

**Campaign Life Coalition**

# EUTHANASIA BRIEFING BOOK

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## WHAT IS EUTHANASIA?

The original Greek meaning of the term “euthanasia” is “easy or good death.” Over time, this meaning has been lost, so that today an acceptable definition of euthanasia would be: ***to act, or fail to act, so as to cause the death of a human being for the purpose of relieving suffering.***

The victim is usually, though not exclusively, a chronically- or terminally-ill patient, not necessarily imminently dying. The person performing the act of euthanasia is usually, but not exclusively, a health-care professional. The participation of the medical profession in these acts has led to the use of the term *medicalized killing*.

As well as understanding the precise definition of euthanasia, it is important to be clear as to which medically-based decisions at the end of life should never be classified as euthanasia. Allowing a terminally-ill person in the last stages of life to die a natural death is not euthanasia. Where the situation is medically hopeless, a decision not to provide or continue extraordinary or heroic measures —where such no longer offer any hope for healing —is ethical, legal and consistent with standard medical practice. It is also consistent with thousands of years of religious belief and practice.

### ***Passive and Active Euthanasia***

A deliberate or purposeful act performed to cause death (for example a lethal injection) is referred to as *active* euthanasia. The failure to act in order to cause death (for instance withholding nourishment or required medication) is referred to as *passive* euthanasia. Regardless of the method, the **intention** is to kill —to cause the death of a human being. From a moral point of view, distinctions between “active” and “passive” are meaningless. The intent is to kill, the method is merely a question of strategy.

### ***Voluntary, Non-voluntary, Involuntary***

Euthanasia is sometimes classified according to the presence or absence of a request by the patient. *Voluntary* euthanasia is carried out at the request of the patient. *Non-voluntary* euthanasia occurs when the patient is incapable of understanding the choice between life and death. *Involuntary* euthanasia is the term used when the individual is capable of consenting to death but does not do so, either because he or she is not asked, or because he or she is asked and chooses to go on living (Practical Ethics [1979], pp.128-130).

### ***Mercy Killing***

Usually, the terms euthanasia and mercy killing are used interchangeably. Because the motive for euthanasia is often alleged to be one of compassion, such as a desire to end the suffering of another person, the term mercy killing may seem an apt description on the surface. Canadian law, however, for good reason does not recognize compassionate motives as justification for killing.

### ***Assisted Suicide***

Assisted suicide is the term used when a mentally competent person has formed the desire to end his or her life, but requires help to perform the act, usually because of physical disability. When a doctor gives the help requested, the act is called physician-assisted suicide. A common form of assistance might be providing a lethal dose of a drug for the person to administer.

# WHAT IS EUTHANASIA?

## Supporting References

*If the physician presumes to take into consideration in his work whether a life has value or not, the consequences are boundless and the physician becomes the most dangerous man in the state.*

Dr. Christoph Hufeland, 1762-1836.

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*The decision for euthanasia is not an exercise of human freedom but the abandonment of human freedom. To attempt to turn one's life into an object that is at the final disposition of another is to become less than human, while it places the other in a position of being more than human—a lord of life and death, a possessor of the personhood of others.*

Richard Neuhaus, "Legalized euthanasia extends the licence to kill,"  
*Financial Post*, January 13, 1992.

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*There is an infinite number of uses for death once its use becomes a legal means of solving a human problem.*

C.P. Harrison, M.D., "Medicine, Terminal Illness and the Law,"  
*Canadian Medical Association Journal*, 1977.

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*Medical treatments can be refused or withheld if they are either useless or excessively burdensome. No one should be subject to useless treatment; no one need accept any and all lifesaving treatments, no matter how burdensome. In making such decisions, the judgement is about the worth of treatments, not about the worth of lives.*

Richard Neuhaus, "Legalized euthanasia extends the licence to kill,"  
*Financial Post*, January 13, 1992.

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*But can there be a "right to be killed?" The cumulative wisdom of centuries has consistently answered in the negative. Although self-determination is an important right, like all other rights it is not absolute; it can be qualified if it*

*conflicts with the rights of others (e.g., no one has a right to self-determine whether to be a thief or a murderer). If put into practice consistently, the principle that death is an acceptable solution to human problems would ultimately destroy the very fabric of society, and with it all individual rights. Therefore, a "right to be killed" cannot derive from the right of self-determination.*

D. Alan Shewmon, M.D., "Active Voluntary Euthanasia: A Needless Pandora's Box," *Issues in Law and Medicine*, Vol.3 No.3., Winter 1987, p.221.

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*[I]f doctors are authorised to kill or help kill, however carefully circumscribed the situation, they acquire an additional role, alien to the traditional one of healer. Their relationship with their patients is perceived to have changed and as a result some may come to fear the doctor's visit.*

British Medical Association testimony to the Select Committee on Medical Ethics, quoted in the *Report of the Select Committee on Medical Ethics*, House of Lords, Great Britain, Session 1993-94, January 31, 1994, p.25.

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*There would also be a risk that the general public would lose trust in health professionals and in our institutions. Who will guarantee patients that their doctors will never practice euthanasia when they are terminal? Who will assure the hospitalized elderly that they will not be surreptitiously injected with a drug to knock them out, to kill them? Even in palliative care circles, there are people who hesitate to enter a palliative care unit because they are afraid euthanasia is practised there.*

Mr. Réjean Carrier, Social Worker, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, April 27, 1994, 3:10.

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*There is no significant moral or ethical difference between euthanasia and assisted suicide. As with euthanasia, assistance in suicide cannot be considered a supportable part of medical care.*

Balfour Mount, M.D., testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, May 11, 1994, 5:33.

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*In defining euthanasia, we need to look as well at whether physician-assisted suicide is different from euthanasia. I would propose to you that it is not. It is even acknowledged in the literature by the people who are pro-choice on euthanasia, for instance Peggy Battin, an American philosopher, who has written that, in this respect, it will be much easier to get the public to agree to physician-assisted suicide than it will be to get them to agree to euthanasia. Therefore, physician-assisted suicide is the preferable term if you are trying to promote the case for euthanasia.*

*Even if you think it is justified, a physician killing you is homicide, not suicide. It is only if you kill yourself that it is suicide.*

Margaret Somerville, PhD., Testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, May 18, 1994, 6:7.

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*Nurses fully understand the consequences of being in the immediate vicinity of a suffering, perhaps dying person. The basis of good nursing care is the trusting, caring relationship between nurses and patient. Most ill patients not only understand but expect that nurses will care about them as well as for them. How quickly and inevitably would it follow, once doctors were allowed to kill some of their patients for any reason, that nurses would be forced to kill some of their patients? The most frightening aspect of any legislation legalizing euthanasia and/or assisted suicide is its blatant attempt to change caregivers into killers.*

Mary-Lynn McPherson, R.N., testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, June 1, 1994, 8:9.

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*[For example] you see the creation not of the right to suicide, but of the liberty to commit suicide, and it is read as the right to commit suicide, and then it is the right to assisted suicide. There is a gradatum progression that occurs step by inexorable step.*

Iain Benson, Lawyer, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, September 26, 1994, 14:29.

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*When euthanasia is legalized, when patients suddenly realize their doctors are licensed and are prepared either to heal them or to kill them, even at their*

*request, that last trust factor will be gone forever. The legalization of euthanasia would damage medicine as a social institution beyond repair.*

Edwin Hui, M.D., Assistant Professor of Medical Ethics, Regent College, Vancouver, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, September 27, 1994, 15:66.

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*The proponents of physician-assisted dying increasingly promote assisted suicide as a morally neutral act for the physician, and I presume that the purpose of this tactic is to push or perhaps to pull the profession on side, as it were. I must repeat, however, that the premise on which this tactic is false. There is no moral distinction between active euthanasia and assisted suicide when conducted by a physician. Both are professionally and, I believe, secularly unethical acts.*

T. Douglas Kinsella, M.D., Professor and Director, Office of Medical Bioethics, Faculty of Medicine, University of Calgary, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, September 28, 1994, 16:7.

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*To divide voluntary and involuntary euthanasia in a law is misleading since it presumes that one will not lead to the other. History proves that an impossible division —voluntary always leads to involuntary euthanasia. Assisted suicide assumes that someone else gives you the means or information but is not actively involved in killing you. However, it supposes that a friend or a physician would stand by idly if you failed in your attempt —for whatever reason —and not finish the task for you to comply with your wishes. This is naïve logic at best, I believe. Mercy killing used to be completely separate and again misleading because a call for euthanasia always leads to a call for legalizing or legitimizing mercy killing. It is only the method of death that is different, not the intent.*

Mr. Harry van Bommel, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, December 7, 1994, 28:17

# THE EUTHANASIA MOVEMENT

## ***Historical Roots***

Euthanasia is not a new concept. The current thinking on euthanasia really has its roots in the 19th century utilitarian philosophy of Hegel.

In 1920, a book was published in Leipzig, Germany entitled *The Release of the Destruction of Life Devoid of Value*. The authors, jurist Karl Binding and psychiatrist Alfred Hoche believed that there were many lives in Germany that were not worth living. Thus they set out proposals to justify the “destruction” of these lives. This justification was taken up by the intelligentsia of the day and spread throughout the German medical profession.

The Nazis adopted this thinking, and by the end of the Nazi euthanasia programme, the number of innocent human beings killed included more than 300,000 mentally handicapped children and adults, and hundreds of thousands of elderly, all who were deemed worthless. Hitler further adapted the system of “destruction” to rid Europe of the Jews, the Gypsies and anyone not considered “useful.”

Dr. Leo Alexander, an Austrian-born psychiatrist and an expert consultant to the Nuremberg War Crimes trial, published “Medical Science Under Dictatorship” in 1949 in the *New England Journal of Medicine*. He pointed out that the holocaust was made possible through a massive public propaganda campaign to undermine medical ethics. The chronically sick, the mentally or physically disabled were, he observed, the first victims. “It started,” Dr. Alexander wrote, “with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as a life not worthy to be lived.

## ***Proponents of Euthanasia***

The Voluntary Euthanasia Legalization Society was formed in Britain in 1935, but because of the bad name euthanasia had received during the war, the movement went underground, to reappear later under a variety of titles.

Similarly, the Euthanasia Education Council, formed 30 years ago in the U.S., is now named Concern for Dying.

In 1989, Dr. C. Everett Koop, former Surgeon General of the U.S., commented on the language gymnastics of the euthanasia movement:

*Like many other areas of legal reform, euthanasia has undergone a change in our vocabulary that is in part inspired by the political aims of some of the participants in that debate. For example, the Euthanasia Society of America, founded in the 1930's, changed its name in the mid-70's to the Society for the Right to Die. The Society acknowledged that the intent to avoid the controversy engendered by the term 'euthanasia' played a part in this decision. 'Right to die' has become a catch-word in this debate, but one that is not well understood.*

Issues in Law and Medicine, Vol. 5, No. 2, 1989.

Most pro-euthanasia groups belong to the World Federation of Right to Die Societies, which claims members in 18 countries. At its 1984 meeting, Helga Kuhse of Australia outlined the strategy to be used to gain public acceptance of euthanasia:

*If we can get people to accept the removal of all treatment and care — especially the removal of food and fluids —they will see what a painful way this is to die, and then, in the patient's best interest, they will accept the lethal injection.*

Fifth Biennial Conference of the World Federation of Right to Die Societies:  
Nice, France: September 21, 1984. Remarks by panel member Helga Kuhse,  
Ph.D., lecturer in philosophy, Monash University, Australia.

### ***American proponents***

The Hemlock Society was founded in California by British journalist Derek Humphry. His first book, *Jean's Way*, describes how he helped his first wife to commit suicide. A second book, *Let Me Die Before I Wake*, includes "recipes" for suicide drugs, and Humphry boasts that "many hundreds" of people have followed his directions to end their lives.

In 1991, Humphry's most controversial book was published. *Final Exit: The Practicalities of Self-deliverance and Assisted Suicide for the Dying* outlines the many ways you can starve, poison, hang, electrocute and freeze yourself to death. Humphry says:

*It [Final Exit] tells you how, where and when to kill yourself or someone else. It breaks the last taboo. Follow my instructions for a perfect death, with no mess, no autopsy, no post-mortem. This is the final guide.*

Derek Humphry, *Sunday Express* (London), July 28, 1991.

*Final Exit* was banned in Britain, but tens of thousands of copies have been sold in North America.

Another figure of note in the United States is former pathologist Jack Kevorkian. Known as Dr. Death, Kevorkian is responsible for the deaths of at least 100 people to date. His various homemade suicide machines dispense either a lethal injection or a deadly gas. The Michigan doctor has “helped” so many people to die that the state enacted legislation against assisted suicide designed specifically to stop him.

Kevorkian’s long-established fascination with death can be seen from articles he has written over the years for the professional journal, *Medicine and Law*. In a 1988 article on planned death, he explains how one could move from euthanasia, or good death, through human experimentation into an area called “eutatosthanasia” or “best death.”

*Planned death is the purposeful ending of human life by direct human action. The concept is broader than euthanasia or ‘mercy killing,’ which are the ways it is usually interpreted. It includes capital punishment, both involuntary and voluntary; obligatory suicide mandated by rigid theistic or philosophical principles; quasi-optional suicide for the relief of suffering resulting from illness, disability, or old age; strictly optional suicide for reasons not known to others; justifiable infanticide or pedicide; and feticide, both intra- and extra-uterine.*

Jack Kevorkian, quoted by Sarah Sullivan, “Kevorkian: The Rube Goldberg of Death,” *The Advocate*, March 1991.

In *Appointment with Dr. Death* author Michael Betzold reveals that Kevorkian tried to convince death-row inmates to consent to living “experiments” before allowing him to administer lethal drug injections. Betzold also reports that Kevorkian transfused blood from corpses into living, able-bodied pathology assistants.

### ***Canadian groups***

The Canadian group Dying With Dignity was founded in June 1980. Dying With Dignity lobbies for pro-euthanasia legislation, and has lobbied the medical profession for support. In 1990, the Executive Director, Marilynne Seguin, said, “I have helped people to die,” adding that if someone comes to Dying With Dignity and wants to die sooner rather than later, “quite often that can be arranged” (Anita Elash, “When is Death a Right?” *The Toronto Sun*, September 19, 1990, p.20).

The Right to Die Society was formed by former journalist John Hofsess in the fall of 1991. Hofsess used Canada Council funds granted to him for a book on death and dying in Canada to launch the group, producing pro-euthanasia television programs for cable TV, as well as a bimonthly magazine *Last Rights*.

Hofsess used the case of Sue Rodriguez, the Victoria woman who took her request for physician-assisted suicide to the Supreme Court of Canada, to bring public attention and funds to his group. However, Rodriguez severed all ties to Hofsess and the Right to Die Society when she learned that Hofsess had forged her signature on communications with the media which she had not seen and with which she did not agree.

### ***Pressures for Euthanasia***

In the years following the world-wide baby-boom, loud cries for population control were heard, and this significantly reinforced the demand for legalized “therapeutic” abortion. As these baby-boomers grow elderly and sick, the new

call for population control through “legalized, therapeutic euthanasia” may be equally as loud.

In less than 20 years, Canada's over-65 population is projected to exceed 4 million people. By the turn of the century, one of every four Canadians will be of retirement age or beyond. By the year 2030, this number will have grown to more than 7 million, over 27% of the population (Population Projections for Canada, Provinces and Territories, 1984-2006, Statistics Canada, 1985).

Worldwide, according to a report in *Scientific American* (April 1993, p.46), 20% of the world's population will be aged 65 or older by the year 2050 and, “population-aging will soon replace growth as most important from a policy standpoint.”

These unprecedented numbers of elderly will exert tremendous pressure on already scarce medical and social services personnel and facilities. The enormous cost of caring for elderly citizens will call for a larger and larger tax-bite from a smaller and smaller number of taxpayers.

A previously unforeseen tragedy, the AIDS epidemic, has created further pressure which fosters agitation for *legalized* euthanasia. With no cure currently available, and the number of victims predicted to reach dramatic proportions, euthanasia will be urged as both a compassionate and economic necessity. According to Marilynne Seguin, Executive Director of Dying With Dignity (Toronto), “people with AIDS are expressing growing interest in euthanasia to avoid suffering during the final stages of the disease...” (“AIDS Patients Voice Interest in Euthanasia,” *Globe and Mail*, May 12, 1987). Dying With Dignity echoes a familiar and dangerous refrain when it calls for the right of AIDS patients to have a “choice” to die with dignity.

Dr. Peter Singer, writing in the *Canadian Medical Association Journal*, spoke of the future if the proponents of euthanasia are successful:

*Of course, proposals to legalize active euthanasia will initially refer to competent, terminally ill and consenting patients. The first well-publicized cases will involve articulate, dying patients who express gratitude that they can escape their suffering.*

*However, very soon —as has already begun to happen in the Netherlands (Wall Street Journal, Sept. 29, 1987:31) —patients who are incompetent, not terminally ill and non-consenting will fall prey to the killing ‘treatment’.*

*At risk will be the elderly, the uneducated, the poor, the retarded. The lives of thousands of vulnerable people will be in danger, if active euthanasia is legalized.*

Peter A. Singer, M.D., “Should Doctors Kill Patients?” *Canadian Medical Association Journal*, Vol. 138, June 1, 1988; pp.1000-1001.

### **“The Duty to Die”**

The idea of the “duty to die” continues to pose a threat as the next stage in the agenda of the pro-euthanasia movement. In 1997, Medical Ethics professor Dr. John Hardwig published an article in the *Hastings Center Report* (Mar./Apr. 1997, Vol. 27, No. 2) advocating the duty to die.

He provided nine criteria against which people should evaluate their lives to determine whether or not they should come forward to be killed. He also argued that the duty to die becomes greater as you grow older and that reaching the age of 75 to 80 without being prepared to die is itself a moral failing.

Dr. Hardwig’s criteria for voluntary dying includes:

- *the inability to make a significant contribution to your family;*
- *imposing a significant emotional or financial burden on your family;*
- *difficulty in making a good adjustment to your illness; and*
- *having lived a full and rich life.*

# THE EUTHANASIA MOVEMENT

## Supporting References

*Medical ethicists will serve as apologists to justify the [cost] cutting as ethical...It would be foolish to think that assisted suicide or direct killing of patients would not be abused for a cost-containing agenda...Even withholding or withdrawing of treatment is subject to abuse, and there is clinical evidence to point to current routine abuse.*

Colleen Clements, M.D. "Physicians Simply Can't Promote 'Mercy' Killing of Patients," *The Medical Post*, June 20, 1989.

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*"The prolongation of life by medical science has placed a staggering burden on hospitals and chronic-care facilities. Eventually society, out of sheer necessity, will understand and accept those who decide to enter eternity painlessly with the help of science, rather than to leave the extent of their misery to the whim of the gods." This is a disturbing commentary: doctors caring more about money than helping and prolonging the life of their patients.*

Statement by Dr. Gifford Jones, "The Doctor Game", *The Globe and Mail*, Jan. 6, 1987; with comment by Jeff Harmon, "Death Wish: Euthanasia Today," *The Pentecostal Testimony*, February 1988.

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*Even if carefully circumscribed at first, legalized euthanasia would become the tool of the social engineers. After killing those who are dying, it would only be a matter of time before we killed those who were soon to die, and then, those who would be better off dead, until no one would be safe.*

Jean Rostand, "Humanly Possible: A Biologist's Notes on the Future of Mankind," quoted in Law Reform Commission Study Paper, *Sanctity of Life or Quality of Life*, 1979.

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*As soon as he goes beyond 60-65 years of age, man lives longer than his capacity to produce, and he then costs society a lot of money...Indeed, from society's point of view, it is preferable that the human machine should stop suddenly, rather than face progressive deterioration...Euthanasia will become one of the essential instruments of our future societies in any case. In the*

*logic of socialism...the problem must be presented as follows: The socialist logic is freedom, and the fundamental freedom is suicide; therefore the right to suicide, either directly or indirectly, is an absolute value in this type of society.*

Jacques Attali, Former President of the European Bank and Aide to French President Francois Mitterand; quoted in *Population Research Institute Review*, March/April 1992.

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*You have raised the concern that increased costs in caring for the elderly may very well increase the pressure on them to choose euthanasia. We hear it often: "I have to die now, because I will not have enough money left for the kids' college education." We could speak about increased pressure on the elderly by others to suggest they choose euthanasia. The pressure will come about by others not only because they want Aunt Minnie's silver, but basically to get them out of the way because the house is not big enough.*

Abbyann Day Lynch, PhD., testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, June 22, 1994, 11:23.

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*Of the 80,000 or so physicians in Germany during the Nazi period, more than 38,000 were members of the Nazi Party. More than 7 per cent of all physicians had joined the SS, in comparison to 0.5 per cent of the general population. It is important to note that no euthanasia law was ever formally enacted in the Third Reich. The Nazis did this, to a large extent, by charging the physicians to care for the societal good rather than the interest of the individual patient. Physicians were empowered to carry out mercy killings, but were never obliged to do so.*

Yoseph Thompson, Director of Development for the Central Organization for Jewish Education, Lubavitch British Columbia, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, September 26, 1994, 14:47.

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*In my experience, I have never come across a person who had no dignity. I do not know why we feel our own dignity is so tenuous. People have a terrible fear of being dependent on others. They want to die before they become a burden. Why is dependence a fate worse than death? That is a very important question.*

Brigitte Champion, Ethicist, Consultant to the Catholic Health Association of Canada, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, September 26, 1994, 14:159.

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*The central stumbling block [to the practice of euthanasia] appears to be the Hippocratic Oath. It is ironic that the profession which prides itself on the Hippocratic Oath does not require its members to take it. Indeed, physicians who have taken the oath are few and far between. (15:43)*

*I have met only a handful of physicians who have taken the oath. It is not mandatory in most medical schools although it was many years ago. Most of the physicians I have met have never even read it. (15:53)*

Eike-Henner W. Kluge, Ph.D., Professor, Department of Philosophy, University of Victoria, testimony before the Special Senate committee on Euthanasia and Assisted Suicide, September 27, 1994, 15:43 and 15:53.

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*When a frail, elderly person who feels that they are a burden on society is asked by their doctor, their family or their priest whether they have considered death as an option, there is a lot of pressure for that person to say that death may be an option. However, right now, death is not an option and that person has the right to live, by default. If we change the law, that person may lose the right to live because someone else has the right to die.*

Dr. Harold Boey, M.D., Manitoba Physicians for Life, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, September 30, 1994, 18:53.

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*It appears that the closer one is to the bedside and working with dying patients, the less accepting one is of the euthanasia option.*

*I saw an article about physicians in Washington State in this regard which I found most interesting. The group which had the greatest acceptance of euthanasia was psychiatrists. I presume that, as a rule, they do not see very many patients who are going on to die, although some of them may. The group most strongly opposed was oncologists.*

*A few similar surveys of physicians indicate that the closeness of contact with dying patients influences views.*

Dr. Neil Macdonald, Director, Cancer Ethics Programme, Center for Bioethics, Clinical Research Institute of Montreal, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, October 27, 1994, 22:40.

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*The motive of those people who are advocating euthanasia and assisted suicide may be described as "compassion", but it is not, it is a means of getting rid of a pain for them as well as for the patient. It is a separation or an isolation.*

Most Reverend Marcel Gervais, Archbishop of Ottawa, Past President of the Canadian conference of Catholic Bishops, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, October 27, 1994, 22:55.

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*When I listen to this ongoing euthanasia debate, I am mystified. During all those years at hundreds of bedsides of the very ill and dying, where were the voices calling for someone to precipitate their death? Did I miss something? I really do not think I did. Not once in almost a decade of hospital work did I hear one expression of that desire in the hundreds of people whom I had the privilege of being close to during the time they were preparing to leave this world.*

Reverend Kenneth Weir, Church of St. John and St. Paul, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, November 17, 1994, 24:21.

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*Internal pressures affecting the individual may include the fear of death, however, for many seniors it is not so much the fear of death itself as the fear of a painful death which causes stress. Loss of control, concern over being able to financially pay for the support required to continue living, and the fear of becoming a burden to family members are further internal pressures that can affect an individual's desire for euthanasia and assisted suicide. In certain situations, individuals may make decisions which are not in their best interests but rather with the intention of protecting and safeguarding their families from the emotional and financial pressures that may ensue.*

Ms. Marian Chapman, Chair, Council on Aging, Ottawa-Carleton, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, January 13, 1995, 32:54.

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*Vulnerable patients and families are themselves beginning to get the message that they are a burden. They are apologizing for their presence and continued survival. In some cases, it is apparent that patients are choosing to forego reasonable life-prolonging treatments in order to avoid being what they have been told is a continued financial burden to society.*

Elizabeth J. Latimer, MD. Professor, Department of Family Medicine at McMaster University and consultant physician in palliative care. Canadian Family Physician, "Euthanasia and Physician-Assisted Suicide." 1997; 43: 189-91.

# EUTHANASIA AND CANADIAN LAW

## ***Current Statutes***

The *Criminal Code of Canada* regards euthanasia, or mercy killing, whether passive or active, as culpable homicide, or murder. A culpable homicide is defined as murder “where the person who causes the death of a human being means to cause his death” (s. 229, *Criminal Code of Canada*). At present euthanasia carries a fixed, minimum penalty of 10 years in prison.

It is also a criminal offence to aid or counsel someone to commit suicide, even if the person voluntarily requests such assistance. S.241 of the *Criminal Code* provides a penalty of 14 years’ imprisonment for helping another to commit suicide.

## ***The Law Reform Commission and Euthanasia***

In 1987, the Law Reform Commission of Canada completed an extensive review of the *Criminal Code* and recommended that euthanasia continue to be regarded as murder.

*The Commission recommends that mercy killing not be made an offence separate from homicide and that there be no formal provision for special modes of sentencing for this type of homicide other than what is already provided for homicide.*

Law Reform Commission of Canada, Report 20, Euthanasia, Aiding Suicide and Cessation of Treatment, p.31.

The Commission explained the reasoning behind its recommendation as follows:

*Law exists to meet real needs. The Commission has concluded, independently of all other arguments, that in Canada today, there are neither wrongs nor needs sufficiently great to justify overturning a well-established tradition based on time-honoured morality. The extraordinary development of palliative care and pain control in recent years is certainly a safer and more positive response to the problem of pain and suffering for the terminally or incurably ill.*

The Commission has also commented upon the common law right to refuse treatment, sometimes mistakenly labelled a passive method of euthanasia:

*The civil law presents no obstacle to the interruption of treatment. The concept of patient autonomy and the right to self-determination have been increasingly recognized by courts and legislatures across the country, particularly in the last two decades. The corollary of the requirement of informed consent prior to treatment is the right of the patient to refuse treatment, either before it is commenced or at any time thereafter. This right is recognized in Quebec by article 19.1 of the Civil Code and by the common law elsewhere in Canada...*

Law Reform Commission of Canada Brief to the Legislative Committee on Bill C-203, Feb. 6, 1992.

## **Recent House of Commons Bills and Motions**

### **Bill C-203**

Bill C-203, *An Act to Amend the Criminal Code (terminally ill persons)*, put forward in 1991 by then-MP Robert Wenman (Lib —Fraser Valley West, BC), was intended “to protect a physician from criminal liability where the physician does not initiate or continue treatment at the request of the patient or where the physician does not prolong life, except at the patient’s request. It would also protect a physician who administers pain killing treatment to a terminally ill patient even though the effect of that treatment will hasten death” (Explanatory Note, Bill C-203).

Campaign Life Coalition, in a brief to the legislative committee studying Bill C-203, stated:

*[Bill C-203] appears at first glance to be an innocuous piece of legislation which simply codifies what is already taking place with medical care of terminally-ill patients across the country. Closer inspection, however, reveals that the Bill cleverly encompasses the concept of “living wills,” and worse, would legalize the direct killing of patients under the guise of alleviating pain and suffering. The Bill has*

*been characterized by one government member as a formula for “passive euthanasia”: in our view it is a formula for more active forms of euthanasia.*

A similar position was taken by the Canadian Physicians for Life who stated at page 8 of their brief to the legislative committee, November 1991:

*It is just as obvious to us that the real purpose of the section of Bill C-203 which would deem medical practitioners not to have committed a criminal offence when they administer care or measures intended to relieve the physical suffering of a person in such a way that these ‘will or are likely to shorten the life expectancy of a person’ is not to permit pain relief but to allow the physician to kill his/her patient.*

Dr. John F. Scott, Director of the Regional Palliative Care Service in Ottawa, said in his presentation to the committee:

*Bill C-203 does not legalize euthanasia but would have the effect of publicly sanctioning it. Without additional changes to the Criminal Code, Bill C-203 could bring about wholesale euthanasia in Canada.*

There was much concern about the motives and the effects of Bill C-203. The bill remained in committee and was never brought to a vote in the House of Commons.

### **Bill C-261**

A second Private Member’s Bill, Bill C-261, was introduced September 18, 1991. This bill, proposed by MP Chris Axworthy (NDP — Saskatoon—Rosetown—Biggar, SK), would have allowed for virtually unrestricted euthanasia, voluntary and non-voluntary, with no provision for conscientious objection. The bill was deemed not votable, and was debated on October 24, 1991.

### **Motion M-397**

On February 17, 1993, MP Ian Waddell (NDP —Port Moody-Coquitlam, BC), moved a motion that urged the Government to legalize assisted suicide by freeing “those assisting terminally ill patients who wish to die” from criminal liability.

In debate, MP Don Boudria (Lib —Glengarry-Prescott-Russell, ON), put it very clearly: “What we are...debating is whether we will give the right to any human being to kill another human being” (*Hansard*, February 17, 1993).

A votable motion, M-397 was defeated 140 to 25 on March 22, 1993.

### **Bill C-215**

Introduced February 16, 1994, by MP Svend Robinson (NDP —Burnaby—Douglas, BC), Bill C-215 sought to amend the *Criminal Code* “to allow for physician-assisted suicide upon the request of a terminally ill person.” This bill was not deemed to be a votable item.

### **Motions M-218 and M-277**

MPs Don Boudria and Svend Robinson introduced opposing motions on the issue of assisted suicide in early 1994. Motion M-277 (Mr. Robinson) sought the approval of the House to consider changes to the *Criminal Code* prohibition of assisted suicide. Motion M-218 (Mr. Boudria) asked the House to reaffirm its support for the prohibition of assisted suicide.

### **S-13**

Bill S-13 was introduced in the Senate by Liberal Senator Sharon Carstairs, but was only at 2<sup>nd</sup> reading when Parliament ended due to the 1997 election call.

The Bill was introduced in response to unanimous recommendations from the Special Senate Committee on Euthanasia and Assisted Suicide and was ostensibly designed to clarify the law as it pertains to health care providers who withhold or withdraw life-sustaining medical treatment and to those who administer pain-relieving medication in doses that may shorten a person’s life.

As such, it dealt only with practices that are already legal. It was argued that present legislation is sufficiently clear and that the changes to the law proposed in S-13 would have the effect of moving Canadian law in the direction of legalizing euthanasia and assisted suicide.

There were some strong reservations with the bill including the fact that it only required one person to be a witness to the patient's request to die. It should have required at least two witnesses, one of whom was not the health care provider. The bill also did not define "life-threatening" illness, opening the door to serious abuses.

Also of great concern was the fact that S-13 would establish the right to refuse treatment as an absolute right that could not be challenged except in court, thus putting in jeopardy the lives of those who may refuse treatment while under a temporary state of depression. The right to refuse treatment has always been recognized in Common Law, but the law also respects the responsibility of health care practitioners to use their discretion to challenge such requests where appropriate.

The bill defined "food and water" as "treatment." The administration of nutrition and hydration, however, should be defined as "care," and the law must make a clear distinction between treatment and care.

### **Bill C-304**

Bill C-215 was re-introduced as Bill C-304 by MP Svend Robinson after being dropped from the *Order Paper* at the end of the 1<sup>st</sup> Session of the 34<sup>th</sup> Parliament. For the second time, it was ruled non-votable. It was debated on March 6, 1997. The government opposed the bill, essentially for technical reasons and because they had already promised to raise the issue when they felt the time was right. Bill S-13 was at the 2<sup>nd</sup> reading stage in the Senate when Bill C-304 was debated and then-MP Gordon Kirkby (Lib —Prince Albert—Churchill River, SK), speaking for the government, noted that S-13, in contrast to C-304, was based on unanimous recommendations from the final report of the Special Senate Committee on Euthanasia and Assisted Suicide.

### **Motion M-123**

Introduced on September 23, 1997 by MP Svend Robinson, M-123 called upon the government to appoint a special committee to review the provisions

of the *Criminal Code* regarding euthanasia and assisted suicide with the intent of introducing legislation to amend these provisions. The Motion was deemed votable by the Committee on Procedural and House Affairs and the first hour of debate took place on November 4, 1997.

The government opposed the Motion, saying that much more needs to be done before considering *Criminal Code* amendments regarding euthanasia and assisted suicide. This includes national guidelines and standards regarding palliative care and pain control as well as progress by the provinces in the area of living wills. The Motion was defeated by a vote of 65-169 on March 25, 1998 (2<sup>nd</sup> hour of debate took place on February 2). Of those who voted, all but four Reform MPs opposed the Motion, and all but eight Liberals. The Progressive Conservatives were split evenly and all but one New Democrat voted in favour of the Motion as did most (33) Bloc Quebecois Members.

### ***Senate Committee on Euthanasia and Assisted Suicide***

A Special Committee of the Senate of Canada was appointed, by the Senate, on 23 February, 1994 “To examine and report on the legal, social and ethical issues relating to euthanasia and assisted suicide.” Testimony was heard for fourteen months and the final report was submitted to the Senate June 1995.

The Committee’s majority recommendations were that:

- *nonvoluntary euthanasia remain a criminal offence.*
- *voluntary euthanasia remains a criminal offence. The Criminal Code, however, should be amended to allow for a less severe penalty similar to that provided for nonvoluntary euthanasia in cases where there is the essential element of compassion or mercy.*
- *the prohibition against involuntary euthanasia continue under the present murder provisions in the Criminal Code.*
- *no amendments be made to the offence of counselling suicide under subsection 241(a) of the Criminal Code.*

The complete report titled “Of Life and Death” is available from:

*The Standing Senate Committee on Euthanasia and Assisted Suicide*

*The Senate of Canada,  
Ottawa, Ontario  
K1A 0A4*

# EUTHANASIA AND CANADIAN LAW

## Supporting References

*Traditionally, both in common law and common morality, human beings have been held to be entitled to great and equal respect; their lives are of such intrinsic importance or dignity that no choice intentionally to bring about an innocent person's death can be right. This is true whether the death is caused by commission or omission, and whether it is caused for "noble" reasons such as "mercy killing" or less noble ones like inheritance. Thus the sanctity of life principle has often been worded "you shall not kill" or "everyone has (an equal and inalienable) right to life."*

The Society for the Protection of Unborn Children (Great Britain),  
*Submission to the House of Lords Select Committee on Medical Ethics*,  
1993, p.1.

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*I believe that occasionally we must accept uncertainty on social issues (such as euthanasia) rather than risk inherent systemic abuses that can come from specific legislation, no matter how well written or well intended.*

Harry Van Bommel, *Dying for Care: Hospice Care or Euthanasia*, New  
Canada Publications, 1992, p.14.

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*Institutional euthanasia is, to our minds, a serious problem that needs to be looked at and guarded against. Within an institution, there is an even greater chance that the person may not be aware of the decisions being made. The chances of abuse and one person imposing their will on the institution are much greater. It concerns us greatly that we can have situations where people such as Dr. Kevorkian decide that they are judge and jury, and operate within an institution. They may or may not discuss what they are doing with the people involved.*

Dr. James G. Young, Chief Coroner, Province of Ontario, testimony  
before the Special Senate Committee on Euthanasia and Assisted  
Suicide, October 17, 1994, 20:5

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*I believe that euthanasia and assisted suicide are ethically unacceptable in principle, and that their legislation has profound negative consequences for*

*society in general, and for vulnerable populations in particular. They are the wrong answers to our fear of dying. They imperil our already fragile support of all vulnerable populations in this country. They profoundly change the nature of the physician-patient relationship, and they further medicalize the human reality of death.*

Dr. Sister Nuala Kenny, From the Izaak Walton Killam Hospital for Children, Halifax, Nova Scotia, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, October 17, 1994, 20:28.

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*My view is similar to that of Dr. Kenny's, (20:28) namely that a legalization of active killing and/or assisted suicide, or assisted death, would eventually result in the involuntary euthanizing of people and persons who were not consenting to that particular procedure.*

Dr. Gordon Crelinsten, Chairman, Biomedical Ethics Committee, Royal College of Physicians and Surgeons of Canada, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, October 17, 1994, 20:40.

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*It is an illusion that we can maintain the high standards of care and protection for the vulnerable, poor, suffering and abandoned people were we to have a law that said euthanasia is socially and ethically acceptable. It is naïve to imagine that such a law, passed by good people with highly humane motives, would not lead to intolerable abuse by those who do not share those intentions or those original motives.*

Dr. David J. Roy, Director, Centre for Bioethics, Clinical Research Institute of Montreal, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, October 27, 1994, 22:10.

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*I must admit that I am somewhat wary. Germany in 1930 or 1935 was awash in regulations. Everything was written down. And we know what happened because regulations were followed. Regulations can also protect evil.*

Doctor James Gordon, Neurologist, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, November 30, 1994, 27:19.

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*I fear that if euthanasia comes to this country, it will not come with a cheer but with a whimper. It will not be wholeheartedly supported. It will be a slim majority. Is that not how this sort of thing comes in, in any event?*

Mr. Mark Pickup, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, November 30, 1994, 27:27.

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*Beyond certain specific cases, we must ask ourselves whether the establishment of a true right to death and its inevitable corollary, the right to administer death, will represent progress for us toward achieving a more humane and fairer society for all its members because that is the question that arises. In this debate, the vocabulary must be clear and there is not room for manipulating opinion. We often witness a kind of manipulation through the mix of concepts that are submitted. Suicide with or without assistance is not euthanasia. Euthanasia is not assisted suicide and the cessation of treatment is quite distinct from both those concepts.*

Doctor Suzanne Philips-Nootens, Faculty of Law, University of Sherbrooke, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, December 12, 1994, 29:20.

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*If we agree that there is indeed not only a freedom to die, but that there is a right to die, one thereby ratifies the right for others to administer death to their fellow citizens.*

Doctor Suzanne Philips-Nootens, Faculty of Law, University of Sherbrooke, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, December 12, 1994, 29:39.

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*Human death is not a right nor a good, but rather something inevitable. It is the right to life that is fundamental and universally valid for all human beings. In principle, all human deaths are of equal value, as are lives and persons.*

Doctor Jean Declos, Doctor of Theology, Faculty of Theology, University of Sherbrooke, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, December 12, 1994, 29:27.

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*We are also concerned that legislation may make suicide seem a more acceptable alternative for those people —especially young people—who feel desperate at a point in their lives when we as a society should be helping them to face the future with confidence.*

Mr. Randy Bottle, Chairman, Alberta Indian Health care Commission, testimony before the Special Senate committee on Euthanasia and Assisted Suicide, December 13, 1994, 30:22.

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*I sincerely believe that legalization, be it for assisted suicide or euthanasia —ethically they are more or less the same thing—I believe that legalization will reinforce in some people, especially our young people whose values are perhaps often different from ours, this perception in our society that it is only youth that is important and that growing old is something abnormal. We can draw inferences from this. But I believe that by legalizing assisted suicide or euthanasia, we will be sending a very subtle, subliminal message to society, which, in my opinion, will have an insidious effect.*

Michel R. Morissette, M.D., Laval University Hospital Centre and Maison Marc Simon, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, January 13, 1995, 32:23.

## EUTHANASIA STUDIES IN OTHER JURISDICTIONS

### **Great Britain**

In February 1993, the British House of Lords appointed a Select Committee on Medical Ethics to study euthanasia and related issues. The terms of reference of the Committee included “the issue of when it is appropriate to discontinue, or not to initiate, medical treatment; the issue of euthanasia as commonly understood, meaning a deliberate intervention undertaken with the express intention of ending life; and the likely effects of changes in law or medical practice on society as a whole.”

The Committee sought written and oral testimony from a variety of medical and non-medical sources, and visited the Netherlands to discuss experiences there. Following a year of study, the Committee published its report on January 31, 1994. The report contains the following conclusions on the issue of voluntary euthanasia:

*The right to refuse medical treatment is far removed from the right to request assistance in dying. We spent a long time considering the very strongly held and sincerely expressed views of those witnesses who advocated voluntary euthanasia. Many of us have had experience of relatives or friends whose dying days or weeks were less than peaceful or uplifting, or whose final stages of life were so disfigured that the loved one seemed already lost to us, or who were simply weary of life. Our thinking must inevitably be coloured by such experience. The account we received from individual members of the public about such experiences were particularly moving, as were the letters from those who themselves longed for the release of an early death. Our thinking must also be coloured by the wish of every individual for a peaceful and easy death, without prolonged suffering, and by a reluctance to contemplate the possibility of severe dementia or dependence. We gave much thought to Professor [Ronald] Dworkin’s [Professor of Jurisprudence at Oxford and Professor at Law at New York University] opinion that, for those without religious belief, the individual is best able to decide what manner of death is fitting to the life which has been lived.*

*Ultimately, however, we do not believe that these arguments are sufficient reason to weaken society’s prohibition of intentional killing.*

*That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia. We acknowledge that there are individual cases in which euthanasia may be seen by some to be appropriate. But individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions. Moreover dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole.*

*Report of the Select Committee on Medical Ethics, House of Lords, Great Britain, Session 1993-94, January 31, 1994, para. 236, 237.*

On the issue of mercy killing the Committee concluded:

*We have considered suggestions that, although deliberate killing should remain a criminal offence, killing to relieve suffering (that is deliberate killing with a merciful motive) should not be murder but that a new offence of "mercy killing" should be created. At present the offence of murder embraces acts of deliberate killing which vary enormously in their character and which most people would agree vary "in degree of moral guilt." The significant question however is whether the law could or should make a distinction between them.*

*We consider that it should not. To distinguish between murder and "mercy killing" would be to cross the line which prohibits any intentional killing, a line which we think it essential to preserve. Nor do we believe that "mercy killing" could be adequately defined, since it would involve determining precisely what constituted a compassionate motive. For these reasons we do not recommend the creation of a new offence.*

*Report of the Select Committee on Medical Ethics, House of Lords, Great Britain, Session 1993-94, January 31, 1994, para. 259, 260.*

The Committee also examined the issue of assisted suicide, and concluded:

*As far as assisted suicide is concerned, we see no reason to recommend any change in the law. We identify no circumstances in which assisted suicide should be permitted, nor do we see any reason*

*to distinguish between the act of a doctor or of any other person in this connection.*

*Report of the Select Committee on Medical Ethics, House of Lords, Great Britain, Session 1993-94, January 31, 1994, para. 262.*

The Committee recommended that there be no change in the law to permit euthanasia, mercy killing, or assisted suicide. It further commended the development and growth of palliative care services in hospices, hospitals and in the community, and recommended that palliative care should be made more widely available. As well, the Committee stated that research into pain relief and symptom control should be more adequately supported.

[For the complete Report of the Select Committee on Medical Ethics, see Appendix A.]

### ***The Netherlands***

The practice of euthanasia in Holland has been offered to other societies as a role model, and the Netherlands has been portrayed as a place where euthanasia is a “last, loving medical treatment.”

Euthanasia is not legal in Holland, but as a result of a series of court decisions, it is routinely undertaken as a “treatment” for the terminally ill. The stage was set in 1973, when the Dutch courts convicted a doctor for killing her mother, but then gave her a one-week jail term. That case established a precedent, and in 1984, the Supreme Court ruled that if specific guidelines which had been advanced by the Royal Dutch Medical Association were adhered to by a euthanizing doctor, then that doctor would be free from charges of criminal liability in the resulting death.

In February 1993, a new euthanasia law was passed in the Dutch Parliament. It was criticized by doctors because it failed to offer “...protection for doctors carrying out euthanasia on patients unable to express their will to die, such as babies or comatose patients” (*Medical Post*, “Dutch doctors wary of new euthanasia law,” March 2, 1993, p.51).

This new law, which came into effect in March, 1994, continues to keep euthanasia illegal but allows doctors who kill their patients to avoid prosecution by filling out an extensive questionnaire:

*On this document, the doctor must give a thorough case history of the patient and say how death was requested. The doctor must also get a second medical opinion.*

*Death does not have to be imminent, nor must the patient be terminally ill. A person who is psychiatrically ill is allowed to request euthanasia. Mercy killing is also allowed without the patient's consent if the person is unable to communicate.*

*Among the items on the questionnaire:*

- *Was the patient suffering so badly that this was or could be regarded as unbearable?*
- *Were there possibilities for making the patient's suffering more bearable and did you discuss these with the patient?*
- *Did the patient make a request freely, quite explicitly and on a well-considered and permanent basis?*

Alanna Mitchell, "Dutch give prosecutors rein," *Globe and Mail*, February 16, 1994.

Canadian physician Will Johnston has outlined the technique used by Dutch doctors to kill patients:

*A strong sedative, such as pentobarbitol, is given intravenously. The patient falls deeply asleep and then curare or succinylcholine, which paralyse completely, are injected, sometimes with potassium chloride which arrests the heart. The technique is painless and instantly fatal.*

Will Johnston M.D., *Euthanasia*, a speech given June 2, 1990, to Kamloops Pro-life Convention.

Since 1984 the practice of euthanasia has been very open, and many claims have been made as to its frequency and its benefits or drawbacks. To establish the facts on euthanasia, a government-sponsored study was undertaken and the report released September 10, 1991. This report, *Euthanasia and other Medical Decisions Concerning the End of Life*, commonly called the Remmelink Report, has revealed disturbing findings.

The population of the Netherlands in 1990 was 15 million. The study findings indicated the following **annual** figures:

- 2300 cases of active voluntary euthanasia.
- 400 cases of assisted suicide (the lethal means for death is provided to the patient for self-administration).
- 1040 cases of involuntary euthanasia (.8% of total deaths in Holland). These cases —averaging almost 3 per day —were those in which the physician prescribed, provided or administered a medicine with the deliberate aim to hasten the end of life, though the patient had made no explicit request for euthanasia.
- 14% of patients whose lives were ended without their explicit request were fully competent.
- 62% of patients whose lives were terminated without their explicit request had never given any indication regarding termination of life.
- An additional 8100 patients died after pain medication (morphine) was administered by physicians who intended to shorten life. The decision to administer the intentional overdose was not discussed with 27% of fully competent patients who died in this manner.

Figures quoted from an analysis of the Rummelink Report (*Medische Beslissingen Rond Het Levensende*, Sdu Uitgeverij Plantijnstraat's-Gravenhage, [1991] The Hague) by Rita L. Marker, *Submission to Legislative Committee on Bill C-203*, November 19, 1991.

The Rummelink Report used a very narrow definition of euthanasia, “active termination of life upon the patient's request.” A report in *The Lancet*, based upon the Dutch reports, acknowledged that “...in cases of euthanasia the physician often declares that the patient died a natural death” (Paul J. van der Maas, Johannes J. M. van Delden, Loes Pijnenborg, and Caspar W.N. Looman, “Euthanasia and Other Medical Decisions Concerning the End of Life,” *The Lancet*, 338:8768, Sept. 14, 1991, p.669).

In plain language, the Dutch doctors admitted that they were prepared to make false statements. When the definition of euthanasia is widened to include those patients who died at the hands of a physician, whether or not

they had requested death, it becomes clear that “the real number of physician assisted deaths, estimated by the Rimmelink Report, is, in reality, 25,306...This amounts to 19.61 per cent of total deaths (129,000) in The Netherlands in 1990” (Fleming, John I., “Euthanasia, The Netherlands, and Slippery Slopes,” *Bioethics Research Notes*, Occasional Paper No. 1, Southern Cross Bioethetics Institute, Adelaide, South Australia, June 1992, p.2).

Of this number (25,306), Richard Fenigsen, M.D., Ph.D., a Dutch cardiologist, finds 14,691 cases of *involuntary* euthanasia, as he explains in *Issues in Law and Medicine*, Volume 7, No.3, 1991, “The Report of the Dutch Governmental Committee on Euthanasia”:

*The figures published in the report indicate that 14,691 cases of involuntary euthanasia occur annually in the Netherlands. This is 11.3% of the total number of deaths in the country. The number 14,691 includes 1,000 cases of active involuntary euthanasia, 8,100 cases in which morphine was given in excessive doses with the intent to terminate life, of which 4,941 cases, or 61% were done without the patient's consent, and 8,750 cases in which life-prolonging treatment was stopped or withheld with the intent to cause death without the patient's consent. This estimate should be supplemented with the cases of involuntary euthanasia on newborns with disabilities, children with life-threatening diseases and psychiatric patients.*

The Committee concluded that up-to-date pain management would not reduce the requests for euthanasia. Those who have for many years administered palliative care would dispute this finding. There is little experience of palliative care in Holland.

Doctor Fenigsen was interviewed on this matter in *ALL About Issues*, Winter 1991. He said:

*To some extent it is true that the acceptance of euthanasia tends to diminish the efforts towards optimal pain control. Indeed, the new perfected forms of palliative care are now making quick advances in Great Britain and Canada, but are non-existent in Holland, where euthanasia is practised instead. It is also true, that the practice of euthanasia adversely influences the care of patients in general*

*because, by offering “the easy solution,” euthanasia inhibits the doctor's motivation to undertake the most difficult and not always successful tasks, and the motivation to do the utmost in investigating and treating severely ill patients.*

Doctor John Scott, presenting to the Legislative Committee on Bill C-203, on November 19, 1991, discussed the sad results of the failure to develop hospice care. On page 6 of his presentation he states:

*Canada faces a choice —to follow the pattern of the United Kingdom or the pattern of the Netherlands. The United Kingdom has pioneered the development of hospices and Palliative Medicine and is known world-wide for the compassionate care and symptom relief its citizens are afforded. The Netherlands failed to develop hospice programs and as a result is known for its poor standards of palliative care and pain relief. In desperation, it has turned to euthanasia as a cheap solution to suffering. Which route will Canada take?*

[For a summary of the Dutch report see Appendix B.]

### **New York State**

The New York State Task Force on Life and the Law issued a report on May 26, 1994 unanimously rejecting physician-assisted suicide and state sanctioned lethal injections by doctors. The Task Force, made up of prominent physicians, attorneys, philosophers and representatives of religious groups, was appointed by Governor Mario Cuomo in 1984 to provide advice on medical-ethical issues.

The Task Force found that:

*The distinction between the refusal of medical treatment and assisted suicide or euthanasia has not been well-articulated in the broader public debate. In fact, the often-used rubric of the “right to die” obscures the distinction. The media's coverage of individual cases as a way of presenting the issues to the public also blurs the difference between a private act and public policy; between what individuals might find desirable or feasible in a particular case and what would actually occur in doctors' offices, clinics, and hospitals, if assisted suicide and*

*euthanasia became a standard part of medical practice. Public opinion polls, focusing on whether individuals think they might want these options for themselves one day, also offer little insight about what it would mean for society to make assisted suicide or direct killing practices sanctioned and regulated by the state or supervised by the medical profession itself.*

Preface, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, The New York State Task Force on Life and the Law, May 1994

The Task Force concluded that allowing physicians to assist suicide or to kill their patients directly would pose extraordinary risks.

*Recent proposals to legalize assisted suicide and euthanasia...would transform the right to decide about medical treatment into a far broader right to control the timing and manner of death. After lengthy deliberations, the Task Force unanimously concluded that the dangers of such a dramatic change in public policy would far outweigh any possible benefits. In light of the pervasive failure...to treat pain and diagnose and treat depression, legalizing assisted suicide and euthanasia would be profoundly dangerous for many individuals who are ill and vulnerable. The risks would be most severe for those who are elderly, poor, socially disadvantaged or without access to good medical care.*

Executive Summary, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, The New York State Task Force on Life and the Law, May 1994.

The Task Force put specific emphasis on the role which depression and uncontrolled pain play in the desire of some patients for an early death.

*In the course of their research, many Task Force members were particularly struck by the degree to which requests for suicide assistance by terminally ill patients are correlated with clinical depression or unmanaged pain, both of which can ordinarily be treated effectively with current medical techniques. As a society, we can do far more to benefit these patients by improving pain relief and palliative care than by changing the law to make it easier to commit suicide or obtain a lethal injection.*

Executive Summary, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, The New York State Task Force on Life and the Law, May 1994.

Task Force chair and New York Commissioner of Health, Dr. Mark R. Chassin stated:

*People fear losing control over treatment decisions and they fear dying in pain. Those are real fears and they must be addressed. But a humane society owes its citizens something more than a prescription for a quick exit, particularly when we have the ability to control pain effectively and to successfully treat the depression that often causes patients to believe that suicide is their only option.*

Media Release, New York State Task Force on Life and the Law, May 26, 1994.

[For the summary and recommendations of the Task Force see Appendix C.]

# EUTHANASIA STUDIES IN OTHER JURISDICTIONS

## *Supporting References*

*Applied medically, the sanctity of life principle excludes medical homicide: killing is among the ways in which healthcare workers may not deal with their patients. Thus traditional medical ethics held that physicians might not be called upon to act as public executioners.*

The Society for the Protection of Unborn Children (Great Britain),  
*Submission to the House of Lords Select Committee on Medical Ethics*,  
1993, p.1.

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*The Remmelink Commission's confidential inquiries show that doctors have taken matters into their own hands to an alarming degree. They are systematically flouting the guidelines that were laid down to regulate euthanasia. They are also falsifying death certificates —no fewer than 72 per cent of doctors admit to concealing euthanasia as the cause of death.*

Ian Gentles, Professor of Population History, Glendon College, York University, *Ottawa Citizen*, "The Right to Die - Good reasons for imposing legal restrictions are still valid," May 30, 1993.

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*The Dutch Physicians' League said that many prospective patients, especially elderly people, feared that they would be subjected to euthanasia against their wishes, or would not receive adequate medical treatment. They said that some patients now insisted on written contracts before consenting to hospitalisation...[The Physicians' League] said that they were afraid of the effects which the practice of euthanasia had on doctors: they suggested that each time a doctor performed euthanasia he or she would make the decision more readily and quickly.*

*Report of the Select Committee on Medical Ethics*, House of Lords,  
Great Britain, Session 1993-94, January 31, 1994.

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*However, I would say that we are at a juncture. One of the fears I have if we were to introduce euthanasia/assisted suicide changes in law is that we would lose the momentum we are achieving for the care of the dying.*

*As an example, when I was in Holland I had an opportunity to teach resident trainees in family medicine. It was very difficult to put forward a positive model for palliative care in the sense that most people, with some incredulity, would say, "Why should we bother to do that when we have the other option?" I think it would confuse our MD group considerably should we have this other option. It certainly would not help us in undergraduate education at all.*

Elizabeth Latimer, M.D., testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, May 4, 1994, 4:9.

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*I say to you that the good in the Holland experience is to alert us to the fact that safe guidelines are not possible, at least not after 20 years of professional attempts.*

Margaret Scott, M.D., testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, May 18, 1998, 6:53.

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*If killing a patient is wise economically, you have a conflict of interest between good patient care and economic budgeting. Many feel that this would not happen, but a survey of students of economics at the Netherlands universities shows that the majority supported euthanasia being considered for economic reasons.*

Jim Lane, M.D., Family Physician, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, September 26, 1994, 14:26.

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*Finally, it is vital that the healers of Canada should not be represented as the killers of Canada. I am proud that my national professional association, the Canadian Medical Association, has gone on record as opposing euthanasia. In doing so, it joins the British, the American, and the World Medical Association in opposing euthanasia.*

Jim Lane, M.D., Family Physician, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, September 26, 1994, 14:27.

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*I know of a gentleman from the Vancouver area who visited Holland last year, fell sick there and ended up in the hospital for two weeks. When he was released, he was told by the doctors, "Sir, you are fortunate that you are a Canadian. If you had been a Dutch citizen, we probably would not have bothered with you."*

Archbishop Adam Exner, Roman Catholic Archdiocese of Vancouver, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, September 27, 1994, 15:99.

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*In the Netherlands, "euthanasia" is defined as "the intentional termination of the (sic) life by someone other than the patient at the patient's request." By "assisted suicide", we mean "intentionally helping the patient terminate his or her own life". Euthanasia and assisted suicide should be seen as twin concepts.*

Dr. Gerrit Van der Wal, Medical Inspector of Health, North Holland, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, October 25, 1994, 21:6 and 21:10.

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*When a nurse is being interviewed for a hospital job, she is asked, "Are you willing to assist a doctor in euthanasia cases?" If she says, "No", she will not be offered the job. I think that that is wrong.*

Mrs. Mary G. Vlaming, Registered Nurse, Holland, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, October 25, 1994, 21:70.

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*With regard to legislation, we have already mentioned that there will be no specific legislation for newborns. It may confuse some that our present law, which encompasses the notification procedure, is extended to cases in which lives of newborns are terminated. Since June 1 of this year, the procedural requirements have been extended to the comatose and newborn situations. That is rather confusing because nothing is said about the moral or legal acceptability of these cases. However, doctors must report when they have performed such an act. That is a difficult situation. It says nothing about acceptability, but forces physicians to report such a case. Doctors must report a case in which the criteria are completely vague, even nonexistent at the moment.*

Professor Johan Legemaate, Professor of Law at The University of Rotterdam, Counsellor for The Royal Dutch Medical Association, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, October 25, 1994, 21:33.

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*Phrasing a proposed law in a pro-euthanasia or pro-assisted suicide format will add credibility to a position which is not favoured by the House of Lords, the medical associations of Canada, Great Britain and the U.S., and emphasizes the supposed needs of 3 per cent of Canadians, rather than the needs of the other 95 per cent who want support during the last months or years of their lives.*

Mr. Harry van Bommel, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, December 7, 1994, 28:23.

## EUTHANASIA OF THE HANDICAPPED

The persons most obviously at risk today from mercy killing decisions are the physically and mentally handicapped. There has been a shift in emphasis from a **value** of life ethic to a **quality** of life ethic, which if unchecked could lead to countless abuses of human rights.

In their book *Withholding Treatment from Defective Newborn Children*, co-authors Eike-Henner W. Kluge and Joseph E. Magnet say mercy killings are now done behind closed doors (p. 36). They also state that, "In America, cases have been reported of withholding all food and water in order to starve the child" (p. 137). The authors clearly oppose withholding nutrition and hydration from newborns and declare, "...it is difficult to see how the legal system could tolerate withholding normal ingestion of food and water in order to hasten death by starvation. The prospect is too macabre" (p.139). Yet the authors propose *Criminal Code* changes to allow for active euthanasia based on "quality of life" standards. If an infant displays "no reasonable potential for development to an existence of acceptable quality," his life may be terminated "as quickly and painlessly as possible" (pp.232-233).

Euthanasia of handicapped children has most commonly been associated with the refusal to undertake certain procedures which would allow the child to continue to live.

### ***Infant Doe***

The most highly publicized of such cases was that of Infant Doe in Bloomington, Indiana, which has been documented in the film *The Slippery Slope*.

Infant Doe was born in 1982 with an intestinal blockage which required corrective surgery. Without surgery, the child could not be fed. Infant Doe was a child with Down Syndrome. His parents, with the backing of the court, refused to allow the surgery. The baby died six days later of dehydration and

starvation. Infant Doe died by the method which Kluge and Magnet said was “too macabre” because his parents decided that his quality of life was not what *they* wanted, although other people wanted to adopt him. He died because he had Down Syndrome and would probably have some mental handicap.

This case poses a threat to the lives of all handicapped persons because it was the first time that the courts sanctioned a life being taken in such a manner. A baby in Bloomington was starved to death and the courts said it could be done because the baby was thought to be retarded.

### ***Stephen Dawson***

In Canada, the case of Stephen Dawson of British Columbia is another illustration of the “quality” of life ethic.

Stephen Dawson was six years old and had multiple severe disabilities due to meningitis suffered as a newborn. A shunt, or plastic drainage tube, had been implanted in his head to relieve the fluid pressure of hydrocephalus. In 1983 the shunt became blocked and needed to be surgically replaced. Stephen’s parents refused permission, apparently in the belief that he would die if the surgery were not performed.

Stephen’s case was taken to court and the Family Court judge ruled that the surgery could be withheld. The implications for all handicapped persons in Canada were ominous if Stephen were to be denied treatment, and appeals for review were made by the B.C. Association for the Mentally Retarded as well as by the Ministry of Human Resources and the Superintendent of Child Welfare of the B.C. government. The first judgement was overturned and Stephen received the necessary surgery.

The statement of Mr. Justice McKenzie of the British Columbia Supreme Court is especially worthy of note:

*I cannot accept [the parents’] view that Stephen would be better off dead...This would mean regarding the life of a handicapped child as not only less valuable than the life of a normal child, but so much less valuable that it is not worth preserving. I tremble at contemplating the*

*consequences if the lives of disabled persons are dependent upon such judgements.*

Mr. Justice McKenzie, reported at [1983] 3 W.W.R. 618, and commented upon in *Canadian Advocates for Human Life Newsletter*, February, 1984.

There continue to be situations where parents are unable to obtain what they consider to be adequate care for their child because the child is mentally handicapped. The United States Commission on Civil Rights reported that infants born with disabilities are frequently denied medically indicated treatment. A 500-page report, *Medical Discrimination Against Children with Disabilities*, September 1989, examines the practice of withholding medical treatment or nourishment from infants born with disabilities, and makes recommendations to remedy deficiencies in existing American law.

The Law Reform Commission of Canada, in its *Report Number 20, Euthanasia, Aiding Suicide and Cessation of Treatment*, July, 1983, expressed concerns about medical decisions made regarding handicapped persons. The Commission stated that, "...the mere existence of a physical or mental handicap in a newborn even if serious, should not be a pretext to refuse treatment on the basis of what are essentially eugenic considerations."

### ***Tracy Latimer***

Tracy Latimer was a 12-year-old disabled girl suffering from cerebral palsy. On Sunday, October 24, 1993 her father, Robert Latimer, killed her by leaving her in the family vehicle in a garage and letting her suffocate from carbon monoxide which he piped into the vehicle.

Despite planning the murder for 12 days, he has never acknowledged that what he did was wrong, arguing that he was acting out of love for his daughter, ending her on-going suffering. He has argued that what he did should be treated as a private family matter, not as a criminal action.

The evidence, however, indicated that Mr. Latimer's action was premeditated murder and that his daughter, far from being perpetually distraught and pain-wracked, was a child who enjoyed many aspects of life despite her limitations. Critics of Mr. Latimer's action have accused him of being more concerned with eliminating the apparent source of his misery.

Mr. Latimer was found guilty of 2<sup>nd</sup> degree murder in two separate trials (the charges from the first trial, having been dismissed due to questions about police actions during the investigation). The conviction carries a minimum life sentence with no chance of parole for 10 years, but presiding Justice Ted Noble issued a rare exemption from this punishment, giving Mr. Latimer only 2 years less a day with the second year to be served on his farm.

Disabled Canadians, observing the public sympathy for Robert Latimer and the court's willingness to treat him leniently, have been left feeling particularly vulnerable.

The lenient sentencing is more alarming when it is realized that no laws exist to provide parameters for "mercy killing." With no legislation to guide the judge to consider a lighter sentence, there is no indication that it was anything but an arbitrary decision, informed by public opinion more than by the letter of the law.

The Saskatchewan Court of Appeal has allowed the Attorney General's appeal against the sentence, imposing the mandatory sentence of life imprisonment without eligibility for parole for 10 years. It also unanimously rejected Mr. Latimer's appeal against his conviction.

# EUTHANASIA OF THE HANDICAPPED

## *Supporting References*

*To have destroyed the defective infant, Helen Keller, would have been to destroy also the teacher-humanitarian who was Anne Sullivan. In countless cases throughout the world a defective child has not been an expensive, heart-rending burden but a priceless gift that has brought out the hidden strengths of a father, a mother and sisters and brothers...*

Father George Tribou, educator, Little Rock, Arkansas, from an unpublished speech, January 31, 1980.

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*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, basic in the euthanasia movement, that there is such a thing as a life not worthy to be lived.*

*This attitude, in its early stages, concerned itself merely with the severely and chronically sick. Gradually, the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and, finally, all non-Germans.*

Leo Alexander, consultant at the Nuremburg doctors' trials: "Medical Science under Dictatorship," *New England Journal of Medicine*, July 14, 1949.

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*I'll wager my entire root system and as much fertilizer as it would take to fill Yale University that you have never received a letter from a vegetable before this one, but, much as I resent this term, I must confess that I fit the description of a "vegetable" as defined in the article "Shall This Child Die?"*

Sondra Diamond, MEd, counselling psychologist and visiting lecturer at 5 U.S. universities, physically disabled due to cerebral palsy; *Newsweek*, December 3, 1973.

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*There is so much abuse out there, we are not even sure if we should go see a doctor. We might have to become our own doctors pretty soon because we are not sure if we can trust the MDs.*

Ms. Theresa Ducharme, Chairman, People in Equal Participation Inc., testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, September 29, 1994, 17:113.

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*I am deeply disturbed by this latest development in Holland. The edict from the judicial authority there is that the courts are to look kindly upon the euthanizing of persons who are mentally disturbed. That has potential for trouble galore. It shows the validity of the slippery slope argument. Once this is under way, it is very hard to arrest it, or even contain it.*

Mr. Don Logan, The Christian Brethren, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, September 30, 1994, 18:39.

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*We can identify suicide as a problem in every other segment of the population; and we react. We identify a suicide problem with our young people, and we create prevention programs. We identify a suicide problem in our native population, and we create prevention programs. The disabled is the only group to whom we are saying, "How can we help you commit suicide?"*

Mr. Richard Sobsey, R.N., Director of Developmental Disability Centre, University of Alberta, Testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, September 30, 1994, 18:140.

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*We cannot take any comfort from those who believe that it is possible to institute safeguards which would adequately protect people. We believe that a move toward legalizing euthanasia or assisted suicide would tremendously increase the vulnerability of people in Canada who have an intellectual disability. Despite the Charter provisions, we think they are very vulnerable now and that any changes would only make them more vulnerable.*

Ms Diane Richler, Executive Vice-President, Canadian Association for Community Living, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, November, 16, 1994, 23:46.

## ASSISTED SUICIDE

### ***The Sue Rodriguez Case***

In December 1992, Sue Rodriguez, a 43 year-old Victoria, B.C. woman, suffering from amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig's disease) petitioned the British Columbia Supreme Court to allow a doctor to set up an intravenous drip containing lethal drugs which she would activate when she felt she no longer wished to live. The B.C. Supreme Court turned her down, as did the B.C. Court of Appeal. Her final recourse was to the Supreme Court of Canada.

Since the act of suicide is not illegal in Canada, Rodriguez's lawyer, Chris Consideine, argued that her constitutional rights to equal benefit of the law and to security of the person were infringed because she could not legally seek assistance to commit an act which would be legal if committed alone by an able-bodied person.

In a 5-4 decision, September 30, 1993, the Supreme Court said that the law prohibiting assisted suicide (Section 241(b) of the *Criminal Code*) does not infringe the constitutional rights of Canadians. Mr. Justice John Sopinka, writing for the majority, stated that:

*Parliament's repeal of the offence of attempted suicide...was not a recognition that suicide was to be accepted within Canadian society [but] that the criminal law was an ineffectual and inappropriate tool for dealing with suicide attempts. Given the concerns about abuse and the great difficulty in creating appropriate safeguards, the blanket prohibition on assisted suicide is not arbitrary or unfair...The prohibition relates to the state's interest in protecting the vulnerable and is reflective of fundamental values at play in our society.... The longstanding blanket prohibition...which fulfils the government's objective of protecting the vulnerable, is grounded in the state interest in protecting life and reflects the state policy that human life should not be depreciated by allowing life to be taken.*

Mr. Justice Sopinka also noted that prohibition of assisted suicide:

*...seems to be the norm among Western democracies, and such prohibition has never been adjudged to be unconstitutional or contrary to fundamental human rights.*

Supreme Court of Canada, Rodriguez v. British Columbia, [Attorney General], May 20, 1993: File No.23476, p.5.

However, the dissenting Justices, in the Statement of Chief Justice Antonio Lamer, found that the law creates an inequality which infringed Rodriguez's rights:

*...since it prevents persons physically unable to end their lives unassisted from choosing suicide when that option is in principle available to other members of the public without contravening the law.*

Supreme Court of Canada, Rodriguez v. British Columbia, [Attorney General], May 20, 1993: File No.23476, p.9.

Following the Rodriguez decision, on November 4, 1993, the Attorney General of British Columbia, Colin Gabelmann, announced new Criminal Justice Branch Policy Guidelines. In his announcement he stated:

*The Criminal Justice Branch will continue to exercise its prosecutorial discretion in the charge approval process, basing any decision on whether to proceed with charges on the usual standards of whether there is substantial likelihood of conviction and whether the public interest requires a prosecution. The new guidelines will now also be considered before a charge decision is made.*

This has raised fears of more flexible prosecution policies for euthanasia cases, but the Minister also expressed readiness to uphold the Canadian criminal law.

The requests for legalization of assisted suicide are not likely to end, and, in this regard, Attorney General Gabelmann, in his November 4, 1993 media release said that:

*The provinces administer justice, but only the federal Parliament can change the criminal law. Because many Canadians are asking for*

*further direction from Parliament on this issue, I will contact the new federal Minister of Justice to suggest that the federal government begin a process of determining what Canadians want their laws to say concerning active euthanasia and assisted suicide.*

Sue Rodriguez died on February 12, 1994. Her death was reported to be as the result of a physician-assisted suicide.

### ***Austin Bastable***

On Monday, May 6, 1996, Austin Bastable committed suicide at Farmington-Mills, Michigan, assisted by Jack Kevorkian. He had been suffering from progressive multiple sclerosis for twenty-six years. Bastable, a 53-year-old native of Windsor, Ontario used the Internet to publicize his call for legal assisted suicide in Canada, and even left his dying message on a web site.

He had an on-going disagreement with “Dying with Dignity,” a Toronto-based right-to-die group over their alleged failure to give him sufficient support in his fundraising efforts. He declared on a video in December 1995 that he would kill himself “after Christmas” and the video was widely publicized after his death.

### ***Maurice Genereux (in the death of Aaron McGinn)***

On December 22, 1997, in the city of Toronto, Dr. Maurice Genereux was convicted of aiding a suicide. The sentence for this offense is imprisonment up to fourteen years.

Genereux was charged June 20, 1996 with aiding the suicide of Aaron McGinn, 31 years of age, who died April 11, 1996. Mr. McGinn was HIV positive, but had no symptoms of AIDS, and was not dying. It appears that although he was in good physical health he was known to be depressed, and wished to die before he suffered the deleterious effects of AIDS. Genereux prescribed a dangerous sedative to McGinn and another man knowing they were both suicidal. McGinn died, but the second man survived the lethal dosage.

After charges were laid, Genereux posted bail and returned to the practice of medicine with the restriction that he not be allowed to prescribe controlled drugs. He continued to give medical care to large numbers of AIDS patients in Toronto. Genereux had twice previously had his license temporarily suspended; once for drug and alcohol problems and again for sexual impropriety. In March, 1998 the Ontario College of Physicians and Surgeons suspended his license to practice, calling his behaviour "reprehensible."

On May 13, 1998 Genereux was sentenced to two years less a day in prison.

### ***Suicide and Assisted Suicide***

Suicide was decriminalized because a person seeking suicide was seen to be a person in need of help, and because punishment such as an ignominious burial seemed to be unfair to innocent relatives of the suicide. Sanctioning assisted suicide sends the message that some people do not deserve help, they deserve death. It is quite normal for someone, especially someone with a terminal illness, to become angry and to be concerned about pain and suffering. With proper counselling and care, however, most work through this stage, and do not ask to be killed.

Suicide and attempted suicide have never been deemed a *right*.

Yale Kamisar states:

*Consider the views of Herbert Hendin, a professor of psychiatry and a leading suicidologist, who is opposed to the legalization of doctor-assisted suicide. He concedes that it is sometimes "rational" for a person with a painful terminal illness to wish to end his life. Indeed, "that is precisely why supporters of the right to suicide or death control position are constantly presenting the case of a patient suffering from incurable, painful cancer as the case on which they based their argument." But Dr. Hendin is quick to add: "In reality ... such understandable cases form only a small percentage of suicides, or potential suicides. The majority of suicides confront us with the problem of understanding people whose situation does not seem, from an outsider's viewpoint, hopeless or often even critical. The knowledge that there are more suicides by people who wrongly believe themselves*

*to be suffering from cancer than there are suicides by those who actually have cancer puts the problem in some perspective.*

Yale Kamisar, "Are Laws against Assisted Suicide Unconstitutional?" *Hastings Center Report*, Vol.23, No.3, New York: May-June 1993. —with quote from: Hendin, H., *Suicide in America*, W.W. Norton, New York, New York: 1982, p. 214.

In the same article, Kamisar also cites James Rachels, "... author of a famous assault on the distinction between killing and *letting die*, [who] maintains that, 'the permissibility of euthanasia follows from the permissibility of suicide—a result that probably will not surprise any thoughtful person'" (James Rachels, *The End of Life: Euthanasia and Morality*, New York: Oxford University Press, 1986, pp.86-87).

Can we distinguish assisted suicide from active euthanasia? Many think not, and the late Joseph Fletcher, the ethicist, who advocated active euthanasia, is quoted by Kamisar, "It is impossible to separate (active voluntary euthanasia) from suicide; it is indeed, a form of suicide," and the case for active voluntary euthanasia, "depends upon the case for the righteousness of suicide" (Fletcher, *Morals and Medicine*, Boston: Beacon Press, 1954, p.176).

In May 1994, the New York Task Force on Life and the Law unanimously rejected the idea of legalizing doctor-assisted suicide for the terminally ill. In its decision, the 24-member group of professionals and lay people cited the inability to prevent abuse of any safeguards to protect the vulnerable—the poor, the elderly, members of certain minority groups and those without access to good medical care. As well the Task Force stated that legalizing assisted suicide will "blunt our perception of what it means...to take another person's life" ("A solid vote against assisted suicide," Robert Sheppard, *Globe and Mail*, May 30, 1994).

# ASSISTED SUICIDE

## Supporting References

*Physician-assisted suicide provides another way to legitimize the power of doctors in our lives. I can think of no good reason why it would be in society's best interest for physicians to be associated with death.*

Al Etmanski, former Executive Director of British Columbians for Mentally Handicapped People, *Vancouver Sun*, "The Doctor is out of Order," March 9, 1993.

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*When people ask to die or be killed, we should throw them a lifeline, not a noose.*

June Scandiffio, President, Toronto Right to Life Association, Ottawa Citizen, "Dying need lifelines, not nooses, group says," October 1, 1993.

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*When Parliament's repealed the offence of attempted suicide, it is submitted that that represented the victory for our self autonomy. But if you read Hansard and look carefully at what was behind that decision, you will find that it was no longer an offence to attempt to commit suicide because our parliamentarians decided that area was for the sciences to deal with, the medical and social sciences, rather than by penal sanction. It was not a victory for self autonomy.*

Angela Costigan, Lawyer, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, July 5, 1994, 12:13.

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*We must see through the artificial distinction being made between assisted suicide and euthanasia, not because there are not some valid distinctions there, but because assisted suicide turns inevitably and inexorably into voluntary euthanasia by the exercise of Charter prohibitions against discrimination on the basis of handicap. At the moment, assisted suicide is promoted as an isolated or limited right. We have to see that it must be turned into voluntary euthanasia because there will always be those too weak to press the button, swallow the pills, or in some way mechanically actuate their own deaths.*

Willard P. Johnston, M.D., Family Physician, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, September 26, 1994, 14:28.

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*We argue that there is no positive right to commit suicide in Canada. That suicide is not proscribed does not mean that it is an enforceable right. If it were such a right, no one could legally stop or attempt to stop a suicide. In fact, there is a strong response both from the police and the medical community.*

Ms. Janet Buckingham, Chairperson, Social Action Commission, Evangelical Fellowship of Canada, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, September 27, 1994, 15:61.

## WITHDRAWAL OF TREATMENT

Modern technology has provided artificial means to aid patients who require assistance with the ordinary functions of life. Although most patients have no difficulty accepting these life-supporting aids on a temporary basis, the patient's attitude may change if the requirement becomes permanent. As a result there is fear that the law would prevent the discontinuation of such treatment once it is begun.

As noted elsewhere, Canadian courts and medical ethics have consistently upheld the right of mentally competent patients to refuse medical treatment. A doctor who initiates, or continues, any treatment without the patient's informed consent is liable to be charged with assault and is certainly acting outside his professional mandate.

In an article entitled "Criteria for Withholding or Withdrawing Treatment" in *The Linacre Quarterly*, August 1990, Dr. William E. May explains that the two criteria which are used to determine "...whether or not it is morally right to withhold or withdraw treatments are those of burdensomeness and uselessness."

*...what is most important is that these criteria draw attention to the **means** used to preserve life. Such **means** can rightly be judged "disproportionate" or "extraordinary" because of objectively discernible features in them and their side-effects, and their negative consequences on the patient's life leads one to the conclusion that their employment is either excessively burdensome or useless. But they do not lead one to conclude that the **life** of the patient-person is either burdensome or useless, for human life, however heavily burdened and devoid of utilitarian values, is always a great and precious good of irreplaceable persons.*

Thus, a person who has no wish to die can still decide that life without treatment is preferable to life with it.

The *Vatican Statement on Euthanasia* (1980) from the Sacred Congregation for the Doctrine of the Faith, “Due Proportion in the Use of Remedies” states:

*It is also permissible to make do with the normal means that medicine can offer. Therefore one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community.*

Similarly, from a joint statement by thirteen Jewish and Christian theologians, philosophers and legal scholars, Richard Neuhaus has quoted the following:

*Medical treatments can be refused or withheld if they are either useless or excessively burdensome. No one should be subject to useless treatment; no one need accept any and all lifesaving treatments, no matter how burdensome. In making such decisions, the judgement is about the worth of treatments, not about the worth of lives.*

Richard Neuhaus, “Legalized euthanasia extends the licence to kill,” *Financial Post*, January 13, 1992.

### **“Nancy B.”**

The issue of treatment withdrawal was legally tested in Canada in the “Nancy B. Case.” In this case Justice Dufour of the Quebec Superior Court ruled on January 6, 1992, that Nancy B., who suffered from an incurable, debilitating disease which caused her to require the permanent use of a respirator, could request that the respirator be removed. The respirator was turned off, and Nancy B. died.

The lawyer for Nancy B., Ms. Lapointe, said that other cases, even though similar to Nancy’s, must be examined individually (“Woman has right to die, court rules,” *Globe and Mail*, January 7, 1992). In other words, this case should not be generalized, and it would not be right to use this judgement as a means to be followed in regard to other handicapped persons needing life-sustaining treatment.

This is made clear in a statement of the Law Reform Commission commenting on the judgement by Justice Dufour:

*From a legal point of view however, it settles the issue only for Nancy B. Not binding even on other trial courts in Quebec, the Nancy B. decision may indeed have the somewhat perverse effect of eliciting similar litigation elsewhere, rather than ending the legal debate. Moreover, if courts in other provinces reach conclusions opposite to that of Judge Dufour, the issue will be settled only if it reaches the Supreme Court of Canada.*

Law Reform Commission of Canada Brief to the legislative committee on C-203, February 6, 1992.

### ***Withdrawal of Nutrition and Hydration***

The provision of food and water, always considered a basic necessity of life, has now become, in some constituencies, a “medical treatment” which can be withdrawn under numerous circumstances. Individuals who are comatose, brain damaged by trauma or illness, or who are in a persistent vegetative state (but who could, and do in fact, survive indefinitely with routine nursing care) are particularly vulnerable when medical treatments are interpreted as including assisted nutrition and hydration. Such patients have been termed “biologically tenacious.”

In *Working Paper 26, Medical Treatment and Criminal Law* (1980), page 59, the Law Reform Commission explained that there has to be a clear distinction between medical **treatment** and medical **care**. A line must be drawn for example, between the use of artificial respiration and artificial nutrition. One can withdraw a respirator without knowing for certain the outcome. Not so with nutrition and hydration—clearly the patient will die. When food is withdrawn, the patient starves to death. Respirators take over a bodily function, breathing; but feeding does not take over digestion.

When nutrition and hydration are removed, patients die through the gross neglect of others and they suffer greatly as they die. Court documents in the case of Paul Brophy of Massachusetts, who died after his feeding was

stopped, listed the effects of starvation and dehydration on the human body as follows:

- *the mouth dries out and becomes caked or coated with thick material;*
- *the lips become parched and cracked or fissured;*
- *the tongue becomes swollen and might crack;*
- *the eyes sink back into their orbits;*
- *the cheeks become hollow;*
- *the lining of the nose may crack and cause the nose to bleed;*
- *skin hangs loose on the body and becomes dry and scaly;*
- *urine becomes highly concentrated, causing burning of the bladder;*
- *the lining of the stomach dries out, causing dry heaves and vomiting;*
- *the patient develops hyperthermia, a very high body temperature;*
- *brain cells begin drying out, causing convulsions;*
- *the respiratory tract dries out, giving rise to very thick secretions which can plug the lungs and cause death;*
- *eventually major organs fail, including the lungs, heart and brain.*

*Brophy v. New England Sinai Hospital Inc. Docket No. 86E0009-91, Findings of Fact, Slip, Op. p.28,29 [Oct.21, 1985] Probate and Family Court.*

In 1989, the World Federation of Doctors Who Respect Human Life passed the following resolution in response to the euthanasia practices of the Netherlands:

*In every case of terminal illness, it is a cruel and anti-medical practice to withdraw nutrition and hydration and thus cause the patient to die of hunger and thirst, which can only increase his suffering. Nutrition and hydration are a basic life-maintaining need even if administered intravenously or by gastric tube. We doctors recognize that it is our duty to assist our patients, reducing their suffering in their dying process which we can never hasten.*

*World Federation of Doctors Who Respect Human Life, Media Release, Rome, December 3, 1989.*

An obvious exception exists in terminally ill patients when death is only hours away, and the administration of food and water could increase suffering.

The British House of Lords Select Committee on Medical Ethics concluded that:

*Development and acceptance of the idea that, in certain circumstances, some treatments may be inappropriate and need not be given, should make it unnecessary in future to consider the withdrawal of nutrition and hydration, except where its administration is in itself evidently burdensome to the patient.*

*Report of the Select Committee on Medical Ethics, House of Lords, Great Britain, Session 1993-94, January 31, 1994, Summary of Conclusions.*

### ***Court-Sanctioned Starvation***

In the past ten years, especially in the United States, there have been a great number of court cases seeking legal permission to starve persons to death. The most recent of these were the cases of Christine Busalacchi, who died March 6, 1993, after ten days with no nourishment, and Nancy Cruzan, who died December 26, 1990, twelve days subsequent to the removal of her feeding tube. Paul Brophy died in 1985, after eight days' starvation. Christine, Nancy and Paul, all young adults and victims of trauma, were not suffering from diseases, and none of them would likely have died without the cessation of nutrition and hydration.

The *Western Report* reported that in Edmonton the feeding of Shirley Dirk was stopped on June 30, 1993, and that she died of starvation on July 10, 1993 ("Compassionately Starved to Death", August 9, 1993). Unlike the American cases, this was done quietly and with little publicity except for some interviews in the *Edmonton Journal* with nurses who apparently felt that Ms. Dirk was only "semi-comatose."

Other court cases have received publicity and have been resolved either by the subsequent death of the person involved or by their being rescued by concerned relatives or staff. Dr. Dwight Harken suggested in 1983 that there

were 250,000 Americans who were “helpless cases” and who would be good candidates for starvation. “Harken was careful to stress that he was suggesting only intravenous feeding. Disconnecting intravenous tubes would slowly starve patients” (*The Gazette*, Montreal, June 1, 1983).

Since 1983, the decline in our economic ability to support handicapped and comatose persons, and the reality of limited health-care dollars have become more obvious. In fact, former Colorado Governor Richard Lamm went so far as to suggest that the terminally ill have a “duty to die” (“Is There a Right to Die?” *U.S. News and World Report*, December 11, 1989). If society and the courts approve of withholding food and water as a means to rid the hospitals of comatose and chronically ill patients, then many, especially the elderly, may translate this into a “duty to die.” As it becomes more evident that we have a dwindling tax base to support an ever-increasing number of elderly and frequently ill citizens, this perceived “duty” will suddenly be very real.

The question of whether to consider nutrition and hydration as “medical treatment” is being addressed today. Canadians must ensure that our long tradition of caring for the most vulnerable in society is not allowed to erode to the stage where we are able to rationalize the starvation deaths of defenceless human beings.

# WITHDRAWAL OF TREATMENT

## *Supporting References*

*The assertion that rejection of life-saving medical treatment by competent patients constitutes suicide has been uniformly rejected--usually based on a distinction between letting nature take its course and initiating external death-causing agents.*

Norman Cantor, "The Permanently Unconscious Patient, Non-Feeding and Euthanasia," *American Journal of Law and Medicine* 15.(1989): p.433.

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*As a reality of nature, killing and letting die are causally different...There must be an underlying fatal pathology if allowing to die is even possible. Killing, by contrast, provides its own fatal pathology. Nothing but the action of the doctor giving the lethal injection is necessary to bring about death.*

Daniel Callahan, *The Troubled Dream of Life: Living With Mortality*, Simon and Schuster: New York, 1993, ch.2 As quoted by: Yale Kamisar, "Are Laws Against Assisted Suicide Unconstitutional?" *Hastings Centre Report* 23, no.3 (1993) 32-41.

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*In palliative care we try to assist our colleagues as they come to realize and recognize when a disease is irreversible and death is near. In these circumstances, we encourage withdrawal of any investigations or treatments that are no longer having their intended purpose. Their continuation may often reflect a frantic and futile attempt to hold back death even when it is imminent.*

John Scott, M.D., testimony before the legislative committee on Bill C-203, November 19, 1991, 5:36.

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*As soon as you withdraw the feeding tube you are killing the patient.*

Dutch euthanasia proponent Peter Admiraal, M.D., quoted in "Stopping Care is Killing," *Vital Signs*, Canadian Physicians for Life newsletter, Winter, 1990.

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*I saw literally thousands of people who had been subject to both dehydration and starvation —both dead and dying. ... Bringing about death through dehydration and starvation is a barbaric and savage way to induce death, and as such is cruel and abusive and not conscionable.*

Richard Field, M.D., Chief of Staff, New England Sinai Hospital, testifying and speaking about Dachau. *Brophy v. New England Sinai Hospital, Inc.* Docket No. 85E0009-G1, Findings of Fact, Slip, Op. p.28,29 (Oct. 21, 1985) Probate and Family Court.

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*If we can get people to accept the removal of all treatment and care — especially the removal of food and fluids —they will see what a painful way this is to die, and then, in the patient's best interest, they will accept the lethal injection.*

Helga Kuhse, Ph.D., Lecturer in Philosophy at Monash University, Melbourne, Australia; Comments at the Fifth Biennial Conference of the World Federation of Right to Die Societies; Nice, France; Sept. 20-23, 1984.

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*Our son, now 24, is fed via a feeding tube and when we were invited to appear on a talk show, the topic centred on whether or not a feeding tube was an artificial means of sustaining life. What a ridiculous notion. A feeding tube is an alternative for oral feeding when a patient is unable to swallow.*

Nicole Moore, Carleton Place, Ontario, Letter to the Editor, *Ottawa Citizen*, October 12, 1993.

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*That (active and passive euthanasia), came up in the Nancy B. case. The hospital was concerned, "Are we not killing the patient if we stop the life support?", to which the court replied, "Not at all. This is the patient's right to refuse." Whether the patient constructs that as suicide or not is a different matter. That is their issue. That is their moral dilemma or problem. However, from the hospital's point of view or the physician's point of view, they do not have a right to treat when it has been refused. It becomes a form of assault.*

Dr. Edward W. Keyserlingk, McGill University, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, March 15, 1994, 1:32.

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*A competent patient can refuse anything. He or she can tell a doctor, "I want everything stopped," period, that is it. If the doctor does anything, he or she can be charged with assault at that stage. The common law is clear on that.*

André Lafrance, M.D., testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, May 25, 1994, 7:18.

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*In the health care community across the country there is a solemn commitment to uphold the principle that a competent individual has the right to refuse treatment or to demand that treatment be stopped, and to the decision that to terminate or not to initiate what is believed to be medically futile treatment is indeed sound clinical practice.*

Ms. Carol Clemenhagen, President of the Canadian Hospital Association, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, October 5, 1994, 19:19.

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*The problem in Holland is that ethical problems have been turned into medical problems. With respect to life-ending activities, we try to make medical decisions. When you cannot do it in a legal way, do it in a medical way. For example, make feeding a medical treatment. Nurses do not understand this.*

Mrs. Mary G. Vlaming, Registered Nurse, Holland, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, October 25, 1994, 21:23.

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*I do not believe it is necessary to ensure that the patient will die immediately, and to give them enough medication so we are sure they will die. We need to give them enough medication to be sure they will be pain-free. If they continue to live after we withdraw the machine, so be it.*

Reverend Anne L. Simmonds, R.N., United Church of Canada, testimony before the Special Senate committee on Euthanasia and Assisted Suicide, November 30, 1994, 27:37.



## PALLIATIVE CARE

Health and Welfare Canada defines palliative care as:

*A program of active compassionate care primarily directed towards improving the quality of life for the dying.*

Health and Welfare Canada, *Palliative Care Services Guidelines*, Ottawa, 1989, Cat. No. H39-32.

Dame Cicely Saunders, who in the late 1960s pioneered palliative care units, or hospices for the terminally ill in the United Kingdom, speaks of it as, “ELC - efficient loving care.” Her philosophy and methods of care for dying patients have spread to all parts of the world (Comfort and Dignity: Care of the Terminally Ill in Ontario, Ontario Advisory Council on Senior Citizens; Position Paper, June 1991).

Palliative care began in Canada in 1975, when units were opened at the St. Boniface Hospital in Winnipeg and the Royal Victoria Hospital in Montreal. One of the first leaders of the hospice movement was Dr. Balfour Mount, of the Royal Victoria Hospital. He described the philosophy of the movement as follows:

*Several features characterize hospice care as being distinct from traditional health care programmes. There is concern for the family and other loved ones as well as the patient. The fears and doubts of all involved, the strain on relationships and financial resources, the need for spiritual care, are all considered in addition to the more traditional issues relating to the disease itself. There is also a relaxation of institutional regulations concerning visitors, food, pets, and other details of daily life. When the length of remaining life is recognized as lying outside the influence of further treatment, the focus is not on curing or prolonging life but on its quality each day; not on death, but on life and on living in the moment!*

Balfour M. Mount, M.D., “Palliative Care of the Dying,” *Care for the Dying and Bereaved*, ed. Ian Gentles (Toronto: Anglican Book Centre, 1982), pp. 7, 18.

Palliative care units have been established in many hospitals across Canada, and as well, many day-care and outpatient support services have become available for those who are able to spend their last days away from a hospital. The goal of those involved in offering palliative care is to relieve pain and thus to reduce the great fear of pain that is sometimes associated with dying. It is this fear which drives people to accept euthanasia as the only available option.

Dr. Larry Librach of the Mount Sinai Hospital palliative care team, formulates the essence of palliative care in this way:

*Palliative care is committed to healing, and that is something different from curing. Healing is to make a person whole, to relieve suffering and to give the individual a sense of who he or she is as a person. Palliative care is person-centred, not disease-centred.*

*Comfort and Dignity: Care of the Terminally Ill in Ontario*, Ontario Advisory Council on Senior Citizens, Position Paper, June 1991, p.4.

Dr. John Scott is the Director of the Regional Palliative Care Service in Ottawa, and Head of the Palliative Medicine Program at the University of Ottawa. He describes present day palliative care service as:

*...a philosophy and a system of care that affirms life when a person with irreversible disease is approaching death...Palliative Care involves a shift of treatment goals —from cure and prolongation to the control of suffering. This shift will often be reflected in the cessation of some therapies and the initiation of new symptom-directed therapies. However, Palliative Care is not passive euthanasia. At the heart of Palliative Care is the affirmation of life, not the choosing of death.*

John Scott, M.D., Submission to the legislative committee on Bill C-203, November 19, 1991, p.1.

In the concluding portion of his submission to the legislative committee on Bill C-203, Doctor Scott said:

*As we watch suffering, we too share in the lament. When death approaches, we cry out and at times even cry out for death, but we must reject the temptation to kill. Hear the cry of life at the heart of the lament. Neither physician nor legislator must presumptuously respond to the lament by silencing the one who issues the cry.*

Because of the current lack of palliative care beds in Canada, patients are often forced into acute care units which are more costly: an acute-care bed for a cancer patient costs \$600 per day, while a hospice bed costs only \$273.70 (Harry Van Bommel, *Dying for Care: Hospice Care or Euthanasia*, New Canada Publications, 1992).

The New York State Task Force on Life and the Law emphasized the need for palliative care and pain management in its May 1994 report on euthanasia and assisted suicide. The Task Force concluded and commented as follows:

*Physicians, nurses, and patients must be aware that psychological and physical dependence on pain medication are distinct phenomena. Contrary to a widely shared misunderstanding, psychological dependence on pain medication rarely occurs in terminally ill patients. While physical dependence is more common, proper adjustment of medication can minimize negative effects.*

*The provision of appropriate pain relief rarely poses a serious risk of respiratory depression. Moreover, the provision of pain medication is ethically and professionally acceptable even when such treatment may hasten the patient's death, if the medication is intended to alleviate pain and severe discomfort, not to cause death, and is provided in accord with accepted medical practice.*

*The education of health care professionals about pain relief and palliative care must be improved. Training in pain relief and palliative care should be included in the curriculum of nursing schools, medical schools, residencies and continuing education for health care professionals.*

*Hospitals and other health care institutions should explore ways to promote effective pain relief and palliative care, and to remove existing barriers to such care.*

*Public education is crucial to enhance pain relief practices. Like many health care professionals, patients and families often have an exaggerated sense of the risks of pain medication, and are reluctant to seek treatment for pain. Nurses and physicians should create an atmosphere that will encourage patients to seek relief from pain. Strategies for pain relief should also maximize patients' sense of control.*

*When a patient requests assisted suicide or euthanasia, a health care professional should explore the significance of the request, recognize the patient's suffering, and seek to discover the factors leading to the request. These factors may include insufficient symptom control, clinical depression, inadequate social support, concern about burdening family or others, hopelessness, loss of self esteem, or fear of abandonment.*

Executive Summary, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, The New York Task Force on Life and the Law, May, 1994.

The provision of palliative care services is one means of stopping the call for legalized euthanasia. At the same time, efforts must be made by governments, and by health care workers, to inform and to educate the public about the necessity of promoting the hospice philosophy of dying. Good palliative care, in all its facets, is the alternative to euthanasia.

# PALLIATIVE CARE

## *Supporting References*

*We have daily contact with some of the most vulnerable people in society at the hardest times of their lives and we know that many of the problems that they suffer, they suffer as a result of poor resourcing. If euthanasia were an alternative then the imperative to provide the resources for these people, whether it is in the education of doctors in pain control or provision of decent facilities for elderly people with physical illness, would be cut at a stroke.*

Royal College of Nurses, testimony to the Select Committee on Medical Ethics, quoted in the *Report of the Select Committee on Medical Ethics*, House of Lords, Great Britain, Session 1993-94, January 31, 1994, p.26.

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*Canadians must not believe the lie that they are faced with a choice between a quick good death and a slow painful death. Palliative care has demonstrated to the world that the pain and other symptoms of advanced disease can be relieved. The methods to relieve suffering are available now.*

John Scott, M.D., "Cancer Pain: a Monograph on the Management of Cancer Pain," Health and Welfare Canada, Ottawa, 1984 (Cat. No. H42-25).

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*We have to make it possible for people to die well in our hospitals. We must examine the components of a good death —having the opportunity to be with family, to make peace, to be free of pain, perhaps even to be released from the confines of a traditional hospital room and routine —and incorporate them into our care of dying patients...This has been happening for some time in palliative care, a specialty in health care that attends exclusively to the dying.*

Bridget Campion, "Taking the Final Steps to a 'Good Death,'" *The Globe and Mail*, Nov. 19, 1993.

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*It is not immoral to relieve the pain of the terminally ill even if the methods used unintentionally hasten death. Deliberately causing death, on the other hand, is gravely wrong and can never be tolerated in a civilized society.*

Vancouver Archbishop Adam Exner, News Release, "Response to the Attorney General's Policy Guidelines on Active Euthanasia and Assisted Suicide," November 4, 1993.

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*Working with dying or chronically ill people, I can see that euthanasia does not confer dignity in death. It robs people of their dignity; It robs the dying of their dignity to be cared for as human beings. It robs their families of the dignity to be with their loved ones. It robs the natural process that is there.*

*We can care for dying people. I have seen people die who were afraid, who had some pain, but who have died naturally with love and dignity.*

Ms. Janet McCaffrey, R.N. (palliative care) as an individual, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, September 29, 1994, 17:121.

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*When death has become inevitable, the balance between minimizing pain and suffering or potentially hastening death must be resolved in favour of relief of pain. Narcotics and other medications to relieve pain should be given by whatever doses and by whatever route necessary. This is both morally and ethically correct. It is both morally and ethically correct to increase the dose of narcotic to whatever is needed, even if this may hasten death, provided the physician's objective is relief of suffering.*

Dr. Gordon Ferguson, New Brunswick Extra-Mural Hospital, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, October 17, 1994, 20:51.

## **ACTIVE EUTHANASIA**

In current Canadian law it is ethical and legal to give high dosages of pain medication to suffering patients even if the medication would hasten death. It is not ethical, or legal, to give substances that would cause death.

The distinction between ethical treatment and euthanasia in the case of pain control drugs is the intent. Such a distinction is non-existent when drugs that have no effective pain control function are administered. The intent in such instances is death.

### ***The Nancy Morrison Case***

Dr. Nancy Morrison, a respirologist at what is now, QE II Health Centre in Halifax, Nova Scotia, was charged May 6, 1997 with murder in the death of Paul Mills. Mr. Mills was a patient in the Intensive Care Unit who was terminally ill with throat cancer. He died November 1996, aged sixty-five.

Dr. Arthur Macniel reported the case to Halifax Regional Police as what he determined to be a matter of "active euthanasia." Police investigated and laid a charge of first-degree murder. Murder in the first degree is a planned and deliberate homicide and the penalty is life imprisonment.

During the investigation in January 1997, Morrison was suspended from the ICU for three months and subsequently began work in an ambulatory care clinic at QE II Health Centre. She was charged with the crime and freed on bail in May to return to her job at the hospital. November 6, 1997 the Crown reduced the charge to manslaughter, a culpable homicide that is not a murder, and which carries a sentence that can vary from four years to life, or even to a suspended sentence.

At a preliminary hearing on February 27, 1998, Nova Scotia provincial court judge, Hughes Randall dismissed the charges against Morrison. He claimed that there was not enough evidence to bring the case to trial. The Crown subsequently decided to appeal the decision and in July, Nova Scotia Justice

Minister Jim Smith said that he would allow the appeal to proceed despite protests from Nancy Morrison's lawyer and supporters.

It was revealed in testimony that Morrison injected nitroglycerine and potassium chloride into the IV line of patient Paul Mills. The confusion arose because an autopsy did not detect the substances, and it was proffered in court that the IV line had come out of the patient's vein. The cause of death, therefore, is still apparently unknown.

In current Canadian law it is ethical and legal to give high dosages of pain medication to suffering patients even if the medication would **hasten** death. The substances given to Paul Mills, on the other hand, would have **caused** his death.

## **ACTIVE EUTHANASIA**

### ***Supporting References***

*There is no way I could prescribe an injection of potassium chloride to be given as a single injection. That would be a fatal administration, and there is no way I could justify that by saying that I thought it might help. It is simply a lethal injection. The line is very, very clear.*

Doctor Robert Buckman, Bayview Regional Cancer Centre, Toronto, testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, November 24, 1994, 26:14.

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