

The Illusion of the “Slippery Slope”: How Religion and Culture Shape Canadian Doctors’ Attitudes toward Euthanasia and Physician-Assisted Suicide

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Abstract: From 1988-1995 the majority of physicians within the Canadian Medical Association supported the prohibition against an intentionally hastened death for the terminally ill. Their main concerns entailed the “slippery slope” of the Dutch medical model and a possible return to Nazi eugenics. However, empirical evidence from this time period did not support physicians’ fears of decriminalization. Therefore, it is important to understand why doctors, known for their reliance on empiricism and rational thought, reverted to uncritical and profoundly held beliefs when it came to discussions over state-sanctioned euthanasia and assisted suicide. This paper suggests that two motives were pivotal in shaping Canadian doctors’ attitudes toward prohibition: the influence of religion and a lack of exposure to cross-cultural perspectives.

Keywords

euthanasia, physician-assisted suicide, “slippery slope,” Holland, Rummelink Report, Nazi eugenics, Canadian Medical Association, sanctity of life, religious attitudes, culture.

Introduction

This paper presents a discourse analysis of Canadian physicians’ attitudes toward euthanasia and assisted suicide. The

methodology is based largely on an examination of editorials, essays, journal articles, and letters to the editor located in the archives of the *Canadian Medical Association Journal (CMAJ)*, supplemented by various other primary and secondary sources. The temporal period runs from 1988-1995 because in this time period, there was an explosion of discussion containing the fullest expression of what Canadian physicians were thinking and feeling about euthanasia and assisted suicide. High-profile court cases, particularly three involving Sue Rodriguez,¹ no doubt triggered nationwide debate over the intentional hastening of death. In addition, ethicist Daniel Callahan (see Crawford, 1995: 79) notes that controversial American figures, such as Derek Humphry, Jack Kevorkian and Timothy Quill, fuelled discussion that eventually entered Canadian ethical and medical discourses. Because euthanasia and assisted suicide are highly contentious issues, emotions run high whenever the possibility of decriminalization is posed.

This article contends that in times of moral panic, doctors—like any group of people—revert to uncritical and profoundly held beliefs. Thus, from 1988-1995 the majority of members within the Canadian Medical Association (CMA) supported the prohibition against an intentionally hastened death for the terminally ill. The paper begins by focusing on the dominant claim made by CMA members during this time period, namely that decriminalization would lead to a “slippery slope” similar to the Dutch experience and a return of Nazi eugenics. An overview of this claim will be followed by an interrogation of the discourse. Here, evidence will be presented that challenges “slippery slope” allegations made against the Dutch medical model. The conclusion highlights two key factors—the influence of religion and a lack of exposure to cross-cultural perspectives—that helped shape Canadian doctors’ attitudes toward prohibition.

Holland's "Slippery Slope" and Nazi Analogue

During debates within the Canadian Medical Association Journal (*CMAJ*) from 1988-1995, one of the most polarized discussions involved Dutch medical acceptance of euthanasia and assisted suicide. Fears concerning the Dutch approach were certainly amplified during the winter of 1988. Euthanasia became headline news within mainstream medicine as a result of an anonymous letter written in the *Journal of the American Medical Association* entitled, "It's Over, Debbie." A gynecology resident knowingly performed a death-hastening act by administering an overdose of morphine sulphate for a 20-year-old woman named Debbie without personally knowing the patient.² The story caused nothing short of a media sensation. As Anne Mullens (1996: 162) acknowledges, "The letter marks the beginning of a constant stream of articles and opinion pieces that still hasn't ceased." Undoubtedly, the American controversy began to influence mainstream medical opinion across the border.

An editorial sent to the *CMAJ* by Dr. Peter A. Singer (1988: 1001-1001), a fellow at the Centre for Clinical Medical Ethics at the University of Chicago, triggered a series of intense debates among Canadian doctors. Dr. Singer felt that medical practitioners in Canada must categorically denounce euthanasia and assisted suicide. In his words, "Physician-mediated killing is bad for patients, doctors, and society, and the only justifiable stand toward active euthanasia can be summarized in one word: abhorrence." Singer used the Netherlands as an example of the "slippery slope," stating that "patients who are incompetent, not terminally ill and nonconsenting 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." Singer also assumed that the Dutch experience signalled a return to Nazi euthanasia. He quoted Dr. Leo Alexander, the prominent American physician and advisor at the Nuremberg medical trial, as saying just before his death, "It [Dutch medical practice] is much like Germany in the '20s and '30s. The barriers against killing are coming down."

In Canada, several physicians replied favourably to Singer's editorial. Dr. Albert J. Kirshen (1988 : 1041) wrote the *CMAJ*, believing that in Holland autonomy and informed consent were not being universally safeguarded: "Apparently dementia sufferers in nursing homes are now subject to active euthanasia."³ Dr. Kirshen (1989: 1258) corresponded again with the *CMAJ* to clarify his position on the issue of patient consent in Holland:

If euthanasia is being practised in a hospital or a nursing home, where probably more than 50% of residents suffer from cognitive impairment and a significant proportion will, therefore, lack the capacity to consent, how can patient decisions be "well informed, free and enduring"? How does the question of competence arise? How and by whom is it decided?

Kirshen also felt that reported use of active *involuntary* euthanasia⁴ in Holland "question[ed] the depiction of euthanasia as strictly voluntary" and was evidence of "the 'can of worms' we open when talking about active euthanasia. . . ." However, Dr. Kirshen was not alone in his critique of the Dutch regime.

A travelling exhibition titled "The Value of the Human Being: Medicine in Germany 1918-1945" arrived at the University of Toronto in 1992. A symposium in conjunction with it provided qualitative evidence of doctors' opinions concerning German physicians who participated in the Nazi eugenics program. Dr. Fritz Stern (see O'Reilly, 1993 : 819) of Columbia University was blunt: "We are talking about nothing less than the perversion of the noblest profession, the systematic violation of all that the white coat has ever stood for." Canadian physicians agreed. Dr. Frederick Lowy (see O'Reilly, 1993: 820), director for the University of Toronto's Centre for Bioethics, felt that given the right circumstances Canadian doctors could be deceived by the same propaganda that seduced German physicians: "It is important to remember that the Nazi doctors were just like all the rest of us. . . . They were trapped by an ideology and a state, but what really turned them in the wrong

direction was the disregard for the individual.” Although Dr. Lowy did not believe in the “inevitability of the slippery slope,” he felt that society “must first recognize that the slope is slippery.”

A group of Alberta doctors sided with Lowy’s concerns over the relaxation of safeguards within traditional medical ethics. However, their views were even more explicit in that they exhibited a strong pro-life bias. Rejecting quality of life judgements, Dr. W. Joseph Askin et al. (1993: 1866) wrote:

We are already sliding down the slope and gaining speed. We self-righteously condemn the Nazis for exterminating people with genetic or mental imperfections, yet we consider ourselves compassionate when we abort fetuses with congenital abnormalities. Either way, lives were and are ended by a system that has decided which lives have value and which don’t.

Ironically, the Alberta doctors added that the basis of their philosophical stance, the sanctity doctrine, demanded the subordination of the individual to the collective good, even if this utilitarian position⁵ resulted in harm to minorities: “The recognition of moral absolutes such as the sanctity of life may cause people with terminal illnesses or women with unwanted pregnancies to suffer but would prevent the repetition of past [Nazi] horrors.”

Affirming the views of the Alberta physicians, several doctors used the Nazi analogue⁶ as a form of “slippery slope.” For instance, Dr. Willi D. Gutowski (1993: 1866) emphasized that physicians in Germany had, at one time, shared similar values with Canadian doctors: “Their intentions and compassion were the same as ours; their search for truth was like ours. . . .” In similar fashion, Dr. William E. Goodman (1993: 1866) highlighted the danger of capitulating with fascist state policies: “Most German physicians, once they abandoned their primary responsibility to the individual patient in favour of what they were persuaded was their responsibility to the body politic, found it easy to not only refuse to confront Hitler’s minions . . .

but also actively rationalize and cooperate in Hitler's mission." Dr. Wena V.P. Hyde-Williams (1993: 1866) was even more succinct: "It was murder, not euthanasia, that was practised under the Nazi regime. To euphemize the barbarism . . . is to trivialize and condone it and is every bit as much a danger sign as 'when economics begins to dictate policy.'"

The issue resurfaced in an exchange of letters from 1993-94, the year Sue Rodriguez sought decriminalization of physician-assisted suicide in the Supreme Court of Canada.⁷ This time, however, Canadian doctors became increasingly vocal about comparisons between Dutch medical practices and Nazi experiments. Dr. Ted Boadway (see Sullivan, 1993: 858), the Ontario Medical Association's director of health policy, told the CMA's General Council in August of 1993 that members were afraid to confront the issue of assisted-suicide because if they did, "they may be compared to Nazis, even by colleagues." In fact, references connecting Nazi atrocities to euthanasia served one main purpose at the CMA's annual meeting in 1993. According to Dr. Douglas Sawyer (1994: 396), Chair of the CMA's Committee on Ethics, the link was used to "inhibit many who might want to speak in favour of PAD [physician-assisted death]."

The Nazi taint continued well into 1994. Dr. Howard Bright (1994: 273) felt that it was "sadly ironic that Dutch physicians, who resisted Hitler so heroically a generation ago, now embrace the utilitarian view of life and death." Dr. Bright (1994: 1396) also noted the key source of anxiety among the elderly and terminally ill: "Fear of physicians is understandable in light of the Remmelink Report, which documented widespread *involuntary* euthanasia in the Netherlands [emphasis mine]."⁸ As an overall critique of the Nazi analogue, Dr. Sawyer (1994: 396-397) tried to explain that doctors in Canada were not asking for active *involuntary* euthanasia nor was there any evidence leading to its implementation:

The Nazi experience was with "involuntary euthanasia"—ending life against a person's wishes. . . . It seems unfair, then, to compare those who favour

legalization of PAD [physician-assisted death] in Canada to Nazis . . . [I]t should be recognized that *no one* is arguing for legalized involuntary euthanasia; the CMA and its Committee on Ethics would never remain neutral on that issue [emphasis mine].

Although scarce, there were some doctors that supported Dutch medical practices. Dr. Morley J. Tuttle (1991: 956) gravitated toward the Dutch medico-legal approach to euthanasia and assisted suicide because it balanced freedom of choice with safeguards against abuse: “Reasonable cases [of euthanasia and assisted suicide] will not attract the attention of public prosecutors, and in other cases the court decisions will in time provide appropriate guidelines.” Dr. Frances S.H. Dartana (1992: 445) hoped that “the terminally ill . . . [would] be given alternatives, as they were in Holland.” Further approval of Holland’s approach was provided by Dr. Arnoldus J. Verster (1992: 1748), who highlighted how euthanasia in the Netherlands was “subject to very strict controls” and was “not a ‘quick fix’ that had been found in desperation.”

However, the majority of Canadian physicians would not be swayed by the Dutch medical model, and divisions within the CMA became further entrenched. When CMA members took a vote at their annual meeting in August 1994 to “specifically exclude participation in euthanasia and physician-assisted suicide,” it was approved by a margin of only 93 votes to 74 (with 18 abstentions).⁹ A letter from Dr. Arnold Voth (1994: 1691-1692) suggested the “slippery slope” argument was the main reason the CMA General Council rightly rejected an intentionally hastened death: “[I]f the issue of physician-assisted suicide is to be decided by the public, then that public must include, almost to the exclusion of all others, those at risk. This means people who are ill, elderly, infirm, and dying.” Dr. Voth even accused the CMA Committee on Ethics of not doing enough to protect the vulnerable:

[T]he CMA Committee on Ethics failed to give voice to disabled and infirm people who oppose any form of

physician-assisted death. . . . [T]hey are not invited to appear before committees, and when they ask for this privilege they are often refused. The Svend Robinsons¹⁰ of this nation do not visit them or trumpet their cause aloud on television. They are disenfranchised.

What the split vote and polarized medical opinion indicated was that an intentionally hastened death, using either euthanasia or assisted suicide, was not a normative stance the CMA could readily accept. Centuries of entrenched values, particularly those surrounding the sanctity of human life and its intrinsic worth, could not be abandoned by the majority of the profession. As Dr. Fred Lowy (see *Refuse*, 1993: 1305), a member of the CMA's Committee on Ethics acknowledged, "It's one thing for society to want to legalize euthanasia or physician-assisted suicide and for the judiciary to allow it, but quite another thing for physicians to be prepared to do it."

Because of overt resistance to decriminalization, jaundiced attitudes toward the Dutch medical model, and fears of a return to Nazi eugenics, it is important to examine whether physicians' remarks were based on evidentiary standards or conjecture. It is pivotal then to compare the empirical findings of euthanasia and assisted suicide in Holland with the opinions of those Canadian physicians who opposed such acts during the 1990s. This will help in clarifying two inquiries: (1) whether any links between Dutch medical practice and Nazi eugenics were indeed warranted; and (2) whether state-sanctioning of euthanasia and assisted suicide would actually lead to a "slippery slope."

Interrogating the Discourse

In 1990 the Dutch appointed a Commission to examine the extent and nature of medical euthanasia. Under the chairmanship of the Attorney-General, Professor Remmelink, the Commission was asked to report on the practice by physicians that involves "performing an act or omission . . . to terminate [the] life of a

patient, with or without an explicit and serious request of the patient to this end” (van der Maas, van Delden and Pijnenborg, 1992a: 4). The Rummelink Report focused particularly on ‘Medical Decisions Concerning the End of Life,’ (MDELs), which included “all decisions by physicians concerning courses of action aimed at hastening the end of life of the patient or courses of action for which the physician takes into account the probability that the end of life of the patient is hastened” (19-20). MDELs were given wide parameters, comprising the administration, supply or prescription of a drug, the withdrawal/withholding of treatment (including resuscitation and tube-feeding), and the refusal of a request for euthanasia and assisted suicide (20). Moreover, euthanasia was differentiated from other MDELs. The definition adopted by the Commission was the “intentional action [lethal injection] to terminate a person’s life, performed by somebody else than the involved person upon the latter’s request” (Keown, 1995: 270). Methodology aside, it is the controversial elements that need to be addressed, particularly cases of an intentionally hastened death involving non-consent.

According to the Rummelink Report, only a small percentage of those who died actually received euthanasia or assisted suicide. Out of 129, 000 deaths in 1990, “2300 [1.8%] resulted from euthanasia and 400 [0.3%] were physician-assisted suicides,” (Mullens, 1995: 1847) in which the doctor provided only the means of death upon request (i.e., prescription drugs). An additional 1000 deaths [0.8%] occurred due to active *nonvoluntary* euthanasia in which consent was not explicit (see appendix). Dr. Paul van der Maas, the Rummelink Commission’s head of research, added that in nearly all these 1000 cases, “the patients were severely ill—most were dying of cancer—and there was visible suffering and the patients were no longer able to make their wishes known” (Mullens, 1995: 1847). In 59% of these cases, “the patient had previously discussed euthanasia with the doctor but as death neared was no longer able to make a formal [explicit] request” (1847). In cases where there was no discussion, this was not possible since the patients were “permanently unconscious” or in a state of “reduced

consciousness” (Singer, 1994: 153). In 80% of the cases, death was caused by increased doses of morphine (Mullens, 1995: 1847). Moreover, in 71% of the cases, “the medical decision [to use active nonvoluntary euthanasia] had shortened life by less than a week” (Singer, 1994: 153).

The more worrisome of the trends, active *involuntary* euthanasia, occurred *zero* times. Unlike atrocities experienced during the Nazi era, no one’s death in Holland was intentionally hastened *against* his or her consent by a physician (van Delden, Pijnenborg and van der Maas, 1993: 24). To summarize, of all deaths that occurred in Holland in 1990, no examples of active *involuntary* euthanasia were recorded, and not even one percent of *nonvoluntary* acts [0.8%] had occurred in a country that did not even have a formal law until 2002 (Petrou, 2005: 23). Since there were no previous comprehensive studies prior to 1990, the authors of the Report concluded that “no empirical data can be marshalled to support the slippery slope argument against the Dutch” (van Delden, Pijnenborg, and van der Maas, 1993: 24, 26). In fact, when a Dutch study was finally made available comparing 1990 euthanasia figures with those in 1995, active *nonvoluntary* euthanasia actually dropped by 0.1 per cent (0.8% to 0.7% of all deaths), and active *involuntary* euthanasia was still non-existent (see appendix). Furthermore, in countries where euthanasia was unlawful in the early 1990s, such as Australia and Belgium, the incidence of active *nonvoluntary* euthanasia was five times higher than in the Netherlands, 3.5%, 3.2%, and 0.7% respectively (van der Maas, van Delden and Pijnenborg, 1991: 669-674). Since public regulation may actually reduce, rather, than increase the incidence of nonvoluntary euthanasia, ethicist Helga Kuhse (see Tännsjö 2004: 66) suggests that “if there is a ‘slippery slope,’ it slopes in the opposite direction: the acceptance and regulation of voluntary euthanasia is linked with a lower incidence of non-voluntary euthanasia.”

Yet the CMA’s position on the intentional hastening of death remained diametrically opposed to that taken by the Royal Dutch Medical Association, which claimed that “a doctor must always be involved if any act of euthanasia is going to take place” (Mullens, 1995: 1845). Dr. Robert Dillmann, secretary of

medical affairs for the Royal Dutch Medical Association, felt that the Dutch were not sliding down a “slippery slope” but were, in fact, rather making their way back up the slope: “I think the tendency in the Netherlands is not downhill but uphill because of the increased awareness of the requirements [for euthanasia and assisted suicide], the increases in the number of doctors reporting and the increased awareness of the inappropriateness of life termination without [explicit] request” (1995: 1848). Dr. Borst-Eilers (see de Wachter, 1992: 24), chair of the Health Council and former medical director of the Academic Hospital at the University of Utrecht, noted that in situations of unbearable suffering, euthanasia becomes “the ultimate act in good terminal care.” It was no wonder that by January 1995 the CMA concluded that Canada needed a study similar to the Rummelink Report so that one could “substantiate or refute the repeated allegations that euthanasia and assisted suicide [already] take place” (Physician-Assisted Death, 1995: 248B).

The Illusion of the “Slippery Slope”: Religious and Cultural Influences

If physicians’ claims concerning Dutch medical abuses, Nazi eugenics, and the “slippery slope” were largely unsubstantiated, it is important to ask why Canadian doctors relied on fears of risk rather than debate the results of empirical data. One possibility lies with the presence of religious beliefs. In one quantitative survey conducted by Marja J. Verhoef, PhD, and Dr. T. Douglas Kinsella (1996: 885, 887), the data supported the premise that doctors did indeed harbour religious biases. The objective of the survey was “to determine whether the opinions of Alberta physicians about active euthanasia had changed” over a three-year period (1991-94) and “to assess the determinants of potential changes in opinion.” During this time frame, one in which controversial figures in the right-to-die movement emerged, “Alberta physicians’ support for the practice and legalization of active euthanasia decreased considerably.” In

fact, “religious activity” was the “most important characteristic associated with changes in opinion.” The authors found that from 1991-94 the proportion of doctors willing to practise legalized active euthanasia “decreased by almost 50%, and the proportion in favour of changing the law to permit active euthanasia decreased from 50% to 37%. They concluded that “religious affiliation was significantly related to changes in opinion about willingness to practise euthanasia if it were legalized.” However, the research only targeted Alberta physicians, not Canadian doctors in general.

When Kinsella and Verhoef (1999: 211-215) studied doctors’ opinions on physician-assisted suicide in a Canadian national survey in the late 1990s, they concluded that doctors’ attitudes were more strongly influenced by personal determinants than by medical/professional determinants. Of all the personal determinants, one of the most important was “levels of religious activity.” Kinsella and Verhoef indicated that for those doctors who were regularly active, occasionally active, and not religiously active, a direct relationship was found: Opposition to assistance in suicide went from over 80% (regularly active), slightly above 50% (occasionally active), and less than 50% (non-active). Overall, 57% of doctors nationwide rejected the personal practice of assisted suicide. Ironically, the authors remarked on a different kind of “slippery slope.” There were disassociations between potential professional behaviours and personal preferences. If physician-assisted suicide were legalized, about 40% of doctors would wish it for themselves, but only half this number would practice it. The authors suggested that conflicts in personal and professional preferences among Canadian physicians “could impair the public’s respect for the profession of medicine if they were perceived to reflect different standards of care for physicians . . . and their patients in end-of-life decisions.”

Global studies demonstrated similar links between religious beliefs and physicians’ attitudes towards an intentionally hastened death. A survey conducted in New South Wales by Baume, O’Malley, and Bauman (1995: 49-54) studied doctors’ religious attitudes and found that physicians without

formal religious affiliation ('non-theists') were more sympathetic to euthanasia, and had practised it more, than doctors who claimed any religious affiliation ("theists"). As the authors of the study indicated, "'Non-theists' were significantly more likely to favour the Dutch arrangements and to indicate support for . . . euthanasia policies and the need for legal changes, compared to all 'theist' doctors," especially those of Catholic and Protestant affiliation.

Similar results were found in Belgium. Broeckaert et al. (2009: 41-50) noted that Flemish palliative care physicians¹¹ who possess a "strong belief in God" and express their faith through "participation in prayer and rituals" tend to be "more critical toward euthanasia"; whereas, physicians who "deny the existence of a transcendent power" and who "hardly attend religious services" are "more likely to approve of euthanasia even in the case of minors and demented patients." The research found that doctors fit into one of four membership clusters: "church-going respondents" (31.6%), "infrequently church-going respondents" (14.7%), "atheists" (23.2%), and "doubters" (30.5%). The cluster of the church-going respondents was the only one with a significant amount of its members also being part of "the opponents of euthanasia." In contrast, a large majority of atheists belonged to the cluster of "the staunch advocates of euthanasia." The infrequently church-going respondents and doubters were "most often staunch advocates of euthanasia." The researchers found that religion was the most important variable in determining attitudes for or against euthanasia. No significant differences were found when accounting for gender, age, and years of experience in palliative care.

Lisker et al. (2008: 452-458) also examined the influence of religion on Mexican physicians' attitudes toward doctor-assisted suicide. Doctors were grouped into two categories, those with strong and weak religious beliefs, and were asked whether or not they agreed with the following: (1) a physician helping terminally patients die; (2) a family's request to remove life-sustaining treatment for a patient in a permanent vegetative state; and (3) asking their own physician to help them

die if they had intolerable suffering due to a terminal illness. Those medical practitioners with strong religious beliefs, and who replied “yes” to the first two questions, were less than those categorized as weakly religious (34.5 vs. 53.4% and 45.4 vs. 58.5% respectively). The reverse was true for those who answered “no” in the last question (46.5 vs. 36.3 respectively). Part of the resistance to doctor-assisted suicide may be attributable to the influence of Christian normative assumptions. The authors noted that by far the most common religion in Mexico is Catholicism, and recent studies confirm the authors’ suspicions. Emanuel (2002: 142-152) analyzed the attitudes of physicians regarding (a) support for; (b) legalization of; and (c) willingness to perform either euthanasia or patient-assisted suicide. He found that physicians who are Catholic or are religious are “significantly less likely to support euthanasia or patient-assisted suicide than others.” The influence of other factors, such as gender, specialty, and years of medical practice, were minimal.¹²

Another reason doctors relied on conjecture may have resulted from a lack of cross-cultural exposure, an area of discourse that was often overlooked by physicians corresponding to the *CMAJ*. By moving beyond the North American context, one can examine how attitudes toward an intentionally hastened death differ both regionally and between Christian and non-Christian cultures. From 1988-1995 the subject was breached only once in a single *CMAJ* article by Lowy, Sawyer, and Williams (1993: 1896). The authors made an important observation in determining why euthanasia and assisted suicide became immoral practices in the East. The arrival of Christian missionaries in the 16th century, along with the British Raj in the 18th century, eventually made euthanasia and assisted suicide illegal in India. Of greater importance was the authors’ statement that an intentionally hastened death was not always viewed in the pejorative by non-Western cultures. In their words, “[A]n important world culture [India] found a way to give positive meaning to self-willed death when the quality of life was considered unacceptable.”

The authors also provided some much needed clarification about the German context. As previously noted, when the Dutch model was discussed by CMA members, a link was often made between euthanasia in Holland and Nazi eugenics. Lowy, Sawyer, and Williams (1993: 1897) admit that “in reaction to the shameful Nazi era, when euthanasia was a euphemism for extermination, even scholarly discussion of any form of direct mercy killing in Germany seems to be taboo.” What is striking, however, about the authors’ report is what Canadian doctors never discussed within the *CMAJ* from 1988-1995: the fact that assisted suicide is both legal and actively practised in Germany. Suicide has not only been decriminalized in Germany since 1751, but as the authors admit, “assisting someone to do it—provided that the person is competent and has made a ‘freely responsible choice’—is permitted.” Margaret P. Battin (1992: 44-51) also points out that German history and culture sanctions “Freitod,” a voluntary and even idealistic form of self-deliverance, an act that does not possess the negative connotations often associated with suicide. Since it is described as “an admirable, heroic—if very difficult—thing to do,” Germans tend to respect *Freitod* as a matter of right, that is, to assume that “one ought not interfere with it and that one always has the right to this choice” (1994: 266).

Although Lowy, Sawyer, and Williams did briefly mention Jain culture, it received scant coverage among CMA members. More recent studies in Jainism have elaborated on alternative perceptions toward hastening death. Admittedly, Jains would condemn killing or any form of physical violence; however, ritual fasting can actually be viewed as a positive act. This practice of “fasting to death,” or “self-killing,” is known commonly as *samadhi-maran* (“death while in meditation”). In one instance of *samadhi-maran*, anthropologist James Laidlaw (2005: 180, 193) describes the respect family members have for those who attempt and succeed at the ritual:

Amarchand-ji’s daughter swelled up with pride as she described [her father’s] final fast for thirty-six days. For the last twenty-four days he did not take even water.

People came from all around to see him. Even on the final day he was sitting up and saying his samayik (meditational prayer) under his breath. At the end he said, “Now I will die. . . .”

In these circumstances Jains accept the role of agency in self-killing and spiritual liberation. In contrast, Western ethicists had at one time considered the removal of nutrition and hydration a crime constituting murder (Singer, 1994; Colby, 2002; Caplin, McCartney and Sisti, 2006).

Literature on the Japanese perspective was also notably absent from the dialogue among CMA members. When hospice care was introduced to Japan from Britain in the 1970s, it was Christian in origin, which created a kind of cultural friction. Susan Orpett Long (2004: 278, 284) discovered that the hospice philosophy surrounding patient involvement in the decision-making process was at odds with Japanese custom. There was a “continuing reluctance on the part of families to discuss a terminal diagnosis, despite official insistence on informed consent and commitment to it on the part of hospice staff.” To the Japanese, protecting the patient from the “shock of bad news” was considered more important than the principle of self-determination. The Japanese approach not only helped to maintain a “calm emotional atmosphere,” but it was also felt that “[g]ood caregivers are those who protect the patient.” Ironically, this cultural norm led the Japanese to accept *nonvoluntary* euthanasia (explicit consent unknown), a category of death-hastening in the Netherlands that created great anxiety for Canadian physicians. If anything, it was a lack of cross-cultural exposure, along with profoundly held religious beliefs, that shaped Canadian doctors’ attitudes toward prohibition.

Concluding Remarks

Overall, it is hoped that an historical overview of Canadian doctors’ attitudes toward euthanasia and assisted suicide can help shed some light on which motivating factors shaped resistance to

an intentionally hastened death. From the opinions expressed in the *CMAJ* from 1988-1995, and from available attitudinal studies, religion was no doubt one factor that influenced physicians' ethical stances. As John R. Williams (1997: 1-28) notes, Christian moral theologians and ethicists were instrumental in shaping the direction of bioethics beginning in the 1960s and 1970s. For those doctors who did reject Dutch acceptance of euthanasia and assisted suicide, the underlying principle for this position was the sanctity of life ethos, a doctrine well known for its Christian biases (Larson and Amundsen, 1988; Kuhse, 1987). Moreover, since both Jews and Christians used the Hippocratic tradition as a tool to reshape Western medicine (Vaux, 1974; Carrick, 2001), it is highly likely that religious normative assumptions still influence medical ethics.

Furthermore, a lack of cross-cultural exposure played some role in the rejection of euthanasia and assisted suicide. Only one *CMAJ* article appeared within a seven-year period to discuss how other cultures, including non-Christian, viewed the intentional hastening of death. More exposure to such perspectives could have played a dual role by (1) expanding doctors' opinions surrounding the death-hastening practices of other cultural groups and by (2) demonstrating how Christian normative assumptions have historically restricted these practices within non-Christian settings. Although other variables may have shaped physicians' attitudes toward prohibition, and are important topics of further research, this article suggests that religion and a lack of cross-cultural perspectives played a significant role in creating unwarranted fears toward the Dutch medical model and a possible return to Nazi eugenics. Hence, in the tension-filled period from 1988-1995, the illusion of the "slippery slope" prevailed over empiricism whenever the intentional hastening of death was discussed among Canadian physicians.

Notes

¹ For a complete legal analysis of Sue Rodriguez's three attempts to decriminalize physician-assisted suicide for the terminally ill, see *Rodriguez v. British Columbia* (1992), British Columbia Supreme Court (SCBC) No. 4040/92, Victoria Registry, Melvin J.; Court of Appeal for British Columbia (1993), No. V01800, Victoria Registry, McEachern C. J., Proudfoot, J., and Hollinrake, J. (1993); *Rodriguez v. British Columbia* (1993) 3 S.C.R. 519 Docket: 23476 (September 30 1993) <http://scc.lexum.umontreal.ca/en/1993/1993rcs3-519/1993rcs3-519.html>.

² Different moral philosophers have called into question the rhetoric surrounding the "Debbie" incident. For instance, Michael J. Hyde suggests that "Debbie" functions as "a call of conscience whose rhetorical interruption is meant to cause a break in one's thinking about the sanctity of life and the right to die." See Michael J. Hyde, *The Call of Conscience: Heidegger and Levinas, Rhetoric and the Euthanasia Debate* (Columbia, South Carolina: University of South Carolina, 2001), 148; also see Kenneth L. Vaux, "Debbie's Dying: Mercy Killing and the Good Death, *Arguing Euthanasia: The Controversy over Mercy Killing, Assisted Suicide, and the 'Right to Die,'* edited by Jonathan D. Moreno (Touchstone: New York, 1995), 31-41.

³ In the spring of 1989, members of the Health Council of the Netherlands replied to Dr. Kirshen's letter, clarifying national codes of conduct pertaining to euthanasia. They stated that the guidelines for euthanasia required an "explicit and repeated request by the patient" and that "the patient's decision be well informed, free and enduring." This meant that "euthanasia cannot be performed on patients with dementia as they are no longer able to express their own will in a valid way." See H. Ritger, E. Borst-Eilers, and H.J.J. Leenen, "Euthanasia in the Netherlands," *Can Med Assoc J* 140 (1 April 1989): 788.

⁴ Although Dr. Kirshen objected to what bioethicists call active *involuntary* euthanasia, meaning to euthanize someone *against* his or her wishes, in the Dutch context Kirshen would have meant *nonvoluntary* euthanasia in which the consent of the patient was unknown. See John Keown, *Euthanasia, Ethics, and Public Policy: An Argument against Legalization* (New York: Cambridge University Press, 2002), 9; Peter Singer, *Rethinking Life and Death: The Collapse of our Traditional Ethics* (New York: St. Martin's Press, 1994), 151.

⁵ As John Stuart Mill acknowledged, utilitarianism implies a communal bias in that "the happiness which forms the utilitarian standard of what is right in conduct is not the agent's own happiness, but that of all concerned." See John Stuart Mill, *The Basic Writings of John Stuart Mill: On Liberty, The Subjection of Women, and Utilitarianism*, introduction by J.B. Schneewind (New York: Random House, 2002), 250.

⁶ Philosopher Michael Stiglitz claims that the Nazi analogue is a weak one, especially when comparing fascist and democratic nations. As he states: "Nazi Germany began with a fascist political ideology, one which held that it was right and good to sacrifice individual lives to the greater glory of the state and

the race. In accord with this ideology, the country did not *end up* with a justification for involuntary euthanasia—they *started* with one. . . . Unless one is deeply pessimistic about the future of liberalism as a political institution in the developed world, the analogy to Nazi Germany seems completely misplaced.” See Michael Stingl, ed., *The Price of Compassion: Assisted Suicide and Euthanasia* (Peterborough, Ontario: Broadview Press, 2010), 4.

⁷ It is important to remember that the Rodriguez Supreme Court trial not only polarized Canadians. It ended in a 5/4 split decision, with the Chief Justice, Antonio Lamer, siding with Rodriguez’s request for physician-assisted suicide.

⁸ See footnote #4 for a clarification between *nonvoluntary* and *involuntary* euthanasia.

⁹ For further details of the CMA’s annual meeting in August of 1994, see J. Rafuse, “CMA Rejects Neutral Stand, Comes Out Firmly against MD Participation in Euthanasia,” *Can Med Assoc J* 151, no. 6 (15 September 1994): 853.

¹⁰ As a controversial member of the New Democratic Party at the time, Svend Robinson was not only an advocate of physician-assisted suicide, but he was also present when Sue Rodriguez chose to have her death hastened with the aid of an anonymous physician.

¹¹ It is important to note that the majority of the physicians in the study self-identified as either Christian or Catholic.

¹² The only other variable that played any other significant role in shaping Mexican doctors’ attitudes toward physician-assisted death was “familiarity attending terminally ill patients.”

Appendix

End-of-life decisions by doctors in the Netherlands 1990–1995

	1990	1995
Deaths in the Netherlands	129,000 (100%)	135,500 (100%)
Requests for euthanasia	8,900 (7%)	9,700 (7.1%)
Euthanasia (i.e. VAE)	2,300 (1.8%)	3,200 (2.4%)
Physician-assisted suicide	400 (0.3%)	400 (0.3%)
Life-terminating acts without explicit request	1,000 (0.8%)	900 (0.7%)
Intensification of pain and symptom treatment	22,500 (17.5%)	20,000 (14.8%)
a. explicitly intended to shorten life	1,350 (1%)	2,000 (1.5%)
b. partly intended to shorten life	6,750 (5.2%)	2,850 (2.1%)
c. taking into account the probability that life will be shortened	14,400 (11.3%)	15,150 (11.1%)
Withdrawing/withholding treatment (incl. tube-feeding)	22,500 (17.5%)	27,300 (20.1%)
a. at the explicit request of the patient	5,800 (4.5%)	5,200 (3.8%)
b. without the explicit request of the patient		
b1. explicitly intended to shorten life	2,670 (2.1%)	14,200 (10.5%)
b2. partly to shorten life	3,170 (2.5%)	—
b3. taking into account the probability that life will be shortened	10,850 (8.4%)	7,900 (5.8%)
Intentional termination of neonates		
a. without withholding/withdrawing treatment	—	10
b. withholding/withdrawing treatment plus administration of medication explicitly to shorten life	—	80
Assisted suicide of psychiatric patients	—	2–5

Note: A dash indicates that no figures are available.

Source: John Keown, *Euthanasia, Ethics, and Public Policy: An Argument against Legalization* (New York: Cambridge University Press, 2002), 126.

*Note: VAE refers to “voluntary active euthanasia.”

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