant or credible evidence, Justice Smith, in effect, uses an exclusionary mechanism to eliminate the evidence of the defendant government’s experts against legalizing physician-assisted suicide. In doing so, she weighs the balance heavily in favour of the relief of suffering as the overriding value and a strong justification for physician-assisted suicide and euthanasia.

After refusing to allow the Attorney General of Canada to bring further evidence to clarify the problems with Justice Smith’s rulings on the evidence, the Supreme Court examined these rulings in relation to Justice Smith’s finding that s. 1 of the Charter’s requirement of “minimal impairment” of Charter rights was not fulfilled, and concluded as follows:

This question [of whether an absolute prohibition of assisted suicide is required] lies at the heart of this case and was the focus of much of the evidence at trial. In assessing minimal impairment, the trial judge heard evidence from scientists, medical practitioners, and others who were familiar with end-of-life decision-making in Canada and abroad. She also heard extensive evidence from each of the jurisdictions where physician-assisted dying is legal or regulated. In the trial judge’s view, an absolute prohibition would have been necessary if the evidence showed that physicians were unable to reliably assess competence, voluntariness, and non-ambivalence in patients;
that physicians fail to understand or apply the informed consent requirement for medical treatment; or if the evidence from permissive jurisdictions showed abuse of patients, carelessness, callousness, or a slippery slope, leading to the casual termination of life (paras. 1365-66). [104]

 […]

As to the risk to vulnerable populations (such as the elderly and disabled), the trial judge found that there was no evidence from permissive jurisdictions that people with disabilities are at heightened risk of accessing physician-assisted dying (paras. 852 and 1242). [107]

 […]

The evidence, she concluded, did not support the contention that a blanket prohibition was necessary in order to substantially meet the government’s objectives [of protection of vulnerable people]. We agree. A theoretical or speculative fear cannot justify an absolute prohibition. [119]

 […]

We find no error in the trial judge’s analysis of minimal impairment [of section 7 rights, required under section 1 of the Charter for the impairing law to be constitutionally valid]. We therefore conclude that the absolute prohibition [on assisted suicide/physician assisted death] is not minimally impairing. [121]

iv) Underlying assumptions and principles

Both Justice Smith and the Supreme Court of Canada make assumptions that assisted suicide (and euthanasia) is not inherently wrong and, moreover, that access to such an intervention is morally required in certain circumstances, in particular, to relieve suffering. In all probability, they are doing the same as in the reports of the Royal Society Expert Panel\(^39\) and the Quebec National Assembly,\(^30\) both of which were admitted in evidence at trial against the defendants’ objections and referred to by the Supreme Court [7]. This is simply to assume, without providing justification, that individual autonomy is the value that always takes priority. Like both those reports, Justice Smith’s entire judgment, and that of the Supreme Court, is also consistent with the adoption of both a philosophical base of moral relativism and an approach of utilitarianism, which favours seeing relief of suffering as an overriding justification for physician-assisted suicide and euthanasia.

In addressing the question of whether the principle of preservation of life has exceptions, Justice Smith first finds that it does and then accepts the evidence of one of the plaintiffs’ expert witnesses, Canadian philosopher Professor Wayne Sumner, to the effect that death is not a loss or bad if there is no benefit in a continuing life; in other words, that a poor quality of life and suffering can justify such an exception. Here’s her reasoning (at 350-351), which includes quoting a passage from Professor Sumner’s evidence:

> With respect to the first question [Does a physician have an overriding duty to support the inviolability of life and refrain from intentionally causing death, or can it be ethical, in an individual case, for a physician to assist a competent and informed patient who requests hastened death?], I think that the real difference of opinion is not about the value of human life; no-one questions that the preservation of human life has a very high value in our society. Rather, the difference of opinion is about whether the preservation of human life is an absolute value, subject to no exceptions. (350)

Professor Sumner explores this point:

> Normally we assume that death is one of the worst fates that can befall us, which is why in both ethics and law the causing of death is taken to be such a serious matter. But what makes death such a bad thing in the normal case is what it takes away from us — the continuation of a life worth living. The disvalue of death is therefore a direct function of the value of the life thereby lost. This is the deprivation account of the badness of death: death is bad for us by virtue of depriving us of the goods of continued life. On this account showing that death would be bad for a person requires a comparison between two possible futures for that person: the one in which he dies and the one in which he lives on. If the goods of further life would outweigh the evils, then it would be better for the person to continue living, and death would therefore be a harm to him since it would deprive him of this good future. [Emphasis in original.] (351)

On the other hand, if the “evils” of continued life outweigh its goods, death is not a harm as nothing good is lost. This is a quality of life argument couched in different terms, those of non-deprivation. The person’s quality of life is seen as being so poor that they are not deprived of any benefit — indeed, they are benefited — by their life being taken.
Killing as Kindness

Although Justice Smith speaks of this approach applying “in an individual case,” this same reasoning could readily be applied to babies with disabilities, people with dementia, and so on. Justifying the taking or not maintaining the lives of such people on the basis of their poor quality of life and the suffering involved in continuing to live is usually supported on the grounds that they are “individual cases,” and the cumulative effect of the decisions taken in those cases is ignored. But the cumulative effect is to wipe out the people with a specified characteristic as a group. For instance, in North America around 85 percent of Down syndrome babies are now aborted. And, in 2011, two bioethicists caused an international furor when they published a paper in a highly respected journal proposing “post birth abortion”: parents who have a Down syndrome child, whom they would have aborted if they’d known of its condition, should be allowed to have it killed after birth (legalized infanticide). In this respect, it is relevant to point out that the Groningen protocol in the Netherlands allows the parents of severely disabled newborn babies to request that they be euthanized.

It merits noting in the context of exploring the cumulative effect of legalizing physician-assisted suicide and euthanasia that both the Royal Society of Canada Expert Panel’s report and the Quebec National Assembly Select Committee’s report raise the issue of whether euthanasia should be available for mentally incompetent people, for instance, for those with Alzheimer’s disease. Neither report comes out against that being allowed, but, rather, they leave the question open, stating that this is an issue to be examined further at a later date. However, if physician-assisted suicide is medical treatment meant to relieve suffering, as its supporters argue, then it would be discriminatory to offer it to mentally competent people and not to incompetent ones.

v) The “no difference” argument

The essence of the “no difference” line of the pro-euthanasia argument, which was accepted by Justice Smith and the Supreme Court, and which is central to their judgments, is that we already accept and practice interventions, such as withdrawal of life-support treatment or the provision of necessary pain management that result in death or could shorten life, respectively, and since there is no ethical or moral difference between these, on the one hand, and physician-assisted suicide and euthanasia, on the other, there ought to be no legal difference. The argument is that the latter are of the same kind as the former and that legalizing them is just a further incremental step along a path we have already taken and which we regard to be ethically and legally acceptable. Justice Smith puts it this way:

That spectrum [of acceptable interventions at the end-of-life] already encompasses decisions where the likely consequence of the decision will be the death of the patient. (1240)

I call this strategy “legalizing euthanasia through confusion.” It depends on a misleading and, I would argue, false analogy. The issue in the “euthanasia debate” is not if we die — we will all die eventually — but the ethics and law of how we die. People who oppose physician-assisted suicide and euthanasia believe these are unethical ways to die and can be validly distinguished from the other ways in which life may be shortened and, consequently, the former should remain prohibited. The difference can be summarized as that between allowing a person to die a natural death and killing the person.

The essential ethically and legally relevant differences between the two kinds of interventions do not include that between an act and an omission, on which pro-euthanasia advocates, such as Canadian law professor Jocelyn Downie, allege anti-euthanasia proponents rely. Like the acts of physician-assisted suicide or euthanasia, an omission — for example, withdrawal of life-support treatment that results in a person’s death — can be (but, unlike physician-assisted suicide or euthanasia, is not necessarily) ethically, morally and legally culpable. The relevant differences between these two kinds of interventions lie in the primary intention with which they are undertaken and in causation of death.

The distinction between pain relief treatment and euthanasia hinges on the physician’s primary intention in giving the treatment and the patient’s need for the treatment given. Pain relief treatment given with a primary intention to relieve pain and which is reasonably necessary to achieve that outcome is not euthanasia, even if it shortens the patient’s life (which is a very rare occurrence for correctly titrated treatment). Any intervention, including the use of pain relief drugs, carried out with a primary intention of causing the patient’s death and resulting in that outcome, is euthanasia.

Acting with a primary intention to kill is a world apart from acting with a primary intention to relieve pain. And this is not a novel or exceptional approach. The law often recognizes the relevance of such distinctions in intention. If we accidentally hit and kill a pedestrian with our car, it is not murder; if we deliberately run him down with our car intending to kill...
him, it is. It’s the same act, but different intentions make the difference.

People in pain are among the most vulnerable persons, so the issue of adequate pain management has special application in relation to them. As Albert Schweitzer said, “Pain is a more terrible Lord of mankind than death itself.” A person in pain can want to die by any means, rather than have to go on living in pain. Consequently, we have serious ethical obligations—and I would argue legal obligations—to offer everyone fully adequate pain management.

An adverse consequence of equating pain management to euthanasia is that it can make people who reject euthanasia reject adequate pain management for ethical or religious reasons, or because of fear that if they consent to it, they will be euthanized. Experience in the Netherlands shows that the latter is not an unjustified fear: It has been alleged that Dutch physicians have interpreted patients’ consent to pain management as consent to euthanasia.38

The primary intention is also different in withdrawing life-support treatment, on the one hand, and physician-assisted suicide and euthanasia, on the other. In withdrawing life-support treatment, the primary intention is to respect the patient’s right to refuse all treatment or to remove medically futile treatment or that where the burden of the treatment for the patient outweighs any benefits. In physician-assisted suicide or euthanasia the primary intention is to help the patient to kill himself or to kill him, respectively. The former intention is ethically and legally acceptable; the latter intentions are not.

Patients have a right to refuse treatment, even if that means they will die. Such a refusal is an exercise of their right to autonomy and self-determination, but the content of that right in such situations is a right not to be touched without their consent—a right to inviolability—not a right to die.

Pro-euthanasia advocates use recognition of the right to refuse treatment even when it results in death to argue that, likewise, patients should be allowed to exercise their right to autonomy and self-determination to choose death through lethal injection. As explained above, they say that there is no morally or ethically significant difference between these situations, and there ought to be no legal difference.

They found their argument by wrongly characterizing the right to refuse treatment as a “right to die,” and then generalize that right to include euthanasia and physician-assisted suicide. But the right to refuse treatment is not a “right to die” and does not establish any such right, although death results from respecting the patient’s right to inviolability. The right to refuse treatment can be validly characterized as a “right to be allowed to die,” which is quite different from a right to be killed that legalized euthanasia establishes.

This particular pro-euthanasia line of argument is just one more example of promoting euthanasia through deliberate confusion between interventions that are not euthanasia (such as acting on valid refusals of treatment) and those that are.

This brings us to the issue of causation, which also differentiates refusals of treatment that result in death from euthanasia.

In refusals of treatment that result in death, the person dies from her underlying disease—a natural death. The withdrawal of treatment is the occasion on which death occurs, but not its cause. If the person had no fatal illness, she would not die. And, moreover, sometimes patients, who refuse treatment and are expected to die, do not die. In contrast in euthanasia, death is certain and the cause of death is the lethal injection. Without that, the person would not die at that time from that cause.

The fact that the patient dies in both refusing treatment that results in death and in euthanasia is one of the causes of the confusion between the two situations. If we focus just on that outcome of death, we miss the distinction between the two situations.

Here’s how Justice Smith articulated the plaintiffs’ expert witnesses’ “no difference” arguments, which she endorsed (see, for example, at 335, 339, 349) and which the Supreme Court not only accepted but also used as a central rationale for overriding its previous decision in Rodriguez:

[The plaintiffs argue that the current line drawn between permissible and impermissible end-of-life care is based upon distinctions that in reality have no practical ethical or moral force. They also argue that there is no ethical distinction between the laws that permit suicide and those that prohibit physician-assisted suicide.” (176)

[...] One of the main arguments for the proposition that physician-assisted death can be an ethical practice is that physician-assisted death is ethically indistinguishable from conventionally ethical end-of-life practices such as withholding or withdrawing treatment or administering palliative sedation.” (186)

[...] However, as set out in my review of the evidence with respect to safeguards, in the
opinion of a number of respected ethicists and practitioners, physician-assisted death in an individual case is not ethically distinguishable from currently legal and ethically accepted end-of-life practices. (1369) (Emphasis added)

The Supreme Court described Justice Smith’s formulation of this “no difference” argument as follows:

The trial judge began by reviewing the current state of the law and practice in Canada regarding end-of-life care. She found that current unregulated end-of-life practices in Canada — such as the administration of palliative sedation and the withholding or withdrawal of lifesaving or life-sustaining medical treatment — can have the effect of hastening death and that there is a strong societal consensus that these practices are ethically acceptable (para. 357). After considering the evidence of physicians and ethicists, she found that the ‘preponderance of the evidence from ethicists is that there is no ethical distinction between physician-assisted death and other end-of-life practices whose outcome is highly likely to be death’ (para. 335). Finally, she found that there are qualified Canadian physicians who would find it ethical to assist a patient in dying if that act were not prohibited by law (para. 319). [23] (Emphasis added)

It is interesting to speculate why Justice Smith, yet again,9 limited her statement to “an individual case.” Read in relation to the judgment as a whole, it is probably because she requires justification for physician-assisted suicide in each case and that would require that the person were “grievously ill” (1271), that is, suffering. But it could also be taken to mean such interventions are not able to be justified as a group or on the whole, because of their cumulative impact on important shared values, in particular respect for life, or at institutional and societal levels, issues which Justice Smith does not consider in any depth or at all. Or it could be that the judge wants to avoid setting a precedent that people with a certain disability are automatically identified by that disability as having a claim — or even a right — with respect to having access to physician-assisted suicide or euthanasia.

The Supreme Court adopts a “no difference” approach and expands on Justice Smith’s reasoning in analysing what respect for the s. 7 Charter rights to “liberty and security of the person” require, making these rights protective of a very broad scope for the exercise and dominance of individual autonomy and, concurrently, more easily breached by any restriction on a person’s “choice”:

We agree with the trial judge. An individual’s response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy. The law allows people in this situation to request palliative sedation, refuse artificial nutrition and hydration, or request the removal of life-sustaining medical equipment, but denies them the right to request a physician’s assistance in dying. This interferes with their ability to make decisions concerning their bodily integrity and medical care and thus trenches on liberty. And, by leaving people like Ms. Taylor to endure intolerable suffering, it impinges on their security of the person. [66] This broad interpretation of s. 7 rights combined with a very narrow interpretation of the valid object of prohibiting assisted suicide allowed the Supreme Court to find, respectively, that each of the rights in s. 7 had been breached and that this had happened without justification.

The Supreme Court also added that requiring respect for “the principles of fundamental justice,” if breaches of s. 7 rights are to be constitutionally valid, is connected with respecting people’s dignity:

In Re B.C. Motor Vehicle Act, [1985] 2 S.C.R. 486 (the “Motor Vehicle Reference”), Lamer J. (as he then was) explained that the principles of fundamental justice are derived from the essential elements of our system of justice, which is itself founded on a belief in the dignity and worth of every human person. To deprive a person of constitutional rights arbitrarily or in a way that is overbroad or grossly disproportionate diminishes that worth and dignity. [81]

In considering the impact on physicians, patients, and palliative care of legalizing physician-assisted suicide, Justice Smith recognizes there will be both positive and negative effects, but concludes the positive ones will outweigh the negative (see 1270-1285):

For physicians who see no ethical distinction between assisted death for grievously ill patients and certain current legal end-of-life practices, the law draws an arbitrary line and promotes a kind of hypocrisy. Removing it would permit physicians a more open relationship with their patients and support intellectual honesty in the ethical debate. Indeed, evidence from other jurisdictions
suggests that physicians are able to provide better overall end-of-life treatment to patients at the end of their lives once the topic of assisted death is openly put on the table. (1271)

As mentioned previously, Justice Smith considered in her judgment the personal stories of people who recount serious suffering because physician-assisted suicide or euthanasia was not available. Personal stories of those who oppose these interventions, while submitted, apparently were not a factor in her deliberations.

Yet, in contrast to the rulings cited above, Justice Smith notes that the Supreme Court of Canada recognized, in Rodriguez, that there is a valid distinction between refusing life-support treatment and euthanasia: Rodriguez also summarized and clarified the law regarding the common law right of patients to refuse consent to life-sustaining medical treatment, and to demand that such treatment be withdrawn or discontinued. As I have earlier described, the majority [of the Supreme Court] accepted that there is a valid distinction between the role of physicians in those situations and the role of physicians in assisted suicide or euthanasia, based on the intention of the physician. (929)

Clearly the Supreme Court is no longer of this view.

In the context of considering the “no difference” line of reasoning, it merits noting that a common thread among all end-of-life interventions, and their goal, is the avoidance or relief of suffering. The pro-euthanasia argument is that such relief is the overriding priority and an end that justifies any necessary means of achieving it, including assisted suicide and euthanasia. While people who are anti-euthanasia are also anti-suffering, they strongly disagree that this outcome should be realized through the infliction of death.

vi) Dismissing slippery slopes

Justice Smith’s rulings regarding the practical and logical slippery slopes in jurisdictions that have legalized “physician assisted death” are of major importance because they were accepted by the Supreme Court which, as noted previously, refused the Attorney General of Canada’s request to submit evidence to show they were wrong.

In assessing the practical slippery slope — the risks of abuse if an absolute ban on physician-assisted suicide is not maintained and the practice is permitted under certain conditions — Justice Smith considers “life ending acts without explicit request” (LAWER) and the presence of mental illness in people wanting physician-assisted suicide. She extensively reviews “medically assisted dying” legislation in Oregon, as well as in the Netherlands and Belgium, and notes that prohibiting physician-assisted suicide and euthanasia does not prevent them from being carried out (see, for example, (523)). And, she again conflates pain relief and withdrawal of treatment, on the one hand, with euthanasia, on the other (525).

The judge’s reassuring conclusions about the effectiveness of safeguards in the jurisdictions she examines are, however, far from universally shared and evidence for the existence of both practical slippery slopes and logical slippery slopes — the expansion of justifications for physician-assisted suicide and euthanasia and of the people eligible and circumstances in which they may have access — is very convincing. In fact, the High Court of Ireland expressly rejected Justice Smith’s findings in this regard in Fleming vs. Ireland and others after extensively reviewing the evidence on which she relied. Here is an excerpt from the summary of the High Court’s judgment in Fleming:

In that case [Carter at the trial level], the Canadian court reviewed the available evidence from other jurisdictions with liberalised legislation and concluded that there was no evidence of abuse. This Court also reviewed the same evidence and has drawn exactly the opposite conclusions. The medical literature documents specific examples of abuse which, even if exceptional, are nonetheless deeply disturbing. Moreover, contrary to the views of the Canadian court, there is evidence from this literature that certain groups (such as disabled neonates and disabled or demented elderly persons) are vulnerable to abuse. Above all, the fact that the number of LAWER (“life-ending acts without explicit request”) cases remains strikingly high in jurisdictions which have liberalised their law on assisted suicide (Switzerland, Netherlands and Belgium) — ranging from 0.4% to over 1% of all deaths in these jurisdictions according to the latest figures — without any obvious official response speaks for itself as to the risks involved.41

Yet, in Carter, the Supreme Court of Canada held: The trial judge then turned to the evidence from the regimes that permit physician-assisted dying. She reviewed the safeguards in place in each jurisdiction and considered the effectiveness of each regulatory regime. In each system, she found general compliance with regulations, although she noted some room for
Killing as Kindness

improvement. [25]
And the Supreme Court decision’s headnote states the
following:
The trial judge made no palpable and overriding
error in concluding, on the basis of evidence
from scientists, medical practitioners and
others who are familiar with end-of-life
decision-making in Canada and abroad, that
a permissive regime with properly designed
and administered safeguards was capable of
protecting vulnerable people from abuse and
error.
A chilling example of the logical slippery slope is
the euthanizing, in December 2012, of 45-year-old
twins in Belgium. Deaf since childhood, Marc and
Eddy Verbessem were facing the additional disability
of blindness. Accepting that they were irremediably
suffering, their physician euthanized them.42
Justice Smith rules that the nature of the risks
of “medically assisted death” is no different from other
end-of-life decisions. In other words, she again adopts
the “no difference” approach, outlined above, to reject
the dangers of physician-assisted suicide opening up
slippery slopes by accepting the plaintiffs’ suggestion
that the very same risks exist with respect to
current end-of-life practices [as with physician-
assisted suicide]. A patient who chooses
to withdraw from life-sustaining treatment
may present exactly the same challenges to
caregivers, who need to know if the patient is
truly giving informed consent, is not suffering
from untreated depression, or is acting under
some kind of duress or coercion. (1237)
Justice Smith does not look at the slippery slope
in the Netherlands constituted by the expansion of
justifications for euthanasia and she does not mention
the major increase in the use of terminal/palliative
sedation (where patients are sedated until they die) in
Belgium.43 This can be “slow euthanasia” (terminal
sedation) where it is used to continuously sedate a
patient until they die from lack of food and fluids, but
is not in circumstances where it is the only reasonable
way to relieve serious pain and suffering (palliative
sedation). In other words, whether sedation is terminal
or palliative depends on all the circumstances, including
the patient’s medical situation, the medication used and
its dosage, and the alternative treatments available.
We can ask why terminal sedation is being
favoured over “classic” euthanasia methods (lethal
injections) that have been used up to the present, for
instance, in the Netherlands. Might palliative sedation
make the patient’s death seem more like a natural death?
Might it reflect a moral intuition there’s something
wrong in intentionally killing another human being
and the killing is less obvious when a lethal injection
is avoided? Or might it just be that administrative
requirements, such as the requirement to report cases of
euthanasia, are inapplicable to terminal sedation?

vii) Prioritizing autonomy and choice
At its simplest, the euthanasia debate can be
seen as a clash between the value of “respect for life”
and the value of respect for individual autonomy, usually
backed up by a “relief of suffering” argument, and
disagreement as to which should take priority. People
who oppose euthanasia give priority to respect for life
and point out that pain and suffering can be relieved
without killing the person who suffers, including, where
warranted, by palliative sedation.
In contrast, the value of individual autonomy and self-
determination, which is implemented through “choice”,
is central to the pro-euthanasia argument, and because
it gives the person a sense of control, it is seen in itself
as reducing suffering. Here are some examples of how
Justice Smith expresses that argument:

No-one should be deprived of liberty, or forced
to suffer, without adequate cause. Failing to
respect an autonomous choice to die risks
paternalism. (315) (Emphasis added)
For people with liberal values, paternalism is always a
major harm. Then Justice Smith rules:

In my opinion, the law [prohibiting
assisted suicide] creates a distinction that is
discriminatory. It perpetuates and worsens
a disadvantage experienced by persons with
disabilities. The dignity of choice should be
afforded to Canadians equally, but the law as
it stands does not do so with respect to this
ultimately personal and fundamental choice [to
die]. (1161) (Emphasis added)

But, even assuming that there is a legally relevant
distinction, in view of the fact that no one has a right to
commit suicide and, where possible, people who attempt
it will be prevented from doing so, one can query
whether the law creates a discriminatory distinction.
The Supreme Court takes a complementary but different
approach; it identifies a lack of access to “physician
assisted death”— a lack of that choice — as a cause of
suffering:

Yet running through the evidence of all the
witnesses is a constant theme — that they suffer
from the knowledge that they lack the ability to
bring a peaceful end to their lives at a time and
in a manner of their own choosing. [14]
I also note here Justice Smith’s use of the phrase “the dignity of choice,” which I have not encountered before. Dignity is a complex and controversial topic in bioethics; and choice is a neutral concept in the sense that some choices will enhance human dignity, others will harm it, and it’s what we choose that makes a choice ethical or unethical, not just the presence of choice itself.

viii) Justifying physician-assisted suicide and euthanasia through relief of suffering

As noted already, respect for individual autonomy and choice is one of the primary values for supporters of legalizing euthanasia; the other is the relief of suffering. Justice Smith links these values to each other and also gives priority to the relief of an individual’s suffering over risks of harm to other individuals from the precedent set by the means used to relieve that suffering. She states:

[M]y review of all the evidence shows that the ethical and practical arguments in favour of making physician-assisted death available to the limited category of patients described [include that] […] it is unethical to refuse to relieve the suffering of a patient who requests and requires such relief, simply in order to protect other hypothetical patients from hypothetical harm. (315(l))

 […]

It must not be overlooked that what is at stake for someone in Gloria Taylor’s situation is not merely autonomy, nor is it simply autonomy with respect to physical integrity. It is the autonomy to relieve herself of suffering. (1156) (Emphasis added)

The Attorney General of Canada argued at trial that the Court must address whether the autonomy interests and suffering of some individuals are outweighed by the public benefits of promoting the value of every life, preserving life, protecting the vulnerable, preventing abuses, maintaining the physician-patient relationship and promoting palliative care. (1247)

But the judge rejects arguments that harm to society can outweigh individuals’ rights to autonomy, although she requires the presence of suffering for those rights to extend to physician-assisted suicide and euthanasia. In doing so, the judge limits the scope of a person’s autonomy to choose death, by requiring the presence of suffering. In other words, the presence of suffering functions as a limiting device on the exercise of a legal right to autonomy with respect to self-willed death and the assistance of a physician in implementing that goal.

The Supreme Court addressed the Attorney General of Canada’s argument that the prohibition of assisted suicide was justified under s. 1 of the Charter because allowing the permissive regulatory regime [of “physician-assisted death”] accepted by the trial judge “accepts too much risk,” and that its effectiveness [to prevent abuse of physician-assisted death] is “speculative” […] [118] The Supreme Court responded that “[t]he burden of establishing minimal impairment [under s. 1 of the Charter] is on the government” [118]. It continued:

The trial judge found that Canada had not discharged this burden. The evidence, she concluded, did not support the contention that a blanket prohibition was necessary in order to substantially meet the government’s objectives. We agree. A theoretical or speculative fear cannot justify an absolute prohibition. […] [T]he claimant “does not have the burden of disproving every fear or every threat”, nor can the government meet its burden simply by asserting an adverse impact on the public. Justification under s. 1 is a process of demonstration, not intuition or automatic deference to the government’s assertion of risk […] [119]

Justice Smith also sees the presence of suffering at the end of life as differentiating suicide in that context from it in other contexts, and as a justification for the former:

[The Attorney General of] Canada mistakenly presumes that Canadians do not see a difference between assisted death in response to intolerable suffering at the end of life, and suicide arising out of mental illness or transitory sadness. (1262)

The judge does not consider that many suicidal people also experience what they perceive as “intolerable suffering” and the likely impact of this passage is the message that suicide is an appropriate response to suffering, at least in some circumstances. The Supreme Court does not address the issue of the impact of legalizing “physician-assisted death” on legitimating suicide in general.

Suffering is a very difficult reality to deal with in post-modern secular democracies, such as Canada. Traditionally we have accommodated suffering in our lives by finding meaning in it, but we largely did that through traditional religion. In secular societies, it is much more difficult for many people to find such
meaning. Yet it can be found, as many stories of deep suffering and bravery that move us profoundly attest.

ix) Accepting physician-assisted suicide and euthanasia as medical treatment

Justice Smith appears to accept the argument that legalizing euthanasia could enhance palliative care (see, for example, 584, 585, and 721) and the Supreme Court notes this finding [see 26 and 107]. This goes some way, at the least, towards treating euthanasia like, as some have termed it, “the last act of good palliative care.” It is also consistent with the “no difference among them” approach to a spectrum of end-of-life medical interventions that include euthanasia and physician-assisted suicide, discussed above. But my colleague, Donald Boudreau, a specialist physician, and I, adamantly reject that euthanasia can ever be medical treatment, as it is fundamentally incompatible with the healing role of physicians.44 It merits noting that in Quebec the definition of palliative care in article 3(3) of An Act respecting end-of-life care was amended, after some Quebec palliative care physicians protested the inclusion of “medical aid in dying” in the definition of palliative care; yet the amendment was not to their satisfaction. It now reads: “end-of-life care” means “palliative care provided to persons at the end of their lives, including terminal palliative sedation, and medical aid in dying.”

Apart from other considerations, whether euthanasia is seen as medical treatment matters in Canada for jurisdictional reasons. Governance of medical treatment is a provincial, not a federal, jurisdiction. This is one reason why the “Dying with Dignity” report of the Quebec National Assembly Select Committee46 and the Quebec College of Physicians and Surgeons both argue that it is medical treatment. In Carter, the Supreme Court has recognized it as such while also recognizing that both levels of government may act:

Health is an area of concurrent jurisdiction; both Parliament and the provinces may validly legislate on the topic […]. This suggests that aspects of physician-assisted dying may be the subject of valid legislation by both levels of government, depending on the circumstances and focus of the legislation. We are not satisfied on the record before us that the provincial power over health excludes the power of the federal Parliament to legislate on physician-assisted dying. [53]

This means that while the federal government may use its criminal law power to govern assisted suicide and euthanasia, provided it does so within the constraints of the Charter, the Quebec Government has the right to pass laws to regulate these “treatments” and to allow physicians to administer them to patients.

But, if, as we are told, society wants physician-assisted suicide and euthanasia legalized, should physicians or some other professionals carry them out? In other words, should we clearly separate those interventions from medical treatment?

It’s a controversial suggestion, but I propose that the “medical cloak” — the “white coat” — must be taken off legalized physician-assisted suicide and euthanasia. In other words, physicians should not be the ones to perform these acts.

One reason, among many, to take the medical cloak off physician-assisted suicide and euthanasia is that it causes people to fear accepting pain relief treatment, hospice and palliative medicine and care, and physicians themselves.

As well, placing a medical cloak on physician-assisted suicide and euthanasia, yet again, causes confusion. It makes these interventions seem safe, ethical and humane, because those are the characteristics we associate automatically with medical care, when, in fact, all of us need to question the ethical acceptability of legalizing physician-assisted suicide and euthanasia and whether physicians should be authorized to carry them out.

One suggestion for alternative practitioners that even shocks euthanasia advocates is to have specially trained lawyers, which is not my original idea.47 The justification put forward for this choice is that lawyers understand how to interpret properly and to strictly apply laws and, for pro-euthanasia advocates, ensuring the law is followed in order to prevent abuse is their major concern, not euthanasia itself.

Justice Smith turns to the British Columbia Prosecutorial policy on assisted suicide for definitional assistance with respect to whether physician-assisted suicide is medical treatment:

In the policy, “palliative care” is defined as “a qualified medical practitioner, or a person acting under the general supervision of a qualified medical practitioner, administering medication or other treatment to a terminally ill patient with the intention of relieving pain or suffering, even though this may hasten death.” The policy states that that conduct, “when provided or administered according to accepted ethical medical standards, is not subject to criminal prosecution.” (303)

In other words, the policy can be expansively interpreted
as placing physician-assisted suicide and euthanasia in the same category as other end-of-life treatment interventions that “may hasten death.” This “no difference” reasoning, which I have discussed already, is central to both the trial judge’s and the Supreme Court’s decisions.

Justice Smith was deeply impressed with the evidence given by American philosopher and bioethicist Professor Margaret Battin, an expert witness for the plaintiffs, who is a prominent advocate of legalizing physician-assisted suicide and euthanasia. She extensively reviewed and endorsed Battin’s views about the core principles central to the [assisted suicide and euthanasia] debate: liberty (also referred to as freedom, self-determination or autonomy) and mercy (compassion, or the right to be free from pain and suffering) […] and a third core value for physicians, non-abandonment. (239)

The judge also extensively reviews research by Battin and her colleagues on euthanasia in the Netherlands and the American state of Oregon and ultimately endorses their findings that abuses are within acceptable limits. She approvingly quotes Battin to the following effect:

Those who oppose physician aid in dying must show that the principles of liberty and freedom from suffering that are basic to an open, liberal and democratic society should be overridden. (241) (Emphasis added)

In short, a reversal of the burden of proof is justified on the basis of respecting liberty and implementing freedom from suffering.

x) Balancing autonomy and the common good

I would like, here, to summarize how I see the Supreme Court of Canada’s judgment in regard to the central issue in Carter: striking the balance between upholding individual autonomy and protecting the common good.

By adopting a very expansive interpretation of the s. 7 Charter rights — life, liberty and security of the person — with respect to the scope of their protection of individuals’ autonomy, the Supreme Court was able to find that they were all violated. In stark contrast, the Court adopted a very narrow interpretation of what was required to protect the common good; in fact, it effectively eliminated this consideration as a valid objective of the prohibition of assisted suicide. The combination of this expansive approach and this narrow approach allowed the Court to rule, first, that all the s. 7 rights were breached by an absolute prohibition of assisted suicide and, second, that these breaches could not be justified under the “saving provisions” of the Charter and, therefore, the absolute prohibition was unconstitutional.

The Court was able to reach this conclusion through three main steps in its reasoning, all of which, in my respectful opinion, raise problems. To summarize: first, as examined already, at the heart of Carter are the “no difference” arguments, which are in error when based on false analogies and failures to distinguish between differences of degree and differences of kind, indeed expressly rejecting such distinctions, as the Court did in ruling there was “no difference” between withdrawing life support treatment to allow a person to die a natural death and inflicting death (helping a person to kill herself or, even, killing her). Second, the Court focused on the requirements for upholding the value of “preservation of life” as the relevant value in determining whether an absolute prohibition on assisted suicide was justified. In ruling that it was not justified, the Court relied heavily on its finding, which is correct, that the value of “preservation of life” is not absolute, citing, once again, the acceptance of the withdrawal of life support treatment as legal and ethical as showing this. The problem, in my opinion and as I have explained previously, is that this is not the correct value against which to test whether an absolute prohibition on assisted suicide is justified. Rather, the value of “respect for life” and what is required to uphold this value is the relevant one, and, I propose, that does require an absolute ban. And, third, the Court was in error in accepting several other “no difference” arguments, including that there is no difference between suicide and assisted suicide. Therefore if suicide is not a crime, assisting suicide should not be a crime.

xi) Values related to human life

Finally, in analyzing Carter, I wish to briefly note the large number of values related to human life that Justice Smith identifies in her judgment, some of which are also found in the Supreme Court judgment, and which inform her decision.

Justice Smith refers to the concepts of a right to life, respect for life, preservation of life, inviolability of life, protection of life, sanctity of life, and quality of life. They are all related — not least by their connecting thread of dealing with life — and some are used interchangeably. There can be, however, differences among them, which, despite sometimes being nuanced, are important to understand for two reasons: (1) such understanding can lead to different conclusions about ethics than would otherwise be the case and (2) it can provide insights that would be otherwise unavailable.
Killing as Kindness

I want to note here the legal rule of statutory interpretation against redundancy, namely, that when a different word or term is used in the same statute, it is meant to refer to something different from a synonymous word or term used in the same statute. Although that rule does not apply to the Carter judgments because they are not legislation, the wide variety of words and terms used in them to describe the same realities raises questions in this regard, which are relevant to how the judgments should be interpreted in some instances.

a) “Right to life”

As discussed previously, both Justice Smith and the Supreme Court ruled that the prohibition of assisted suicide affected Ms. Taylor’s right to life because it might shorten her life: “Ms. Taylor’s reduced lifespan would occur if she concludes that she needs to take her own life while she is still physically able to do so, at an earlier date than she would find necessary if she could be assisted.” (17) This reasoning converts the right to life to a right to death by physician-assisted suicide or euthanasia.

b) “Respect for life”

Justice Smith links “respect for life” with “protection of life,” which I discuss shortly, and interprets it through that latter lens, which radically alters how the requirements of the former are defined. She writes:

[The Attorney General of] Canada says that the preservation of human life is a fundamental value in Canadian society and that respect for life transcends individual, religious and diverse cultural values. Canada does not assert a state interest in the absolute protection of all human life. It says, however, that respect for this fundamental value is reflected in the state’s interest in not condoning the taking of human life, and embodied in the criminal law. (168) […]

For the purposes of both its s. 7 and s. 1 [Charter] analyses, the majority [in Rodriguez] held that the objective of s. 241(b) is the protection of the vulnerable who might be induced in moments of weakness to commit suicide. It held that objective to be grounded in the state interest in protecting life, and in the state policy that human life should not be depreciated by allowing life to be taken. (926) Limiting the purpose of prohibiting assisted suicide to the protection of vulnerable people means that if, in a given case, they don’t require this protection (as the judge rules Ms. Taylor does not), then abandoning it does not contravene respect for life. This creates a large unprotected population, the “end-of-life population” (to use Justice Smith’s vague phrase), for whom the protections promised to the population at large will not hold. They are excluded by judicial fiat.

Compare this with the reverse order of analysis, which starts from respect for life: respect for life requires protection of vulnerable people as members of the human community — indeed, it requires protection of all human lives — and failure to provide that protection contravenes respect for life. As this comparison shows, starting points of analyses and basic presumptions are not neutral with respect either to decisions based on them or to outcomes.49

As well, Justice Smith looks at respect for life only at the level of the individual person or, at most, primarily through that lens. She does not consider what might be required if we are to maintain respect for human life, in general, and at institutional and societal levels. Those analyses could result in different conclusions as to what is required.

But focusing the analysis, in particular of the risks, harms and benefits of physician-assisted suicide, at the level of the individual patient is inevitable when the analysis is directed through a Charter lens, as is true in Carter. The Charter’s main purpose is to protect individuals from wrongful exercises of state power that unjustifiably interfere with their rights. Any competing claims of society and avoiding harm to institutions or society are taken into account mainly at a secondary justificatory analytic stage under s. 1 of the Charter. As can be seen in Carter, the judiciary can downplay these latter claims. The Carter judgment, both at trial and the Supreme Court, contains little in-depth consideration of the impact on societal values and on the institutions of law and medicine of legalizing physician-assisted suicide. It merits noting that the same failure to give sufficient weight to societal claims and needs, and unwillingness to uphold those claims, is manifested in Parliament’s enormous reluctance to use the Charter’s “notwithstanding clause,” which allows Parliament to validate legislation that the courts have found to be unconstitutional.50

The Charter makes available so many tests for assessing whether legislation complies with its provisions that courts can use it to “analyze to death” any legislation (see an example of such analysis by Justice Smith at (1358)). This can have wide implications, including that individuals can use the Charter, in effect, to overrule democracy. For instance,
the April 2010 vote in Parliament of 228 “against” and 59 “for” a private member’s bill that would have legalized physician-assisted suicide and euthanasia, which is noted by Justice Smith (112), is, in practice if not in theory, overruled by the Carter judgment. Yet it is difficult, especially for politicians, to criticize court rulings based on the Charter, without running the risk of being labeled in a stigmatizing way.

c) “Preservation of life”

As has been discussed earlier in this article, “preservation of life” is another term used in Carter. It can be distinguished from “respect for life.” While the former is not always required, ethically or legally, the latter is. Not preserving life by justifiably allowing a person to die a natural death does not contravene the requirements of respect for life. For instance, in certain circumstances, withdrawing life support treatment when a competent patient gives an informed refusal of such treatment, either at the time or through “advance directives,” is not only justified but also ethically and legally required.

In addressing the question of whether the principle of preservation of life has exceptions, Justice Smith, first finds that it does (a finding endorsed by the Supreme Court) and then, as discussed previously, accepts the evidence of one of the plaintiffs’ expert witnesses, Professor Wayne Sumner, to the effect that death is not a loss or bad if there is no benefit in a continuing life; in other words, that a poor quality of life can justify such an exception.

d) “Inviolability of life”

Justice Smith uses the term “inviolability of life” (171, 244, 245, and 348). This is not a concept in common use, at least in Canada, and it seems that she employs it to mean a belief, which she does not share, that life must never be intentionally taken. The right to inviolability is, however, frequently spoken of in the context of medical ethics and law and encompasses the right not to be touched without one’s consent, a right that protects a person’s physical and mental integrity. It is a negative content right (a right against unconsented interference), not a positive content right (a right to something).

The doctrine of informed consent, which the judge explores at length, is linked to inviolability. One’s right to inviolability is not breached by interventions to which consent has been given. And consent protects one’s rights to autonomy and self-determination. But just because one consents to an intervention does not mean that it is ethical or legal as, for instance, the Criminal Code provides: “No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.” As a result of Carter, this provision will no longer apply to “physician-assisted death” carried out in accordance with the requirements specified by the Supreme Court:

Section 241(b) and s. 14 of the Criminal Code unjustifiably infringe s. 7 of the Charter and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. [147]

e) “Protection of life”

Justice Smith also refers to “protection of life” as a valid goal, for instance, in this passage:

To reiterate, the purpose of the prohibition against assisted suicide is the protection of vulnerable persons from being induced to commit suicide at times of weakness, a purpose grounded in the respect for and the desire to protect human life. (1362)

One question this raises is the difference, if any, between protection of life and respect for life. Intentionally taking human life can be justified when that is the only reasonably possible way to save human life, as in justified self-defence or “just war.” These actions involve taking the life of an aggressor in order to protect the lives of the persons placed in serious danger by the aggressor. But the judge is not speaking of such a situation here. She speaks of protecting the lives of vulnerable people, not taking life to protect life, and of respect for and protection of life in general. Her interpretation of the “right to life” could, however, help in interpreting what she contemplates by protection of life: she views the right to life as requiring that physician-assisted suicide be allowed in certain circumstances, because when people with disabilities know that they can have assistance to commit suicide, if they are unable to do so without such assistance, they will wait longer to end their lives. Might the judge also see this as protecting life for the same (misguided) reason?

f) “Sanctity of life”
Killing as Kindness

Although many people use the terms “sanctity of life” and “respect for life” interchangeably, they can be distinguished, in some regards. The former tends to be used by people whose values are primarily based on religious beliefs and who can have even more stringent requirements with regard to what is required to respect human life, than those who are anti-euthanasia and use the term “respect for life” to describe the basis for their opposition.

Because the concept of “sanctity of life” is often associated with religion, that association is commonly used to dismiss claims based on it. In contrast, the existence of a “societal consensus” is often argued in support of a claim for legalizing euthanasia. The following passage from the trial judgment is one example that manifests both approaches:

[The plaintiffs say that if the purpose of the law is to uphold a particular religious conception of morality [namely sanctity of life] (about which there is not a consensus in Canadian society), it is an invalid purpose. They suggest that there is a societal consensus supportive of their claim (177) [...] to legalize physician-assisted suicide, namely) that the current line drawn between permissible and impermissible end-of-life care is based upon distinctions that in reality have no practical ethical or moral force. (176).

As to a societal consensus, alone, ethically validating a claim, we should keep in mind that just because a majority supports a certain position does not mean that stance is ethical: democracy is only as ethical as the people who vote. And it is interesting to contemplate that the etymology of the word religion is re-ligare: to bind and re-bind together through shared belief (i.e., societal consensus).

In assessing the relevance of “the principle of sanctity of life,” which Justice Smith finds was “espoused in the Rodriguez decision” (300), she takes into account the British Columbia Prosecutorial Policy for the crime of assisted suicide. This sets out the conditions for initiating such prosecutions, which has the effect of limiting such prosecutions, overall. She rules the policy is relevant for three reasons:

First, the policy may shed some light on social consensus about the ethics of assisted suicide or euthanasia. Second, the British Columbia policy incorporates by reference accepted medical ethical standards. Finally, the plaintiffs suggest that the prosecution policy marks a significant change since Rodriguez. The plaintiffs characterize the B.C. policy as “remarkable” because, they say, it appears to allow for the exercise of discretion not to prosecute a person who has violated the assisted suicide provision and thus to contradict the principle of sanctity of life espoused in the Rodriguez decision.

(300)

It’s important to point out, as the BC Prosecutorial policy accurately states, that recognizing “society’s interest in protecting the sanctity of human life [...] does not require life to be preserved at all costs” (307). In other words, “the prohibition of euthanasia does not imply a commitment to vitalism, namely the doctrine that life should be prolonged at all costs.”

But not adhering to a value of preserving life no matter the cost is not the same as intentionally inflicting death.

In referring to “sanctity of life” Justice Smith writes that the plaintiffs argue there is “no societal consensus supporting a principle of the absolute sanctity of human life but that there is a societal consensus supporting the principle of a person’s autonomy over his or her own body” (167). She accepts this argument and finds that personal choice (autonomy) trumps sanctity of life. In doing so, as pointed out previously, she echoes the assumption on which both the reports of the Royal Society Expert Panel and the Quebec National Assembly Select Committee are based.

The Report of the Select Committee of the National Assembly of Quebec on “Dying with Dignity” is especially interesting with respect to the concept of sanctity of life. Like Justice Smith, the Committee starts from and takes throughout its report a purely utilitarian approach and it adopts, as the overriding value, respect for individuals’ rights to autonomy and self-determination, justifying this stance on the basis, among other examples, of the decline in adherence to religion. The committee writes that « La valeur du caractère sacré de la vie a subi une transformation notable » (“The value of the sanctity of life has undergone a significant transformation”) relative to other values, which means that now it doesn’t necessarily take priority (Translation: Margaret Somerville).

As mentioned above, pro-euthanasia advocates often argue that seeing life as “sacred” is a religious value and, because of that, it should not be taken into account in the public square. The Quebec Committee report endorses this view: « Rappelons cependant que dans un État laïque comme le nôtre, les croyances de certains ne sauraient servir de base à l’élaboration d’une législation applicable à tous. » (“However, note that in a secular state like ours, the beliefs of some cannot be the basis for the development of legislation applicable to all.”) (Translation: Margaret Somerville).
Although the world’s major religions uphold the principle of sanctity of life/respect for life, it is not simply a religious precept. (I prefer to use the term “respect for life,” rather than “sanctity of life,” to avoid religious connotations and associations.) What German philosopher Jürgen Habermas calls “the ethics of the [human] species” and I call “human ethics,” which must guide secular societies such as Canada, also embrace this principle. Whatever one’s views regarding the value of sanctity of life/respect for life, it’s a foundational value of all societies in which reasonable people would want to live, as the Charter recognizes in enshrining it. As is true of the Quebec Committee report, the Royal Society report, and the Carter judgment, pro-euthanasia advocates dismiss the harm to the value of respect for life, especially respect for human life, in general, at the societal level, that legalizing euthanasia would necessarily entail.

Justice Smith concludes that

[the sanctity of life is a principle that is not absolute in our society (it is subject to exceptions such as self-defence) and, while it is central to the value system of a number of religions, that does not settle its place in a secular society. (315)]

As mentioned already, the exception of self-defence that the judge mentions does, indeed, inform the scope of what the value of respect for life requires. The only justification for intentionally taking human life in self-defence is when it is the only reasonably available way to save human life. (The same requirement that human life may only be justifiably taken to save human life is true for “just war”; traditionally abortion, which was only justified when necessary to save the mother’s life; and capital punishment, which was justified as preventing the condemned person from killing again.)

Physician-assisted suicide and euthanasia do not fulfill that requirement.

And the Supreme Court of Canada opines on the sanctity of life as follows:

The sanctity of life is one of our most fundamental societal values. Section 7 is rooted in a profound respect for the value of human life. But s. 7 also encompasses life, liberty and security of the person during the passage to death. It is for this reason that the sanctity of life “is no longer seen to require that all human life be preserved at all costs” [...]. And it is for this reason that the law has come to recognize that, in certain circumstances, an individual’s choice about the end of her life is entitled to respect. [63]

In this passage, the Supreme Court commingles respect for human life, the value of human life, sanctity of human life, and the preservation of human life; it gives priority to individual autonomy in relation to all of these concepts; and it espouses a moral relativist philosophy in deciding “that, in certain circumstances, an individual’s choice about the end of her life is entitled to respect.”

g) “Quality of life”

I have already mentioned the concept of “quality of life,” which is often spoken of as being in opposition to “sanctity of life.” One difference between these two concepts is that “quality of life” is based in moral relativism and utilitarianism — it all depends on the circumstances whether life is worth living and, if not, physician-assisted suicide and euthanasia are ethical — whereas “sanctity of life/respect for life” is based, in principle, on a belief that all human life has dignity and must not be taken, because it is inherently wrong to do so.

As discussed previously, “quality of life” was initially developed as a concept intended to promote life through the argument that everyone had a right to the resources, especially those of healthcare, needed to maintain an acceptable “quality of life.” Now the concept is used, paradoxically, to achieve the exact opposite outcome, namely, that a person’s “quality of life” is so poor that they are better off dead or, at the least, don’t merit the expenditure of resources to keep them alive.

Although assessment of quality of life is often treated as an objective exercise, we know there is a great deal of subjectivity and discretion involved. Research has shown that healthcare professionals assessed patients’ quality of life as lower than the patients themselves assessed it. Factors such as dis-valuation — we grade a negative event, such as going blind, as much worse when we have not experienced it than when we have — and decision-making about hypothetical traumas are not the same as the decisions we make when faced with those traumas in real life.

In conclusion of this section on “Values related to human life,” both ethics and the law operate on the basis of a presumption in favour of life. This does not mean that life must be preserved at all costs, but it does mean that if our acts or omissions will have an effect of shortening life or not sustaining it, we must be able to justify what we do. In short, the default position in both law and ethics is a presumption in favour of life. Justice Smith’s judgment does not reflect that position and her interpretations of many of the concepts I have discussed
show the same approach. It remains an open question whether the same can be said of the Supreme Court’s judgment, but in answering this question, it is relevant to recall that the Supreme Court strongly endorses Justice Smith’s reasoning and findings.

4. LOOKING BEYOND THE INTENSE INDIVIDUALISM OF THE CARTER CASE

There is a radical difference between, on the one hand, valuing only what we want in relation to our own life and, on the other hand, also valuing the lives of generations to follow and of deciding what we owe to them and how to act accordingly. Legalizing physician-assisted suicide or euthanasia in order to allow personal preferences concerning death to prevail, as Justice Smith and the Supreme Court do in Carter, is an example of the former. Rejecting physician-assisted suicide or euthanasia, because of the harm we believe it would do to individuals, our shared values, societal institutions, society, and future generations, is an example of the latter. Before we would legalize assisted suicide or euthanasia, we need to ask ourselves, “If we do that, how might our great-great grandchildren die?” and answer honestly.

Physicians and nurses must be sensitive to patients’ pain and suffering and meet it with great compassion, but that must be done without intentionally inflicting death. We must never equate reducing suffering with inflicting death.

Physicians’ and nurses’ absolute rejection of intentionally inflicting death is necessary to maintain both the trust of people in their own physicians and the trust of society in the medical profession as a whole. This is true, in part, because physicians and nurses have opportunities to kill that are not open to other people.

Physicians and nurses need to continue to have a clear line that powerfully manifests to them, their patients, and society that they do not inflict death. Both their patients and the public need to know with absolute certainty — and be able to trust — that is the case. Anything that blurs that line, damages that trust, or makes physicians or nurses less sensitive to primary obligations to protect and respect life is unacceptable. Legalizing physician-assisted suicide or euthanasia would do all of these.

Moreover, it is a very important part of the art of medicine to sense and respect the mystery of life and death, to hold this mystery in trust, and to hand it on to future generations — including future generations of physicians. We must consider deeply whether legalizing physician-assisted suicide or euthanasia would threaten this art, this trust, and this legacy. I believe it would.

The “euthanasia debate” is a momentous one. It involves our individual and collective past (the ethical, legal, and cultural norms that have been handed down to us as members of families, groups and societies); the present (whether we will change those norms); and the future (the impact that this would have on those who come after us). We need a much broader analysis and a great deal more thought before we would follow down the path that Justice Smith and the Supreme Court of Canada map out in Carter.

The central issue in Carter is not just what having compassion for Ms. Taylor (and others in the same situation) might lead people to recommend who do not have ethical or moral problems with physician-assisted suicide or euthanasia—a group that appears to include Justice Smith and the nine judges of the Supreme Court. The central issue is whether we will abandon some of the most important foundational values of our Canadian society. If we are going to do that, we should, at the least, explicitly recognize that is what we are doing. At both the trial stage and in the Supreme Court, the Carter judgments are, with respect, a total failure in that regard.

5. LOOKING BACK TO HUMAN MEMORY BEFORE THE CARTER CASE

Pro-euthanasia advocates decry citing the Nazis as a relevant example for consideration in today’s euthanasia debates, claiming it as irrelevant and unfounded fear-mongering. Those who are anti-euthanasia avoid it for fear of weakening their case and providing an easy reason to dismiss their voice in the public debate. But an article in the New York Times of 8 October 1933, “Nazis Plan to Kill Incurables to End Pain; German Religious Groups Oppose Move,” resonates so clearly with the rhetoric and arguments in our contemporary debates, and contains such powerful warnings that I will quote it in its entirety. The article, in retrospect, offers a chilling example of where we can end up when human dignity and its protections are seen as something we receive from being able to perform in certain ways – that is, – as the pro-euthanasia lobby’s reasoning and justifications manifest, we are “human doings” – rather than something we already have simply as human beings:

Berlin, Oct 7. – The Ministry of Justice, in a detailed memorandum explaining the Nazi aims regarding the German penal code, today announced its intention to authorise physicians to end the sufferings of incurable patients. The memorandum, still lacking the force of law, proposed that ‘It shall be made possible
for physicians to end the tortures of incurable patients, upon request, in the interests of true humanity. ’ This proposed legal recognition of euthanasia — the act of providing a painless and peaceful death — raised a number of fundamental problems of a religious, scientific and legal nature.

The Catholic newspaper Germania hastened to observe: ‘The Catholic faith binds the conscience of its followers not to accept this method of shortening the sufferings of incurables who are tormented by pain.’ In Lutheran circles too, life is regarded as something that only God alone can take. A large section of the German people, it was expected in some interested circles, might ignore the provisions for euthanasia, which overnight has become a widely discussed word in the Reich.

In medical circles the question was raised as to just when a man is incurable and when his life should be ended. According to the present plans of the Ministry of Justice, incurability would be determined not only by the attending physician, but also by two official doctors who would carefully trace the history of the case and personally examine the patient.

In insisting that euthanasia shall be permissible only if the accredited attending physician is backed by two experts who so advise, the Ministry believes a guarantee is given that no life still valuable to the State will be wantonly destroyed.

The legal question of who may request the application of euthanasia has not been definitely solved. The Ministry merely has proposed that either the patient himself shall ‘expressly and earnestly’ ask it, or ‘in case the patient no longer is able to express his desire, his nearer relatives, acting from motives that do not contravene morals, shall so request’ [emphasis added].

“A guarantee is given that no life still valuable to the State will be wantonly destroyed”: “human doings” would not be euthanized, but “human beings” who were perceived as “useless” could be — and were.

Hendrik van der Breggen, Associate Professor of Philosophy at Providence University College in Otterburne gives yet another warning through comparison with the Nazis. He writes:

“Physician-assisted suicide threatens to dangerously weaken a society’s life-respecting foundations. Consider this observation from Leo Alexander, medical advisor at the Nuremberg war crimes trials: ‘Whatever proportions these (Nazi) crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude... that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick.”

CONCLUSION

I believe that what our societies decide about legalizing physician-assisted suicide and euthanasia will be one of the defining events for each of them of the first half of the 21st century. Those decisions will affect their foundational values, their “ethical and legal tones”, and their norms with respect to how we die, in that if physician-assisted suicide and euthanasia are legalized in any given society inflicted death will replace natural death as the norm in that society.

In making those decisions, we need to keep in mind an old saying in human rights: “Nowhere are human rights more threatened than when we act purporting to do only good.” This warns us that the good that we hope to realize can blind us to the harms and risks also unavoidably involved in doing that good. When the good we seek is the relief of serious suffering, our moral intuition that it is wrong to intentionally kill another human being can be overwhelmed. Such intuitions are important guides in making good ethical decisions. And while we ignore our feelings at our ethical peril, our emotional reactions to an individual person’s suffering need to become “examined emotions,” if we are to avoid the danger of them misleading us ethically.

By arguing against physician-assisted suicide and euthanasia, I am proposing that there are and should be ethical and legal limits to our freedom to alleviate suffering and that these interventions are not legitimate means of doing so. Just as the axiom “freedom in fetters” tells us that we must restrict freedom to some extent in order to protect and maintain the conditions that make freedom possible, so we must restrict what we do to relieve suffering in order to protect and maintain the shared values that are necessary, if we are not to risk creating a society in which no reasonable person would want to live.

These limits mean that within bioethics and
What Does Dying with Dignity Mean?

Killing as Kindness

biolaw we must position our moral and legal obligations to relieve suffering such that they are consistent with upholding respect for human life, both at the level of the individual person and human life, in general, at the societal level. Fortunately, we have new tools to relieve suffering that will help us to achieve that balance. Often, the unprecedented powers of new medicine and science face us with additional serious ethical difficulties. In relation to relieving pain and suffering, the opposite is true. Research is providing us with means never before possible to help those who need our help to relieve their pain and suffering.

For millennia, our kinds of societies have prohibited euthanasia and assisted suicide. Why then now, when there is nothing new about the circumstances in which these interventions are called for and there is so much more we can do to relieve suffering, do we think intentionally inflicting death is a good response to suffering? A wise answer to that question requires much thought.63 What would be the long-term impact of death by euthanasia becoming the norm? How would that affect the way in which we view and treat people who are old, vulnerable and disabled? We must address these and many other questions before changing the law to allow the intentional infliction of death.

I hope that my analysis of the Carter case in this article will convince you that we cannot overemphasize the gravity of the situation we now face as a result of the Supreme Court of Canada’s decision in that case.

This decision does not represent an evolution in the foundational values that bind us together as a society, but a revolution, a radical departure from upholding the value of respect for life. This value implements the belief and practice that we must not intentionally kill another human being. To allow that constitutes radical change not only for individual Canadians but also to the institutions of both law and medicine, because the law is changed to allow killing and physicians are authorized to carry it out. In a secular society, such as Canada, law and medicine carry the value of respect for life for the society as a whole. Their capacity to do that in Canada is seriously damaged by this decision, which is primarily focused on what an individual wants, that is on individual autonomy and self-determination.

Making euthanasia and assisted suicide part of medical practice is not, as pro-euthanasia advocates claim, and the trial judge and Supreme Court agreed, a small incremental change consistent with interventions that we accept as ethical and legal, such as honouring patients’ refusals of life-support treatment that allow them to die. Allowing physicians to inflict death on their patients is different-in-kind, not just different-in-degree, from other interventions we accept as ethical and legal. Moreover, legalizing euthanasia represents a seismic shift in our fundamental societal values, not just another step on a path we’ve already taken.

And for 2,400 years, consistent with the Hippocratic Oath, euthanasia has never been characterized as a medical treatment. It should not be now. Indeed, if it is legalized, it should be kept out of medicine.

Just as we now realize our actions could destroy our physical ecosystem and we must hold it in trust for future generations, we must likewise hold our metaphysical ecosystem — the collection of values, principles, beliefs, attitudes, shared stories, and so on that bind us together as a society — in trust for them. In this regard, there is no more important value than respect for life. That requires that we always react to pain and suffering with deep compassion and assistance to relieve it, but that we kill the pain and suffering, not the person with the pain and suffering.64

Therefore, in conclusion, we must consider the values that we should hold in trust for future generations if they are to inherit a world in which reasonable people would want to live. We must ask ourselves how our great-great-grandchildren will die if we legalize euthanasia. And we must recognize that history will see what we decide about “physician inflicted death” as having been an unprecedented defining ethical-legal-societal event of the 21st century, which means it is a momentous decision.

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Endnotes

4 Somerville, Death Talk.
10 The analysis of the trial level judgment of the Carter case was first published in Margaret Somerville, “Exploring Interactions between Pain, Suffering, and the Law,” in Suffering and Bioethics, ed. Ronald M. Green and Nathan J. Palpant (New York: Oxford University Press, 2014), 201-227. I am grateful for the kind permission of the editors and publisher to use the content of that chapter as a basis for this article.
11 Supra, note 6.
14 Supra, note 13.
15 Supra, note 7.
16 Charter, section 7.
20 P.D. James, The Children of Men (Canada: Knopf Canada, 1992), 68-79.
25 Keith G. Wilson, Harvey Max Chochinov, Christine J. McPherson et al., “Desire for Euthanasia or Physician-Assisted Suicide in Palliative Cancer Care,” Health Psychology 26, no.3 (2007): 314–323. Also, see the work of Dr. Harvey Max Chochinov, a Manitoba psychiatrist who specializes in psychiatric care of terminally ill people.
26 Supra, note 7.
27 I am indebted to Canadian bioethicist, Dr. Tom Koch, for this formulation of the issue.
28 Supra, note 7.
29 Supra, note 17.
30 Report of the Select Committee of the National Assembly of Québec, Dying with Dignity (Québec: Bibliothèque et Archives nationales du Québec, 2012) (Chair: Maryse Gaudreault).
33 Supra, note 17.
34 Supra, note 30.
35 In this section in using the word euthanasia, I intend it to include physician-assisted suicide.
37 Jocelyn Downie, Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada (Toronto: University of Toronto Press, 2004).
39 Supra, note 6, at paras 161, 162, 249, 337, 338, 342, 356, 358.
41 Ibid.
44 J. Donald Boudreau and Margaret A. Somerville, “Euthanasia is not medical treatment,” British Medical Bulletin 106 (2013):
Killing as Kindness

45 National Assembly of Québec, Bill 52, An Act respecting end-of-life care, 40th Legislature, 1st Session.
46 Supra, note 30.
48 As noted already the High Court of Ireland came to the opposite conclusion after reviewing the evidence on which Justice Smith relied.
50 Charter, s. 33.
51 Criminal Code, s. 14.
53 Supra, note 17.
54 Supra, note 30.
57 Somerville, Death Talk.
60 Somerville, The Ethical Imagination, 28-31, 62-72.
63 Somerville, Death Talk, 105-118.
64 Ibid, 218-232.