

Of Stewardship, Suffering and the “Slippery Slope”:
A Vattimian Analysis of the Sanctity of Life Ethos in
Canada (1972–2005)

Stuart Chambers

Thesis Directors: Dr. Peter F. Beyer and Dr. Theodore De Bruyn

Degree Sought: Doctorate in Philosophy in Religious Studies

Department of Classics and Religious Studies
Faculty of Arts
University of Ottawa

© Stuart Chambers, Ottawa, Canada, 2011

For Lynn and Alexander

“The complexity of the moral phenomena always outruns our ability to capture them in general norms.” (Henry Richardson)

Abstract

This dissertation examines from a Vattimian perspective the challenge that euthanasia and assisted suicide posed to the sanctity of life ethos in Canada from 1972–2005. Gianni Vattimo’s central themes—*metaphysics* (absolute values), “*event of being*” (lived experiences that call absolute values into question), and *passive-reactive nihilism* (the use of “masks” or “disguises” to prevent the dissolution of metaphysics)—are pivotal to understanding the way religious and secular beliefs are interwoven within ethical, medical, legal and political discourses in Canada. Vattimo’s philosophico-ethical approach was specifically chosen because as a theoretical tool, it helps to illuminate the presence, weakening, and resilience of metaphysics in discourses surrounding an intentionally hastened death.

To demonstrate how Vattimo’s major themes apply empirically to the research, a social constructionist approach was adopted in the form of a discourse analysis. Particular emphasis was placed on an examination of the three most important cases of death and dying in Canada, namely, Nancy B., Sue Rodriguez and Robert Latimer. The bulk of the evidence suggests that when these “events of being” challenged the sanctity doctrine as the ultimate foundation for life-terminating decisions, ethical, medical, legal and political discourses converged to promote three normative positions or authorizing discourses used in the tradition of Christian ethics: (1) *stewardship*—the view that since life is a “loan from God,” sacred, and of infinite worth, death cannot be intentionally hastened (“nature must take its course”); (2) *value in prolonged suffering*—the view that since suffering possesses transcendent meaning or purpose, its prolongation is justified in

individual circumstances; and (3) the “*slippery slope*”—the view that any weakening of the sanctity of life ethos inevitably harms or threatens the community.

Generally speaking, religious and secular advocates of the sanctity of life ethos reacted similarly in cases involving an intentionally hastened death. In other words, *both* the religious *and* the secular embraced metaphysics (absolute values), condoned and rationalized the prolongation of suffering, and relied on the “slippery slope” as a “mask” to maintain the sanctity of human life as first principle. The research strongly suggests that Canada is still significantly indebted to Christian notions when it comes to discussions surrounding the decriminalization of euthanasia and assisted suicide.

Keywords:

sanctity of life ethos, quality of life ethos, euthanasia, assisted suicide, stewardship, suffering, "slippery slope," metaphysics, "event of being," passive-reactive nihilism, Nancy B., Sue Rodriguez, Robert Latimer, religious attitudes, Christian, metaphysicians, Vattimian postmodernists.

Contents

Acknowledgements	7
Introduction	8
Statement of Purpose	8
Method	17
Personal Bias	19
Previous Work in the Field	21
Contribution to Knowledge	26
Interested Parties	27
Chapter Summaries	34
Chapter I: The Vattimian Perspective	40
Vattimo: The Personal is Political	40
Vattimo's Central Themes	43
Applying Vattimo to the Dissertation	58
Chapter II: Global Trends and the "Eventuation of Being"	64
The American Context	65
i) Redefining Death	65
ii) Karen Ann Quinlan: "Passive" Euthanasia on Trial	67
iii) Nancy Cruzan: Acts of Omission in Flux	73
Britain: Anthony Bland and Quality of Life Considerations	80
Canada: The <i>Qualified</i> Sanctity of Life Ethos Prevails	84
Holland's Gradualism	91
Australia: A Brief Encounter with the Quality of Life Ethos	96
Switzerland: Pushing the Boundaries	99
Germany's "Free Death"	102
Japanese Ambivalence	105
Concluding Remarks	110
Chapter III: Ethical and Religious Discourses in Canada	112
The Religious as Metaphysicians	113
Religious Exceptions	129
Metaphysics Interwoven in Secular Discourse	131
Vattimian Postmodernists	142
Metaphysical "Traces" in Quality of Life Discourse	148
Chapter IV: Medicine's Rejection of Euthanasia and Assisted Suicide	151
The CMA Code of Ethics: A History of "Eventuation"	153
Holland's "Slippery Slope" and the Nazi Analogue	161
The Omission / Commission Moral Distinction	172
Hospice / Palliative Care Workers: The Metaphysical / Postmodern Divide	178

Metaphysicians in Hospice / Palliative Care	178
Vattimian Postmodernists in Hospice / Palliative Care	193
Health Care Representatives as Metaphysicians	196
Health Care Representatives as Vattimian Postmodernists	206
Chapter V: The “Weakening” of the Sanctity of Life Ethos in Law	214
Metaphysics and the Law Reform Commission of Canada	215
Sue Rodriguez and the Weakening of Metaphysics	221
i) The Metaphysical / Postmodern Divide in the Courts	226
ii) Facta of the Interveners: Religious Opposition	241
iii) Secular Opposition and “Civil Rights” Discourse	245
iv) Interveners as Vattimian Postmodernists	248
Tracy Latimer, Suffering, and the Sanctity of Life Ethos	253
i) The Interveners: Religious Organizations	263
ii) The Interveners: Secular Organizations	266
iii) “Civil Rights” Discourse	268
iv) Vattimian Postmodernists	271
v) Metaphysics Maintained in the Latimer Affair	272
Chapter VI: Political Discourse in Canada	276
Robert Wenman and the <i>Qualified</i> Sanctity of Life Ethos	277
Chris Axworthy and the Quality of Life Ethos	284
Ian Waddell, Raymond Skelly, and the Continuing Postmodern Trend	288
Svend Robinson and the Aftermath of the Rodriguez Case	314
The Metaphysical / Postmodern Divide of the 21st Century	329
Chapter VII: Interrogating the Discourse: The “Slippery Slope” as a Form of Passive-Reactive Nihilism	336
The Dutch “Slippery Slope” Unmasked	337
The “Slippery Slope” from the Dutch Viewpoint	343
“Behind the Mask”: How Religion Shapes Attitudes toward Prohibition	352
“Masking” Causation: Nancy B. and Absolute Moral Distinctions	356
Conclusion	368
An Overview of the Vattimian Perspective	368
Limitations, Challenges, and the Promise of the Vattimian Perspective	394
Appendix	400
Works Cited	401

Acknowledgements

First and foremost, I would like to thank my supervisors, Peter Beyer and Theodore DeBruyn, for their unwavering support and faith in my project. Their patience, guidance, and sense of excellence allowed me to bring it to its final form.

I would also like to thank the following people for their unconditional support throughout this process: Leslie Armour, Lori G. Beaman, Glen Choi, Theresa Corneau, Lynn Chambers, Don Dawson, Ian Dowbiggin, Jocelyn Downie, Michel Gardaz, Tom Goodale, Marie-Françoise Guédon, Michael Hutton, Michael J. Hyde, Jane Karchmar, Eike-Henner W. Kluge, Dr. Larry Librach, Dr. Timothy E. Quill, Heather Shipley, Peter Singer, Steve Tomlins, Ann Vallely, Leo Van Arragon, and John R. Williams.

Finally, I would like to give special thanks to Dr. J. Brian Scott, whose mentorship over nearly a quarter century speaks to the “life-giving gift of acknowledgement.”

Introduction

Statement of Purpose

Upon reading *After Christianity* (2002) and *Nihilism and Emancipation* (2003), I was inspired by the philosophical ethics of Gianni Vattimo. It was particularly his nihilistic approach—“the history of how objective truth gradually dissolves”¹—that helped illuminate the relationship between religious (metaphysical) positions and the issue of death and dying in Canada, specifically the controversy surrounding euthanasia and assisted suicide. Moreover, his central themes—metaphysics (supreme values), “event of being” (lived experiences that call absolute values into question), and passive-reactive nihilism (the use of “masks” or “disguises” to prevent the dissolution of metaphysics)—are pivotal to understanding the way secular and religious beliefs are interwoven in ethical, medical, legal, and political discourses in Canada. As Vattimo notes, “A secularized culture is not one that has simply left religious elements of its tradition behind, but one that continues to live them as traces, as hidden and distorted models that are nonetheless profoundly present.”² For the purposes of this dissertation, Vattimo’s theoretical perspective provides a suitable framework in which to analyze the prohibition against the intentional hastening of death because it demands an overview of first principles, an observation of their potential weakening, and a resolution in terms of either the “death of God” (death of absolutes) or the perpetuation of metaphysics. Since I am using Vattimo’s central themes as the core of my analysis, specific forms of rhetoric

¹ Gianni Vattimo with Piergiorgio Paterlini, *Not Being God: A Collaborative Biography*, translated by William McCuaig (New York: Columbia University Press, 2009), 24.

² Gianni Vattimo, *The Transparent Society* (Malden, Massachusetts: Polity Press, 1992), 42.

will undoubtedly become more accentuated than others in order to disclose the function of metaphysics in contemporary discourse.

This dissertation examines from a Vattimian perspective the challenge that euthanasia and assisted suicide posed to the sanctity of life ethos in Canada from 1972–2005. I contend that “traces” of the Christian metaphysical tradition continue to dominate and shape the discourse on euthanasia and assisted suicide in Canada—a discourse that at times purports to be secular but is, in fact, only so in appearance. Evidence suggests that when the sanctity of human life principle (sanctity of life ethos or sanctity doctrine) was challenged as the foundation for life-terminating decisions, ethical, medical, legal, and political discourses converged to promote three Christian normative positions: (1) *stewardship*—the view that since life is a “loan from God,” sacred, and of infinite worth, death cannot be intentionally hastened (“nature must take its course”); (2) *value in prolonged suffering*—the view that since suffering possesses transcendent meaning or purpose, its prolongation is justified in individual situations; (3) the “*slippery slope*”—the view that any weakening of the sanctity of life ethos inevitably harms or threatens the community. These normative assumptions above are specifically founded in Christian theological discourse. Therefore, it is important to acknowledge their Christian roots before recognizing their presence in contemporary discourse on death and dying.

The notion of stewardship is rooted in the Christian understanding of human beings having been created from an act of God. According to Ferngren, this implies that

every human being is of equal worth at all stages of life and that life is inviolable.³ Paris and Moreland emphasize the Catholic viewpoint in that suicide is not only considered “a violation of God’s dominion,” but it is also viewed as “the ultimate act of defiance—the assertion of self over divine authority.”⁴ Furthermore, Battin notes that the metaphors and analogies central to theistic debates concerning suicide involve “property relationships” (e.g., life as a “loan” or “trust” from God) and “role relationships” (e.g., human beings as “God’s children” or “trustees”).⁵ Grayling argues that the Christian tradition has from its legalization consistently and unequivocally prohibited suicide. Individuals possess “limited personal autonomy” and cannot “dispose of their bodies as they will” because they have been given purpose from a deity that is “not open to the individual to question or obstruct.”⁶ Because stewardship is foundational to Christian thought, Childress addresses its impact on contemporary discourse: “This fundamental belief in God’s sovereignty . . . challenge[s] secular (and some religious) arguments in support of suicide, assisted suicide, and euthanasia.”⁷ Likewise, Manning summarizes the relationship between this central tenet of the Christian tradition and the intentional hastening of death: “Humans usurp God’s sovereignty when, through the use of

³ Gary B. Ferngren, “The Imago Dei and the Sanctity of Life: The Origins of an Idea,” in *Euthanasia and the Newborn: Conflicts about Saving Lives*, edited by R.C. Macmillan, H.T. Englehardt, and S. F. Spicker, (Dordrecht, Netherlands: Reidel, 1987), 23–45.

⁴ John J. Paris and Michael P. Moreland, “A Catholic Perspective on Physician-Assisted Suicide,” in *Physician-Assisted Suicide: Expanding the Debate*, edited by Margaret P. Battin et al. (New York: Routledge, 1998), 326.

⁵ Margaret P. Battin, *Ethical Issues in Suicide* (Englewood Cliffs, New Jersey: Prentice Hall, 1995), chapter 1.

⁶ A.C. Grayling, *What Is Good? The Search for the Best Way to Live* (London: The Orion Publishing Group Ltd., 2003), 178.

⁷ James F. Childress, “Religious Viewpoints,” in *Regulating How We Die: The Ethical, Medical, and Legal Issues Surrounding Physician-Assisted Suicide*, edited by Linda L. Emanuel (Cambridge, Massachusetts: Harvard University Press, 1998), 121.

euthanasia, they propose to bring about death *before its time* [italics mine].”⁸ For the purposes of this dissertation, any normative assumption that presupposes stewardship will be subsumed under that heading (e.g., life being “sacred,” a “gift,” possessing “infinite worth,” and the implication that “nature must take its course”).

Moreover, Christians have viewed their own acceptance of suffering as “a sharing in, or even completion of, Christ’s sufferings,” something that can “sanctify and transform us, bringing us closer to God.”⁹ Dowbiggin acknowledges that from a Christian perspective, “suffering was also viewed as punishment for past sins and a means of emulating the passion of the Saviour himself.”¹⁰ Dowbiggin adds that from the first century A.D. to the twentieth century, “virtually all Christians condemned suicide as a means of escaping the suffering that afflicts human beings.”¹¹ Larson and Amundsen found that for early Christians suffering was seen as “a training ground that enabled [them] . . . to participate in and minister to the sufferings of their fellow Christians,” something that “transformed [the suffering] into a positive force in Christians’ lives . . .”¹² Such a belief in “patient endurance” is antithetical to the taking of one’s own life, “even when one is afflicted by prolonged suffering attendant upon chronic or terminal illness.”¹³ Amundsen asserts that value in prolonged suffering is intrinsically linked to stewardship. This is because Christian attitudes and responses to suffering “must be

⁸ Michael Manning, *Euthanasia and Physician-Assisted Suicide: Killing or Caring?* (New York: Paulist Press, 1998), 23.

⁹ The Washington Report, *Assisted Suicide and Euthanasia: Christian Moral Perspectives* (Harrisburg, Pennsylvania: Morehouse Publishing, 1997), 24, 34.

¹⁰ Ian Dowbiggin, *A Concise History of Euthanasia: Life, Death, God, and Medicine* (Maryland: Rowman and Littlefield Publishers, Inc., 2005), 18.

¹¹ Ian Dowbiggin, *A Merciful End: The Euthanasia Movement in Modern America* (Oxford: Oxford University Press, 2003), 3.

¹² Edward J. Larson and Darrel W. Amundsen, *A Different Death: Euthanasia and the Christian Tradition* (Downers Grove, Illinois: InterVarsity Press, 1998), 79.

¹³ *Ibid.*, 84.

molded by the reality that their Creator and Sovereign will cause all things to work together for their good” and that “for Christians to take their own lives in order to escape from the trials and testings ordained by Him would be a failure of love and a breach of trust.”¹⁴ Lavi points out that for both Catholics and Protestants in the nineteenth century, a “good death was not a painless death but one in which pain was suffered with resignation.”¹⁵ For the purposes of this dissertation, both the transcendent meaning of suffering, as well as the justifications for its prolongation, will be highlighted to note how the Christian prohibition against an intentionally hastened death remained absolute even for cases of intractable suffering.

Lastly, the concept of the “slippery slope,” or “wedge” principle, is central to Christian ethical deliberations as a means of safeguarding against threats to communal norms. According to Dowbiggin, Christians believe that “the sanctity of human life and the supreme value of the individual soul would suffer incalculable harm . . . if men were at liberty to determine the conditions under which they might put an end to their own lives and the lives of other men.”¹⁶ Catholic theology also teaches that “slope” concerns negate any possibility of examining individual circumstances when applying collective morality. For Sullivan, this implies that “an act which, if raised to a general line of

¹⁴ Darrel W. Amundsen, “Suffering and the Sovereignty of God: One Evangelical’s Perspective on Doctor-Assisted Suicide,” *Christian Bioethics* 1, no 3 (1995): 285.

¹⁵ Shai J. Lavi, *The Modern Art of Dying: A History of Euthanasia in the United States* (Princeton, New Jersey: Princeton University Press, 2005), 65. Lavi was specifically referring to the Methodist belief in Christian perfection, namely, “the conscious certainty of the fullness of one’s faith” (25). Since this was a truth Methodists and their founder, John Wesley, held sacrosanct for the deathbed, “medical euthanasia” was out of the question. Seeing as an intentionally hastened death would defy God’s sovereignty and rob the dying of the opportunity to face death and overcome it, the price of such defeat was eternal damnation, a price far greater than having to endure extreme physical suffering. As Lavi notes, “Pain, for Methodists, was far from being intolerable, not only because it was seen as a necessity of human life after the Fall but also because it had a purpose. Suffering had the power of redeeming from sin, of awakening one to acknowledge one’s sinfulness and to seek grace” (35).

¹⁶ Ian Dowbiggin, *A Concise History of Euthanasia: Life, Death, God, and Medicine*, 11.

conduct would injure humanity, is wrong even in an individual case.”¹⁷ Communal rhetoric is also magnified whenever absolute moral distinctions are challenged, especially those differentiating between acts of omission and commission. Once the line is crossed between “allowing to die” and “killing,” Christian moral philosophers warn not only that society would hit the “bottom of the slippery slope,” but that the “good of the community would be seriously threatened by allowing socially sanctioned killing of the innocent” through euthanasia and assisted suicide.¹⁸ The “slippery slope” then is often played as a trump card to prevent any weakening of communal normative assumptions, especially those related to the sanctity of human life.¹⁹

This dissertation claims that whenever the sanctity of life ethos was challenged as a first principle, particularly during debates over euthanasia and assisted suicide, secular organizations/individuals reverted back to faith positions. In other words, sanctity of life advocates—religious and secular—consistently made reference to the notion of stewardship, value in prolonged suffering, and the “slippery slope” when arguing for the prohibition against an intentionally hastened death. Therefore, the above normative assumptions will be highlighted to demonstrate how the Christian tradition still lives on as a “trace” in secular society. As previously noted, Vattimo’s theoretical perspective was instrumental in shaping the selection of these rhetorical patterns.

To demonstrate how religious beliefs are interwoven in secular discourse, it will be important to address the most controversial cases of death and dying in Canadian

¹⁷ Joseph F. Sullivan, *Catholic Teaching on the Morality of Euthanasia* (Washington, D.C.: Catholic University of America Press, 1949), 54.

¹⁸ H. Bouma III, et al., *Christian Faith, Health, and Medical Practice* (Grand Rapids, Michigan: Eerdmans, 1989), 300.

¹⁹ As Lori G. Beaman notes, “harm” or “risk” are fluid concepts that are subject to perspective and (ab)use by any interested party. See Lori G. Beaman, *Defining Harm: Religious Freedom and the Limits of the Law* (Vancouver: UBC Press, 2008), 86.

history, namely, Nancy B., Sue Rodriguez, and Robert Latimer. These individuals are central to the debate over euthanasia and assisted suicide because, as “events of being,” they were part of a moral revolution²⁰ in which societal values began to shift away from the sanctity of life ethos as first principle and toward a quality of life ethic. What separates the two paradigms is that the latter sanctions the intentional hastening of death based on considerations of the quality or kind of human life.²¹ For instance, in 1989 Nancy B. was afflicted with Guillain–Barré syndrome. Because her body’s immune system was attacking its nervous system, she was left completely paralyzed, including respiration, but her mental capacities remained intact. As a result, she required the permanent use of a ventilator. However, after two and a half years without improvement, Nancy B. wanted her ventilator removed so she could die. The hospital in charge of her care, Hôtel-Dieu de Québec, went to court to make sure they were not committing murder. The Quebec Superior Court declared that removal of the respirator was simply “nature taking its course,” not the active killing of a patient.²² Because this case reinforced absolute moral distinctions between acts of omission and commission, it helped solidify a shift that had already been occurring. Vitalism (preserving human life at all costs) had given way to the *qualified* sanctity of life ethos as first principle. After

²⁰ Kwame Anthony Appiah, *The Honor Code: How Moral Revolutions Happen* (New York: W.W. Norton & Company, 2010). According to Appiah, moral revolutions occur because globalization, mass media, and key historical figures shift the public’s focus toward certain sociological issues. This revolution is achieved by magnifying the degree of suffering, shame, or dishonour a nation will experience if it continues to sanction specific behaviours. Although Appiah’s examples include duelling, footbinding, slavery, and “honour killing,” quality of life advocates have emphasized the suffering of the terminally ill and their loss of dignity as rhetorical strategies to modernize attitudes toward euthanasia and assisted suicide.

²¹ Helga Kuhse, *The Sanctity of Life Doctrine in Medicine: A Critique* (Oxford: Oxford University Press, 1987), 197–220.

²² CBC Digital Archives, “‘Nancy B’ Dies after Winning Right to Refuse Treatment,” broadcast date: February 13, 1992; accessed September 22, 2010. <archives.cbc.ca/politics/rights_freedoms/clips/6406/>

Nancy B., one could still not intend death using acts of commission, but one could refrain from prolonging it by withholding or withdrawing treatment (acts of omission).

Sue Rodriguez, a forty-one-year-old British Columbia woman suffering from amyotrophic lateral sclerosis, or ALS, challenged the sanctity doctrine by asking the Supreme Court of Canada to permit physician-assisted suicide for a terminally ill, competent adult. The Rodriguez case was particularly important because, unlike Nancy B.'s or Tracy Latimer's circumstances, there were few (if any) ancillary reasons to doubt that Rodriguez's request and/or actions were anything but self-determined and intentional. Rodriguez was not a minor, was not dependent on a respirator, was mentally sound, could provide consent, and was seeking help from a third party (a physician).²³ Therefore, the refusal of her specific request for a doctor-assisted suicide illustrates how Christian ethical and legal discourse, influenced by Christian metaphysical tradition, maintains an absolute prohibition against intentional killing, even for competent, terminally ill adults.

Finally, Robert Latimer's series of trials emphasized the question "Who can play God?" in the intentional hastening of death for children experiencing extreme pain and suffering. Latimer placed his severely disabled daughter Tracy in a pickup truck, ran a hose from the exhaust to the cab, and watched her die from carbon monoxide poisoning. He told authorities he had no choice but to kill his twelve-year-old daughter because of the intractable suffering caused by her deteriorating physical condition. Although he sought a constitutional exemption for mercy killing or *nonvoluntary* euthanasia (Tracy could not communicate her wishes), he was eventually convicted of second-degree

²³ CBC Digital Archives, "'Sue Rodriguez and the Right-to-Die Debate: Suicide,'" broadcast date: February 21, 1994; accessed September 22, 2010. <archives.cbc.ca/politics/rights_freedoms/topics/1135/>

murder and sentenced to ten years in prison.²⁴ The verdict was a clear indication that social acceptance of intentional killing, especially of minors, was too radical a position for Canadian moral sensibilities in the 1990s.

The temporal focus of this research, 1972–2005, is important because the majority of debate surrounding euthanasia and assisted suicide occurred in this period. Within this time frame, several historical events are worthy of note: the decriminalization of suicide in 1972, which simultaneously maintained the absolute prohibition against assistance in suicide; the Law Reform Commission of Canada studies on euthanasia and assisted suicide from 1976–1986; the views of physicians within the Canadian Medical Association from the late 1980s to the mid-1990s; Nancy B.’s request in 1992 to have her ventilator removed; Sue Rodriguez’s three attempts at decriminalizing physician-assisted suicide in 1993; Robert Latimer’s court cases and/or appeals from 1993–2001; attempts to decriminalize euthanasia and assisted suicide in the House of Commons from 1991 to 2005; and testimony from the *Special Senate Committee on Euthanasia and Assisted Suicide* from 1994–1995, highlighting the voices of key activists for and against decriminalization.

As previously mentioned, a discourse analysis will be used to review the three most important legal cases in Canada involving euthanasia and assisted suicide, those being Nancy B., Sue Rodriguez, and Robert Latimer. Using a Vattimian analysis of these cases, I wish to understand how the metaphysic of stewardship (e.g., the sanctity of life as absolute) remains embedded in secular discourse, how ontological difference (e.g., those “hard cases” suffering from intractable pain) weakened the sanctity doctrine, and how

²⁴ CBC News Online, “Compassionate Homicide: The Law and Robert Latimer,” last updated: March 17, 2008; accessed September 22, 2010. <www.cbc.ca/news/background/latimer/>

“masks” or “disguises” are used to maintain the sanctity of human life as first principle. In other words, I seek to understand how Vattimo’s main themes—metaphysics, “event of being,” and passive-reactive nihilism—apply empirically to the ethical, medical, judicial, and political discourses that converged around the above three legal matters.

Method

Using a discourse analysis, I chose to focus on the voices of elites (theologians, ethicists/bioethicists, medical practitioners, justices, and politicians). Admittedly, these groups can never tell the whole story, but they do offer a unique window into how discursive intersections come together to govern the issue of an intentionally hastened death. In other words, the discourses of elites coalesce to solidify the prohibition against euthanasia and assisted suicide. At pivotal moments in which “events of being” begin to challenge the reigning orthodoxy—in this case, the sanctity of life ethos—it is important to understand the metaethical principles that ultimately found decisions concerning euthanasia and assisted suicide as well as the normative assumptions that undergird such foundations.

Although there are countless documents one could potentially analyze, the primary sources in this study were chosen for reasons of both authority and expediency: *legal sources*—court cases (at the provincial, appeals, and Supreme Court level), facts of the interveners, and five Law Reform Commission of Canada reports, which expand on the mitigating circumstances surrounding Nancy B., Sue Rodriguez, and Robert Latimer; *ethical sources*—thirty-two Senate Committee reports plus a summary report (*Of Life and Death: Report of the Special Senate Committee on Euthanasia and Assisted Suicide*),

which examine both the views of ethicists and those groups/individuals from major institutions with ethical concerns; *political sources*—Debates of the House of Commons (Hansard) and bills/motions, which highlight the normative assumptions of Canada’s five major political parties; *medical sources*—the archives of the *Canadian Medical Association Journal (CMAJ)* as well as the aforementioned *Special Senate Committee* reports, which provide an overview of the attitudes of medical practitioners toward euthanasia and assisted suicide. The documents selected represent the most comprehensive package of religious and secular opinion by those groups/individuals most vocal about the possible decriminalization of euthanasia and assisted suicide in Canada. Since all the major documents appeared during the 1980s-1990s, this indicates that euthanasia and assisted suicide were a major concern for elites during this time period.

The Vattimian perspective was used as a guide in the selection of specific discourses from primary and secondary documents. While analyzing the discourses of *both* religious *and* secular advocates of the sanctity of life ethos, specific words, phrases and statements were chosen if they illuminated Vattimo’s main themes: metaphysics (absolute values or immutable principles); (2) “event of being” (lived experiences that call absolute values into question); and (3) passive-reactive nihilism (the use of “masks” or “disguises” to prevent the dissolution of metaphysics). The normative assumptions of sanctity of life advocates were then compared to those used by *quality of life* advocates in order to illustrate key differences between them. I was also careful to note if *quality of life* advocates adhered to their own absolutist beliefs or if traces of both paradigms existed in any of the discourses. Since secular and religious discourses converged in important legal matters surrounding the intentional hastening of death—particularly in

the cases of Nancy B., Sue Rodriguez, and Robert Latimer—a comparison of their normative assumptions helps to reveal how “traces” of the Christian metaphysical tradition live on in secular guise.

Specific sources were also selected because they were more easily obtainable. For example, legal cases and facts of the interveners were located electronically through the Supreme Court of Canada, the Quebec Superior Court, and the Saskatchewan Court of Appeal. The *Canadian Medical Association Journal*’s archives (CMAJ) were available to the public on-line. As well, Senate Committee reports were accessed through the Library of Parliament, and additional copies were published for public consumption. Moreover, the Law Reform Commission of Canada reports were found at the University of Ottawa Law Library as were Debates of the House of Commons (Hansard). Additional legal and political documents were located at the National Library of Canada. In addition, other primary and secondary sources included scholarly journals, books, magazine articles, and newspaper editorials.

Personal Bias

Researchers tend to be positioned in their own social, political and economic worlds, which no doubt influences their choice of theorists and theories. Hence, my own personal academic interests will also have an impact on the research. I tend to gravitate toward postmodern pluralism and the nihilistic perspective of Gianni Vattimo. In other words, I believe that all values and normative assumptions are situated, contested, and contextual rather than absolute. Not surprisingly, this means that I am less likely to sympathize with metaphysicians or those who adopt a deontological approach to ethics

(principle-based ethicists). However, this dissertation is limited in very specific ways to minimize the impact of bias on its methodology and conclusions.

First, the main objective is to demonstrate how religious normative assumptions are still embedded in secular culture. This makes the discourse analysis comparative and descriptive rather than prescriptive. Second, I will not be making claims as to which of the two competing paradigms—the sanctity of life or quality of life ethos—is inherently more valuable in any *universal* sense. Admittedly, no single principle can encapsulate all knowledge. Although the sanctity of life ethos does come under more scrutiny than the quality of life ethos, this is for sound methodological reasons. In the Canadian context—particularly, the 1990s—the *qualified* sanctity of life ethos was still the dominant paradigm of the time. It was this ethos—particularly its emphasis on absolute distinctions between acts of omission and commission—that elites wished to maintain as immutable. Therefore, when paradigms are viewed in absolutist terms (as metaphysics), I seek to understand how interested parties react whenever the authority of these positions is challenged by alternative realities, or what Vattimo terms “events of being.”

The research will show, however, that the *qualified* sanctity of life ethos was equally supported by the religious and secular alike. Surprisingly, there were even times when supporters of the quality of life ethos promoted a “secular absolute” without being aware of their own dependency on metaphysics. Therefore, by demonstrating “traces” of the Christian metaphysical tradition in so-called secular institutions and by highlighting the reality of secular absolutes, I hope to avoid two pitfalls: (1) an overt bias toward secularism; and (2) any omission of absolutist stances taken by quality of life advocates.

Previous Work in the Field

Over the past two decades, the research on death and dying, particularly in the areas of euthanasia and assisted suicide, has expanded greatly due to the competing value systems embraced by sanctity of life and quality of life advocates. Some researchers—most notably, Ramsey,²⁵ Amundsen,²⁶ Manning,²⁷ and Dyck²⁸—have defended the sanctity of life ethos using overt Christian normative assumptions, such as “the intrinsic value of human life,” the “transcendent meaning and purpose” of suffering, and the inherent social “risks” and “dangers” associated with decriminalization of euthanasia and/or assisted suicide. Cross-cultural studies, especially the works of Eastwell,²⁹ Lowy, Sawyer and Williams,³⁰ Baume, O’Malley and Bauman,³¹ Mullens,³² Kinsella and Verhoef,³³ and Long,³⁴ have also shown how religious beliefs, particularly Christian, shape the prohibition against an intentionally hastened death. Presently, however, the majority of researchers supporting the sanctity doctrine have become reactionary to the growing influence of the quality of life ethos in contemporary discourse. Causal links

²⁵ Paul Ramsey, *Ethics at the Edges of Life: Medical and Legal Implications* (New Haven: Yale University Press, 1978).

²⁶ Darrel W. Amundsen, “Suffering and the Sovereignty of God: One Evangelical’s Perspective on Doctor-Assisted Suicide,” *Christian Bioethics* 1, no. 3 (1995): 285–313.

²⁷ Michael Manning, *Euthanasia and Physician-Assisted Suicide: Killing or Caring?* (New York: Paulist Press, 1998).

²⁸ Arthur J. Dyck, *Life’s Worth: The Case against Assisted Suicide* (Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 2002).

²⁹ H. D. Eastwell, “The Forefather Needs No Fluids: Voodoo Death and Its Simulacra,” *American Anthropologist* 86, no. 1 (1984): 133–36.

³⁰ Frederick Lowy, Douglas M. Sawyer, and John R. Williams, “Canadian Physicians and Euthanasia: 4. Lessons from Experience,” *Can Med Assoc J* 148, no. 11 (1993): 1895–99.

³¹ Peter Baume, Emma O’Malley, and Adrian Bauman, “Professed Religious Affiliation and the Practice of Euthanasia,” *Journal of Medical Ethics* 21 (1995): 49–54.

³² Anne Mullens, “Of ‘Savages’ and ‘Saviours,’” in *Timely Death: Considering Our Last Rights* (Toronto: Alfred A. Knopf, 1996).

³³ T.D. Kinsella and M.J. Verhoef, “Determinants of Canadian Physicians’ Opinions about Legalized Physician-Assisted Suicide: A National Survey,” *The Annals of the Royal College of Physicians and Surgeons* 32, no. 4 (1999): 211–15.

³⁴ Susan Orpett Long, “Negotiating the ‘Good Death’: Japanese Ambivalence about New Ways to Die,” *Ethnology* 40, no. 4 (2004): 271–89.

have been made between decriminalization and the inevitability of the “slippery slope,” specifically problems associated with the Dutch medical model, Nazi eugenics, and the potential of abuse. The most vocal critics of the quality of life ethos are those who favour either principle-based ethics or liberal communitarianism (Doerflinger;³⁵ Kamisar;³⁶ Callahan;³⁷ Emanuel;³⁸ Smith;³⁹ Somerville;⁴⁰ Keown;⁴¹ Dowbiggin;⁴² Gorsuch;⁴³ Jones⁴⁴).

In contrast, others have criticized the sanctity of life ethos as untenable, claiming that Western medicine already sanctions an intentionally hastened death based on quality of life considerations. Researchers have highlighted legal exceptions to the prohibition against an intentionally hastened death, such as the use of terminal sedation, the omission of nutrition/hydration, the removal of life-support, and non-treatment decisions

³⁵ Richard Doerflinger, “Assisted-Suicide: Pro-Choice or Anti-Life?,” *Hastings Center Report* 19, no 1 (Jan./Feb. 1989): 16-19.

³⁶ Yale Kamisar, “Physician-Assisted Suicide: The Problems Presented by the Compelling, Heartwrenching Case,” *Journal of Criminal Law and Criminology* 88, no. 3 (1998): 1121-46; Yale Kamisar, “The Reasons So Many People Support Physician-Assisted Suicide – And Why These Reasons Are Not Convincing,” *Issues in Law & Medicine* 12, no. 2 (1996):113-31. For a more recent discussion of Kamisar’s influence, see Norman L. Cantor, “On Kamisar, Killing, and the Future of Physician-Assisted Death,” *Michigan Law Review* 102 (2004): 1793-1842.

³⁷ Daniel Callahan, *The Troubled Dream of Life: In Search of a Peaceful Death* (New York: Simon & Shuster, 1993).

³⁸ Ezekiel J. Emanuel, *The Ends of Human Life: Medical Ethics in a Liberal Polity* (Massachusetts: Harvard University Press, 1994).

³⁹ Wesley J. Smith, *Forced Exit: The Slippery Slope from Assisted Suicide to Legalized Murder* (New York: Random House, 1997).

⁴⁰ Margaret Somerville, *Death Talk: The Case against Euthanasia and Physician-Assisted Suicide* (Montreal and Kingston: McGill–Queen’s University Press, 2001).

⁴¹ John Keown, *Euthanasia Examined: Ethical, Clinical, and Legal Perspectives* (Cambridge: Cambridge University Press, 1995); also see John Keown, *Euthanasia, Ethics, and Public Policy: An Argument against Legalization* (New York: Cambridge University Press, 2002).

⁴² Ian Dowbiggin, *A Merciful End: The Euthanasia Movement in Modern America* (Oxford: Oxford University Press, 2003).

⁴³ Neil M. Gorsuch, *The Future of Assisted Suicide and Euthanasia* (Princeton: Princeton University Press, 2006).

⁴⁴ Robert P. Jones, *Liberalism’s Troubled Search for Equality: Religion and Cultural Bias in the Oregon Physician-Assisted Suicide Debates* (Notre Dame, Indiana: University of Notre Dame Press, 2007).

(Walton;⁴⁵ Kuhse;⁴⁶ Singer;⁴⁷ Orentlicher;⁴⁸ Downie⁴⁹). Exceptions to intentional killing have also been noted outside the medical context, namely the use of lethal injections for first-degree murderers and the killing of soldiers and civilians in a “just-war” (Spong;⁵⁰ Childress⁵¹). As well, the quality of life ethos has been promoted as beneficent and pragmatic because of its situational applications and respect for self-determination. This has been the fastest growing body of literature over the past three decades (Kluge;⁵² Rachels;⁵³ Humphry;⁵⁴ Kevorkian;⁵⁵ Quill;⁵⁶ Bernie and Rodriguez;⁵⁷ Beauchamp;⁵⁸ Leary;⁵⁹ Filene;⁶⁰ Colby;⁶¹ Schiavo and Hirsch⁶²).

⁴⁵ D. Walton, *On Defining Death: An Analytic Study of the Concept of Death in Philosophy and Medical Ethics* (Montreal: McGill-Queen's University Press, 1979).

⁴⁶ Helga Kuhse, *The Sanctity of Life Doctrine in Medicine: A Critique* (Oxford: Oxford University Press, 1987).

⁴⁷ Peter Singer, *Rethinking Life and Death: The Collapse of Our Traditional Ethics* (New York: St. Martin's Press, 1994).

⁴⁸ David Orentlicher, “The Supreme Court and Terminal Sedation: An Ethically Inferior Alternative to Physician-Assisted Suicide,” in *Physician-Assisted Suicide: Expanding the Debate*, edited by Margaret P. Battin et al. (New York: Routledge, 1998), 301–11.

⁴⁹ Jocelyn Downie, *Dying Justice: A Case for Decriminalizing Euthanasia & Assisted Suicide in Canada* (Toronto: University of Toronto Press, 2004).

⁵⁰ John Shelby Spong, “Death: A Friend to Be Welcomed, Not an Enemy to Be Defeated,” in *Physician-Assisted Dying: The Case for Palliative Care & Patient Choice*, edited by Timothy E. Quill and Margaret P. Battin (Baltimore: The John Hopkins University Press, 2004), 150–61.

⁵¹ James F. Childress, “Religious Viewpoints,” in *Regulating How We Die: The Ethical, Medical, and Legal Issues Surrounding Physician-Assisted Suicide*, edited by Linda L. Emanuel (Cambridge, Massachusetts: Harvard University Press, 1998), 120–47.

⁵² Eike-Henner W. Kluge, *The Ethics of Deliberate Death* (New York: Kennikat Press, 1981).

⁵³ J. Rachels, *The End of Life: Euthanasia and Morality* (New York: Oxford University Press, 1986).

⁵⁴ Derek Humphry, *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying* (New York: Random House, 1991).

⁵⁵ Jack Kevorkian, *Prescription: Medicide, the Goodness of Planned Death* (New York: Prometheus Books, 1991).

⁵⁶ Timothy E. Quill, *Death and Dignity: Making Choices and Taking Charge* (New York: W.W. Norton & Company, 1993).

⁵⁷ Lisa Hobbes Birnie and Sue Rodriguez, *Uncommon Will: The Death and Life of Sue Rodriguez* (Toronto: Macmillan Canada, 1994).

⁵⁸ Tom L. Beauchamp, ed., *Intending Death: The Ethics of Assisted Suicide and Euthanasia* (New Jersey: Prentice-Hall, 1996).

⁵⁹ Timothy Leary, *Design for Dying* (New York: HarperCollins Publishers, 1997).

⁶⁰ Peter G. Filene, *In the Arms of Others: A Cultural History of the Right-to-Die in America* (Chicago: Ivan R. Dee, 1998).

⁶¹ William H. Colby, *Long Goodbye: The Deaths of Nancy Cruzan* (Carlsbad, California: Hay House, 2002).

⁶² Michael Schiavo with Michael Hirsh, *Terri: The Truth* (New York: Penguin Books, 2006).

Organizations themselves have made both important contributions to the literature on death and dying, with a particular focus on debates involving the sanctity of life and quality of life ethos. The Law Reform Commission of Canada authorized five reports to discuss legal and ethical issues surrounding the intentional hastening of death, most notably *Sanctity of Life or Quality of Life in the Context of Ethics, Medicine and Law* (1979), *Euthanasia, Aiding Suicide and Cessation of Treatment*, better known as “Working Paper 28” (1982), and *Report on Euthanasia, Aiding Suicide and Cessation of Treatment* (1983).⁶³ In addition, the Canadian Medical Association established a forum for debating medical ethics in the *Canadian Medical Association Journal (CMAJ)*.⁶⁴ The archival material clearly demonstrates that 1988–1995 was the most contested period of debate among physicians. At this time, there was an explosion of discussion containing the fullest expression of what Canadian physicians were thinking and feeling about euthanasia and assisted suicide. Lastly, the Senate of Canada issued thirty-two reports from 1994 to 1995 (as well as a summary report) to bring together the most diverse views nationwide on euthanasia and assisted suicide.⁶⁵ Both religious and secular perspectives are given full recognition in these reports.

There is also a tendency among contemporary scholars to expand on the Vattimian perspective through the general fields of philosophy, hermeneutics, ethics, and

⁶³ Law Reform Commission of Canada, *Sanctity of Life or Quality of Life in the Context of Ethics, Medicine and Law*, Protection of Life Series by Edward W. Keyserlingk (Ottawa: Minister of Supply and Services Canada, 1979); *Euthanasia, Aiding Suicide and Cessation of Treatment* (Ottawa: Minister of Supply and Services Canada, 1982); *Report on Euthanasia, Aiding Suicide and Cessation of Treatment* (Ottawa: Minister of Supply and Services Canada, 1983).

⁶⁴ CMAJ archives are located on-line at <http://www.pubmedcentral.nih.gov/tocrender.fcgi?journal=77&action=archive>.

⁶⁵ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issues No. 1–32 (February 24, 1994–January 13, 1995); also see Senate of Canada, *Of Life and Death: Report of the Special Senate Committee on Euthanasia and Assisted Suicide*, Minister of Supply and Services Canada (May 1995).

anthropology. This is especially apparent in the works of Rorty,⁶⁶ Zabala,⁶⁷ Caputo,⁶⁸ and Girard.⁶⁹ However, one scholar specifically parallels my own work. Marta Frascati-Lochhead points out in *Kenosis and Feminist Theology: The Challenge of Gianni Vattimo* that the Vattimian perspective is complementary to feminist theory because the “unraveling of metaphysics and the unmasking of patriarchy are both concerned with not only emancipation but also with overcoming the violent closure of thought.”⁷⁰ As she states, one of the goals in feminist theology is “to strip traditional patriarchal theology of its metaphysical features, to reduce its violence, to bring about a transformation through the dissolution of patriarchal thought, through a kenosis of the male god.”⁷¹ Like Frascati-Lochhead, I will be applying the Vattimian perspective to a specific field, that being medical ethics. However, I will be using more applicable terms—namely, metaphysics, “event of being,” and passive-reactive nihilism—in order to elaborate on the following: (1) how Vattimo’s philosophical ethics exposes “traces” of the Christian metaphysical tradition within secular discourse; (2) how normative assumptions associated with this tradition are weakened by “events of being” (the lived experiences of the chronically/terminally ill); and (3) how metaphysicians create “masks” and “disguises” to prevent any weakening of the reigning absolute(s).

⁶⁶ Richard Rorty and Gianni Vattimo, *The Future of Religion*, edited by Santiago Zabala (New York: Columbia University Press, 2005).

⁶⁷ Santiago Zabala, ed., *Weakening Philosophy: Essays in Honour of Gianni Vattimo* (Montreal and Kingston: McGill–Queen’s University Press, 2007).

⁶⁸ John D. Caputo and Gianni Vattimo, *After the Death of God*, edited by Jeffrey W. Robbins (New York: Columbia University Press, 2007).

⁶⁹ Gianni Vattimo and René Girard, *Christianity, Truth, and Weakening Faith: A Dialogue* (New York: Columbia University Press, 2009).

⁷⁰ Marta Frascati-Lochhead, *Kenosis and Feminist Theology: The Challenge of Gianni Vattimo* (Albany: State University of New York Press, 1998), 3.

⁷¹ *Ibid.*, 7.

Contribution to Knowledge

This dissertation's contribution to knowledge differs from the efforts of previous scholars in that it highlights four distinct discourses surrounding the euthanasia/assisted suicide debate in Canada. First, instead of portraying "sanctity of life" and "quality of life" as a religious/secular polemic, I submit that religious and secular advocates of the sanctity doctrine react similarly in cases involving an intentionally hastened death. In other words, *both* the religious *and* the secular embrace metaphysics (absolute values, fixed principles), condone and rationalize the prolongation of suffering when faced with ontological difference, and use the "slippery slope" as a "mask" to maintain the sanctity of human life as absolute. This indicates that Canada is still significantly indebted to Christian notions when it comes to discussions involving an intentionally hastened death. Second, religious and secular lobbyists that supported the quality of life ethos also mirrored one another's rhetoric. Both emphasized subjective, self-determined choice, the relative value of human life, and the feasibility/flexibility of safeguards. Since these normative assumptions are fluid and contextual in nature, this indicates that postmodern sensibilities compete alongside metaphysical suppositions for space in the euthanasia/assisted suicide debate. Although less common, two other rhetorical patterns emerged. In rare instances, secular organizations adopted absolutist positions ("civil rights" discourse) involving the principles of "equality" or "autonomy." These values were deemed immutable by such groups, even if their universal application in legal matters contributed to prolonged suffering. Lastly, the rhetoric of "sanctity of life" and "quality of life" was sometimes interwoven, resulting in a hybrid of Christian/metaphysical and secular/postmodern positions.

Overall, the highlights/objectives of my dissertation are as follows: (1) to show that discussions surrounding the sanctity of life ethos expose religious/metaphysical biases within Canadian ethical, medical, legal, and political discourses; (2) to determine how these discourses converge to limit euthanasia and assisted suicide as death-hastening options; (3) to demonstrate that secular advocates of the sanctity of life ethos are not always aware of the doctrine's religious (Christian) origins; (4) to show that, in rare instances, quality of life advocates also fall back on absolutist positions; and (5) to establish that the sanctity of life ethos is entering a new phase—a post-Christian phase—with the weakening of the sanctity of life ethos as first principle. In general, Vattimo's philosophico-ethical approach can offer itself as a resource to the fields of ethics, medicine, law, and politics, helping organizations understand how moral absolutes—and the “events of being” challenging such absolutes—continue to influence policy.

Interested Parties

There are several academic fields that may find a Vattimian approach to the sanctity of life ethos of interest. Those studying sociological approaches to religion, especially the works of Émile Durkheim, will find that his research complements Vattimo's philosophical ethics. An essential claim made by Durkheim in *The Elementary Forms of Religious Life* was that not only do “collective ideas and practices invariably acquire a religious character,” but social institutions are also religious in character, that is, “they possess collective beliefs, values, and practices that profoundly shape moral identities.”⁷² One could argue that, from a Durkheimian perspective, “sanctity of life”

⁷² Émile Durkheim, *The Elementary Forms of Religious Life*, translated by Carol Cosman (New York: Oxford University Press, 2001), xii, xiii, 314. Durkheim hypothesized that religion becomes a set of beliefs

(and the normative assumptions surrounding it) is a religious paradigm that promotes collective Christian values—namely, stewardship, meaning in prolonged suffering, and the “slippery slope”—and that these beliefs shape the moral identity of secular institutions as well.

Those familiar with Peter Berger’s work may also find connections between his sociological theory of religion and a Vattimian analysis of the sanctity of life ethos. In Berger’s *The Sacred Canopy*, religion is a coherent system of beliefs that provide security, shelter, and meaning for the community. The collective manifests itself by its “coercive power,” meaning that “[t]he final test of its [society’s] objective power is its capacity to impose itself upon the reluctance of individuals.”⁷³ To maintain this collective “canopy,” society “directs, sanctions, controls, and punishes individual conduct” not in alignment with societal goals.⁷⁴ The purpose of such social control is to “‘bring back into line’ recalcitrant individuals or groups” using political or legal institutions.⁷⁵ Because religion as a social construction aids in the ordering of experience, Berger insists that “a meaningful order, or *nomos*, is imposed upon the discrete experiences and meanings of individuals.”⁷⁶ From a Vattimian perspective, religious normative assumptions that provide structure, identity, and a shared sense of meaning also reinforce and legitimate metaphysics (immutable, eternal values).

and practices by which society represents *itself to itself*; consequently, religion is a concept in which divinity and society become one, and God (or a divinity) becomes a figurative expression of society. In terms of his thesis surrounding totemism, Durkheim stated: “If the totem is both the symbol of god and of society, are these not one and the same? . . . The god of the clan . . . must therefore be the clan itself, but transfigured and imagined in the physical form of the plant or animal species that serve as totems” (154).

⁷³ Peter L. Berger, *The Sacred Canopy: Elements of a Sociological Theory of Religion* (New York: Anchor Books, 1990), 11.

⁷⁴ Ibid.

⁷⁵ Ibid.

⁷⁶ Ibid., 19.

Those who appreciate the anthropological approach of René Girard will also relate to this dissertation. Girard's thesis outlines the necessity to locate scapegoats during a community-wide dilemma, something that involves "the persecution of innocent victims, who are expelled, scapegoated, and victimized most intensely at moments of crisis."⁷⁷ In his seminal work, *The Scapegoat*, the persecutors always convince themselves that a "small number of people, or even a single individual, despite his relative weakness, is extremely harmful to the whole of society."⁷⁸ The predicament for any community is that it does not hold a monopoly on truth; hence, the scapegoat's "ontological difference" is a constant reminder of this fact.⁷⁹ The scapegoat is sacrificed, s/he dies for "our sins" (read: our religiously understood need to maintain communal values), and what is sacred is maintained. The profane is gone—driven from the community—and the victim's sacrifice prevents further weakening of the reigning metaphysic. For the purposes of this dissertation, the need to prolong individual suffering in the hopes of protecting society from the "slippery slope" is consistent with Girard's thesis surrounding the scapegoat.

Those working in philosophical ethics may also find a direct link between the Vattimian concept of metaphysics—a belief in absolute values—and nihilism. Although nihilism is often thought synonymous with having "no authentic values, no real ends,"⁸⁰ it is actually a much more complex concept. In its earliest European roots, nihilism was initially used as a form of labelling. If modern trends threatened to weaken

⁷⁷ Vattimo and Girard, *Christianity, Truth and Weakening Faith: A Dialogue*, 7.

⁷⁸ René Girard, *The Scapegoat*, translated by Yvonne Freccero (Baltimore: The John Hopkins University Press, 1986), 15.

⁷⁹ Vattimo and Girard, *Christianity, Truth and Weakening Faith: A Dialogue*, 96.

⁸⁰ Meerten B. ter Borg, "The Problem of Nihilism: A Sociological Approach," *Sociological Analysis* 49, no. 1 (Spring, 1988): 2.

metaphysics—either Christian hegemonic principles or tradition in general—labelling would be used to create a status of inferiority for the newcomers.⁸¹ This is because, as Meerten B. ter Borg explains, traditionalists typically have a stake in their own normative positions: “The absoluteness of the form of life [one supports] makes people feel safe and at home. This means that all people in it have a great interest in the maintenance of their form of life and its absoluteness.”⁸² The existence of alternative beliefs or values, or “ontological difference,” is both a challenge and a threat to the traditionalist because it shows people that “their own form of life is not as absolute as they thought it was, and this makes them feel uncertain. . . . What begins as the challenge to an alternative may end as the destruction of the original form of life.”⁸³ Through the effect of labelling, religious traditionalists could claim that modernists (nihilists) “would not feel bound by moral norms,” and as a result would “lose the sense that life has meaning and therefore tend toward despair and suicide.”⁸⁴ Similarly, within my analysis of discourse, alternative normative assumptions that could potentially weaken or challenge the sanctity of life

⁸¹ Ibid. During the seventeenth and eighteenth centuries, ter Borg notes, modernization in France meant that power shifted from the traditional feudal nobility to a central government filled with well-trained bourgeois professionals. Nobility was said to counterbalance royal power, which would become despotic if not kept in check. If power shifted to responsible government, the nobility claimed that such centralization would lead to death and destruction—in other words, anarchy and *nothingness*. Those upsetting the status quo were deemed nihilistic, a derogatory label requiring no serious burden of proof.

⁸² Ibid., 12.

⁸³ Ibid.

⁸⁴ Paul Edwards, ed., “Nihilism,” *The Encyclopedia of Philosophy* vol. 5–6 (New York: MacMillan Publishing Co., Inc. and The Free Press, 1967), 515. Edwards notes the infamous words Dostoyevsky put into Ivan’s mouth in *The Brothers Karamazov*: “If God does not exist, everything is permitted.” In actuality, this has often led to a misleading portrayal of nihilism. Not everything could be permitted; in fact, nihilists still lived according to temporal value judgements, social norms, or foundations of one kind or another. In Ivan Turgenev’s highly acclaimed novel *Fathers and Sons*, the central character, Bazarov, acquired a “disdain for tradition and authority, great faith in reason, commitment to a materialist philosophy . . . and an ardent desire to see radical changes in contemporary society.” Moreover, real-life Russian nihilist Dimitri Pisarev developed his own nihilistic ultimatum, one that did not reject all values but only those that no longer worked: “[W]hat can be smashed should be smashed; what will stand the blow is good; what will fly into smithereens is rubbish; at any rate, hit out right and left—there will and can be no harm from it.”

ethos were consistently labelled as a “danger” or “risk” to the community (of little or no value).

Nietzschean scholars may also find this dissertation of some benefit. Nietzschean perspectivism was less about values and more about a condition of human existence, a kind of despair over the fact that our highest values could not be realized, resulting in the death of God (absolute values).⁸⁵ What Nietzsche rejected was the belief that one could create a totalizing system to explain all truths. In fact, he repudiated any philosophical ambition or dogmatic proselytizing that attempted to show “how the entire body of knowledge [could] be derived from a small set of fundamental, self-evident propositions.”⁸⁶ This implies that one live according to a constant reevaluation of values. By taking full responsibility for this task, humankind engages in the “eternal recurrence”—a recurrence of life-affirming values based on acceptance of *becoming* and the *impermanence of values*.⁸⁷ Throughout my dissertation, Vattimian postmodernists will present competing normative assumptions, ones that challenge the sanctity of life as first principle, in an attempt to highlight the contingencies surrounding cases of death and dying. It is this tension between metaphysicians (maintaining the reigning table of values) and postmodernists (creating a new table of values) that is at the heart of the euthanasia/assisted suicide controversy in Canada.

Lastly, theorists of multiculturalism will find connections between their own research interests and the subject matter contained in this dissertation, especially the relationship between multiculturalism and postmodernism. For example, Charles

⁸⁵ Gianni Vattimo, *The End of Modernity* (Baltimore: Johns Hopkins University Press, 1988), 20.

⁸⁶ Bernard Reginster, *The Affirmation of Life: Nietzsche on Overcoming Nihilism* (Cambridge, Massachusetts: Harvard University Press, 2006), 3.

⁸⁷ *Ibid.*, 14–15.

Taylor's "politics of difference" implies that a person's identity is fundamentally a defining characteristic of a human being. Therefore, ostracizing or silencing an identity is to limit the potential of citizenship. States Taylor:

. . . [O]ur identity is partly shaped by recognition or its absence, often by the *misrecognition* of others, and so a person or group of people can suffer real damage, real distortion, if the people or society around them mirror back to them a confining or demeaning or contemptible picture of themselves. Nonrecognition or misrecognition can inflict harm, can be a form of oppression, imprisoning someone in a false, distorted, and reduced mode of being.⁸⁸

As with Vattimo, Taylor believes that to distort another's identity is not just disrespectful. It is, in actuality, a form of violence: "[M]isrecognition . . . can inflict a grievous wound, saddling its victims with crippling self-hatred. Due recognition is not just a courtesy we owe people. It is a vital human need."⁸⁹ This Taylorian emphasis on individual identity is at the heart of the arguments presented by quality of life advocates who insist that end-of-life decisions are a subjective, personal matter that cannot be decided collectively.

As with Taylor's "politics of difference," Tariq Modood's theory of "multicultural citizenship" emphasizes "a respect for identities that are important to people."⁹⁰ In fact, minority difference is a gift given to the majority to facilitate a clearer understanding of alternative identities. Admits Modood:

Minorities can be bearers of distinctive knowledge. They are a primary source about the marginalization and discrimination they experience . . . They have a take on their societies that the majority does not experience and so offers to the majority a very different perspective on their shared society, its institutions, discourses, and self-image. They hold a critical mirror to that society. They are also likely to have sensibilities, ways of thinking and living, heritages they can call upon to widen the pool of available experience and wisdom.⁹¹

⁸⁸ Charles Taylor, "The Politics of Recognition," in *Multiculturalism*, edited by Amy Gutmann (Princeton, New Jersey: Princeton University Press, 1994), 25.

⁸⁹ *Ibid.*, 26.

⁹⁰ Tariq Modood, *Multiculturalism* (Cambridge, UK: Polity Press, 2007), 37.

⁹¹ *Ibid.*, 64–65.

Modood also acknowledges the fluid character of identity and, hence, its link to postmodern pluralism: “[T]here is considerable internal diversity [of identity], overlap between members of so-called different groups and that not only do individuals belong to more than one group but different groups will be salient in different contexts.”⁹² This is why multiculturalism constantly celebrates the presence of diverse cultures because it “challenges either the fact or the value of a single culture” or “the unlikelihood of a single culture realizing every conceivable good.”⁹³ The fluid nature of Modood’s “multicultural citizenship” is closely associated with Vattimo’s concept of “weak thought” (the rejection of objective, given structures) since both make room for subjective identity formation.

Like Modood, William Connolly supports engagement by favouring a “bicameral orientation to citizenship.” This implies “keeping a foot in two worlds, straddling two or more perspectives to maintain tension between them.”⁹⁴ As a derivative of Connollyian bicameralism, the idea of “agonistic respect” entails a two-step process: (1) one must absorb the agony of having elements of one’s faith called into question; and (2) one must fold others’ contestations into a respect for them and their influence on one’s evolving faith.⁹⁵ Thus, Connolly elaborates on the impact of adopting a more flexible model for belief: “You sacrifice the demand for the unquestioned hegemony of your faith to curtail the occasions when its defense calls upon you to impose otherwise unnecessary violence or suffering on others.”⁹⁶ Hence, both Connolly and Vattimo note the connection

⁹² Ibid., 92.

⁹³ Rajeev Bhargava et al., eds., *Multiculturalism, Liberalism, and Democracy* (New Delhi: Oxford University Press, 2008), 4.

⁹⁴ William Connolly, *Pluralism* (Durham and London: Duke University Press, 2005), 3–4.

⁹⁵ Ibid., 123–24.

⁹⁶ Ibid., 33.

between metaphysics and violence in that a defence of immutable principles, and the singularity of identity it produces, inevitably lead to the “metaphysics of pain.”⁹⁷

Chapter Summaries

Chapter I provides an overview of the Vattimian philosophical perspective, beginning with a brief depiction of Vattimo’s life experiences. Specific personal events were instrumental in shaping his postmodern sensibilities, so these unique encounters deserve some mention. This will help address the question, “Who is Gianni Vattimo?” Second, Vattimo’s key philosophical terms will also be examined in detail. These will provide a clearer understanding of his *nihilistic* philosophy, an approach that rejects any notion of eternal principles or absolute values. Lastly, Vattimo’s influence on the dissertation’s thesis will be explained by selecting key themes central to his philosophical perspective. These concepts will help clarify how the Vattimian theoretical approach expands on the death and dying debate in Canada, specifically the controversy surrounding euthanasia and assisted suicide.

Chapter II deals with global trends in medical ethics and emphasizes shifting cultural attitudes toward euthanasia, assisted suicide, and cessation of treatment. Highlighted will be the policies and/or laws of various countries/states in the post-World War II era that dealt with the intentional hastening of death and how legislation changed over time and context. The paradigmatic shift from vitalism (preserving human life at all costs) to the *qualified* sanctity of life ethos (maintaining an absolute distinction between acts of omission and commission) was not a smooth transition. For instance, in the state

⁹⁷ See Chapter I for a more detailed explanation of Vattimo’s link between metaphysics and violence.

of Missouri in the 1980s, the case of Nancy Cruzan demonstrated that initially not all acts of omission were permissible. The removal of a respirator was considered a type of medical treatment and, therefore, legal; however, removing nutrition/hydration was considered illegal. By the 1990s, however, Missouri no longer prohibited these forms of omission, even if such methods hastened the patient's death. Moreover, in terms of applying the quality of life ethos to medical ethics, various jurisdictions drew the boundaries for an intentionally hastened death at different points. While Holland officially legalized both euthanasia and physician-assisted suicide in 2002, the state of Oregon only allowed the latter method of death-hastening. Australia sanctioned euthanasia and physician-assisted suicide for a brief period of time in 1996, only to prohibit both acts less than a year later. The Swiss allowed physician-assisted suicide for tourists, a policy Oregonians rejected. Canada, on the other hand, has never legalized acts of commission that intentionally hasten death. Overall, cultural, historical, political, and religious differences have greatly influenced which nations embraced which ethos—sanctity of life or quality of life—and to what degree.

Chapter III examines ethical discourse relating to an intentionally hastened death in Canada. Using reports issued by the *Special Senate Committee on Euthanasia and Assisted Suicide*, a comparison was made between religious bodies/individuals supporting the sanctity of life as first principle (almost exclusively Christian testimonials) and the discourses of ethicists/bioethicists from secular institutions. Whenever the possible decriminalization of euthanasia and assisted suicide was discussed, *both* the religious *and* the secular consistently emphasized the rhetoric of stewardship, value in prolonged suffering, and the “slippery slope” to buttress their support for prohibition. The discourse

of religious and secular organizations/individuals in support of decriminalization likewise had much in common. As advocates of the quality of life ethos, their rhetoric entailed self-determination, the relative value of human life, and the feasibility/flexibility of safeguards.

Chapter IV deals with medicine's rejection of an intentionally hastened death in Canada. The discourse of physicians and other medical professionals was analyzed by examining the archives of the Canadian Medical Association (CMA) as well as witness testimony from the above-mentioned Senate reports. Initially, a brief history of the CMA is provided to demonstrate Vattimo's concept of "history as eventuation." The CMA never relied on fixed principles but changed with the "sentiments of the world" as new "events of being" emerged. This historical overview will be followed by an examination of the attitudes of physicians from 1988–1995 who supported either the sanctity of life or quality of life ethos. Since this was the most controversial period in Canadian history involving euthanasia and assisted suicide, the normative assumptions of metaphysicians were most pronounced in this time period. The chapter ends with a discourse analysis of the attitudes of hospice/palliative care workers as well as representatives from major health care institutions from 1994-95. As with ethical discourse, the difference in normative assumptions between metaphysicians (sanctity of life advocates) and Vattimian postmodernists (quality of life supporters) was quite striking. Medical practitioners in support of prohibition resisted any weakening of the sanctity doctrine as well as any tempering of absolute moral distinctions between acts of omission and commission. They feared that, if Canada permitted an intentionally hastened death, "vulnerable populations" would be at risk. In opposition, medical professionals

attempting to modernize Canada's laws viewed the acceptance of an intentionally hastened death from what I term a Vattimian postmodernist perspective—in other words, as another example of the historical eventuation of being.

Chapter V discusses how the law in Canada adopted a “middle path” for death-hastening practices. Although Canadian law clearly rejects vitalism, neither does it condone the quality of life ethos. The *qualified* sanctity of life ethos—a paradigm that sanctions acts of omission (e.g., cessation of treatment) but not acts of commission (e.g., euthanasia or assisted suicide)—became an acceptable compromise. This is evident by examining the discourse of the Law Reform Commission from 1976 to 1986 as well as those court cases in which the prohibition against an intentionally hastened death was considered constitutional (i.e., Sue Rodriguez and Robert Latimer). In terms of the court proceedings, justices, attorney generals, and interveners that supported the sanctity of life ethos promoted stewardship, value in prolonged suffering, and the “slippery slope” as authorizing discourses. Those who adopted a “quality of life” ethic, especially Rodriguez and Latimer, gravitated toward one or more of the following normative positions: self-determination, the relative value of human life, and the feasibility/flexibility of safeguards to ward off the possibility of abuse. However, in rare instances, those who adopted a quality of life ethic were also, in a sense, metaphysicians. In these situations, euthanasia or assisted suicide could not be supported because an intentionally hastened death was not available to others (absolute equality demanded) or because the afflicted could not provide consent (absolute autonomy demanded).

Chapter VI discusses the political landscape in Canada from 1991 to 2005. A discourse analysis clearly demonstrates that metaphysics is a centre-right phenomenon.

Liberals, Progressive Conservatives, and members of the Conservative Party/Reform Party of Canada used the same normative assumptions as other religious and secular advocates of the sanctity of life ethos: life possessed “infinite value,” prolonged suffering acquired some “transcendent meaning,” and the community was at risk from the “slippery slope.” As a result, politicians of the centre-right would not vote for any bill/motion that potentially weakened the sanctity doctrine. Killing was wrong without exception, and only a principle-based approach to ethics and law was permissible. However, those clearly on the left of the political spectrum—the New Democrats and the Bloc Québécois—adopted a postmodern position on euthanasia and assisted suicide. Autonomy rights, the need to relinquish suffering, and flexible safeguards trumped the “objective” values of metaphysicians. What is interesting in this section is the fact that all three paradigms—vitalism, the *qualified* sanctity of life ethos, and the quality of life ethos—were supported in some manner. Even vitalism had not completely left the mindset of Canadian politicians in this time period. It should also be noted that for some politicians, rhetoric surrounding “sanctity of life” and “quality of life” merged to form a hybrid of both philosophico-ethical stances.

Chapter VII provides an analysis of discourse. Two particular claims made by sanctity of life advocates will be challenged in this section. First, metaphysicians—particularly medical practitioners—asserted that a “slippery slope” in the form of Dutch medical “abuses” and a return to Nazi eugenics principles was inevitable if Canada decriminalized euthanasia and assisted suicide. The data—both quantitative and qualitative—suggests otherwise. In times of moral crisis, doctors—like any group of people—fall back on faith positions rather than rely on available evidence. Second,

moral distinctions were deemed absolute. More specifically, acts of commission, such as euthanasia and assisted suicide, were thought to “intentionally hasten death”; whereas, acts of omission were seen as “nature taking its course.” I assert that not only is such a distinction argumentative, but that in the case of Nancy B., full disclosure of mechanical and scientific causation is “masked” in order to preserve the core of the sanctity of life ethos, that being the absolute prohibition against an intentionally hastened death. From a Vattimian perspective, using “masks” or “disguises” to maintain the reigning metaphysic is a form of negative nihilism (passive-reactive). It is important to reiterate: metaphysicians behave nihilistically whenever full disclosure of evidence is cloaked or competing interpretations are decentred by the use of such “disguises.” This chapter not only reveals how the Dutch medical community’s normative assumptions differ from those of Canadian physicians, but also provides evidence that suggests that religious motives undergird the prohibitionist stance.

The dissertation’s conclusion will summarize how the Vattimian perspective—particularly, the application of metaphysics, “event of being,” and passive-reactive nihilism—applies specifically to an analysis of discourse surrounding euthanasia and assisted suicide in Canada. This will be followed by a discussion of the limitations, challenges, and potentialities of Vattimo’s philosophical ethics in a post-Christian world.

Chapter I: The Vattimian Perspective

Vattimo: The Personal Is Political

Gianni Vattimo was born on January 4th, 1936, in Turin, Italy. He witnessed first-hand the violence of metaphysics, or absolutist beliefs, by the Nazi regime and the destruction of his home by bombardments during the Second World War. In the post-World War II era, Catholic education and practice dominated the experiences of his youth. By the end of high school, he had become the diocesan representative of the Student Movement's Catholic Action Group. It was at this point, however, that Vattimo sensed something too dogmatic in the Church's educational system. His distrust of the Church was amplified by its rigid anticommunist ideology, a position which stood more and more in opposition to his progressive, left-wing attitudes. Although he rejected authoritarian forms of communism, Vattimo felt that Christian socialist principles would help to rectify social justice issues. This, he hoped, would result in a democratic shift toward the left in Italian politics. Vattimo eventually combined his interests in religion and politics by embracing "weakening philosophy," a postmodernist approach to metaphysics in which all absolutist systems and perspectives were deemed suspect.¹

Vattimo also gravitated toward controversial social issues, or "events of being," that challenged the reigning orthodoxy. As a gay male in post-World War II Italy, Vattimo noted how a hustler once threatened to blackmail him over his homosexuality,² a tactic that left those closeted vulnerable to the whims of the blackmailer.³ Because of the

¹ Santiago Zabala, ed., *Weakening Philosophy: Essays in Honour of Gianni Vattimo*, 4-6.

² Gianni Vattimo with Piergiorgio Paterlini, *Not Being God: A Collaborative Biography*, 56.

³ In the post-World War II era in the West, the law against homosexual acts (sodomy) contributed to indefinite prison sentences, job dismissals, and the possibility of being "outed" as a communist sympathizer. These sanctions made homosexuals, particularly males, easy targets for blackmail. For more

pressure to conform to heterosexual, religious, and communal normative assumptions, Vattimo had internalized the guilt homosexual men feel after a furtive sexual encounter.⁴ It was in this context—as a stigmatized minority—that Vattimo began to act in defence of the oppressed. On one occasion, he stopped the police from beating up a “rent boy” (hustler). Not only was Vattimo himself assaulted for the interruption, but his heroics created a suspicion as to why a “reputable university teacher” would come to the defence of so-called deviants. He ended up in police files after the incident.⁵ Because of the stigma placed on homosexuality, Vattimo began to recognize the impact of legal moralism⁶ on those who fell outside society’s normative boundaries. Consequently, incidents such as these contributed to his eventual rejection of all universal “natural” laws.

His non-absolutist stance on other social issues placed Vattimo clearly on the political left. Ironically, he even upset left-wing members of the European Parliament by defending prostitution, viewing the issue from a practical and relativist standpoint. For those who chose to practise it, Vattimo asserted that it was “a trade like any other,” that “some prostitutes were trying to form a union,” and that “society ought to defend them

details, see British Medical Association Council, *Homosexuality and Prostitution: A Memorandum of Evidence/Prepared by a Special Committee of the Council of the British Medical Association for Submission to the Departmental Committee on Homosexuality and Prostitution* (London: British Medical Association, 1955), 37–38; also see Great Britain, *Committee on Homosexual Offences and Prostitution: The Wolfenden Report* (New York: Stein and Day, 1963); John D’Emilio and Estelle B. Freedman, *Intimate Matters* (New York: Harper & Row, 1988), 292–93.

⁴ Vattimo with Paterlini, *Not Being God: A Collaborative Biography*, 58.

⁵ *Ibid.*, 59.

⁶ Legal moralism involves two criteria. First, if a common morality is shared by the majority, this alone is sufficient to include it in the criminal law. Second, because a common morality holds society together, legal moralism is justified on the grounds of “self-preservation,” meaning that a “slippery slope” in the form of danger and/or risk to the community is inevitable unless a common morality is imposed. See Dan E. Beauchamp, “Morality and the Health of the Body Politic,” in *The AIDS Reader: Social Political Ethical Issues*, edited by Nancy F. McKenzie (New York: Meridian, 1991), 408–21.

instead of leaving them in the clutches of the Mafia.”⁷ Moreover, Vattimo acknowledged that when Catholic orthodoxy adopted a sacrificial stance—for instance, an absolute prohibition against abortion, divorce, and embryonic stem cell research—it was simply perpetuating violence.⁸ His support for gender equality also included the ordination of women as priests. According to Vattimo, the Catholic restriction in this area did not represent some universal truth but was simply a creation of “historical circumstance.”⁹

However, it is only recently (2009–10) that Vattimo has taken any official position on the topic of euthanasia. Once again, his leftist bias is clear in this regard. He not only rejects immutable precepts—even when killing is involved—but also views such rigidity as an unnecessary restriction on human freedom: “I do not believe in the absoluteness of the principle of not killing. Faced with a person who is suffering greatly and who asks me to assist him with euthanasia . . . the one thing I must not violate is his liberty, by which I mean his soul, not his physical life.”¹⁰ Because of his affinity for individual autonomy over communalism, Vattimo became an advocate for the right to intentionally hasten one’s own death. He clearly distinguishes such an act from the domination and control associated with absolute foundations: “I am not entirely convinced that violence and killing amount to the same thing because I am a defender of euthanasia, for example. Violence for me is rather an act of imposition on the other and

⁷ Vattimo with Paterlini, *Not Being God: A Collaborative Biography*, 142. Some studies have indicated that a link exists between one’s moral ideology, the rejection of prostitution, and the creation of restrictive public policy. Ironically, political adversaries on the left and right that would normally disagree on social issues, such as feminists and evangelicals, will co-operate by lobbying against legislative attempts to legalize prostitution. See Ronald Weitzer, “The Mythology of Prostitution: Advocacy Research and Public Policy,” *Sex Res Soc Policy* 7 (2010): 15–29; also see Ronald Weitzer, “The Social Construction of Sex Trafficking: Ideology and Institutionalization of a Moral Crusade,” *Politics & Society* 35 (2007): 447–75.

⁸ Gianni Vattimo and René Girard, *Christianity, Truth, and Weakening Faith: A Dialogue*, 29.

⁹ *Ibid.*, 41.

¹⁰ *Ibid.*, 56.

her liberty.¹¹ It is not surprising that in his collaborative autobiography, *Not Being God*, Vattimo has been described as the philosopher “who has fought all his life against the confines of object-ivity and the absolutes that imprison us.”¹² The philosopher has consistently rallied against all claims of fixed principles and eternal values since these “translate into political oppression and oppression of conscience.”¹³

Vattimo’s Central Themes

It is this sense of “strong structures”—the immutability of any first principle—that Vattimo refers to as *metaphysics*, a key concept in the understanding of his philosophical perspective. Vattimo holds that “[w]herever there is an absolute . . . metaphysics is always present in the form of a supreme principle. . . .”¹⁴ He dismisses any claim by metaphysicians that one can “grasp an ultimate foundation of reality in the form of an objective structure located outside of time and history.”¹⁵ Truths, therefore, are always contested, situational, and interpretative. Siding with Martin Heidegger, Vattimo denies the existence of any “stable, objective, structural conception of Being,” adding: “Being cannot be thought in terms of objectivistic metaphysics.”¹⁶ In terms of its regulative function, metaphysics is characterized by Vattimo as normatively asymmetrical because it seeks to “master reality at a stroke, grasping . . . the first principle on which all things depend (and thus giving itself an empty guarantee of power over events).”¹⁷ Because absolute truths do not conform to the pluralistic reality of

¹¹ Ibid., 45.

¹² Vattimo with Paterlini, xi.

¹³ Ibid., 153.

¹⁴ Gianni Vattimo, *After Christianity* (New York: Columbia University Press, 2002), 3.

¹⁵ Vattimo with Paterlini, 19.

¹⁶ Ibid.

¹⁷ Gianni Vattimo, *The Transparent Society*, 8.

earthly existence, Vattimo contends that the idea of metaphysics “does not ‘apply’ to a particular human mode of being.”¹⁸ Since human beings are not gods and, therefore, not privy to totalizing knowledge, Vattimo argues that “[i]t is illusory to think that there exists a supreme or comprehensive viewpoint capable of unifying all others.”¹⁹

Vattimo believes that, as a philosopher, he is obligated to posit alternatives to the metaphysical tradition. Citing Santiago Zabala in *The Future of Religion*, Vattimo agrees that “[w]henver there is an authority that, in the guise of a scientific or ecclesiastical community, imposes something as objective truth, philosophy has the obligation to proceed in the opposite direction: to show that truth is never objectivity but always interpersonal dialogue that takes effect in the sharing of a language.”²⁰ This is why in *The Responsibility of the Philosopher* Vattimo rejects the notion that philosophy should be reduced to the “fixed methods, cumulative results, and repeatable experiments” associated with science.²¹ Instead, Vattimo promotes the idea that philosophy is “a discourse more edifying than demonstrative, it is oriented more toward the edification [enlightenment] of humanity than toward enhanced formal comprehension and advancement in knowledge.”²² Vattimo began studying philosophy not to yield “objective knowledge” in the metaphysical sense, but “to transform humanity” through a “program of emancipation.”²³

If, however, metaphysics is antithetical to human freedom, it is important to inquire into its staying power. Vattimo ponders this question with reference to

¹⁸ Gianni Vattimo, *The Adventure of Difference*, translated by Cyprian Blamires with the assistance of Thomas Harrison (Cambridge, U.K.: Polity Press, 1993), 62.

¹⁹ Vattimo, *The Transparent Society*, 3.

²⁰ Richard Rorty and Gianni Vattimo, *The Future of Religion*, 8; also see Vattimo with Paterlini, 110.

²¹ Gianni Vattimo, *The Responsibility of the Philosopher*, edited by Franca D’Agostini (New York: Columbia University Press, 2010), 47.

²² *Ibid.*, 62–63.

²³ *Ibid.*, 105.

Heidegger: “[I]f neither Dasein [human existence] nor being-in-the-world are thinkable under the category of objectivity and pure presence, then ‘why does Being . . . always keep coming back to exercise its dominion?’”²⁴ This resurrection occurs because of society’s desire for strong structures, a dilemma that concerns Vattimo. Paraphrasing Nietzsche, he reminds us that the death of God has to be “lived out as the death of the very notion of [absolute] truth itself, otherwise our enslavement to some supreme value or other would never cease: God would only have changed his name, the oppressive effects of the domination would live on.”²⁵ However, Vattimo adds that there is always a temptation to fall back into the “myth of the real,” what Heidegger refers to as “the fall back into metaphysics.”²⁶ Certainty is re-established because metaphysicians refuse to acknowledge the crumbling of supreme values. Vattimo elaborates: “[W]e have faced up to the absence of [absolute] foundations but have not rid ourselves of our grief at the loss we have suffered, and nostalgia for full Being continues to dominate us.”²⁷

Vattimo is also forthright about the link between metaphysics and violence. He claims that this connection becomes more visible once people have to deal with “incommensurable paradigms, or outlooks that differ profoundly from one another.”²⁸ Vattimo insists that through the temporal articulation of experience one cannot arrive at an ultimate conclusion without resorting to some sort of totalitarian edict. Metaphysics, therefore, “must be imposed because it constitutes finality attained.”²⁹ Vattimo accepts the arguments forwarded by Nietzsche and Heidegger in that the metaphysical tradition

²⁴ Vattimo, *The Adventure of Difference*, 64.

²⁵ Gianni Vattimo, *Nihilism and Emancipation: Ethics, Politics, and Law* (New York: Columbia University Press, 2003), 54.

²⁶ Vattimo with Paterlini, 157.

²⁷ Gianni Vattimo, *Nihilism and Emancipation: Ethics, Politics, and Law*, 140.

²⁸ Franca D’Agostini, ed., in Gianni Vattimo, *The Responsibility of the Philosopher*, 3.

²⁹ *Ibid.*, 61.

tends toward violent thinking: “With its predilection for unifying, sovereign and generalizing categories . . . it manifests a fundamental insecurity and exaggerated self-importance from which it then reacts into overdefensiveness.”³⁰ Seeking to monopolize truth, metaphysics becomes both the cause of, and the symbol for, suffering. This is why Vattimo asserts that “pain is the very essence of metaphysics, that there is no metaphysics except the metaphysics of pain. . . .”³¹ Whenever any claim to *the* truth is made, this peremptoriness of Being manifests the violent essence of metaphysics. In other words, “If Being *is*, that is, Being gives itself in objectivity and immutability, then everyone must be silent in front of such evidence.”³² In general, Vattimo targets metaphysics as the main source of hardship and affliction: “[I]t’s absolute certainties that have got us where we are now, speaking of tragedies. So let’s get rid of them altogether, these [absolute] truths!”³³

His critique is particularly directed toward forms of communal violence. Borrowing from the Girardian anthropological perspective, Vattimo notes how a communalist metaphysic can result in “the persecution of innocent victims, who are expelled, scapegoated, and victimized most intensely at moments of crisis.”³⁴

³⁰ Vattimo, *The Adventure of Difference*, 5.

³¹ Vattimo, *Nihilism and Emancipation: Ethics, Politics, and Law*, 71.

³² Edison Higuera in Silvia Benso and Brian Schroeder, eds., *Between Nihilism and Politics: The Hermeneutics of Gianni Vattimo* (Albany: SUNY Press, 2010), 105. The violence often associated with “objective” Being has also been a topic of discussion in cultural studies. Amartya Sen warns of the “illusion of singularity,” acknowledging that this kind of theoretical reductionism is a major contributor to sectarian religious and political strife. This is because “singularity has the effect of momentarily impoverishing the power and reach of our social and political reasoning.” See Amartya Sen, *Identity & Violence: The Illusion of Destiny* (Toronto: Penguin Group, 2006), xv–xvi.

³³ Gianni Vattimo and René Girard, *Christianity, Truth, and Weakening Faith: A Dialogue*, 42.

³⁴ *Ibid.*, 7. Girard also notes that scapegoating starts with collective persecutions, meaning acts of violence committed directly by a mob, or the crowd, such as the persecution of the Jews during the Black Death or witches during the Salem witch hunts. Such persecutions generally take place during times of crisis or moral panic because there is a perceived weakening of social institutions. Mob formation results from this feeling of social instability. According to Girard, difference that exists outside the system appears “terrifying because it reveals the truth of the system, its relativity, its fragility, and its mortality.” The

Communities seek to marginalize those acts that contravene established norms, judging deviance as a “dangerous contagion” and a potential threat to that which is held sacred.³⁵ According to Vattimo, the only way to contain the risk is to attribute responsibility of harm to the individual and/or group representing the “event,” all the while avoiding any substantive critique of the reigning metaphysic. As a result, a communal ethos will set in motion the need to “hunt for—and find—new victims every time, fresh scapegoats who are believed guilty but are actually innocent.”³⁶ Society can emancipate itself from this scapegoating mechanism; however, safeguarding the Metaphysical Fact prevents an awareness of “the innocence of all those victims sacrificed to that end and of the substantial arbitrariness and injustice of their persecution.”³⁷

Vattimo contrasts metaphysics with his own preference for *postmodernism*. The postmodern condition implies the “disappearance of the metarécits as ways of legitimization.”³⁸ Such metanarratives are deconstructed by Heidegger’s notion of “recollection” (An-denken), that is, by the retrieval of the turning points of the whole

community reacts by seeking a scapegoat to conceal a truth, that being its propensity for violence to preserve values it deems sacred or absolute. See René Girard, *The Scapegoat*, 1–23; also see René Girard, *Violence and the Sacred*, translated by Patrick Gregory (New York: Continuum, 2005).

³⁵ Pivotal here are the ideas of Mary Douglas. She explains how taboo is used to constrain or to protect society from anomic behaviour perceived as a “dangerous contagion.” Transgressions are, therefore, punished to impose a communal system that accentuates a contrast between the blessed and the cursed. As Douglas claims, “There must be contrariness between holiness and abomination which will make over-all sense of all the particular restrictions.” When the community perceives an attack on its sacred norms, deviance can be punished to publicly affirm communal values. See Mary Douglas, *Purity and Danger: An Analysis of the Concepts of Pollution and Taboo* (New York: Routledge, 1966), 3, 50–51, 141.

³⁶ Vattimo and Girard, 8. Attribution theory helps to explain how the community assigns responsibility or blame to the agent who is deemed to either create a problem or influence an event that contradicts societal norms. If a behaviour offends the *symbolic attitudes* of the community—a moral code or sense of how society should be organized—and the agent effecting change possesses both *personal causality* and *controllability*, the society tends to be less sympathetic and more angry toward the individual. Consequently, judgments of responsibility are harsher, as are punishments. See Bernard Weiner, *Judgements of Responsibility: A Foundation for a Theory of Social Conduct* (New York: The Guilford Press, 1995).

³⁷ Vattimo and Girard, 9.

³⁸ Gianni Vattimo, “The End of (Hi)story,” *Chicago Review* 35, no. 4 (1987): 20.

metaphysical tradition.³⁹ According to Vattimo, this “recollection” of metaphysics in “archeological” terms creates a distortion because “it deprives metaphysics of its authoritarian character, disregarding its claims to being a knowledge of the stable principles of reality.”⁴⁰ Vattimo notes that once we have “discovered the rhetorical and the power-relation implications that lay at the basis of (the notion of) history as a unitary course of events, history becomes impossible, both in its notion and in its pretended objective development.”⁴¹

Without metanarratives, Vattimo notes how postmodernism allows for an infinite number of ways to interpret reality. He refers to the postmodern as an “irresistible pluralization [that] renders any unilinear view of the world and history impossible.”⁴²

Vattimo argues that a postmodern world—a world of mass media and generalized communication—results in

a multiplicity of ‘local’ rationalities—ethnic, sexual, religious, cultural or aesthetic minorities—that finally speak up for themselves. They are no longer repressed and cowed into silence by the idea of a single true form of humanity that must be realized irrespective of particularity and individual finitude, transience and contingency.⁴³

With the liberation of diversity, Vattimo claims that minorities “‘find their voice,’ present themselves and so ‘get into shape’ for recognition.”⁴⁴ Eventually, with experience, we are made to realize the contingency and relativity of the world in which we live. Vattimo clarifies: “‘Other’ possibilities of existence are realized before our very

³⁹ Ibid., 26.

⁴⁰ Ibid.

⁴¹ Ibid., 22–23. Vattimo provides examples of how the notion of history as a unitary course became inconceivable. The notion of twentieth-century rationality as a metarécit ended with Auschwitz; the metarécit of the socialist revolution ended with Stalin’s gulags; and the metarécit of the free-market economy ended with recurrent crises in capitalist societies (20–21).

⁴² Vattimo, *The Transparent Society*, 6.

⁴³ Ibid., 8–9.

⁴⁴ Ibid., 9. As previously mentioned, Vattimo’s reference to “recognition” complements multicultural theory, particularly the work of Charles Taylor. See Charles Taylor, “The Politics of Recognition,” in *Multiculturalism*, 25–73.

eyes, in the multiplicity of ‘dialects’ and in the different cultural universes opened up by anthropology and ethnology.”⁴⁵ Vattimo accepts that Being within a postmodern framework “does not . . . coincide with what is stable, fixed and permanent” but instead “show[s] us how to take the experience of oscillation in the postmodern world as an opportunity of a new way of being (finally, perhaps) human.”⁴⁶

The views of metaphysicians and postmodernists eventually collide with one another whenever a new “*event of being*” emerges. For metaphysicians, the “event” can create discomfort and uncertainty because what is held to be sacred or authoritative is challenged by ontological difference. As Vattimo notes, “To rethink being . . . is to shift the ground from under that which we take for granted. . . .”⁴⁷ Because Being reveals itself as “event,” Vattimo asserts that “being is *not*, but *happens*” and that “only on these conditions . . . [can being] acquire meaning and become the theme of a radical theoretical reflection.”⁴⁸ In fact, the only possible history of Being for Vattimo is “the growing lighter, the losing weight (*alleggerimento*) of Being itself,” meaning that the history of Being is “the history of how objective truth gradually dissolves.”⁴⁹ Since Being has no fixed, objective structure, it “eventuates in history in different cultures, in different epochs. . . . In the epochs, different horizons open up, with different truth criteria.”⁵⁰ This implies that the history of Being has to do with “the passing on of linguistic messages, cultural messages,” and that such occurrences teach us to “mistrust dogma and anything else presented as necessity.”⁵¹ Thus, for Vattimo, the truth of human freedom is

⁴⁵ Vattimo, *The Transparent Society*, 10.

⁴⁶ *Ibid.*, 11.

⁴⁷ Vattimo with Paterlini, 110.

⁴⁸ Vattimo, *The Transparent Society*, 73.

⁴⁹ Vattimo with Paterlini, 24.

⁵⁰ *Ibid.*, 106.

⁵¹ Vattimo, *The Responsibility of the Philosopher*, 78–79, 91.

“something we construct through the remembering of ontological difference.”⁵²

Ultimately, Being is synonymous with the postmodernist position: “[T]o correspond to Being,” states Vattimo, “means to correspond to its pluralism.”⁵³

Seeing that the “event” is not outside of historical time and space, Vattimo acknowledges the uniqueness of one’s ontology of actuality—or lived reality—within any given cultural context. Ontology then is nothing other than “the interpretation of our condition or situation. . . .”⁵⁴ The point of origin for ethical discussion becomes internal and existential, not something that can be judged from a supraempirical level. As Vattimo explains, “[T]here is no origin located somewhere outside the actuality of the event.”⁵⁵ Concurring with Nietzsche that the history of metaphysics entails a devaluation of the human condition,⁵⁶ Vattimo describes an ontology of actuality not as an abstraction but as “a [point of] discourse that attempts to clarify what Being signifies in the present situation.”⁵⁷ Vattimo insists that an ontology of actuality abandons all absolute foundations, offering instead “a certain vision of the ongoing historical process and a

⁵² Robert T. Valgenti in Gianni Vattimo, *A Farewell to Truth*, translated by William McCuaig (New York: Columbia University Press, 2011), xi.

⁵³ Vattimo with Paterlini, 112.

⁵⁴ Gianni Vattimo, *The End of Modernity*, 3.

⁵⁵ Vattimo, *Nihilism and Emancipation: Ethics, Politics, and Law*, 87.

⁵⁶ Nietzsche was overtly critical of Christian metaphysics, believing that the Christian religion was nihilism incarnate. Since Christian theology involved a metaphysical reversal of temporal reality, the Christian God became the “deification of nothingness, the will to nothingness pronounced holy.” Thus, Nietzsche argued that Christian metaphysics was an impediment to life-affirmation, since the former attempted to negate the value of the latter “for the sake of another life in another world that is essentially its opposite.” Overall, Nietzsche believed that a reliance on the supernatural over the ontological inverted the power of meaning and value, placing it in a context that was foreign to its origin. As Nietzsche explains, “If one shifts the centre of gravity of life out of life into the ‘Beyond’—into *nothingness*—one has deprived life of its centre of gravity . . . So to live that there is no longer any *meaning* in living; *that* now becomes the ‘meaning’ of life.” See Thomas J.J. Altizer, “The Challenge of Nihilism,” *Journal of the American Academy of Religion* 62, no. 4 (Winter, 1994): 1013, 1018; also see Bernard Reginster, *The Affirmation of Life: Nietzsche on Overcoming Nihilism*, 49; Friedrich Nietzsche, *The Anti-Christ*, translated by R.J. Hollingdale (Harmondsworth, England: Penguin Books, 1968), 43.

⁵⁷ Vattimo, *Nihilism and Emancipation: Ethics, Politics, and Law*, 3–4.

certain interpretation . . . of its positive potential, judged to be such on the basis not of eternal principles but of argumentative choices from within the process itself.”⁵⁸

As with any metaphysical limitation on liberty, Vattimo notes that liberal communitarianism is often used to distort the significance of the ontological. In fact, communitarian discourses used in applied ethics emphasize how individual behaviour will negatively affect societal norms of influence.⁵⁹ Furthermore, the normative assumptions surrounding communalism can delimit the personal, focusing more or less exclusively on the “social permissibility of the behaviours in question.”⁶⁰ Vattimo warns that this shift in power from the individual to the collective subordinates one’s unique ontology, replacing it instead with a collective metaphysic:

What counts . . . is the fulfillment of a social duty . . . more than the personal dilemma, which is no longer central, since it too is seen as connected to social custom, the circumambient culture. . . . It can be summed up as a shift of attention from the inner realm of individual behaviour . . . to what we might generically call the sphere of the social.⁶¹

Since the “event” itself weakens strong structures by exposing the asymmetry between metaphysics and other ontological realities, it is the idea of “weak thought” that also requires clarification. By “weak” Vattimo essentially refers to two things—pluralistic and incomplete—with each path becoming a postmodern reply to metaphysics:

The first evokes synchronicity (many theses, many ‘truths,’ many interpretations are simultaneously legitimate), the second diachronicity (no text, no truth can be said to be definitive and conclusive), hence they correspond to two classic forms of relativism: epistemological and historical.⁶²

⁵⁸ Ibid., 88.

⁵⁹ With reference to communitarian philosophical arguments and their critiques of liberal neutrality and justice, see Ezekiel J. Emanuel, *The Ends of Human Life: Medical Ethics in a Liberal Polity* (Massachusetts: Harvard University Press, 1994); also see Robert P. Jones, *Liberalism’s Troubled Search for Equality: Religion and Cultural Bias in the Oregon Physician-Assisted Suicide Debates* (Notre Dame, Indiana: University of Notre Dame Press, 2007).

⁶⁰ Gianni Vattimo, *Nihilism and Emancipation: Ethics, Politics, and Law*, 61.

⁶¹ Ibid., 63. When the community begins to control truth and knowledge rather than facilitate their expansion, it is engaging in a metaphysical exercise of power, something Foucault referred to as its “regime of truth.” See Michel Foucault, *The Foucault Reader*, edited by Paul Rabinow (New York: Pantheon Books, 1984), 73–74.

⁶² D’Agostini, ed., in Gianni Vattimo, *The Responsibility of the Philosopher*, 3.

The weakening of absolutes is to be perceived, ironically, as a show of strength.

Notes Vattimo: “Weak thought becomes strong thought, on the one hand, because we realize through it that our life is conditioned by history and, on the other hand, because it is a responsible ethical project, since we must live our lives in an authentic form [non-absolutist]. . . .”⁶³ Instead of seeing weakness as some kind of deficiency, Vattimo believes philosophers should view error as “a source of the wealth that constitutes us and that gives interest, colour, and Being to the world.”⁶⁴ This “ontology of decline” actually promotes a shift in power from the metaphysical to the humanistic. As Vattimo reminds us, it is

an invitation to overcome metaphysics by involving it in a relation of reciprocity . . . because ‘innovation’ prevails over ‘conditioning’. . . . This new, weak way of thought not only opens up alternative directions, it also recovers tradition: the relationship between the believer is not conceived as power-laden but as a gentler relationship, in which God hands over all his power to man.⁶⁵

Hence, “weak thought” lends itself to democratic principles. This is because the weakening of Being allows for an infinity of voices to contribute to the dialectic, meaning that a weakened approach “supplies philosophical reasons for preferring a liberal, tolerant, and democratic society rather than an authoritarian and totalitarian one.”⁶⁶ In terms of enhancing liberty and reciprocity, “weak thought” could not be more pertinent to the discussion. States Vattimo:

[T]he emancipation and liberation that mankind has always sought are attainable through a weakening of strong structures, a reduction of claims, and that implies, in general terms . . . that listening to what others have to say counts for more than measuring objects with precision. In all fields, including science, truth itself is becoming an affair of consensus, listening, participation in a shared enterprise, rather than a one-to-one correspondence with the pure hard objectivity of things. . . .⁶⁷

⁶³ Santiago Zabala, ed., *Weakening Philosophy: Essays in Honour of Gianni Vattimo*, 17.

⁶⁴ Gianni Vattimo, *The End of Modernity*, 170.

⁶⁵ Santiago Zabala, ed., *The Future of Religion*, 3.

⁶⁶ Gianni Vattimo, *Nihilism and Emancipation: Ethics, Politics, and Law*, 19.

⁶⁷ *Ibid.*, 35.

From the basis of “weak thought,” we are forced into an arena of dialogue and conversation that defies the intellectual fundamentalism of metaphysics. Explains Vattimo: “An ethics that no longer refers to the Other, meaning to a transcendent being, will be an ethics of negotiation and consensus rather than an ethics of immutable principles or categorical imperatives speaking through the reason of everyone.”⁶⁸ Only through the weakening of strong structures can a more transparent, democratic process, be experienced. This entails “[welcoming] the other in the name of the dialogical principle of charity, that is, by listening to the non-violent reasons of the other.”⁶⁹

With the weakening of the Absolute in the era of postmodernity, the dilemma over “strong” relativism—the claim that all interpretations are equally valid—is also addressed by Vattimo. He rejects an “anything goes” position because it would allow knowledge to become infinitely fragmented and, therefore, of no more value than knowledge unified under a single metaphysic. As Vattimo makes clear:

There is a risk attached to taking a step backward, distancing ourselves from the concrete alternatives, which . . . may lead to the adoption of a relativistic metaphysics. Relativism [strong] can perfectly well be described as metaphysical because only from a position strongly anchored in some universal point of view can (should we) gaze on multiplicity as multiplicity. Relativism, one might say, is the (self-contradictory and impractical) metaphysical rigidification of finitude.⁷⁰

This means that “weak thought” is not just an amalgamation of relative truths. It is, in fact, “a calculated combination of different modes of relativism in order to get to somewhere else beyond relativism.”⁷¹

Vattimo also posits *secularization* in opposition to metaphysics because the former is a kind of “weakening” that complements both the Christian tradition and liberal

⁶⁸ Vattimo, *Nihilism and Emancipation: Ethics, Politics, and Law*, 67.

⁶⁹ Gianni Vattimo, *Belief*, translated by Luca D’Isanto and David Webb (Stanford, California: Stanford University Press, 1999), 14.

⁷⁰ Vattimo, *After Christianity*, 42.

⁷¹ Franca D’Agostini, ed., in Vattimo, *The Responsibility of the Philosopher*, 4.

democracy. He defines secularization in nonabsolutist terms to mean “the effective realization of Christianity as a nonsacrificial religion.”⁷² From Vattimo’s understanding of Girard, he takes this to mean that “[t]he very history of Christianity is the history of the dissolution . . . of the sacred-violent and natural-sacred elements that the church has retained.”⁷³ In this sense, secularization should be seen as a positive theory in which “charity takes the place of discipline.”⁷⁴ The full hermeneutical process can now be experienced, which entails “[welcoming] the other in the name of the dialogical principle of charity, that is, by listening to the non-violent reasons of the other.”⁷⁵ Hence, secularization merely allows Christians to see their faith in a different light. Summarizing Vattimo’s thoughts, Richard Rorty elaborates on the ability of the secular to strip away only the metaphysical, submissive components of religion in the search for a more profound truth: “[S]ecularization is Christianity by other means. Both represent the triumph of love over law, of kindness over obedience.”⁷⁶ In point of fact, secularization merges Millian liberalism, and its emphasis on self-regarding acts,⁷⁷ with the Golden Rule in an ethics of reciprocity. Admits Vattimo: “Above all, the establishment of liberal principles in a liberal society and in the political organization (do anything you will as long as it does not infringe upon the freedom of all others) is a secular symbolizing of the Christian message.”⁷⁸

⁷² Vattimo and Girard, *Christianity, Truth, and Weakening Faith: A Dialogue*, 28.

⁷³ *Ibid.*, 27-28.

⁷⁴ *Ibid.*, 28.

⁷⁵ Gianni Vattimo, *Belief*, 14.

⁷⁶ Richard Rorty, in Vattimo, *Nihilism and Emancipation: Ethics, Politics, and Law*, xx.

⁷⁷ 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); also see Gerald Dworkin, ed., *Morality, Harm, and the Law* (Oxford: Westview Press, Inc., 1994).

⁷⁸ Vattimo, *After Christianity*, 119.

Lastly, Vattimo outlines how *nihilism* shapes his own philosophical position by differentiating between two types, the positive and the negative. First, *passive-reactive* forms of nihilism contribute to a decline and retreat of the human spirit's power. When supreme values are crumbling and their objectivity is perceptible, *passive-reactive* nihilists act as metaphysicians, refusing to acknowledge the annihilation of the highest values. In order to revive a specific metaphysical position, negative (passive-reactive) nihilists will use "a variety of disguises: religious, or moral or political or aesthetic etc."⁷⁹ Vattimo realizes that they will also view the loss of transcendence as "a disaster to be resisted with all strength, rather than accepting it . . . as a vocation."⁸⁰ For passive-reactive nihilists, there is no argumentative process in which to engage, since metaphysics negates hermeneutics. According to Vattimo, "That things have qualities in themselves, irrespective of interpretation and subjectivity, is a perfectly idle hypothesis: it would presuppose that interpreting and being subjective are not essential."⁸¹ The connection between passive and reactive is also one of codependency in the sustainability of metaphysics. Passive-reactive nihilists avoid the creative task of inventing new values based on contingencies, and as a reaction to the discrediting of the highest values, they will invent "every sort of disguise and ideological mask" since they "refus[e] to admit that neither *objective* meanings and values nor *given* structures of Being exist—and that therefore they have to be actively created."⁸² Thus, the creation of illusions is an attempt to instil ultimate meaning into that which has none. For language to enlighten, however, what is required is the "removal of every obstacle to the complete transparency of

⁷⁹ Gianni Vattimo, *Dialogue with Nietzsche*, translated by William McCuaig (New York: Columbia University Press, 2006), 135.

⁸⁰ Vattimo, *Nihilism and Emancipation: Ethics, Politics, and Law*, 64.

⁸¹ Vattimo, *Dialogue with Nietzsche*, 135.

⁸² *Ibid.*

communication,” especially “all those various kinds of social, ideological and psychological obstacles that actually make communication opaque and imperfect.”⁸³

In contrast, the concept of *positive nihilism* emphasizes life-affirmation through a widening of dialogue. As initially outlined by Nikos Kazantzakis, positive nihilism states that the philosopher must “pass the gauntlet of complete nihilism and, having rejected the currently dominant values, he must raise other values, by virtue of which life and the universe cannot only be justified but also become endearing and valuable.”⁸⁴ Rejecting any unworkable table of values, humankind now “erects another table with a new ranking of values and new ideals of humanity, society, and state.”⁸⁵ Positive nihilism—in both its negation of the absolute as redundant and its acceptance of infinite alterity—is life-affirming since it involves “the obliteration only of the currently reigning table of values, which is to be succeeded by a heroic and joyous acceptance of life.”⁸⁶

For Vattimo, positive nihilism provides the intellectual foundation on which to widen perceptions of truth and knowledge. The positive, active form, as an increased power of human spirit, involves two processes: “First, it doesn’t stop at unmasking the hollowness of all [eternal] meanings, structures, and values but goes on to produce and create new values and new structures of meaning, new interpretations.”⁸⁷ After the overcoming of nihilistic despair—the conviction that absolute values cannot be achieved⁸⁸—Vattimo is adamant that positive nihilism as life-affirmation can finally

⁸³ Vattimo, *The Transparent Society*, 19.

⁸⁴ Nikos Kazantzakis, *Friedrich Nietzsche on the Philosophy of the Right and State* (Albany: State University of New York Press, 2006), 19.

⁸⁵ *Ibid.*, 20.

⁸⁶ *Ibid.*, 17.

⁸⁷ Vattimo, *Dialogue with Nietzsche*, 135.

⁸⁸ Reginster, *The Affirmation of Life: Nietzsche on Overcoming Nihilism*, 28. For Nietzsche, nihilistic despair, or pessimism, occurred when we realize that “the world does not have the value that we believed.”

arrive at the emancipatory phase of its accomplishment: “[I]t reaches its extreme form, by consuming Being in value. This is the event that finally makes it possible, and necessary, for philosophy today to recognize that [positive] nihilism is our (only) chance.”⁸⁹

Therefore, in its positive form, nihilism is effective once it completes its full function of disclosure. As Vattimo notes in *The Responsibility of the Philosopher*, “[Positive] nihilism is accomplished when the contradiction internal to the hermeneutic experience of truth is fully acknowledged.”⁹⁰ By aiding in a process that discovers enlightenment through contingencies, positive nihilism prevents the exclusionary effect of metaphysics, the inertia associated with nihilistic despair, and the apathy of moral relativism. It is at this point that Vattimo’s goal of an accomplished nihilism can enter its life-affirming stage.

Overall, the Vattimian perspective not only provides the means for overcoming the heritage of exclusivist metaphysics, but also demonstrates that the disclosure of truth values is better facilitated under the banner of postmodern pluralism. This can be accomplished by linking the metaphysical tradition of Being with suffering and violence while recognizing that, within a postmodern context, “something is better understood the more one is able to say about it.”⁹¹ Furthermore, when absolute foundations are weakened by an “event of being,” two possible scenarios follow: One can either accept that there are no metaphysical absolutes and attempt to discover other truth values (positive nihilism), or one can continue to conceal a discredited metaphysic (negative

See Friedrich Nietzsche, *The Will to Power, 1883–1888*, translated by W. Kaufmann and R.J. Hollingdale (New York: Random House, 1968), 32.

⁸⁹ Gianni Vattimo, *The End of Modernity*, 23.

⁹⁰ Vattimo, *The Responsibility of the Philosopher*, 81.

⁹¹ Zabala, ed., *The Future of Religion*, 8.

nihilism). It is this metaphysical-postmodern dichotomy that is the crux of Vattimo's nihilistic philosophy.

Applying Vattimo to the Dissertation

A discourse analysis will be used to operationalize three of Vattimo's main concepts: (1) *metaphysics* (absolute values); (2) "*event of being*" (lived experiences that call absolute values into question); and (3) *passive-reactive nihilism* (the creation of "masks" or "disguises" to prevent the dissolution of metaphysics). I will be using Vattimo's major themes to explain how the cases of Nancy B., Sue Rodriguez, and Robert Latimer relate to a concrete analysis of the data, that being the ethical, medical, judicial, and political discourses surrounding euthanasia and assisted suicide. I want to see just how closely Vattimo's theoretical concepts and the empirical data are linked.

During the research, I inquired as to whether or not the discourse on euthanasia and assisted suicide in Canada followed a particular rhetorical pattern based on the Vattimian perspective. More specifically, whenever the intentional hastening of death was sought, I wanted to ascertain whether ethical, medical, legal, and political discourses converged to (1) accentuate the necessity of metaphysics; (2) marginalize ontological difference or "events of being" to sustain the reigning metaphysic; and (3) create "masks" or "disguises" whenever the authority of metaphysics was challenged. The evidence suggests that the Vattimian perspective applies most consistently to proponents of the sanctity of life ethos—both religious and secular—and, in rare instances, to supporters of the quality of life ethos as well. Therefore, Vattimo's central themes illuminate an

understanding of the way secular and religious beliefs are interwoven in discourses involving the intentional hastening of death in Canada.

For the purposes of this dissertation, *metaphysics* will refer to any claim of an absolute or immutable first principle made within the discourse surrounding euthanasia and assisted suicide. Since the evidence suggests that metaphysical claims were held mostly by sanctity of life advocates (both religious and secular), it is important to outline the two versions of the sanctity of life ethos that were most commonly invoked. In a minority of cases, proponents of the sanctity doctrine—those who believe that human life is inviolable—rejected any attempt to intentionally hasten death using acts of *either* omission *or* commission. This vitalist position holds that because human life is an absolute moral value “it is wrong either to shorten the life of a patient or to fail to strive to lengthen it.”⁹² From the 1970s–1980s, this belief even applied to the removal of respirators or artificial nutrition and hydration, most notably in the cases of Karen Ann Quinlan and Nancy Cruzan.⁹³

However, the *qualified* sanctity of life ethos has become the more dominant metaphysic in Canada since the 1990s. It reads: *It is absolutely prohibited to intentionally kill a patient and to base decisions relating to the shortening of human life on considerations of its quality or kind; it is, however, sometimes permissible to either*

⁹² See John Keown, *Euthanasia, Ethics, and Public Policy: An Argument against Legalization*, 39.

⁹³ Peter G. Filene, *In the Arms of Others: A Cultural History of the Right-to-Die in America* (Chicago: Ivan R. Dee, 1998); also see William H. Colby, *Long Goodbye: The Deaths of Nancy Cruzan* (Carlsbad, California: Hay House, Inc., 2002). After Karen Ann Quinlan slipped into a permanent vegetative state, medical personnel, supported by New Jersey’s criminal law, would not permit the removal of her respirator, since an intentional act that resulted in someone’s death—whether by omission or commission—was technically a homicide. Likewise, after her car accident, Nancy Cruzan’s family wanted artificial nutrition and hydration removed as part of Nancy’s treatment, but both acts of commission and omission were considered criminal under Missouri law and, thus, counter to the principle of vitalism.

intentionally let a patient die or to refrain from preventing death [original italics].⁹⁴

Since acts of omission have now become part of standard medical practice (e.g., withdrawing respirators or making non-treatment decisions), acts of commission hastening death are viewed by the majority of sanctity of life advocates as unethical and criminal without exception. Consequently, the *qualified* sanctity of life ethos can never be weakened to permit positive acts that result in an intentionally hastened death—not even for chronically/terminally ill patients suffering from intractable pain.

In addition, “*event of being*,” or what Vattimo terms “ontological difference,” will refer to any legal case that challenged the reigning metaphysic. I submit that Nancy B., Sue Rodriguez, and Robert Latimer weakened the sanctity of life as first principle by exposing it to contingencies, namely, the intractable pain and suffering of the chronically/terminally ill. The ontology of actuality, or lived reality of those suffering, challenged the supremacy of the sanctity doctrine in unique ways. In the case of Nancy B., a precedent was established that allowed acts of omission to be used in the hastening of death for those dependent on a respirator. Prior to Nancy B., it was not clear whether removing such life-support constituted murder. However, an absolute distinction was drawn between negative and positive acts to prevent any further weakening of the sanctity of human life as first principle. Because Sue Rodriguez was dying from anterior lateral sclerosis (ALS), she sought physician-assisted suicide for a competent, terminally ill adult. Just providing the means to assist in a suicide was considered contrary to the sanctity of life ethos and the *Criminal Code* of Canada. Although she would eventually die of suffocation, Rodriguez’s request for physician-assisted suicide was rejected by the

⁹⁴ Helga Kuhse, *The Sanctity of Life Doctrine in Medicine: A Critique*, 23. For the sake of clarity, some slight modifications have been made in the wording of Kuhse’s original definition.

Supreme Court of Canada because it violated the “sanctity of life.” However, Robert Latimer’s challenge of the sanctity doctrine was the most radical. He sought a constitutional exemption for the mercy killing of his daughter Tracy (a minor), based on mitigating circumstances (i.e., extreme suffering). Any leniency shown by the state would have meant that active nonvoluntary euthanasia (consent unknown) was sometimes permissible under rare circumstances, a *de facto* admission that life could be intentionally hastened based on quality or kind. As with Rodriguez, Latimer lost his Supreme Court bid.

Furthermore, whenever the sanctity of life ethos was weakened to the point of losing its normative authority, *passive-reactive nihilism* (negative nihilism) became a philosophical position adopted by sanctity of life advocates (and a minority of quality of life supporters) to discredit the arguments of postmodernists. In other words, “masks” or “disguises” were used by metaphysicians in two distinct ways: (1) to discourage the viable use of positive acts in the intentional hastening of death (i.e., Sue Rodriguez and Robert Latimer); and (2) to disguise mechanical and scientific causation for acts of omission that hastened death (i.e., Nancy B.). In this latter scenario, the sanctity of life as absolute led to a reversal of attribution theory. Causal responsibility for the death of Nancy B. was, in actuality, attributed to “nature,” thereby negating responsibilities of judgment against the physician or the patient.⁹⁵ Whether discussing acts of omission or commission, the goal is the same: maintaining the authority of the sanctity of life ethos as first principle.

From the discourses on death and dying in Canada, two groups with two very different belief systems were identifiable, namely those who for the purposes of this

⁹⁵ Weiner, *Judgements of Responsibility: A Foundation for a Theory of Social Conduct*, 1–24.

dissertation I will call *metaphysicians* and those whom I will term *Vattimian postmodernists*. For metaphysicians (religious, secular, or non-Christian), normative assumptions informed, historically and in the present, by Christian tradition (i.e., stewardship, value in prolonged suffering, and fear of the “slippery slope”) were embraced whenever the discussion shifted to the possibility of an intentionally hastened death (i.e., euthanasia and assisted suicide). For metaphysicians, a principle-based ethical approach was adopted, which assumes that some acts are inherently wrong according to natural law.⁹⁶ In contrast, Vattimian postmodernists lobbied for a paradigmatic shift toward the quality of life ethos. This principle permits an intentionally hastened death in some circumstances based on the following normative assumptions: self-determination, the relative value of human life, and the feasibility/flexibility of safeguards. Because of their affinity for situation ethics, Vattimian postmodernists challenged the sanctity of life ethos by exposing it to contingencies. Due to the extreme suffering experienced by Nancy B., Sue Rodriguez, and Tracy Latimer, quality of life supporters argued that “sanctity of life” as a fixed and uncontested principle was no longer viable.

Overall, a discourse analysis and subsequent critique allow for a historical examination of the main issues, an overview of the positions taken by key groups/individuals, and an examination of the degree of consistency and/or inconsistency within such positions. I will also identify religious beliefs that were invoked, implicitly

⁹⁶ Margaret Somerville, “Law and Ethics: Who’s the Boss?” *McGill Faculty of Law* (15 November 2005): <<http://www.law.mcgill.ca/minilaw/somervilleqanda.htm>> Somerville explains the difference between principle-based and situation ethics: “The legal positivists are like the ethical utilitarians – they believe there are no absolutes in terms of something being wrong, it all depends on the balance of harms and goods and the goods outweighing the harms in any particular situation (they are sometimes called situational ethicists). And the natural law proponents are like the principle-based or deontological ethicists – the first question they believe we must ask is ‘Is that inherently wrong?’ If it is, we must not do it no matter how much good would result. In other words, ends do not justify inherently wrong means.”

or explicitly, to support such claims. However, it is through the use of Vattimo's theoretical concepts—namely, *metaphysics*, “*event of being*,” and *passive-reactive nihilism*—that I hope to illuminate the presence, weakening, and resilience of metaphysics in Canadian discourse on death and dying, especially debates surrounding euthanasia and assisted suicide.

Chapter II: Global Trends and the “Eventuation of Being”

When examining euthanasia and assisted suicide in the global context, one is reminded of Vattimo’s belief in “history as eventuation.” In opposition to objectivistic metaphysics, Being “alters its stance towards us, that it does eventuate for us again, not ‘in presence’ but rather as rents in history that inaugurate new epochs.”¹ In the post-World War II era, the death and dying debate consisted of a series of “events”—or ontological challenges—that instigated new ways of thinking about an intentionally hastened death. Although the sanctity of human life had been perceived as a supreme, immutable principle, a process of weakening occurred due to the emergence of other competing principles. A shift had begun in the 1970s and ’80s away from vitalism, which requires that human life be preserved at all costs, and toward a growing tension between two principles: the *qualified* sanctity of life ethos and the quality of life ethos. The former maintained an absolute moral distinction between acts of omission and commission, while the latter required no such distinction. That said, these models were often fluid in nature. Supporters of vitalism sanctioned some acts of omission that resulted in a hastened death (e.g., removing respirators) but forbade other forms of “passive” euthanasia (e.g., removing artificial nutrition and hydration). In addition, advocates of the *qualified* sanctity of life ethos often made quality of life judgments when deciding whether to terminate life. Nor were proponents of the quality of life ethos immune from absolutist assumptions. They too accepted inherent moral distinctions, such as the ethical difference between euthanasia and assisted suicide.

¹ Vattimo, *Not Being God: A Collaborative Autobiography*, 23.

The central focus of this chapter is to demonstrate that, from a global perspective in the post-World War II era, the sanctity of human life as absolute, or sanctity doctrine, began losing its hegemonic influence within medical ethics, becoming one principle competing among several. Because the United States, Britain, and Canada often reference one another in legal matters, it is important to begin with “events of being” in these countries that challenged the prohibition against an intentionally hastened death. This will be followed by an overview of the diverse approaches to euthanasia, assisted suicide, and cessation of treatment exhibited in other jurisdictions worldwide. In general, the context often dictated the degree to which an intentionally hastened death was acceptable. While outlining the multiplicity of death-hastening practices, the presence or absence of religious beliefs will be duly noted. Particular emphasis will be placed on the Vattimian notion of how secular culture continues to live religious elements of its tradition as “traces.”²

The American Context

Redefining Death

One of the most important changes in American medicine—an “event” that began a shift away from vitalism—was the development of new criteria for determining irreversible coma or brain death. In 1968, Henry Beecher, chairman of the Harvard Brain Death Committee, sought consideration of a new ethical question. Beecher felt that because of the demand for heart organ transplants, “the time had come for a further consideration of the definition of death,” since “[e]very major hospital ha[d] patients

² Vattimo, *The Transparent Society*, 40.

stacked up waiting for suitable donors.”³ To promote its mandate, the Committee highlighted both a practical concern—the demand for organs—as well as the need to address quality of life considerations. Thus, new criteria for brain death were established:

Our primary purpose is to define irreversible coma as a new criterion for death. There are two reasons why there is a need for a definition: (1) Improvements in resuscitative and supportive measures have led to increased efforts to save those who are desperately injured. Sometimes these efforts have only a partial success so that the result is an individual whose heart continues to beat but whose brain is irreversibly damaged. The burden is great on patients who suffer permanent loss of intellect, on their families, on the hospitals, and on those in need of hospital beds already occupied by these comatose patients. (2) Obsolete criteria for the definition of death can lead to controversy in obtaining organs for transplantation.⁴

However, an ethical dilemma occurred in the context of the late 1960s in that removing the heart of a living patient was considered murder. Pragmatism, however, had begun to collide with vitalism, and a “middle path” was required to resolve the impasse. As Beecher himself admitted, the solution to this problem was anything but “objective”:

There is indeed a life-saving potential in the new definition, for, when accepted, it will lead to greater availability . . . and thus countless lives now inevitably lost will be saved . . . At whatever level we choose death, it is an arbitrary decision. Death of the heart? The hair still grows. Death of the brain? The heart may still beat. The need is to choose an irreversible state where the brain no longer functions. It is best to choose a level where, although the brain is dead, usefulness of other organs is still present. This we have tried to make clear in what we have called the new definition of death.⁵

Sanctity of life advocates, especially Catholics, had a major reason for supporting this shift toward the *qualified* sanctity of life ethos. It was hoped that a “third way” would not only avoid the impracticalities of vitalism but would also stem the tide of growing support for euthanasia. Dennis J. Horan, president of American Citizens United for Life, stated that the new definition of total-brain-death complemented the pro-life

³ David Rothman, *Strangers at the Bedside* (New York: Basic Books, 1991), 160–61.

⁴ Peter Singer, *Rethinking Life and Death: The Collapse of Our Traditional Ethics*, 25.

⁵ Henry Beecher, “The New Definition of Death: Some Opposing Viewpoints,” *International Journal of Clinical Pharmacology* 5 (1971): 120–21. In the Canadian context, the whole-brain criterion of death was introduced in the case *R. v. Kitching and Adams* (1976) 6 W.W.R. 697 (Manitoba Court of Appeal). For further clarification of the whole-brain criterion of death, see R. Pucetti, “Does Anyone Survive Neocortical Death?,” in R.M. Zaner, ed. *Death: Beyond the Whole-Brain Criterion* (Dordrecht: Kluwer Academic Publishers, 1988).

movement “by prohibiting euthanasia and allowing only those to be declared dead who are really dead.”⁶ Germain Grisez and Joseph Boyle, two leading American Catholic pro-life philosophers, added that “a correct definition of death, if it would eliminate some false classifications of dead individuals among the living, could relieve some of the pressure for legalizing euthanasia.”⁷ For the pro-life movement, the definition of death could not be relativized. As metaphysicians, they believed that human life was sacred, something that possessed absolute value from conception until natural death. Consistent in their core beliefs, Grisez and Boyle confessed that Beecher’s new definition of death—the irreversible loss of all cognitive function—was “without any radical shifts in meaning, arbitrary stipulations, or subjective evaluations.”⁸ However, since all such definitions require both criteria for evaluation and a cultural context to interpret them, “brain death” was going to require specific case studies, or “events of being,” to solidify its acceptance from a religious, legal, ethical, and socio-political perspective.

Karen Ann Quinlan: “Passive” Euthanasia on Trial

The shift from vitalism (to maintain biological life at all costs) to the *qualified* sanctity of life ethos (to refrain from prolonging death using acts of omission) was not an easy transition. In mid-1970s America, arguments were still unclear as to whether passive euthanasia was permissible and, if so, what types of negative acts were ethically viable. One emotionally charged “event” put passive euthanasia on trial. In 1975,

⁶ President’s Commission for the Study of Ethical Problems in Medicine, *Defining Death: A Report on the Medical, Legal and Ethical Issues in the Determination of Death* (Washington, DC: U.S. Government Printing Office, 1981), 11.

⁷ Ibid.

⁸ Germain Grisez and Joseph M. Boyle, Jr., *Life and Death with Liberty and Justice: A Contribution to the Euthanasia Debate* (Notre Dame, Indiana: University of Notre Dame Press, 1979), 61.

twenty-one-year-old Karen Ann Quinlan fell unconscious after coming home from a party and lapsed into a permanent vegetative state. After Quinlan was kept alive on a respirator for several months without improvement, her parents requested the hospital discontinue active care and “allow her to die.” The hospital refused, and subsequent legal battles ensued. Not only was the case groundbreaking legally, but it also exposed overt appeals to religious norms. Although several aspects of Catholic moral theology were critical in deciding the case, these same principles were also being challenged by the growing presence of secularism.

After realizing that all hope was lost for their daughter’s recovery, the Quinlans signed a form directing their physician, Dr. Morse, to “discontinue all extraordinary measures, including the use of a respirator for [their] daughter Karen Quinlan.”⁹ They also released Dr. Morse and St. Claire’s Hospital, a Catholic facility, from any liability.¹⁰ However, Dr. Morse was torn between two ethical stances. He sympathized with Karen’s family, but as a Catholic and a doctor, his obligation was to the sanctity of human life. He viewed the respirator as “ordinary” treatment and adopted a vitalist position: Karen was technically still alive (some lower brain stem function), and removal of the respirator was, in his opinion, a mercy killing.¹¹ Even New Jersey law provided weight for Dr. Morse’s convictions. An intentional act that resulted in someone’s death—whether an act of omission or commission—was homicide.¹² Karen’s parents, however, viewed the termination of life-prolonging treatment differently. On behalf of Karen, they were attempting to “chang[e] the calculus” by “replacing a concern for [the sanctity of] life

⁹ Peter G. Filene, *In the Arms of Others: A Cultural History of the Right-to-Die in America*, 19.

¹⁰ “The Law: Between Life and Death,” *Time*, 29 September 1975, 75.

¹¹ Filene, 20–21.

¹² *Ibid.*, 21.

with a concern for the quality of life.”¹³ Thus, the Quinlan affair was the beginning of a realignment in values that was taking place in post-war America between sanctity and quality of life advocates.

Initially, however, the New Jersey Superior Court sided with Dr. Morse and St. Claire’s hospital. The guardian *ad litem*, Daniel Coburn, claimed that Mr. Quinlan was asking the state to commit homicide, which violated the state’s obligation to protect life. Embracing the vitalist position, Coburn remarked: “I’ve heard ‘death with dignity,’ ‘self-determination,’ ‘religious freedom,’ and I consider that to be a complete shell game that’s being played here. This is euthanasia.”¹⁴ The attorney representing Karen’s doctors, Ralph Porzio, added that siding with the Quinlans was equivalent to the mentality of the Third Reich: “And so,” he told Judge Muir, “once you make a decision [for the Quinlans], I think it is like turning on the gas chamber.”¹⁵ Porzio asserted that had the medical profession in Nazi Germany refused to participate in experimentation, “perhaps the Holocaust would not have been so great in terms of human lives and deformities.”¹⁶ For Porzio the greater peril lay in “forgetting the sanctity of life and substituting for it the quality of life. . . .”¹⁷

Although Judge Muir sympathized with the Quinlans, he realized the significance his decision would have on “the raging issues of euthanasia.”¹⁸ He pointed out that a judge had a duty to decide such a case according to “the high standard of morality and abstract right. . . .”¹⁹ Since Judge Muir believed that “[t]he single most important

¹³ Ibid., 171.

¹⁴ Ibid., 27.

¹⁵ Ibid., 28.

¹⁶ Ibid., 40.

¹⁷ Ibid., 39–40.

¹⁸ Ibid., 42.

¹⁹ Ibid.

temporal quality Karen Ann Quinlan ha[d] [was] life,” then the court could “not authorize that life to be taken from her.”²⁰ Adopting a strict vitalist position, Judge Muir agreed that even if Karen were “on the threshold of death or in a terminal condition,” removing the respirator was still murder.²¹ He ruled that not only was Dr. Morse correct in maintaining life support, but also that Mr. Quinlan could no longer be Karen’s legal guardian. The decision sent shock waves throughout the United States. As Ian Dowbiggin noted, “The plight of Karen Ann Quinlan personalized euthanasia in vivid and moving terms.”²² Likewise, Margaret Pabst Battin emphasized how the case “brought home the possibility that situations like Karen’s could happen to anyone.”²³

The Quinlans appealed all the way to the New Jersey Supreme Court in the first American case of its kind, *In re Quinlan*. In his testimony, the aforementioned Dr. Morse stated that he used an electroencephalogram to measure the electrical rhythm of Karen’s brain, characterizing the result as “abnormal” but showing “some activity” in the lower brain stem.²⁴ Dr. Morse testified with certainty that Karen was not “brain dead” according to criteria set out by Henry Beecher’s Ad Hoc Committee back in 1968. Brain death referred to the death of two brain functions, vegetative and sapient. Karen may no longer be a sentient being, but some parts of her body still functioned. This meant that, technically, she was still “not biologically dead,” existing only at a “primitive reflex

²⁰ Ibid.

²¹ Ibid.

²² Ian Dowbiggin, *A Concise History of Euthanasia: Life, Death, God, and Medicine*, 122.

²³ Margaret Pabst Battin, *The Least Worst Death: Essays in Bioethics on the End of Life* (New York: Oxford University Press, 1995), 4.

²⁴ *In re Quinlan*, Supreme Court of New Jersey 70 N.J. 10; 355 A.2d 647; 1976 N.J. LEXIS 181; 79 A.L.R.3d 205, 7.

level.”²⁵ As a philosophico-ethical position, vitalism was still present as a “trace” in decisions over life and death.

What is equally interesting is how Catholic moral theology could also be interpreted from a nonvitalist perspective. The Court noted that because Joseph Quinlan was “deeply religious,” he was “imbued with a morality so sensitive that months of tortured indecision preceded his belated conclusion . . . to seek the termination of life-supportive measures sustaining Karen.”²⁶ Mr. Quinlan sought guidance from the Catholic religion to make his final determination as to Karen’s best interests. He consulted both his parish priest as well as the Catholic chaplain of St. Claire’s Hospital, testifying that “he would not have sought termination if that act were to be morally wrong or in conflict with the tenets of the religion he so profoundly respects.”²⁷ The Court also analyzed Joseph Quinlan’s position by examining an *amicus curiae*, the New Jersey Catholic Conference, which represented the view of the Catholic bishops of New Jersey. They too had rejected the vitalist position, preferring instead the *qualified* sanctity of life principle for those in a permanent vegetative state. Noting Pope Pius’s address to anesthesiologists in 1957, the Catholic Conference agreed that if treatments constitute “extraordinary means of preserving life,” there was “no obligation to use them.”²⁸ Consequently, the Quinlan family was “bound to use only ordinary means,” and the removal of Karen’s life-support was “not to be considered euthanasia in any way.”²⁹ Therefore, the Catholic Conference validated the decision of Joseph Quinlan:

²⁵ Ibid., 8, 9.

²⁶ Ibid., 13.

²⁷ Ibid., 14.

²⁸ Ibid., 14–15; also see Robert F. Weir, *Abating Treatment with Critically Ill Patients: Ethical and Legal Limits to the Medical Prolongation of Life* (New York: Oxford University Press, 1989), 216–21.

²⁹ Ibid., 15.

The continuance of mechanical (cardiorespiratory) supportive measures to sustain continuation of her [Karen's] bodily functions and her life constitute extraordinary means of treatment. Therefore, the decision of Joseph Quinlan to request the discontinuance of this treatment is, according to the teachings of the Catholic Church, a morally correct decision.³⁰

Inevitably, the Court sided with the more relaxed position of the New Jersey Catholic Conference over the vitalist position held by Dr. Morse. It recognized that “humane decisions against resuscitation or maintenance therapy are frequently a recognized *de facto* response in the medical world to the irreversible, terminal, pain-ridden patient, especially with familial consent,” adding: “And these cases, of course, are far short of ‘brain death.’”³¹ The Court felt that by permitting acts of omission (i.e., withdrawal of a respirator) and rejecting as legally viable acts of commission (i.e., euthanasia), such attitudes represented “a balanced implementation of a profoundly realistic perspective on the meaning of life and death and that they respect the whole Judeo-Christian tradition of regard for human life.”³² This is not to say that the *qualified* sanctity of life principle did not involve quality of life considerations. Indeed, the Court admitted as much when referring back to the reasoning of the Harvard Brain Death Committee: “The evidence in this case convinces us that the focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of that biological vegetative existence to which Karen seems to be doomed.”³³

The New Jersey Supreme Court's conclusions were significant. Although it admitted that termination of treatment would “accelerate Karen's death,” such an omission was not a criminal act, since the ensuing death would be “expiration from

³⁰ Ibid., 15–16.

³¹ Ibid., 30.

³² Ibid.

³³ Ibid., 33.

natural causes.”³⁴ As a result, the guardian *ad litem* was discharged, and Joseph Quinlan was appointed as Karen’s legal guardian in treatment decisions.³⁵ After the withdrawal of life support, Karen lived another nine years until her death from pneumonia in 1985.³⁶ If anything, *In re Quinlan* demonstrated the fluidity and ultimate contingency of competing philosophico-ethical positions. From a Vattimian perspective, the eventuation of paradigms is a reminder of the dissolution of metaphysics. In other words, “Being is not structure but occurrence, that which eventuates in history in different cultures, in different epochs.”³⁷ In America, vitalism was beginning to give way to the *qualified* sanctity of life ethos, and religious organizations—particularly Catholic—preferred this compromise to the growing concern over the *quality of life* ethos and euthanasia.

Nancy Cruzan: Acts of Omission in Flux

After *Quinlan*, another “event of being” would challenge vitalism’s influence in medical ethics. In 1983, twenty-five-year-old Nancy Cruzan crashed her car, was thrown from the vehicle, and landed face down in a ditch. She stopped breathing for about fifteen minutes, and although paramedics got her heart and lungs working, she was left with severe brain damage from a lack of oxygen to her brain.³⁸ Unlike Karen Ann Quinlan, Cruzan was not on a respirator; moreover, she was not technically a terminally ill patient. What was required for her continued living was nutrition and hydration, along with basic nursing care. In 1987, four years after the accident, the Cruzans asked the nursing home looking after Nancy to remove her feeding tube, but the nursing home

³⁴ Ibid., 34.

³⁵ Ibid., 37.

³⁶ Dowbiggin, *A Concise History of Euthanasia: Life, Death, God, and Medicine*, 122.

³⁷ Vattimo with Paterlini, 106.

³⁸ Dowbiggin, *A Concise History of Euthanasia: Life, Death, God, and Medicine*, 134–35.

refused. When Nancy's parents filed suit for the removal of the tube, the Missouri Department of Health appealed, forcing the case all the way to the United States Supreme Court. Lester "Joe" Cruzan, Nancy's father, saw no value in keeping Nancy alive, viewing it as an affront to her *biographical* life: "Nancy died that night [of the car accident]. We've got her body left, but she has no dignity whatsoever. . . .What's the purpose in this [in keeping her alive]?"³⁹ Mr Cruzan was also willing to accept his role as the arbiter of death: "What—if the decision's wrong, if we're playing God, then I'll have to live with that, and I'm willing to."⁴⁰

The transition from *Quinlan* to *Cruzan*—from turning off respirators to removing artificial nutrition and hydration—was still problematic. In other words, just what types of "passive" acts were justifiable was a work in progress, as was the degree of emphasis one could place on quality of life considerations. "Pulling the plug" and allowing "nature to take its course" was considered a type of treatment that could be sanctioned. In the culture of late 1980s Missouri, however, removing food and water from a patient in a permanent vegetative state was deemed morally unacceptable. Although a passive act, the cause of death was too easily attributable to the act itself. The patient would not die from some underlying disease but from dehydration and malnutrition. Donald Lamkins, the hospital administrator where Nancy was cared for, made a clear moral distinction between types of acceptable omissions: "No, we can't do it [remove Nancy's nutrition and hydration]. We know that we can unplug a machine. . . .This isn't nearly as hard for

³⁹ Frontline, "The Death of Nancy Cruzan," Air Date: March 24, 1992.
<www.pbs.org/wgbh/pages/frontline/programs/transcripts/1014.html>

⁴⁰ Ibid.

us to accept. But the fact that we starve somebody to death—we don't do that. That's beyond our ability to think, even, at this point, in Missouri.”⁴¹

Religion certainly played some role in shaping Missouri's statutes surrounding acts of omission. The Missouri legislature adopted a living will law in 1985, but the Catholic Church opposed such laws, believing they “cheapened life.”⁴² Consequently, the Missouri Catholic Conference, the public policy agency for the Catholic Church in Missouri, lobbied aggressively to limit the applicability of the living will law. Their lobbying succeeded, as the Missouri legislature defined “terminal illness” more narrowly than other states. Added to the statute was the clause: “This law does not condone, authorize, or approve mercy killing or euthanasia nor permit any affirmative or deliberate act or omission to shorten or end life.”⁴³ Although one form of omission—the withdrawal of respirators—was permitted, the Missouri legislature made it clear that “any procedure to provide nutrition or hydration” was not considered medical treatment. Even if administered through a tube, artificial nutrition and hydration could not be removed by a living will.⁴⁴

Two ethical positions were now in play. As with the position taken by the Catholic Conference, the Missouri Supreme Court also erred on the side of life. In contrast, the Cruzans' quality of life position was unmistakable: “to hold that the cost of maintaining Nancy's present life [was] too great when weighed against the benefit that life conveys both to Nancy and her loved ones and that she must die.”⁴⁵ Although the Court concluded that “[o]nly the coldest heart could fail to feel the anguish of these

⁴¹ Ibid.

⁴² William Colby, *Long Goodbye: The Deaths of Nancy Cruzan*, 91.

⁴³ Ibid., 92.

⁴⁴ Ibid.

⁴⁵ *Cruzan v. Harmon*, 760 S.W.2d 408, 57 USLW 2324 (Mo. Nov 16, 1988) (NO. 70813), 7.

[Nancy's] parents who have suffered terribly these many years,"⁴⁶ it reversed a previous lower court decision permitting the withdrawal of nutrition and hydration. Metaphysics was certainly foundational to the final decision. As the Court noted, concern for the sanctity of life "rests on the principle that life is precious and worthy of preservation *without regard to its quality* [emphasis mine]."⁴⁷ The Court feared that if the issue centred on quality of life concerns, "persons with all manner of handicaps might find the state seeking to terminate their lives. Instead, the state's interest is in life; that interest is unqualified."⁴⁸ The Court could not accept the Cruzans' argument that Nancy would not recover, calling such quality of life considerations "a thinly veiled statement that her life in its present form is not worth living . . . a diminished quality of life does not support a decision to cause death."⁴⁹

In dissent, Judge Blackmar's arguments illustrate the difference between metaphysicians and Vattimian postmodernists. He did not believe that the state's interest in preserving life was unqualified, noting three distinct examples to prove his point: capital punishment demonstrated a "relativity of values," living wills encouraged "the pre-planned termination of life," and the state was not prepared to "finance the preservation of life, without regard to cost, in very many cases."⁵⁰ For Blackmar, it was "unrealistic to say that the preservation of life is an absolute, without regard to the quality of life," describing those supporting the absolutist provision as "crypto-philosophers"

⁴⁶ Ibid.

⁴⁷ Ibid., 15.

⁴⁸ Ibid., 17.

⁴⁹ Ibid., 19. Ironically, the majority cited more than fifty appellate decisions from sixteen jurisdictions that supported and validated the trial court's judgement in favour of Nancy Cruzan's parents, yet the Missouri Supreme Court still rejected the Cruzans' petition. See Judge Higgins in dissent.

⁵⁰ Ibid., 26.

who “dwell in ivory towers.”⁵¹ To distance himself from metaphysics, he called his approach to the Cruzan case “realistic rather than absolute” because it was “not possible to express absolutes in situations such as these.”⁵² He concluded that the principal opinion ignored contingencies because it “attempt[ed] to establish absolutes, but [did] so at the expense of human factors.”⁵³ The result was that Nancy and her family were subjected to “continuous torture which no family should be forced to endure.”⁵⁴

After the loss, the Cruzans’ ordeal was not over. In a split decision, the U.S. Supreme Court agreed that Missouri acted legitimately by siding with the “protection and preservation of human life.”⁵⁵ However, the Cruzans would not be deterred and went back to probate court, this time armed with “clear and convincing evidence” of Nancy’s wishes. Three of Nancy’s former acquaintances came forward with recollections of her statements that “she wouldn’t want to be kept alive by respirator or force-feeding.”⁵⁶ This time around, however, *Cruzan* was interpreted differently because of a change in the socio-political climate. The Missouri attorney-general, William Webster, withdrew the state from the case for two reasons: He planned on running for governor in 1992, and according to polls, “89 percent of Missourians would want to end treatment if they were hopelessly ill or in a vegetative state.”⁵⁷ Once the state withdrew, Judge Teel from the appellate court ordered, as he had in 1988, that the feeding tube be removed.⁵⁸ Twelve days later—and seven years after being thrown from her car—Nancy Cruzan was now *biologically* dead.

⁵¹ Ibid., 27.

⁵² Ibid.

⁵³ Ibid.

⁵⁴ Ibid.

⁵⁵ Filene, 178.

⁵⁶ Ibid., 181.

⁵⁷ Ibid., 182.

⁵⁸ Ibid.

Oregon: Toward the Quality of Life Ethos

Cruzan certainly galvanized right-to-die supporters in America who felt that perhaps Oregon might provide constitutional recognition of the right to a doctor-assisted suicide. The hope for quality of life advocates was that acts of commission would become more socially and legally acceptable. One hurdle was crossed when the Oregon Death with Dignity Act (Ballot Measure 16) was passed by a 51–49 percent margin in 1994. The Roman Catholic Church had led the anti-Measure 16 cause, hoping to prevent a shift from the *qualified* sanctity of life ethos—with its emphasis on the omission/commission moral distinction—toward the quality of life ethos, which rejected any inherent distinction between positive and negative acts. The Catholic Church began pouring millions into its Oregon campaign, as it had in defeating initiatives in Washington and California three years earlier.⁵⁹ Therefore, the right-to-die debate in Oregon was depicted in polemic terms as “a battle between rigid religionists and compassionate rationalists.”⁶⁰ The climate of the state was certainly conducive to such rhetoric. Although Catholics were the largest religious group in Oregon at the time (12 percent of the population), in the 1990s Oregon was 62 percent “unchurched,” making it more secular than most jurisdictions.⁶¹ In fact, church attendance was highly correlated with voter resistance to Measure 16, the core opposition consisting of Catholic women, Republican women, and lesser-educated voters.⁶²

⁵⁹ For details surrounding the Washington and California initiatives, see Daniel Hillyard and John Dombrink, *Dying Right: The Death with Dignity Movement* (New York: Routledge, 2001).

⁶⁰ Ian Dowbiggin, *A Merciful End: The Euthanasia Movement in Modern America*, 171.

⁶¹ Daniel Hillyard and John Dombrink, *Dying Right: The Death with Dignity Movement* (New York: Routledge, 2001), 71.

⁶² *Ibid.*, 79.

The new law would allow patients in the terminal phase of their disease (with less than six months to live) to ask a physician for a lethal dose of drugs to end unbearable suffering; however, to avoid the controversy over euthanasia, the patient had to self-administer the drugs.⁶³ The strategy for the pro-Measure 16 lobbyists was postmodernist in the Vattimian sense: Measure 16 was designed to prevent the imposition of religious views, the terminally ill could avoid a lingering, painful death with the choice of physician-assisted suicide, and safeguards were deemed feasible.⁶⁴ In contrast, the Catholic Church embraced metaphysics, reminding parishioners that “humans [were] mere stewards of lives granted by God,” that “life [was] sacred,” and that a “slippery slope would be created” if Measure 16 succeeded.⁶⁵ According to Hillyard and Dombrink, when Measure 16 was finally passed, it “reversed two thousand years of Western medical ethics and law.”⁶⁶ In 1997, Measure 51 was largely initiated by the Catholic Church to repeal Measure 16; however, Oregonians roundly endorsed the original statute by a 60–40 margin.⁶⁷

⁶³ Ibid., 81.

⁶⁴ Ibid., 78.

⁶⁵ Ibid., 90, 95. Accusations of a “slippery slope” in Oregon have failed to generate evidence of widespread abuse. Under the Oregon Death with Dignity Act, the overwhelming number of patients receiving assistance in death is white, well-educated, and financially secure, and their gender approximates that of the general population. With respect to palliative care, there is evidence that its quality has actually improved since the adoption of the new law. See P. Goodwin, “The Distortion of Cases in Oregon,” in *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice*, eds. T. Quill and M. Battin (Baltimore, Maryland: John Hopkins University Press, 2004), 184–189; also see A. Sullivan, K. Hedberg, and D. Hopkins, “Legalized Physician-assisted Suicide in Oregon, 1998–2000,” *New England Journal of Medicine* 342 (2000): 598–604; Oregon Department of Human Services, *Summary of Oregon’s Death with Dignity Act-2007 and Tables 1 and 2*. <www.Oregon.gov/DHS/ph/pas/ar-index.shtml>

⁶⁶ Ibid., 98.

⁶⁷ Ibid., 99–117. The accusation that safeguards for physician-assisted suicide would not work became a major theme for the Catholic Church during the Measure 51 campaign in 1997. The appeal forces claimed that physician-assisted suicide “fails 25 percent of the time, often resulting in a prolonged death and increased suffering for patients.” This data, however, was based on a phone interview with Dutch physician Dr. Pieter Admiraal. His study actually showed that 96 percent of his sample died within five hours of taking life-ending medication. The other 4 percent died within two days. Admiraal openly concluded that “opponents of assisted suicide were badly misusing his research” (102).

Britain: Anthony Bland and Quality of Life Considerations

In Britain it was the case of Anthony Bland that moved ethical opinion away from the sanctity of life as an absolute principle (vitalism). In fact, this “event” set a precedent for allowing quality of life considerations to factor into the debate over an intentionally hastened death. In April 1989, Tony Bland went to Hillsborough Football Stadium in Sheffield to watch a football game between Liverpool and Nottingham Forest. When the game began, fans were trying to enter the grounds, and a fatal crush occurred. As thousands were pushed against a fence, ninety-five people were killed in the worst sports disaster in British history. Although Tony Bland survived, his lungs were crushed by the pressure of the crowd, depriving his brain of oxygen. Consequently, he was in a persistent vegetative state and would never recover.⁶⁸ When the physician in charge of Bland’s case, Dr. J.G. Howe, notified the coroner that he intended to withdraw artificial feeding, the coroner delivered a mixed message. While agreeing that Bland’s condition was pointless, the coroner informed Dr. Howe that he ran the risk of criminal charges—or quite possibly murder—if he intentionally ended Bland’s life.⁶⁹ Thus, Anthony Bland became a catalyst that sparked debate over the sanctity of life human life as absolute.

The testimony of several judges provided clear evidence of a movement away from vitalism and toward quality of life considerations for those in a permanent vegetative state. As Lord Keith of Kinkel made clear, the sanctity doctrine as absolute was already in dispute:

Given that existence in the persistent vegetative state is not a benefit to the patient, it remains to consider whether the principle of the sanctity of life . . . is an absolute one. It does not compel a medical practitioner on pain of criminal sanctions to treat a patient, who will die if he does not, contrary to the express wishes of the patient. It does not authorize forcible feeding of prisoners on

⁶⁸ Peter Singer, *Rethinking Life and Death: The Collapse of our Traditional Ethics*, 58.

⁶⁹ *Ibid.*, 59.

hunger strike. It does not compel the temporary keeping alive of patients who are terminally ill where to do so would merely prolong their suffering.⁷⁰

However, Lord Keith understood that such a shift in ethical opinion had limits.

While quality of life judgments extended to omissions, they could not be used to justify acts of commission:

[The principle of the sanctity of life] forbids the taking of active measures to cut short the life of a terminally ill patient. In my judgment it does no violence to the principle to hold that it is lawful to cease to give medical treatment and care of a P.V.S. patient who has been in that state for over three years, considering that to do so . . . confers no benefit upon him.”⁷¹

Evidence of the sanctity doctrine’s weakening was also provided by Lord Goff of Chieveley. Although he agreed that the sanctity of human life was a principle “long recognized not only in our own society but also in most, if not all, civilised societies throughout the modern world,” it was still “not absolute.”⁷² As with Lord Keith, Lord Goff highlighted exceptions to the sanctity doctrine:

Indeed, there are circumstances in which it is lawful to take another man’s life, for example by a lawful act of self-defence, or (in the days when capital punishment was acceptable in our society) by lawful execution. . . . We are concerned with circumstances in which it is lawful to withhold from a patient medical treatment or care by means of which his life may be prolonged. But here too there is no absolute rule that the patient’s life must be prolonged by such treatment or care, if available, regardless of the circumstances.⁷³

Certainly, Lord Goff’s position had shifted toward the *qualified* sanctity of life ethos. He admitted that, due to changes in medicine and law, vitalism was no longer universally applicable. Using the Canadian case of Nancy B. as an example, he confirmed that for non-treatment decisions, “the principle of the sanctity of human life must yield to the principle of self-determination.”⁷⁴ He added that, if taken to the extreme, the prolongation of life at all costs “would be most startling, and could lead to

⁷⁰ *Airedale Hospital Trustees v. Bland* [1992] UKHL 5 (4 February 1993), 3.

<www.bailii.org/uk/cases/UKHL/1992/5.html>

⁷¹ *Ibid.*, 3–4.

⁷² *Ibid.*, 9.

⁷³ *Ibid.*

⁷⁴ *Ibid.*

the most adverse and cruel effects upon the patient, if any such absolute rule were held to exist.”⁷⁵ Although he was supportive of acts of omission, Lord Goff explained how the law “draws a crucial distinction between cases in which a doctor decides not to provide, or to continue to provide, for his patient treatment or care which could or might prolong life, and those in which he decides, for example by administering a lethal drug, actively to bring his patient’s life to an end.”⁷⁶

Yet Lord Goff certainly struggled with the bifurcated rhetoric surrounding negative and positive acts. He noted that the “drawing of this distinction may lead to a charge of hypocrisy” because “it can be asked why, if the doctor, by discontinuing treatment, is entitled in consequence to let his patient die, it should not be lawful to put him out of his misery straight away, in a more humane manner, by a lethal injection, rather than let him linger on in pain until he dies.”⁷⁷ However, there were several reasons given for his legal justification of the *qualified* sanctity of life ethos. For one, an exception granted for an act of commission would lead to its universal application. As Lord Goff noted, “[T]he law does not feel able to authorise euthanasia, even in circumstances such as [Anthony Bland’s]; for once euthanasia is recognised as lawful in these circumstances, it is difficult to see any logical basis for excluding it in others.”⁷⁸ Moreover, the cause of death for non-treatment decisions could still be attributed to the disease itself, not to a third party. Consequently, the doctor would be “allowing his patient to die in the sense that he is desisting from taking a step which might . . . prevent

⁷⁵ Ibid., 10.

⁷⁶ Ibid.

⁷⁷ Ibid., 11.

⁷⁸ Ibid.

his patient from dying as a result of his pre-existing condition.”⁷⁹ When referencing other negative acts, however, Lord Goff suggested a causal link between the omission of treatment and the death of the patient. He concluded that Bland’s doctors would be entitled to “discontinue both the artificial feeding of Anthony, and the use of antibiotics,” since it was “plain by the evidence that Anthony, in his present condition, [would be] very prone to infection and . . . [would] succumb to infection which, if unchecked, [would] spread and *cause* his death [emphasis mine].”⁸⁰

Lastly, Lord Browne–Wilkinson provided an overview of how two competing paradigms—sanctity of life and quality of life—affected how one perceived the Bland case. On the one hand, he admitted that doctors had adopted a quality of life ethic by “‘exercis[ing] their own discretion, in accordance with medical ethics,’ in cases such as this one, and had taken responsibility for deciding ‘whether the perpetuation of life was pointless.’”⁸¹ On the other hand, Lord Browne–Wilkinson agreed that medical and nursing staff opposed to an omission that ends life (vitalism) “genuinely believe in the sanctity of human life, no matter what the quality of that life.”⁸² He also understood that one’s meta-ethical beliefs would eventually shape one’s opinion of the Bland case:

The doctor’s answer may well be influenced by his own attitude to the sanctity of life. In cases where there is no strictly medical point in continuing care, if a doctor holds the view that the patient is entitled to stay alive, whatever the quality of such life, he can quite reasonably reach the view that the continuation of intrusive care, being the only way of preserving such life, is in the patient’s best interests. But, in the same circumstances another doctor who sees no merit in perpetuating a life of which the patient is unaware can equally reasonably reach the view that the continuation of invasive treatment is not for the patient’s benefit.⁸³

⁷⁹ Ibid.

⁸⁰ Ibid., 15.

⁸¹ Singer, *Rethinking Life and Death: The Collapse of our Traditional Ethics*, 59.

⁸² *Airedale Hospital Trustees v. Bland* [1992] UKHL 5 (4 February 1993), 27.
<www.bailii.org/uk/cases/UKHL/1992/5.html>

⁸³ Ibid., 31.

In the end, Lord Browne–Wilkinson chose a “middle path” between vitalism and the quality of life ethos, agreeing that Bland’s life could be ended solely by an act of omission. Although he submitted that the law made such a distinction possible, he was unsure as to its credibility:

[T]he conclusion I have reached will appear to some to be almost irrational. How can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks from lack of food but unlawful to produce his immediate death by a lethal injection, thereby saving his family from yet another ordeal to add to the tragedy that has already struck them? I find it difficult to find a moral answer to that question. But it is undoubtedly the law and nothing I have said casts doubt on the proposition that the doing of a positive act with the intention of ending life is and remains murder.⁸⁴

The House of Lords eventually decided that Bland’s life could be ended by an act of omission, that being the withdrawal of nutrition and hydration. As Peter Singer acknowledged, the judgments in the Bland case broke new ground in two crucial ways: They allowed “considerations of the quality of life to enter into a decision whether life should be prolonged,” and they accepted as lawful “a course of conduct that has as its aim and object the death of an innocent human being.”⁸⁵ In other words, the House of Lords’ position was no longer vitalistic. However, the legal acceptance of acts of omission meant that British society had made a marked transition toward the *qualified* sanctity of life ethos. Acts of commission permitted under a quality of life ethic would have to await a new “event of being.”

Canada: The *Qualified* Sanctity of Life Ethos Prevails

In Canada, the prohibition against assistance in suicide was originally legislated in 1892. At that time, the law was unequivocal in its condemnation of such an act: “Everyone is guilty of an indictable offence and liable to imprisonment for life who

⁸⁴ Ibid., 32.

⁸⁵ Singer, *Rethinking Life and Death: The Collapse of our Traditional Ethics*, 65.

counsels or procures any person to commit suicide, actually committed suicide in consequence of such counselling or procurement, or who aids or abets any person in the commission of suicide.”⁸⁶ Suicide was considered so taboo that the law also condemned attempted suicide, legislation that remained unchallenged until the late 1960s. In a context of rapid social change, however, the nineteenth-century statute was called into question. Just as other behaviours, such as homosexuality, were being viewed as a medical, as opposed to a legal, problem,⁸⁷ suicide also began to be seen in a more compassionate light. In 1966, Ian Watson (Châteauguay–Huntingdon–Laprairie, Lib.) introduced Bill C–124 to amend the *Criminal Code*’s prohibition against attempted suicide. Subsequent attempts were made by Milton L. Klein (Cartier, Lib.) in 1968 with Bill C–205 and Marcel Prud’homme (Saint–Denis, Lib.) in 1969 with Bill C–173.⁸⁸ Some conservatives warned against changes to the *Criminal Code*, citing religious concerns. For instance, Marcel Lambert (Edmonton–West, PC) admitted that attempted suicide was “an immoral act” and that an individual did not have the right to “cast aside [his] life.”⁸⁹ It was not as if some anxiety was not warranted. It was pointed out by the Hon. Jean–Luc Pepin (Minister of Industry, Trade and Commerce, Lib.) that suicide rates in the late 1960s had increased on a per capita basis.⁹⁰

⁸⁶ *Criminal Code*, 1892, S.C. 1892, c. 29, s. 237.

⁸⁷ Stuart Chambers, “Pierre Elliott Trudeau and Bill C–150: A Rational Approach to Homosexual Acts, 1967–69,” *Journal of Homosexuality* 57, no. 2 (February 2010): 249–66.

⁸⁸ See Ian Watson, “Amendment Respecting Attempted Suicide by Mentally Ill,” *Commons Debates* (1st Session, 27th Parliament) Vol. II (February 14th–March 4th, 1966), 1299–1300; also see M.L. Klein, “Criminal Code,” *Commons Debates* (2nd Session, 27th Parliament) Vol. VII (February 26th–April 23rd, 1967–68), 7405; Marcel Prud’homme, “Criminal Code: Amendment Respecting Attempted Suicide,” *Commons Debates* (2nd Session, 28th Parliament) Vol. II (November 24th–December 19th, 1969), 1946.

⁸⁹ Marcel Lambert, “Criminal Code,” *Commons Debates* (1st Session, 28th Parliament) Vol. VII (March 20th–April 25th, 1969), 7612.

⁹⁰ Hon. Jean–Luc Pepin, “Deaths from Alcoholism, Drugs and Suicide,” *Commons Debates* (1st Session, 28th Parliament) Vol. VI (February 19th–March 19th, 1969), 5699–5700. Pepin noted that from 1965–67, suicide rates had moved from 8.7 to 9.0 per 100,000.

After several more attempts to amend the *Criminal Code* were made from 1970–71,⁹¹ a shift had occurred with reference to the sanctity of life ethos as absolute. Before the House of Commons Standing Committee on Justice and Legal Affairs, Justice Minister John Turner announced in 1971 that attempted suicide would no longer be a criminal offence. The Liberal government wanted to bring the law into line “with contemporary attitudes,” feeling that “the proper sanction should not be penal but psychological treatment.”⁹² Turner informed the Standing Committee on Justice and Legal Affairs that “the crime of attempted suicide as it affects personal conduct is deserving more of medical attention than a criminal sanction.”⁹³ Acquiring Turner’s justice portfolio in 1972, Otto Lang agreed that a therapeutic approach to attempted suicide was more practical than the use of punitive measures. Therefore, suicide did not “require a legal remedy, that it ha[d] its roots and its solutions in sciences outside of the law and that . . . deterrent under the legal system [was] unnecessary.”⁹⁴ By June of that year, “attempted suicide” was removed from the *Criminal Code*.⁹⁵ That said, the act of suicide had to be a solitary one. A third party that aided another to kill him/herself was still guilty of a homicide. As it now reads, s.241 of the *Criminal Code* states: “Everyone who (a) counsels a person to commit, or (b) aids or abets a person to commit suicide,

⁹¹ See “Public Bills,” *Commons Debates* (3rd Session, 28th Parliament) Vol. I (October 8th, November 12th, 1970), 389; also see J.M. Forrestall, “Criminal Code: Amendment to Remove Attempted Suicide as an Offence,” *Commons Debates* (3rd Session, 28th Parliament) Vol. III (January 11th–February 12th, 1971), 2929.

⁹² John Burns, “Suicide Attempt Won’t Be Crime Under New Law, Turner Says,” *The Globe and Mail*, 3 March, 1971, A1.

⁹³ John Turner, “Respecting Bill C–218, An Act to Amend the Provisions of the Criminal Code Relating to the Release from Custody of Accused Persons before Trial or Pending Appeal,” *Minutes of Proceedings and Evidence of the Standing Committee on Justice and Legal Affairs*, Issue 10 (2 March 1971), 10.

⁹⁴ Otto E. Lang, “Criminal Law Amendment Act, 1972: Amendment to Criminal Code, Criminal Records Act, National Defence Act and Visiting Forces Act,” *Commons Debates* (4th Session, 28th Parliament) Vol. II (March 20th–May 5th, 1972), 1699.

⁹⁵ *Criminal Code Law Amendment Act*, 1972, S.C. 1972, C.13, s.16.

whether suicide ensures or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.”⁹⁶

In the 1980s, the Law Reform Commission of Canada tackled the growing controversy surrounding the sanctity of life and quality of life ethos. There had been increased public support for active voluntary euthanasia in Canada since the late 1960s. Although only 45 percent supported such an act in 1968, this had risen to 66 percent by 1984.⁹⁷ Consequently, the Commission had to find a way to confront paradigmatic shifts in medical ethics. It concluded that absolute moral distinctions between acts of omission and commission were legitimate; in other words, “allowing nature to take its course” and “letting die” were ethically distinct from the intentional hastening of death.⁹⁸ Fearing possible abuses and further weakening of the sanctity doctrine, the Commission maintained the prohibition against euthanasia and assisted suicide.⁹⁹

In the 1990s, there was a growing acceptance of quality of life considerations, particularly in cases of intentional death. In fact, in twenty cases where an intentionally hastened death became known to Canadian authorities, no charges were laid in three cases, charges were stayed or dropped in two cases, the accused were found not guilty in three cases, and of eleven convictions, eight resulted in suspended or conditional

⁹⁶ Criminal Code, R.S.C., c. C-46, s. 241 [*Criminal Code*].

⁹⁷ Margaret Otlowski, *Voluntary Euthanasia and the Common Law* (New York: Oxford University Press, 1997), 261–62. It is interesting to note that since 1968, Gallup Canada has regularly conducted polls using the same question: “When a person has an incurable disease that causes great suffering, do you, or do you not think that competent doctors should be allowed by law, to end the patient’s life through mercy killing, if the patient has made a formal request in writing?” By 1995, the number in support of active voluntary euthanasia in Canada had risen to 75 percent.

⁹⁸ Law Reform Commission of Canada, *Euthanasia, Aiding Suicide and Cessation of Treatment* (Working Paper 28) (Ottawa: Minister of Supply and Services Canada, 1982).

⁹⁹ Law Reform Commission of Canada, *Report on Euthanasia, Aiding Suicide and Cessation of Treatment* (Ottawa: Minister of Supply and Services Canada, 1983). More details of the Commission’s findings will be discussed in Chapter V under “Metaphysics and the Law Reform Commission of Canada.”

sentences or probation.¹⁰⁰ Several other cases also demonstrated that Canada provided lenient sentences for mercy killings. For instance, in 1990, Dr. Thomas Perry gave an injection of morphine to his father, who was dying of cancer. After Dr. Perry admitted that the morphine dosage might have shortened his father's life, the B.C. College of Physicians and Surgeons concluded that he had done nothing wrong, and no criminal charges were laid.¹⁰¹ In 1991, Dr. Peter Graaf ordered dosages of morphine and valium for two patients that a British Columbia coroner felt had far exceeded the amount necessary. When the B.C. College of Physicians and Surgeons investigated and found that he had indeed acted inappropriately, Dr. Graaf was not charged with professional misconduct or any criminal offence. The Royal Canadian Mounted Police decided not to arrest him "primarily because both families refused to press charges and praised Graaf for his compassionate care."¹⁰² Moreover, in 1992, an Ontario coroner launched an inquiry into fifteen deaths at the Christopher Robin home for severely handicapped children. When children became ill with treatable diseases, a morphine drip was initiated. A coroner's jury found that morphine was a factor in the cause of death in eleven of the fourteen deaths and a definite factor in two of the deaths. However, the authorities did not press charges, largely due to problems assessing causation.¹⁰³

Several other cases also demonstrated that Canada provided lenient sentences for mercy killings. In each of these scenarios, the court's decision was an indication that quality of life considerations were being accepted as mitigating circumstances. *R. v.*

¹⁰⁰ Jocelyn Downie and Simone Bern, "Rodriguez Redux," *Health Law Journal* 16 (2009): 30.

¹⁰¹ Anne Mullens, "Society Must Lead in Determining Canadian Position on Euthanasia, Doctors Say," *Can Med Assoc J* 148 (15 April 1993): 1367.

¹⁰² *Ibid.*

¹⁰³ Jocelyn Downie, *Dying Justice: A Case for Decriminalizing Euthanasia & Assisted Suicide in Canada*, 30–31.

Mataya involved a doctor using a fatal dose of potassium chloride on a seventy-eight-year-old patient to shorten his agony after a respirator was pulled. In the case of *R. v. de la Rocha*, a doctor used potassium chloride on a seventy-year-old woman dying from lung cancer after an endotracheal tube was removed. A husband and wife in *R v. Myers and Power* deliberately killed the wife's father, who was dying of lung cancer, by placing a pillow over his head and suffocating him. In *R. v. Brush* an eighty-one-year-old woman murdered her eighty-one-year-old ailing husband suffering from Alzheimer's. In all of the above, the defendants were given noncustodial sentences. As well, in Alberta in 1994, Robert Cashin was charged with attempted murder in the death of his terminally ill mother. He had placed a large number of pills in his mother's hand, which she had then taken. After her death three days later, the son pled guilty to administering a noxious substance, was given a suspended sentence, and placed on probation for two years. Lastly, in 1997, Dr. Nancy Morrison was charged with first-degree murder following the death of a cancer patient, Paul Mills. After his treatment was withdrawn, standard medication failed to relieve his suffering, so Dr. Morrison gave Mills a lethal injection of potassium chloride. The charges were eventually dropped, and Dr. Morrison received a letter of reprimand from the Nova Scotia College of Physicians and Surgeons.¹⁰⁴

However, the cases of Nancy B., Sue Rodriguez, and Robert Latimer were "events of being" that had the most impact on the Canadian debate over cessation of treatment, euthanasia, and physician-assisted suicide. Nancy B. suffered from a rare neurological disorder and was completely paralyzed, requiring a ventilator to breathe. Showing no signs of improvement after two and a half years, she went to court and won the right to refuse treatment, even though this act of omission would lead to her demise.

¹⁰⁴ Ibid., 38–43.

The 25-year-old Quebec woman was sending a message that she preferred death rather than a life paralyzed with no hope of recovery.¹⁰⁵ The case of Sue Rodriguez was arguably the most important in the fight over physician-assisted suicide. Dying from amyotrophic lateral sclerosis, or ALS, she asked the Supreme Court of Canada to allow a doctor to help terminate her life in order to avoid further suffering. A split decision in Canada's highest court (5–4) was an indication that the country was moving toward the quality of life ethos but had not yet reached that stage. Although she lost her final court battle, Rodriguez put the issue of how, when, and who controls the way we die on the public agenda.¹⁰⁶ Finally, the case of Robert Latimer was undoubtedly the most complex. Latimer chose to end the suffering of his daughter Tracy, who had since birth been afflicted with a severe form of cerebral palsy. Latimer placed her in the cab of his Chevy pickup, ran a hose from the exhaust to the cab, and watched her die of carbon monoxide poisoning. Seeking a constitutional exemption for nonvoluntary active euthanasia, or “mercy killing,” he eventually lost every court battle all the way up to and including the Supreme Court of Canada.¹⁰⁷ Because Latimer's actions constituted a positive act without explicit consent, he was given a ten-year prison sentence for second-degree murder.

Overall, these precedent-setting cases indicated that, although the sanctity of life ethos in Canada was being called into question as to its supremacy as first principle, it had not “weakened” to the point of allowing an intentionally hastened death. Vitalism

¹⁰⁵ CBC Digital Archives, “‘Nancy B’ Dies after Winning Right to Refuse Treatment,” Broadcast Date: February 13, 1992: accessed September 22, 2010. <archives.cbc.ca/politics/rights_freedoms/clips/6406/>

¹⁰⁶ CBC Digital Archives, “‘Sue Rodriguez and the Right-to-Die Debate: Suicide,’” Broadcast Date: February 21, 1994: accessed September 22, 2010. <archives.cbc.ca/politics/rights_freedoms/topics/1135>

¹⁰⁷ CBC News Online, “Compassionate Homicide: The Law and Robert Latimer,” Last Updated: March 17, 2008: accessed September 22, 2010. <www.cbc.ca/news/background/latimer>

may have been discredited, and quality of life considerations may have entered into court decisions, but Canadian law was unequivocal: Acts of commission used to commit euthanasia and assisted suicide were still unethical and illegal. Therefore, the *qualified* sanctity of life ethos was as far as the country was willing to go in terms of its acceptance of a hastened death.

Holland's Gradualism

Rather than legislating euthanasia and assisted suicide, something that might create political schisms, Holland adopted a step-by-step approach. What is important to understand is how the law, through a series of judicial proceedings, weakened over time, eventually permitting the decriminalization of *both* euthanasia *and* physician-assisted suicide. Unlike most Western nations and/or states, the quality of life ethos came to be fully embraced by the Dutch.

The Netherlands became the focus of world attention when in 1971 Dr. Geertruida Postma not only ended the life of her own mother with a fatal injection of morphine, but also reported her actions to the director of the nursing home where her mother resided. She was subsequently charged with mercy killing, facing a possible sentence of twelve years in prison.¹⁰⁸ Her mother pleaded with her daughter to end her life since she was suffering from numerous ailments, namely a cerebral hemorrhage, paralysis, deafness, and pneumonia. This led Dr. Postma to make a quality of life judgment in her final analysis: "When I watched my mother, a human wreck, hanging in that chair, I couldn't stand it anymore. So I shouted in her ear, 'It's all right, Mother! I

¹⁰⁸ David C. Thomasma et al., eds., *Asking to Die: Inside the Dutch Debate about Euthanasia* (Dordrecht, The Netherlands: Kluwer Academic Publishers, 1998), 7.

will take care of you.’ The next day I gave her the fatal shot.”¹⁰⁹ When discussing her mother’s overall suffering at trial, Dr. Postma had no regrets for what she had done: “Her physical suffering was serious, no more. But the mental suffering became unbearable. . . . Now, after all these months, I am convinced I should have done it much earlier.”¹¹⁰ The verdict handed down by the Court of Leeuwarden in the Province of Friesland reflected public sympathy. After finding her guilty in 1973 of mercy killing, the Court sentenced her to a suspended sentence of one week imprisonment and a year’s probation.¹¹¹

The legal issue at stake in the Postma case—whether quality of life considerations warranted an intentionally hastened death—would be tested once again in 1984 in the *Alkmaar* case (named after the district where the initial trial took place). The defendant, Dr. Schoonheim, euthanized his ninety-five-year-old patient, Caroline Barendregt, who was seriously ill and wanted to die before she was unable to make the decision herself. She had extensively discussed her decision with Dr. Schoonheim and signed a living will requesting euthanasia “should she arrive at a condition from which no recovery to a reasonable and dignified state of life could be expected.”¹¹² Once her condition deteriorated after a fractured hip at ninety-four, the patient wished to die as soon as possible. Dr. Schoonheim complied with the request because of the burden of her unbearable suffering.¹¹³ After the lethal injection was administered, Dr. Schoonheim notified the authorities and was subsequently charged with mercy killing. However, the

¹⁰⁹ “The Law: Implications of Mercy,” *Time*, 5 March 1973, 70.

¹¹⁰ Derek Humphry and Ann Wickett, *The Right to Die: An Historical and Legal Perspective of Euthanasia* (Eugene, Oregon: The Hemlock Society, 1990), 172. Dr. Postma even received considerable public sympathy for her actions. A handful of people in Dr. Postma’s village banded together to form the Society for Voluntary Euthanasia, which later became the world’s largest euthanasia society.

¹¹¹ David C. Thomasma et al., eds., *Asking to Die: Inside the Dutch Debate about Euthanasia*, 7.

¹¹² *Ibid.*, 8.

¹¹³ J. Gevers, “Legal Developments Concerning Active Euthanasia on Request in the Netherlands,” *Bioethics* 1 (1987): 156, 159.

doctor claimed that he was conflicted by two duties: the duty not to kill and the duty to relieve unbearable suffering. These grounds were based on the concept of “force majeure,” which recognizes extenuating circumstances such as conflicts of duty.¹¹⁴ The case went all the way to the Dutch Supreme Court, which in 1984 ruled that in rare situations the intentional hastening of death may be required:

As a general rule euthanasia is punishable . . . however, when physicians are confronted with a conflict of duties they may invoke the defence of necessity. A conflict of duties arises when the doctor’s professional ethical obligations to honor a patient’s request to die with dignity force the physician to act inconsistently with the formal provisions of the Penal Code . . . the decision that the defence of necessity is available to a physician should be based on an investigation whether the physician made a responsible medical judgment, tested against criteria derived from medical ethics.¹¹⁵

In Holland, there had been a growing curiosity as to the number of actual requests for euthanasia and assisted suicide as well as those being complied with by doctors.¹¹⁶ In 1990, the Rummelink Commission was asked to report on the practice by physicians that involved “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.”¹¹⁷ The Rummelink Commission 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.”¹¹⁸ In its final report presented in 1991, the data showed that as a percentage of all deaths in 1990, euthanasia and assisted suicide accounted for 2,300 (1.8%) and 400

¹¹⁴ H.J.J. Leenen and C. Ciesielski-Carlucci, “Force Majeure (Legal Necessity): Justification for Active Termination of Life in the Case of Severely Handicapped Newborns after Forgoing Treatment,” *Cambridge Quarterly of Healthcare Ethics* 2 (1993): 271–74.

¹¹⁵ Thomasma et al., *Asking to Die: Inside the Dutch Debate about Euthanasia*, 9–10.

¹¹⁶ Humphry and Wickett, *The Right to Die: An Historical and Legal Perspective of Euthanasia*, 172–73.

¹¹⁷ P.J. van der Maas, J.J.M. van Delden, and L. Pijnenborg, *Euthanasia and Other Medical Decisions Concerning the End of Life: An Investigation Performed upon Request of the Commission of Inquiry into the Medical Practice Concerning Euthanasia* (Amsterdam: Elsevier, 1992), 4.

¹¹⁸ *Ibid.*, 19–20.

(0.3%) respectively. However, it was the 1,000 cases of active nonvoluntary euthanasia (hastening death without explicit consent) that created the most controversy.¹¹⁹

Depending on one's ethical position, the statistics either justified the workability of safeguards or were a vindication for prohibition.

From the 1980s–1990s, attempts to formally legalize euthanasia and physician-assisted suicide had met stiff political resistance. When the Democrats 66, a socially liberal, dominant political party, attempted to draw up a bill in favour of legalization, it was strongly opposed by the Christian Democratic Party. Christian Democrats put forth their own bill, one that retained the prohibition against euthanasia and physician-assisted suicide without punishing those who followed strict guidelines set out by the Royal Dutch Medical Association (i.e., persistent requests, informed consent, intolerable suffering, no acceptable alternatives to euthanasia, and consultation with another physician).¹²⁰ Political tensions and gathering jurisprudence in such matters eventually led to Holland's first formalized law. By 1993, the Dutch Senate went beyond the previous formal agreement between the medical association and the Ministry of Justice by passing Bill 22572. Parliament chose not to decriminalize an intentionally hastened death, and a legal mechanism was established by which doctors could report euthanasia and assisted suicide to the public prosecutor. As Thomasma et al. note, this compromise suggested that “while the Christian Democrats got the theory, the Social Democrats got the practice.”¹²¹ However, the bill created a paradox. Although euthanasia was still

¹¹⁹ Anne Mullens, “The Dutch Experience with Euthanasia: Lessons for Canada?” *Can Med Assoc J* 152, no. 11 (1 June 1995): 1845–52. See chapter VII under “The Dutch ‘Slippery Slope’ Unmasked” for further details concerning the Rummelink Report's findings.

¹²⁰ Thomasma et al., eds., 9.

¹²¹ *Ibid.*, 11.

technically a crime, the state continued to provide advice to physicians on how to commit this offence in order to avoid prosecution.¹²²

Dutch tolerance, however, was put to the test in the *Chabot* case. A psychiatrist, Dr. Boudewijn Chabot, was prosecuted for assisting in the suicide of a fifty-year-old woman, Hilly Boscher, because of persistent grief over the death of her two sons. The Dutch Supreme Court held that such mental distress could amount to unbearable anguish, thus equating the validity of somatic and mental suffering.¹²³ The Court agreed with the Royal Dutch Medical Association in that “a person suffering from a psychiatric disorder can express a wish to die that is legally the result of a competent and voluntary judgement.”¹²⁴ However, the Court convicted Chabot because of procedural, rather than substantive, abuse. None of the psychiatrists he consulted had personally examined the patient, which prevented any independent examination of Chabot’s claim of a hopeless condition. He was later reprimanded by the Amsterdam Medical Disciplinary College.¹²⁵ The Court still did not impose any jail sentence after taking into account “the personality of the accused, as well as the surrounding circumstances of the case.”¹²⁶ The verdict was received favourably by the Dutch, although some degree of criticism was expressed.¹²⁷

¹²² J. Legemaate, “Legal Aspects of Euthanasia and Assisted Suicide in the Netherlands 1973–1994,” *Cambridge QHealthcare Ethics* 4 (1995): 112, 118. Dutch physicians made the argument that unless the law against active voluntary euthanasia was not fully decriminalized, a proportion of doctors would simply not report their actions, fearing prosecution.

¹²³ John Keown, *Euthanasia, Ethics, and Public Policy: An Argument against Legalization*, 87; also see Senate of Canada, *Of Life and Death: Report of the Special Senate Committee on Euthanasia and Assisted Suicide*, Minister of Supply and Services Canada (May 1995), A–131–4.

¹²⁴ Otlowski, 406.

¹²⁵ M. Spanjer. “Dutch Psychiatrist Reprimanded for Assisting Suicide,” *Lancet* 345 (1995): 914.

¹²⁶ Otlowski, 407.

¹²⁷ For views critiquing the Court’s reasoning regarding non-somatic suffering and a proper examination by an independent colleague, see J. Griffiths, “Assisted Suicide in the Netherlands: The Chabot Case,” *Mod. L. Rev.* 58 (1995): 232, 234; also see J. Keown, “Physician-Assisted Suicide and the Dutch Supreme Court,” *Law Q Rev.* 111 (1995): 394.

One would think such controversies would result in a more restrictive climate in the Netherlands, but an important political change occurred after 1994. A new government was elected for the first time in seventy-five years without the participation of the Christian Democrats. The three parties forming the new government had all expressed their willingness to legalize justifiable cases of euthanasia and assisted suicide.¹²⁸ In 2002, legislation was finally formalized, making the quality of life ethos a legal, not just an experimental, reality. The Termination of Life on Request and Assisted Suicide (Review Procedures) Act finally codified into law the body of cases decided since 1973.¹²⁹

Australia: A Brief Encounter with the Quality of Life Ethos

As early as 1973, a shift toward the quality of life ethos was apparent in the Australian mindset. The Doctors' Reform Society had publicly endorsed active voluntary euthanasia as part of its mandate "to promote reform and improvement in Australian health services and changes in Australian society conducive to the health of the Australian people."¹³⁰ At its national conference in Brisbane in 1988, the Society adopted a formal policy statement to include an intentionally hastened death, seeking patients' rights to both passive and active euthanasia based on the Dutch medical model.¹³¹ In the *Medical Journal of Australia*, the editor, Martin Van Der Weyden, wrote: "The time has surely come for society to openly address the taboo of dying.

¹²⁸ Thomasma et al., eds., 29.

¹²⁹ Netherlands, *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, Dutch Ministry of Foreign Affairs—Netherlands Ministry of Foreign Affairs.
<www.minbuza.nl/binaries/en-pdf/pdf/euth-amendedbill'en.pdf.>

¹³⁰ Otlowski, 323.

¹³¹ Ibid.

Active euthanasia should be widely discussed in an open forum free of the polemics of opponents and advocates, and without the political, religious and legal prohibitions that have stifled the debate.”¹³² Thus, the ethical climate was transitioning away from the *qualified* sanctity of life ethos.

Although the official position of the Australian Medical Association has been traditionally to oppose active voluntary euthanasia, there have also been some overt expressions of support for an intentionally hastened death from its members.¹³³ The first survey to be conducted on the attitudes and practices of doctors in Victoria was in 1987 by Professor Peter Singer and Dr. Helga Kuhse. One survey question was directed at ascertaining doctors’ attitudes toward taking assertive measures to hasten a patient’s death. Of those surveyed, 62 percent believed that it was sometimes right for a doctor to take active steps to hasten the death of a patient who had requested it, while 34 percent felt it was wrong.¹³⁴ Interestingly, more than half of the doctors surveyed felt that it would be a good thing if the Netherlands situation existed in Australia (59 percent to 37 percent), and a slight majority (52 percent) were of the view that their professional organization should take a similar stand to that of the Royal Dutch Medical Association.¹³⁵ As for legalizing active voluntary euthanasia, 60 percent of respondents indicated a change in the law to support it in some circumstances.¹³⁶

¹³² Martin Van Der Weyden, “Medicine and the Community—the Euthanasia Debate,” *MJA* 162, (1995): 566.

¹³³ *Ibid.*, 318; also see M. Parker, “Moral Intuition, Good Deaths and Ordinary Medical Practitioners,” *J Med Ethics* (1990): 28.

¹³⁴ H. Kuhse and P. Singer, “Doctors’ Practices and Attitudes Regarding Voluntary Euthanasia,” *MJA* 148, (1988): 623.

¹³⁵ *Ibid.*

¹³⁶ *Ibid.* The authors noted that there was also majority support amongst most religious groups except Roman Catholics.

In 1993, a survey conducted by Peter Baume and Emma O'Malley found that in the state of New South Wales a clear majority of doctors (59 percent) believed that it was sometimes right for a doctor to actively hasten the death of a consenting patient. In terms of physician-assisted death, another majority (56 percent) felt that it was sometimes right for a doctor to provide the means to suicide. Majorities (59 and 52 percent respectively) also believed that the Netherlands situation should be introduced in Australia and that their professional organization should take a stand to approve active voluntary euthanasia.¹³⁷

Although the majority of Australian physicians supported an intentionally hastened death, the Australian Association for Hospice and Palliative Care issued a Position Statement on Voluntary Euthanasia in 1995, stating that "legalization of active voluntary euthanasia is not a substitute for proper provisions of palliative care services to all Australians and that currently accepted palliative care does not include the deliberate ending of life, even if this is requested by the patient."¹³⁸ While the Association acknowledged that pain and suffering needed to be addressed, it admitted that "complete relief [was] not always possible in all cases, even with optimal palliative care."¹³⁹ The Association also recognized that there was "a wide divergence of views about voluntary euthanasia in Australian society" and that "some people rationally and consistently request[ed] active voluntary euthanasia."¹⁴⁰

Such pluralistic attitudes eventually led to the tabling of the "Rights of the Terminally Ill Bill 1995" and the passage of legislation in the Northern Territory

¹³⁷ Peter Baume and Emma O' Malley, "Euthanasia: Attitudes and Practices of Medical Practitioners," *MJA* 161 (1994): 137.

¹³⁸ Otlowski, *Voluntary Euthanasia and the Common Law*, 324–25.

¹³⁹ *Ibid.*, 325.

¹⁴⁰ *Ibid.*

permitting both active voluntary euthanasia and doctor-assisted suicide in 1996. The vote was passed by the 25-member Northern Territory Assembly by a 15–10 majority.¹⁴¹ As a result of this shift from the *qualified* sanctity of life ethos to the quality of life ethos, the Northern Territory became the first jurisdiction to formerly legalize *both* acts of omission *and* commission in the intentional hastening of death for the terminally ill.¹⁴² However, the passage of the bill met with mixed reactions. The legislation was applauded by HIV/AIDS groups but met resistance from mainstream churches, “right to life” groups, and the Australian Medical Association, along with a new group called the “Coalition against Euthanasia,” formed by the Catholic Church and the Northern Territory branch of the Australian Medical Association.¹⁴³ Because of opposition from religious groups and medical elites, the law was repealed in 1997 at the federal level. In 2002, the Australian Medical Association remained steadfast in its position, rejecting any proposal to decriminalize euthanasia or physician-assisted suicide.¹⁴⁴ Thus, from a legal perspective, Australia had readopted the *qualified* sanctity of life ethos.

Switzerland: Pushing the Boundaries

Considered one of the most liberal nations in the right-to-die debate, Switzerland has permitted assisted suicide since 1918. Unlike the United Kingdom, where the intentional killing of another results in a murder conviction, such an act is not synonymous with murder in Switzerland as long as the rationale behind the assistance is one of benevolence. Article 115 of the Swiss penal code states: “Whoever, from selfish

¹⁴¹ Ibid., 345.

¹⁴² Mollie Dunsmuir, *Euthanasia and Assisted Suicide*, Library of Parliament: Law and Government Division (24 November 2004), 22.

¹⁴³ Otlowski, 357.

¹⁴⁴ Dowbiggin, *A Concise History of Euthanasia: Life, Death, God, and Medicine*, 149.

motives, induces another person to commit suicide or aids him in it, shall be confined in the penitentiary for not over five years, or in prison, provided that the suicide has either been completed or attempted.”¹⁴⁵ Switzerland’s solution to an intentionally hastened death is unique in several ways. Contrary to the sanctity doctrine, the permissibility of an altruistic motive in the Swiss context “cannot be overridden by a duty to save a life.”¹⁴⁶ Moreover, Article 115 does not require the involvement of a physician, nor does the patient need to be terminally ill.¹⁴⁷ Although Switzerland permits foreigners access to its services, the reasons for assisting must still be altruistic, as the law requires. That said, only one of the country’s four right-to-die organizations, DIGNITAS, chooses to assist foreigners.¹⁴⁸ Such liberal attitudes have even been supported by the Swiss medical community. At the 12th International Conference of the World Federation of Right to Die Societies (Zurich, Switzerland, 1998), the Zurich Declaration on Assisted Dying stated clearly that medical professionals have a “major responsibility for ensuring that it becomes legally possible for all competent adults, suffering severe and enduring distress, to receive medical help to die, if this is their persistent, voluntary and rational request.”¹⁴⁹

Most controversial, however, has been the debate over the right to suicide for the mentally ill. In a 2006 ruling by the Swiss Federal Supreme Court, guidelines were laid out for the first time outlining how assisted suicide is permissible for psychiatric patients

¹⁴⁵ Switzerland, *Criminal Code of the Swiss Confederation*, art. 115, Legislationline <www.legislationline.org/legislations.php?jid=49&Itid=15>; also see Christian Schwarzenegger and Sarah J. Summers, *Hearing with the Select Committee on the Assisted Dying for the Terminally Ill Bill*, House of Lords. University of Zurich: Faculty of Law (3 February 2005), 1.

¹⁴⁶ Samia A. Hurst and Alex Mauron, “Assisted Suicide and Euthanasia in Switzerland: Allowing a Role for Non-Physicians,” *BMJ* 326, no. 7383 (Feb. 1, 2003): 271.

¹⁴⁷ *Ibid.*

¹⁴⁸ *Ibid.*, 273.

¹⁴⁹ The World Federation of Right to Die Societies, “The Zurich Declaration on Assisted Dying,” 12th International Conference of the World Federation of Right to Die Societies, Zurich, Switzerland (October 12–15, 1998) <www.worldrtd.net/node/155>

and others suffering from mental illnesses.¹⁵⁰ The case involved a fifty-three-year-old manic depressive who claimed the right to self-determination. The Swiss high court upheld the right for those individuals with “severe, long-term mental illness who have made ‘rational’ and ‘well-considered’ decisions to end their lives to avoid further suffering.”¹⁵¹ The Court’s rationale was similar to those rulings supporting the terminally ill. Serious mental disorders “could make life seem as unbearable to some patients as serious somatic ailments do to others.”¹⁵² In other words, the twin goals of maximizing individual autonomy and minimizing human suffering apply equally to both somatic and psychological disease.¹⁵³

This does not mean that the Swiss model is completely permissive. In 1997, the Swiss federal government commissioned a working group of specialists to examine the decriminalization of euthanasia. Like the Law Reform Commission of Canada, the Swiss group recommended that euthanasia remain illegal.¹⁵⁴ Whether or not physicians should play a role in assisting death is still uncertain. Technically, they can participate, but many hospitals have barred such methods. However, in a 1999 survey, 68 percent of the Swiss public supported physician participation in a hastened death, and in 2001, the Swiss parliament rejected a bill that would have barred doctors from assisting in a suicide.¹⁵⁵ In general, the Swiss have embraced the *quality of life ethos* but only to a point. While assisted suicide is state-sanctioned, euthanasia remains illegal. Thus, the

¹⁵⁰ Jacob M. Appel, “A Suicide Right for the Mentally Ill? A Swiss Case Opens a New Debate,” *Hastings Center Report* 37, no. 3 (May–June 2007): 21.

¹⁵¹ *Ibid.* The Court distinguished between “temporarily impaired individuals,” whose psychological disturbances are treatable, and those whose mental illnesses were “severe” and “long-term.”

¹⁵² *Ibid.*

¹⁵³ *Ibid.*

¹⁵⁴ Samia A. Hurst and Alex Mauron, “Assisted Suicide and Euthanasia in Switzerland: Allowing a Role for Non-Physicians,” 272.

¹⁵⁵ *Ibid.*

Swiss make an absolute moral distinction between two positive acts whenever death is intentionally hastened.

Germany's "Free Death"

With Nazism haunting Germany's present, one would think practices surrounding an intentionally hastened death would be the most conservative among Western nations. However, various influences have permeated German history and culture to soften its stance on assistance in suicide. While suicide was decriminalized in England and Canada in 1961 and 1972 respectively, Germany had actually decriminalized suicide centuries earlier, in 1751. Even assisted suicide is not a crime, provided that "the person is competent and has made a 'freely responsible choice.'"¹⁵⁶ Margaret P. Battin 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.¹⁵⁷ In fact, this kind of "free death," or "voluntary death," is viewed in a positive light. It is described as "an admirable, heroic—if very difficult—thing to do."¹⁵⁸ Therefore, 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."¹⁵⁹

In Germany's post-World War II period, autonomy had become the central ideological thrust of right-to-die groups. Founded in 1980, the German Society for

¹⁵⁶ Frederick Lowy, Douglas M. Sawyer, and John R. Williams, "Canadian Physicians and Euthanasia: 4. Lessons from Experience," 1897.

¹⁵⁷ Margaret P. Battin, "Assisted Suicide: Can We Learn from Germany?" *Hastings Center Report* 22, no. 2 (1992): 44–51.

¹⁵⁸ Margaret P. Battin, *The Least Worst Death: Essays in Bioethics on the End of Life*, 265.

¹⁵⁹ *Ibid.*, 266.

Humane Dying (DGHS) encouraged individual participation in the final death-hastening act. After a person becomes a member for at least a year, s/he can request a booklet entitled “Dignified and Responsible Death,” which provides information on drug types and dosages. Unlike Derek Humphry’s *Final Exit*, which published general toxicology information on drugs that *might* prove successful,¹⁶⁰ the DGHS actively sought feedback on suicide and attempted suicide. Because assistance in suicide was not illegal in Germany, the DGHS was able to collect reports from its own members’ experiences, periodically revising and updating its drug recommendations based on greater empirical reliability.¹⁶¹ However, in 1993 the DGHS was hit by a scandal. Its founder and President, Hans Henning Atrott, was selling cyanide for exorbitant sums and pocketing the profit. Although the DGHS received extensive negative publicity, most of the press targeted Atrott’s profiteering rather than *Freitod*.¹⁶²

Germans, however, direct criticism at one distinct form of intentionally hastened death: active voluntary euthanasia. Unlike the Netherlands, in which euthanasia and physician-assisted suicide are both legal, Germany accepts one form of intended death while simultaneously condemning another. As Lowy et al. admit, “[I]n 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.”¹⁶³ The authors add that many German intellectuals, politicians, lawyers, and physicians “[warn] strongly against the danger of the contemporary international euthanasia debate, which, it

¹⁶⁰ Derek Humphry, *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying* (New York: Random House, 1991), 163–66.

¹⁶¹ Margaret P. Battin, *The Least Worst Death: Essays in Bioethics on the End of Life*, 259–260.

¹⁶² *Ibid.*, 260–61, 266–67. Ironically, when the German publication *Der Spiegel* denounced Atrott’s profiteering, it used the term *Freitod* in reference to thirteen assisted suicides in which Jack Kevorkian had participated.

¹⁶³ Frederick Lowy, Douglas M. Sawyer, and John R. Williams, “Canadian Physicians and Euthanasia: 4. Lessons from Experience,” 1897.

is felt, is actually a process of legitimating the practice.”¹⁶⁴ This has even led to the banning of entire speeches and/or conferences in Germany for those seeking to legitimize euthanasia.¹⁶⁵ Several proposals to amend Section 216 of the German Penal Code dealing with “homicide at the request of the person killed” have also been unsuccessful, particularly one initiated by the DGHS.¹⁶⁶

More recently, Germany has continued to support death that is freely chosen. In 2010, Germany’s highest court held that it was not a criminal offence to cut off life-sustaining treatment for a patient. The court overturned the convictions of a lawyer who in 2009 was found guilty of attempted manslaughter for advising his client “to sever the intravenous feeding tube that was keeping her mother alive, although in a persistent vegetative state.”¹⁶⁷ Moreover, by claiming that an inherent moral distinction existed between euthanasia and assisted suicide, the court was clearly distinguishing between “killing with the aim of terminating life” and an action that “lets a patient die with his or her own consent.”¹⁶⁸ In the spirit of *Freitod*, Germany’s justice minister, Sabine Leutheusser-Schnarrenberger, supported the decision, claiming that “[t]he will freely formulated by a human being must be respected in all circumstances of life.”¹⁶⁹

¹⁶⁴ Ibid.

¹⁶⁵ See Peter Singer, “On Being Silenced in Germany,” *The New York Review of Books* (15 August 1991), 36–42; also see Bettina Schöne-Seifert and Klaus-Peter Rippe, “Silencing the Singer: Antibioethics in Germany,” *Hastings Centre Report* 21, no. 6 (1991): 20–27.

¹⁶⁶ Senate of Canada. *Of Life and Death: Report of the Special Senate Committee on Euthanasia and Assisted Suicide*, A168–A169. Advocating euthanasia, the DGHS attempted to amend Section 216 of the German Penal Code by suggesting the homicide provisions did not apply in cases of extreme suffering, where consent was known, where the person was physically unable to kill him/herself, and where there was no evidence of coercion.

¹⁶⁷ Victor Homola and Nicholas Kolish, “German Court Liberalizes Rules for Right to Die Cases,” *New York Times* <www.nytimes.com/2010/06/26/world/europe/26berlin.html>

¹⁶⁸ Ibid.

¹⁶⁹ Ibid.

Japanese Ambivalence

As with Western nations, Japan began its transition toward the *qualified* sanctity of life ethos in the post-World War II era; however, public consensus over active euthanasia and physician-assisted suicide proved elusive. In 1976, the Japan Society for Dying with Dignity initiated a law “allowing for the withdrawal of life-sustaining treatment, according to a patient’s previously expressed instructions.”¹⁷⁰ Likewise, in 1989, the Ministry of Health and Welfare and the Japan Medical Association published a manual to guide end-of-life decisions, with an emphasis on acts of omission: “Mere life prolonging treatment for terminally ill patients should be considered in terms of respect for human dignity as well as the psychological burden for the family in question. . . . From now on, patients’ will and rights of self-determination should be respected in this area of medical care.”¹⁷¹ In the coming years, Japanese opinion was conducive to such changes in medical ethics. In a nationwide newspaper poll in 1992, 86 percent of the respondents accepted the idea of death with dignity, defined in passive terms only, as “forgoing life-support in case a patient is hopelessly ill and death is imminent,” while 74 percent said “they would want to choose ‘death with dignity’ if they became terminally ill.”¹⁷² The Science Council of Japan, acting as the representative organization of Japanese scientists, supported the general concept of “death with dignity.” In a report in 1995, the Council stated that cessation of life-prolonging treatment was permissible if

¹⁷⁰ Akira Akabayashi, “Euthanasia, Assisted Suicide, and Cessation of Life Support: Japan’s Policy, Law, and an Analysis of Whistle Blowing in Two Recent Mercy Killing Cases,” *Social Science & Medicine* 55 (2002): 518.

¹⁷¹ *Ibid.*, 519.

¹⁷² *Ibid.*, 518.

three conditions were met: (1) the patient was terminally ill; (2) the patient's will was known while conscious; and (3) the doctor performed the final act.¹⁷³

However, euthanasia was not considered "death with dignity," and no organization would openly condone the practice. In 1992, the Bioethics Council of the Japan Medical Association felt that euthanasia was "not appropriate at present," citing "slippery slope" arguments in which "small advancements in favor of euthanasia legislation might lead to dangerous and unforeseen consequences."¹⁷⁴ Likewise, the aforementioned Science Council of Japan stated that active euthanasia was a prohibited medical act: "Killing . . . by drug administration cannot be permitted even if it is intended to relieve patients' pain."¹⁷⁵ This ambiguity and uncertainty surrounding euthanasia was compounded by the results of attitudinal studies of the medical profession. In one 1999 survey, a majority of doctors and nurses (88 and 85 percent, respectively) agreed that a patient's request to hasten death can sometimes be rational, yet when asked if voluntary euthanasia was sometimes right, whether the law should be changed to allow it, and if they would ever practise voluntary euthanasia if it were legal, only a minority answered in the affirmative (33–23, 26–14, 22–14 percent, respectively).¹⁷⁶ In the early 1990s, even the Japanese Society for Dying with Dignity felt that the nation was not ready to condone acts that intentionally hasten death: "It is too early, taking the spiritual climate of Japan into consideration," said the chairman, Taneo Oki. "We aim at passive euthanasia, which means that terminally ill patients should be allowed to die without

¹⁷³ Ibid., 520.

¹⁷⁴ Ibid., 519.

¹⁷⁵ Ibid., 520.

¹⁷⁶ Atsushi Asai, et al., "Doctors' and Nurses' Attitudes towards Experiences of Voluntary Euthanasia: Survey of Members of the Japanese Association of Palliative Medicine," *Journal of Medical Ethics* 27, no. 5 (Oct. 2001): 326.

being given treatment to keep them alive.”¹⁷⁷ Anthropologist Susan Orpett Long notes that Japanese acceptance of passive acts (omissions) is culturally conducive with its view of a “natural death.” The ideal death for many Japanese would be *rōsui* (a gradual decline leading to death in old age) or *pokkuri* (unintentional sudden death). Both imply that a “good” or “natural” death is nonmedicalized, unintended, and one that occurs without prolonged suffering or illness.¹⁷⁸

Even with the emphasis on a “natural death,” several prominent cases have challenged the traditional Japanese attitude prohibiting euthanasia. In April 1991, the Tokai University Hospital Case involved a patient with multiple myeloma (cancer of plasma cells). As his condition deteriorated, life-sustaining measures were withdrawn at the family’s request; however, to ease the patient’s suffering, the physician provided a lethal injection of potassium chloride. The doctor was found guilty of homicide, sentenced to two years’ imprisonment, and then given a suspended sentence.¹⁷⁹ In April 1996, the Kyoto Keihoku Town Hospital Case involved a terminally ill cancer patient suffering from intractable pain. After determining that morphine injections were not adequate to dull the patient’s pain, Dr. Yoshihiro Yamanaka administered a fatal dose of muscle relaxant; the patient died minutes later.¹⁸⁰ Although Dr. Yamanaka was demoted, he was not indicted because of the “difficulty in proving a direct link between the

¹⁷⁷ “Euthanasia around the World,” *British Medical Journal* 304, no. 6818 (Jan 4, 1992), 7.

¹⁷⁸ Susan Orpett Long, “Becoming a Cucumber: Culture, Nature, and the Good Death in Japan and the United States,” *Journal of Japanese Studies* 29, no. 1 (Winter 2003): 44, 67. As Long points out, the Japanese are not immune to religious impulses surrounding death. Despite Japanese grounding in a scientific understanding of the world, there continues to be an underlying assumption of “continued interaction between the living and the dead” (39). As Long notes, studies of ancestral rites and memorialized fetuses, as well as public opinion polls, indicate that most Japanese share some sense of a “life after death” perspective alongside a scientific worldview.

¹⁷⁹ Noritoshi Tanida, “‘Bioethics’ is Subordinate to Morality in Japan,” *Bioethics* 10, no. 3 (1996): 204–5.

¹⁸⁰ “Outrage in Japan over Euthanasia without Consent,” *British Medical Journal* 312, no. 7047 (Jun. 29, 1996): 1627.

medication administered to the patient and the man's death."¹⁸¹ Finally, in November 1998, the Kawasaki Kyodo Hospital Case involved a fifty-eight-year-old patient who had suffered brain damage as a result of an asthma attack. This led to the development of hypoxemia (a low level of oxygen in the blood). After removing a trachea tube at the family's request, the patient continued to breathe on his own. To prevent further suffering, the doctor injected a muscle relaxant, prompting the man's death. At the trial in March 2005, the doctor was found guilty of homicide, sentenced to three years' imprisonment (with hard labour), but was eventually given a five-year suspension of his initial sentence.¹⁸²

Future cases of death-hastening in Japan remain controversial because of a possible transition toward the *quality of life ethos*. For instance, when hospice care was introduced to Japan from Britain in the 1970s, it created a kind of cultural friction. Susan Orpett Long discovered that the traditional 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."¹⁸³ 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

¹⁸¹ Akira Akabayashi, "Euthanasia, Assisted Suicide, and Cessation of Life Support: Japan's Policy, Law, and an Analysis of Whistle Blowing in Two Recent Mercy Killing Cases," 526.

¹⁸² Katsunori Kai, "Euthanasia and Death with Dignity in Japanese Law," *Waseda Bulletin of Comparative Law* 27 (2009): 5–6. When the doctor appealed to the Tokyo High Court in February 2007, she was again found guilty of homicide, sentenced to 1.5 years' imprisonment (with hard labour), and given a suspended sentence of three years. The Tokyo High Court took the existence of the family's consent into consideration (7).

¹⁸³ Susan Orpett Long, "Negotiating the 'Good Death': Japanese Ambivalence about New Ways to Die," *Ethnology* 40, no. 4 (Autumn 2004): 278.

that “[g]ood caregivers are those who protect the patient.”¹⁸⁴ Ironically, as Long notes, these cultural attitudes may eventually lead the Japanese to prefer *nonvoluntary* euthanasia (explicit consent unknown).¹⁸⁵

One may ask: What then causes Japanese ambivalence toward euthanasia? Precedence for euthanasia—and the requirements for its legal sanctioning—had already been established as early as 1962 and reaffirmed in the Tokai University Hospital Case. The requirements included (1) unbearable suffering; (2) imminent death; (3) no available alternatives to palliative treatments; and (4) patient consent.¹⁸⁶ However, the view that euthanasia is somehow legal in Japan is somewhat misleading. The Japanese constitution does not mention euthanasia explicitly, and the Supreme Court has not made any judgment on euthanasia binding.¹⁸⁷ Furthermore, not only is it difficult for a patient to fulfill all the requirements for a legally sanctioned euthanasia, but no clinical or legal cases of euthanasia have been performed.¹⁸⁸

Japan’s cautionary approach over euthanasia most likely rests in culture, religion, and “morality.” Noritoshi Tanida asserts that the personality of Japanese people is not centred on individualism as much as it is on family, community, or society. This means that, if a new practice or act “spreads widely,” it will be considered “good” or “right.” Thus, the Japanese have a tendency to think and act collectively, something Tanida refers to as “mutual dependency.” In contrast, the Western bioethical approach, with its renewed emphasis on individuality and pluralism, has had difficulty gaining a foothold in

¹⁸⁴ Ibid., 284.

¹⁸⁵ Ibid.

¹⁸⁶ Akabayashi, “Euthanasia, Assisted Suicide, and Cessation of Life Support: Japan’s Policy, Law, and an Analysis of Whistle Blowing in Two Recent Mercy Killing Cases,” 526.

¹⁸⁷ Ibid., 522.

¹⁸⁸ Ibid.

Japanese bioethics.¹⁸⁹ Religious views also play some part in Japanese attitudes toward an intentionally hastened death, especially in shaping the passive/active dichotomy. Tanida found that while studying Shinto, Buddhist, and Christian groups, a total of 68 percent of the religious corporations accepted voluntary passive euthanasia (i.e., non-use of antibiotics), yet only a total of 19 percent supported voluntary active euthanasia (i.e., use of potassium chloride at the patient's request). In the latter case, all Catholic corporations "disagreed" or "disagreed strongly" with the doctor's act. This latter figure dropped to a total of 12–16 percent of respondents "agreeing strongly" or "agreeing" with nonvoluntary active euthanasia (i.e., potassium chloride for a comatose patient).¹⁹⁰

Concluding Remarks

If any general observation can be made from a global perspective, it is that policies surrounding death and dying vary depending on the context. Each country, because of its different historical background, philosophico-religious influences, and cultural constructs, has adapted to the debate over euthanasia and assisted suicide in its own unique way. No single method of dying developed from these varied experiences, nor has any legal precedence remained static over time. To reiterate: Withholding and withdrawal of treatment, euthanasia, and assisted suicide are terms that are situated, contested, and contextual. Nevertheless, in Western societies, one general trend has emerged, that being the social and legal acceptance of all forms of "passive euthanasia" or acts of omission. However, acts of commission still remain prohibited by law. For example, Australia briefly flirted with the legalization of active euthanasia and assisted

¹⁸⁹ Noritoshi Tanida, "'Bioethics' is Subordinate to Morality in Japan," 202–3, 207.

¹⁹⁰ Noritoshi Tanida, "The Views of Religions toward Euthanasia and Extraordinary Treatments in Japan," *Journal of Religion and Health* 39, no. 4 (Winter 2000): 345.

suicide in 1996, only to repeal the law in 1997. While permitting “passive” methods of death-hastening, Japan, England, Canada, and most American states still prohibit all forms of euthanasia and assisted suicide. The shadow of Nazism has also led to a ban on euthanasia and doctor-assisted suicide in Germany, even though one can seek help from a German citizen to achieve a “heroic death.” It is this emphasis on the *qualified* sanctity of life ethos as absolute—as objectivistic metaphysics—and the Christian normative assumptions that undergird it—that will now be examined in the Canadian context.

Chapter III: Ethical and Religious Discourses in Canada

The most comprehensive documentation on death and dying in Canada can arguably be found in a series of reports by the *Special Senate Committee on Euthanasia and Assisted Suicide* (1994–95). During the Committee’s hearings, witness testimony demonstrated how religious beliefs still permeate secular discourse in the form of objectivistic metaphysics.¹ In other words, secular culture has not left elements of its religious tradition behind but, as Gianni Vattimo notes, “continues to live them as traces, as hidden and distorted models that are nonetheless profoundly present.”² By comparing the testimonies of sanctity of life and quality of life advocates, four observations are noteworthy: (1) a distinct polarization exists between metaphysicians (“sanctity of life” supporters) and Vattimian postmodernists (“quality of life” supporters) in terms of their normative assumptions; (2) a minority of religious organizations support an intentionally hastened death using “quality of life” justifications; (3) metaphysical “traces” from the Christian tradition figure prominently in secular discourse; and (4) “sanctity of life” and “quality of life” discourses are sometimes interwoven, resulting in a hybrid of metaphysical/postmodern positions. The co-existence of these paradigms indicates that a transformation was underway in the 1990s in which the quality of life ethos became a competing principle against the traditional sanctity doctrine. This transition was largely

¹ For the purposes of this dissertation, objectivistic metaphysical assumptions will remain consistent with the Vattimian perspective, meaning any references to absolutes. This will include any absolutist concepts that presuppose stewardship (death can “never be intended,” and “nature must take its course”), the belief that life possesses absolute or infinite value, and any assertion that moral distinctions are absolute (i.e., inherent distinctions between acts of omission and commission). Such normative assumptions are depicted as “objective,” fixed, and immutable. See Vattimo, *After Christianity*, 3-5.

² Gianni Vattimo, *The Transparent Society*, 40.

due to new “events of being” that expanded the death and dying debate, most notably the circumstances surrounding Nancy B., Sue Rodriguez, and Robert Latimer.

Opponents of euthanasia and assisted suicide, including *both* religious *and* secular advocates of the sanctity of life ethos, affirmed the same metaphysical assumptions: (1) that life is a stewardship (a loan or “gift”), is of infinite value, and cannot be intentionally terminated; (2) that suffering possesses transcendent meaning and purpose and therefore must be endured; and (3) that the “slippery slope” is inevitable whenever the sanctity of life ethos is weakened. In contrast, supporters of decriminalization, including *both* religious *and* secular proponents of the quality of life ethos, embodied three main beliefs: (1) self-determination in the intentional hastening of death; (2) the relative value of human life; and (3) the feasibility and flexibility of safeguards. The latter paradigm was supported by very few religious groups, Unitarianism and the Liberal Catholic Church being the only “religious exceptions.” Quality of life proponents, represented by secular organizations/individuals, were almost exclusively Vattimian postmodernists. Hence, at the metaethical level, the two competing principles—*sanctity of life* and *quality of life*—were foundational to the rhetoric of metaphysicians and Vattimian postmodernists respectively. This dichotomy, as well as exceptions to it, will be clarified by examining the discourse of religious bodies/individuals and comparing it to the rhetoric of ethicists and bioethicists from secular institutions.

The Religious as Metaphysicians

Consistent with their belief in the sanctity of human life as first principle, the majority of churches and church-run organizations were vocal opponents of euthanasia

and assisted suicide. The only Jewish viewpoint was provided by Mr. Yoseph Thompson, Director of Development for the Central Organization for Jewish Development in British Columbia. Speaking from the traditional Torah, or biblical, perspective, he explained that the Jewish tradition “teaches that ‘the sanctity of human life,’ in fact all life, is paramount.”³ He told the Committee that the foundation of the sanctity doctrine “flows from a Divine Creator who we recognize as the Almighty and others recognize under a different name.”⁴ Thus, since life was a stewardship, a “natural” death was the only moral option for the dying: “Man does not possess absolute title to his life or body,” asserted Mr. Thompson, because it is “given to us in trust, to use, to grow with, and to return to its Creator at the time of the choosing of the Almighty.”⁵ The witness also insisted that quality of life judgments used to justify “mercy killing” were anathema to the inviolability of life:

Life was blown into man by God. Every moment of a human life is of infinite value. The value of life itself is infinite. Any attempt to depreciate the value of any time segment of a life destroys the absolute value of the entire life. Any attempt to shorten the life of a dying patient because that life is no longer considered to be worth living will destroy the infinite and inestimable value of all human life in the eyes of society.⁶

Moreover, a direct link was made between the weakening of the sanctity of life ethos and the inevitability of the “slippery slope.” Mr. Thompson elaborated for the Committee: “Over the centuries, societies have used the protection of life as a keystone for their moral foundations. Any move from this stance will endanger all of society and its values by undermining the fundamental principles of the sanctity of life and our

³ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 14 (Monday, September 26th, 1994), 43. For Jewish perspectives on the sanctity of life ethos, see Noam J. Zohar, “Jewish Deliberations on Suicide: Exceptions, Toleration, and Assistance,” in *Physician-Assisted Suicide: Expanding the Debate*, edited by Margaret P. Battin et al. (New York: Routledge, 1998), 362–72; also see Noam J. Zohar, *Alternatives in Jewish Bioethics* (Albany, New York: SUNY Press, 1997).

⁴ Ibid.

⁵ Ibid., 50, 52.

⁶ Ibid., 43.

responsibility to protect life.”⁷ Highlighting a specific example of the “wedge” principle, the witness claimed that “[i]f certain lives [were] deemed to no longer hold sufficient value, the result would be that scarce resources would not be allocated to extend such lives.”⁸ In Thompson’s opinion, it was a small step from voluntary euthanasia (killing with known consent) to *involuntary* euthanasia (killing against consent). He reminded the Committee that the Third Reich’s betrayal of the sanctity of life resulted in “the killing of the mentally ill, physically disabled, and those who the society determined not to have a life of social value.”⁹ Although Thompson agreed that the Nazi regime’s own brand of communitarianism led to the subordination of patients’ interests,¹⁰ he still embraced a communal ethos, stating that “[t]he society has a responsibility that overrides the individual right.”¹¹

In terms of Catholic representation, Rev. John Horgan of the Catholic Health Association of British Columbia outlined the first principle of his organization’s mission statement. As with Mr. Thompson, respect for the inherent dignity of each person was considered “a gift to us from the Creator.”¹² Rev. Horgan’s moral assumptions led him to believe that suffering possessed a transcendent quality: “The word ‘suffering’ has always had the meaning of significance to what is endured. Our view of suffering is derived

⁷ Ibid., 45.

⁸ Ibid., 46.

⁹ Ibid., 47. Other scholars reject the claim that legalized euthanasia led to the involuntary euthanasia practised by the Third Reich. Since the victims of the Holocaust never expressed consent and since death was not administered to alleviate suffering, Holocaust historian Lucy Dawidowicz admits that we cannot “usefully apply the Nazi analogy to gain insight or clarity to help us resolve our [current bioethical] problems and dilemmas.” See Michael Burleigh, *Ethics and Extermination: Reflections on Nazi Genocide* (Cambridge: Cambridge University Press, 1997), 146.

¹⁰ Ibid.

¹¹ Ibid., 55.

¹² Ibid., 146, 153.

from our view of the . . . purpose of life.”¹³ In fact, when it came to extreme cases of suffering, Rev. Horgan believed that such scenarios did not warrant a change in the status quo. Addressing the Committee, he replied: “You have heard a great deal about worst-case scenarios regarding the suffering of the terminally ill. Worst-case scenarios teach us a great deal, but I believe that they are not a sufficient basis for the creation of law.”¹⁴

Likewise, Archbishop Adam Exner from the Roman Catholic Archdiocese of Vancouver discounted euthanasia as a viable medical option because it was a direct challenge to the principles of stewardship: “[I]t [euthanasia] beckons us to be masters over life and death. In other words, it promises us that we can be our own gods.”¹⁵ Embracing God’s omnipotence, Archbishop Exner concluded that we do not own our lives but are “stewards over what we have been given, remaining accountable to the owner for the way we maintain our lives.”¹⁶ He warned that a violation of Christian natural law would be “to the detriment of civilization,” adding that “if killing goes, anything goes.”¹⁷

Representing the Canadian Conference of Catholic Bishops (“CCCCB”), Archbishop Marcel Gervais, Archbishop Bertrand Blanchet, and Father Ron Mercier defended Christian normative positions or “objectivistic metaphysics.” Archbishop Blanchet began by explaining that because life was a stewardship, it was sacred in and of itself, not a good among others:

We participate in the debate seeking to defend and to affirm the intrinsic value of human life. . . . We believe that life differs essentially from other human goods and this directly affects our rights over it. Within the Christian tradition, this essential difference arises from the divine origin of

¹³ Ibid., 148.

¹⁴ Ibid., 149.

¹⁵ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 15 (Tuesday, September 27th, 1994), 95.

¹⁶ Ibid., 96.

¹⁷ Ibid., 97, 98.

human life—a gift of God’s love. We serve as stewards, not owners, of what remains always a most precious gift.¹⁸

Similarly, Father Ron Mercier explained how specific properties that presuppose stewardship meant that death could never be intentionally hastened. For instance, since life possessed intrinsic value, all other considerations were secondary: “While we highly value the legitimate freedom and self-determination of the person, we cannot help but be deeply concerned about control becoming the dominant value subordinating all other goods, even life itself.”¹⁹ As well, the belief that death could only occur “naturally” (not intentionally hastened) led Archbishop Gervais to embrace a distinction between the Christian doctrine of “double effect” and lethal injections: “Euthanasia is not administering medication for the relief of pain even if the foreseen but unintended effect may be to hasten death. . . . In euthanasia, the intention is to cause death. The patient does not die naturally but before his or her time.”²⁰ Supporting Archbishop Gervais’ position, Archbishop Blanchet reminded the Committee that death cannot be hastened except by nature itself: “. . . [W]hen equipment is unplugged, a natural death occurs; in the case of euthanasia, a death occurs that might be described as artificial. That death is caused by an artificial means by the intervention of third party.”²¹ This distinction between death following a “natural” course, caused by the removal of life support, and death resulting from the intentional act of another is the sort of absolute boundary that many proponents of the sanctity of life ethos espoused in the hearings.

¹⁸ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 22 (Thursday, October 22nd, 1994), 45, 50.

¹⁹ *Ibid.*, 46.

²⁰ *Ibid.*, 44. For an overview of the doctrine of double effect, see Helga Kuhse, *The Sanctity of Life Doctrine in Medicine: A Critique*, 83–165.

²¹ *Ibid.*, 50.

Even the purpose of suffering was addressed by the CCCB. Although somewhat hesitant, Archbishop Gervais recognized the utility of some types of suffering: “We would not argue that suffering always ennobles, nor that suffering represents a good. . . . At the same time, we affirm the value of heroic suffering, and, as Catholics, we affirm the way in which suffering unites us to God and to others in a particular way.”²² Although they recognized the intense suffering experienced by individual patients, Father Mercier and Archbishop Gervais could not accept further weakening of the sanctity of human life. An exchange between them and Senators Lavoie–Roux and Carstairs best illustrates this position:

Senator Lavoie–Roux: Palliative care can cover most eventualities, but there may be some cases where it does not answer the human needs of the person who is about to die. What is your view of that?

Father Mercier: Do we make a change in principle because of the difficult cases, or do we search for different ways to deal with difficult cases? Since it is a matter of the principle of law, not just a matter of dealing with the exception, that is the central issue.

Senator Carstairs: . . . [Y]ou talk about the social dimension of suffering and the need for it to be rediscovered. . . . Do you believe that those people who are advocating euthanasia and assisted suicide are doing so primarily out of what they see as a sense of compassion for those who are dying without dignity and in a great deal of pain?

Archbishop Gervais: They may be doing this out of a sense of compassion, but it certainly is misguided. . . . I hate to use this image, but it is the “flush toilet syndrome” of getting rid of a problem by an injection, a pill, or whatever, to get rid of the problem. . . . In communities which respond to suffering; for example, the volunteers surrounding palliative care units, this has the effect of bonding and bringing together a large group of people. . . . 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.²³

Those representing the CCCB also questioned the impact euthanasia and assisted suicide would have on society at large. For Father Mercier, communalism was not only fundamental to his religious beliefs, but its erosion meant that vulnerable populations would be placed at risk:

²² Ibid., 47.

²³ Ibid., 54–55.

The intrinsic relationship between personal freedom and the vitality of our common life forms one of the hallmarks of Christian tradition. . . . Rights, for us, do not separate us from one another, but bind us together in building a common life. We strongly oppose, therefore, the attempt to redefine human rights in an individualist way because it undermines the sense of mutual responsibility which is so critical to our lives together. Once the sense of responsibility and interdependence erodes, the poor, the isolated, and the vulnerable will likely pay the price.²⁴

Archbishop Blanchard agreed. Any devaluation of the intrinsic worth of human life would mean that “[t]he frail, poor, elderly and others who are vulnerable [would] be subject to pressure from third parties or even themselves if an earlier death [was] an option.”²⁵ Additionally, Archbishop Blanchard felt that legitimizing euthanasia and assisted suicide would “diminish respect for human life and erode the basic trust . . . that human life will be protected.”²⁶ As a rhetorical device, the inevitability of the “slippery slope” was consistently adopted by religious supporters of the sanctity of life ethos.

As spokespersons for The Catholic Health Association of Manitoba, Drs. Pat Murphy and Larry Reynolds outlined how their normative assumptions fell from their philosophico-religious beliefs. Dr. Murphy explained to the Committee that the ethical foundation of her organization’s caregiving was based on “the dignity of the human person in community” and “the value of persons as persons,” principles which guided her group’s “reasoned and faith-informed analysis of the issues of euthanasia and assisted-suicide.”²⁷ In terms of the actual practice of euthanasia and assisted suicide, Dr. Reynolds viewed this as “a radical interference in the natural process of death and dying.”²⁸ For the witness, this meant that moral distinctions between positive and negative acts must remain absolute. For instance, euthanasia and assisted suicide were

²⁴ Ibid., 47.

²⁵ Ibid., 49.

²⁶ Ibid.

²⁷ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 18 (Friday, September 30th, 1994), 62.

²⁸ Ibid.

depicted as “direct killings”; whereas, “[d]eaths following the omission of treatment . . . [were] caused by the disease.”²⁹ Quoting ethicist Daniel Callahan, Director of the Hastings Institute, Dr. Reynolds added that some forms of suffering had to be endured. In other words, medicine should try to relieve somatic suffering, “suffering which is brought on by illness and dying as biological phenomena,” but “not the suffering which comes from anguish or despair at the human condition.”³⁰ He concluded that legalization of an intentionally hastened death could never protect “conscious and vulnerable people against subtle manipulation.”³¹

Representing the Catholic Parish of Sts. John and Paul in New Brunswick, Reverend Kenneth Weir adopted normative assumptions similar to those of other metaphysicians. He initially informed the Committee of his commitment to the sanctity of life ethos: “Life is something which is sacred and valuable in all its forms.”³² However, if euthanasia became legalized, Rev. Weir feared for the future of medicine: “I cannot imagine what that [legalization] will do to our medical and nursing staff. It will be blown wide open. . . . If the law were changed, I would be fearful of what would happen.”³³ Instead of intentionally hastening a suffering patient’s death, Reverend Weir suggested that one must “walk the walk with them” and “journey with the individual.”³⁴ Nonetheless, when he attempted to reinterpret the lived reality of Sue Rodriguez by his

²⁹ Ibid., 64. For a critique of the omission / commission distinction, see James Rachels, *The End of Life: Euthanasia and Morality* (Oxford: Oxford University Press, 1986).

³⁰ Ibid., 66. Ethicist Daniel Callahan is well known for his Christian bias toward suffering. He appeals to suffering as a higher duty, something in which one “transcends persecution” and “creates meaning.” See Daniel Callahan, *The Troubled Dream of Life: In Search of a Peaceful Death*, 151.

³¹ Ibid., 65.

³² *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 24 (Thursday, November 17th, 1994), 25.

³³ Ibid., 30.

³⁴ Ibid., 28.

own moral standards, Senator Carstairs vehemently disagreed with his position on the transcendent value of suffering:

Senator Carstairs: . . . [I]f you take the example of Sue Rodriguez—she is the most obvious example—she knew what she was doing. . . . [S]he came to terms with her life, with her son’s life, with her former husband’s life, with her friends and with her community. At the end of that, she then said, “I no longer want to live.” What do we say?

Reverend Weir: . . . [S]he was with a physician who did not really know her and a politician [New Democrat Svend Robinson] who was only an acquaintance. That is the extent of it. It is a sad commentary on life. . . . That is [a] very cold way to die; that is, in the presence of two near-strangers.

Senator Carstairs: She was with two people who were prepared, I would suggest, to be in a situation which was clearly in violation of the law. That takes great courage on the part of those two people.

Reverend Weir: What is so wrong with saying “no”? What is so wrong with saying, “No, let me walk with you in your pain. Let me be with you.” What is so wrong with saying “no”?

Senator Carstairs: There is an aboriginal expression which, when translated, means that you will not understand a man until you walk a mile in his moccasins. With respect, how can either you or I walk a mile in the moccasins of a terminally [ill] person when we ourselves are not terminally ill?

Reverend Weir: I can be with a pregnant woman and not be pregnant and feel her pain.

Senator Carstairs: No, you cannot, Father, with greatest respect.³⁵

Other Christian-based organizations and/or churches concurred with the Catholic viewpoint. Betty Green and Ted Gerk from the Pro-Life Society of British Columbia asserted that Canada was duty-bound to protect and uphold the right to life and to guard against risk and danger to the community. Relying on the interpretation of data by Dutch critic John Keown, Mr. Gerk stated that in 1990 doctors in Holland accelerated the death of 20,000 patients.³⁶ Quoting ethicist Daniel Callahan, Mr. Gerk believed that there would be no limits to assisted death, insisting that the “road to euthanasia . . . could soon turn into a convenient and commodious expressway.”³⁷ He also referenced the New

³⁵ Ibid., 31–32.

³⁶ Ibid., 8. For a further analysis of John Keown’s own critique of the Dutch model, see John Keown, *Euthanasia Examined: Ethical, Clinical, and Legal Perspectives* (Cambridge: Cambridge University Press, 1995); also see John Keown, *Euthanasia, Ethics, and Public Policy: An Argument against Legalization* (New York: Cambridge University Press, 2002).

³⁷ Ibid., 9.

York State Task Force on Life and Law, which suggested that “legalizing assisted suicide would be unwise and dangerous public policy.”³⁸ Mr. Gerk concluded that any failure to uphold the sanctity of human life would “send us down a road from which it would be difficult to return.”³⁹

However, when confronted by Senator Lucier on the purpose of suffering, Mr. Gerk and Ms. Green provided interesting insights as to how stewardship, suffering, and the “slippery slope” were metaphysically linked:

Senator Lucier: If a person wants to terminate his life one week, two weeks or three weeks early, then who benefits if we prevent him or her from doing that? Who will benefit in a system whereby . . . they [the terminally ill] are forced to die by a method that would really not be their preferred choice?

Ms Green: Those of us who are Christians or Jews believe that there is a soul and that there is life after death. We, of course, are constrained from any thought of killing ourselves because we have been taught that it is wrong. We have been instructed that we cannot take our own lives. . . . Life, no matter how bad it is, is better than nothing. If they [non-believers] are wrong and there is a life after death, and we agree with them that they should be killed and we try to kill them, then we may be condemning them to eternal life in hell. . . . The natural human instinct is to maintain life, to want to live. It is unnatural for someone to say, “I want to die.”

Mr Gerk: [W]e have to ask ourselves the question: Do we in Canada shift our attitude for a small segment of population. . . . [T]he implication in our shift in attitude would be so great that it would be difficult to control the “genie,” so to speak. The price would be too great.⁴⁰

In addition, several representatives from the Evangelical Fellowship of Canada (“EFC”) explained how their mandate supported stewardship, purpose in suffering, and the prevention of communal harm. Stanley Grenz, Professor of Theology and Ethics at Vancouver’s Carey Theological College, submitted that “our bodies are not our own; they belong to the one who created us . . . Consequently, not only life but even death is to be viewed as a stewardship.”⁴¹ For Mr. Grenz, human lives were valuable insofar as they

³⁸ Ibid. For a summary of the complete policy on euthanasia and assisted suicide in New York State, see New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (New York, 1994).

³⁹ Ibid., 12.

⁴⁰ Ibid., 14, 15, 16.

⁴¹ Ibid., 59.

were “connected with a purpose greater than our individual existence.”⁴² Fellow member Mr. Bruce J. Clemenger, Director of Public Affairs for EFC, was of the opinion that “[p]ersons facing death [did] not need help in dying; they need[ed] support to live in the face of suffering.”⁴³ Also representing the EFC was Edwin Hui, Assistant Professor of Medical Ethics at Vancouver’s Regent College. Although he sympathized with the suffering of terminally ill patients, he, like his colleagues, favoured a communal approach to the problem: “I think he or she should be persuaded to consider the common good . . . In other words, I think we ought to learn that even though a week of misery or suffering is costly to oneself, the concern is how it would impact on other people if I have the ability to choose my death.”⁴⁴

Ms. Cheryl M. Eckstein, Founder and President of the Christian organization Compassionate Healthcare Network, promoted similar metaphysical positions. She began by expressing the foundational belief underlying prohibition: “To accept the shortening of even one life in society,” remarked Eckstein, “is to dismiss the inviolability and dignity of all human life.”⁴⁵ Furthermore, her commitment to the sanctity doctrine led her to believe that intractable pain should be endured. In her plea to the Committee, she cautioned that “we cannot lose our will to face suffering boldly . . . and to accept the natural dying process. . . .”⁴⁶ Ms. Eckstein explained that if the incentive to advance palliative care was not addressed, there would be a “moral cost to society” once Canadians accepted “the advent of the easy way out.”⁴⁷

⁴² Ibid., 60.

⁴³ Ibid., 58.

⁴⁴ Ibid., 69.

⁴⁵ Ibid., 111.

⁴⁶ Ibid., 113.

⁴⁷ Ibid.

Representing The Christian Brethren, a worldwide organization, Don Logan made his religious convictions explicitly clear. Mr. Logan viewed the Holy Scriptures as “the inspired word of God,” and his organization’s members sought “to regulate every detail of [their lives] by that [metaphysic].”⁴⁸ He maintained that the majority of Canadians still “[held] human life in special esteem as given from God, distinct from the animal life and the rest of creation.”⁴⁹ The heart of the issue for Mr. Logan was the inviolability of life, which “preclude[d] any consideration of human life as a mere chattel to be disposed of at will according to what may appear convenient at a given moment.”⁵⁰ Because stewardship and the sanctity of human life were foundational to his belief system, Mr. Logan judged suicide as “the ultimate degradation, an attempt to usurp God’s authority over life and death, and as remote from true dignity as anyone can get.”⁵¹ From the witness’s perspective, there was a need “to get back to first principles” and “certain absolutes in human existence.”⁵² To separate religious from secular viewpoints, Mr. Logan targeted non-believers as the source of decriminalization: “I believe that the main pressure for doctor-assisted suicide and euthanasia comes from that quarter, from persons without any deep roots in faith, fearful of the agonies of the end, wanting an easy way out.”⁵³

From the Conference of Mennonites in Canada, two representatives expressed the link between their religious beliefs and the prohibition against an intentionally hastened death. Mr. Doug Pritchard conveyed his group’s theological outlook as one based on

⁴⁸ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 18, 28.

⁴⁹ *Ibid.*, 33.

⁵⁰ *Ibid.*

⁵¹ *Ibid.*, 34.

⁵² *Ibid.*, 36, 39.

⁵³ *Ibid.*, 31–32.

stewardship: “[W]e accept that there is a time for all of us to die; that death, as with life, is within God’s hands and it is not for us to dictate or to take over that responsibility.”⁵⁴

The organization’s emphasis on the collective good meant that “an individual right is never exercised in isolation from others in society” and that exercising such a right had “an effect upon [the] community as a whole.”⁵⁵ Although fellow member Ms. Roma Quapp recognized the “great pain which causes people to wish to kill themselves,” she felt that an intentionally hastened death “reflect[ed] a general devaluation of life and a loss to the community.”⁵⁶

From the United Church of Canada, Rev. Anne L. Simmonds admitted that her normative assumptions stemmed from the Christian belief in stewardship. In her words, “We are created by God, and we are loved by God, and we have value because of that.”⁵⁷ Rev. Simmonds also clarified how her metaphysical beliefs shaped her attitudes toward suffering. Although her church did not believe that “suffering [was] a punishment for sin, or that suffering [was] ever intended by God,” believers could alleviate suffering “short of intentionally causing a person to die.”⁵⁸ Moreover, Rev. Simmonds placed ethical value on the *qualified* sanctity of life principle in which one could refrain from preventing death: “We believe there is a significant moral difference between allowing someone to die and actually hastening their death with assisted suicide or euthanasia.”⁵⁹ Unlike religious opposition in *Cruzan*, Rev. Simmonds was adamant that non-treatment decisions, such as removing artificial nutrition and hydration, were ethically viable: “We

⁵⁴ Ibid., 111.

⁵⁵ Ibid., 109.

⁵⁶ Ibid., 113.

⁵⁷ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 27 (Wednesday, November 30th, 1994), 47.

⁵⁸ Ibid., 30.

⁵⁹ Ibid., 32.

believe that an acceptable alternative to euthanasia that does not require external assistance is to stop eating and drinking.”⁶⁰

The Right Reverend J.A. Baycroft, Bishop of Ottawa, professed beliefs from the perspective of the Anglican Church of Canada. Not only did Anglicans and Roman Catholics “derive from the scriptures and tradition the same controlling vision of the nature and destiny of humanity and share the same fundamental moral values,” but there was a “deeply rooted commitment to upholding reverence for life and refusing to be swayed by the arguments for euthanasia.”⁶¹ Religious commitment to the sanctity of human life meant “uphold[ing] the common good even when it require[d] some limitation of the right to respond to the desires of individuals.”⁶² Moreover, Rev. Baycroft reminded the Committee of the inevitability of the “slippery slope,” especially if society were to “allow reverence for life to be set aside for special cases.”⁶³ Fearing that euthanasia and assisted suicide would lead to a collapse of societal foundations, he warned: “You eventually get to the point where society will become so fragmented and there will be so much alienation of one from another that society will become unstuck.”⁶⁴

The “hard cases”—those experiencing intractable pain—became a point of contention between Rev. Baycroft and Senators Lavoie–Roux and Carstairs. Their exchange demonstrates the desire to maintain the sanctity of life as absolute, even amidst extreme suffering:

Senator Lavoie–Roux: [W]e are left with the 3 percent of people who do not respond to pain relief. . . . What do we have to offer these people?

⁶⁰ Ibid., 34.

⁶¹ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 28 (Wednesday, December 7th, 1994), 4.

⁶² Ibid., 5.

⁶³ Ibid., 5.

⁶⁴ Ibid., 13–14.

Mr Baycroft: There are some things that cannot be solved by changing the law. . . . I do not think changing the law will be of much help in these extreme cases. . . . Sometimes you have to do what is best for the common good. . . . It may sound strange, but being with people as they die is kind of ennobling. There is something which makes you feel good about the human spirit as it copes with this kind of thing.

Senator Carstairs: If a person chooses to be euthanized, or to have an assisted suicide, and they have made that decision with the support and encouragement of their families, how does that impinge upon the common good?

Mr Baycroft: I believe that my life is part of the whole of human life, that it is not simply my individual possession. . . . You do not look convinced.

Senator Carstairs: I am talking about the consensual adult with intractable pain, the 3 to 5 percent of cases about which Senator Lavoie–Roux spoke. I am talking about those people who have decided that there is no dignity left in their lives . . . What do we say to those people? Do we say that they must continue to live that way because there is a common good that must be preserved and that their individual right must therefore be denied?

Mr Baycroft: Does the fact that my life is well nigh intolerable give me the right to require someone else to do something which is fundamentally contrary to our overall value system in which we are opposed to taking life? . . . *I am not saying that all law should forever stay the same. I am just talking about euthanasia and assisted suicide* [emphasis mine].⁶⁵

Others represented the Christian viewpoint simply as individuals. Mr. Humphrey Waldock worried over the usurpation of absolute foundations and the impact of this “weakening” on the community. He was initially concerned that life would no longer possess transcendent meaning. Before the Committee, he declared: “You are facing a crisis of authority. No one is able to come forward and say that you must follow this or that authority to know what the purpose of human life is.”⁶⁶ Mr. Waldock added that society must have a “unity of values”; otherwise, it would “cause our civilization to fall apart in dispute.”⁶⁷ He summarized by claiming that there could be no challenge to first principles because “[t]he natural law is the sole source of all value judgments.”⁶⁸

Likewise, Mr. John Boram rejected any notion of euthanasia or assisted suicide because “they arrogate to man a prerogative which belongs entirely to God.”⁶⁹ He, too,

⁶⁵ Ibid., 6–9.

⁶⁶ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 14, 88.

⁶⁷ Ibid., 88.

⁶⁸ Ibid., 90.

⁶⁹ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 15, 75.

argued that when we deliberately hasten the deaths of terminally ill persons “we presume to wrest life out of the hands of the Creator and into our own. . . . Euthanasia is a violation of God’s law.”⁷⁰ Siding with the normative positions of other Christian groups, Mr. Boram acknowledged that although “[s]uffering can be a terrible experience . . . [w]e should not deprecate the moral value of this normal part of life that draws us closer to God and nearer to the Lord Jesus Christ.”⁷¹ He concluded that suffering not only “builds character and produces endurance” but that it also “provides unique opportunities for reconciliation, both to God and to men.”⁷²

Lastly, Mr. Mark Pickup, a Roman Catholic with multiple sclerosis, embraced the sanctity of human life as first principle. He informed the Committee that “the underpinnings of Canada’s law did accept that there was something sacred about human life.”⁷³ For Mr. Pickup, the sanctity of life ethos implied a communal bond, something that negated the individual’s right to intentionally hasten his or her death: “A society committed to a caring, significant community has no place for euthanasia.”⁷⁴ Unless life remained inviolable, Mr. Pickup felt that society would “forfeit the right to be called civilized, and that cost [was] too high.”⁷⁵ Consequently, the legalization of euthanasia and assisted suicide would not just affect the individual involved but would “affect [the] nation by further entrenching the notion that there are some lives that are not worth living.”⁷⁶ In closing, Mr. Pickup reminded the Committee of what was at stake for all vulnerable populations: “Canada stands at a crossroads about how we view human life. . .

⁷⁰ Ibid., 75–76.

⁷¹ Ibid., 78.

⁷² Ibid.

⁷³ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 27, 27.

⁷⁴ Ibid., 25.

⁷⁵ Ibid., 26.

⁷⁶ Ibid.

. In its darkest terms, euthanasia is hostility disguised as compassion toward the disabled, the chronically and the terminally ill.”⁷⁷

Religious Exceptions

The discourse of religious exceptions—those religious voices in support of decriminalization—gravitated toward postmodern pluralism in the Vattimian sense. Self-determination in the intentional hastening of death, the relative value of human life, and the workability/flexibility of safeguards were the normative assumptions most emphasized. Of all religious witnesses that testified before the *Special Senate Committee on Euthanasia and Assisted Suicide*, only two organizations supported decriminalization: Unitarians and members of the Liberal Catholic Church. For instance, Rev. Brian Kiely of the Canadian Unitarian Council highlighted individual conscience as the cornerstone of Unitarianism: “[E]ach individual has a right to decide matters of faith for her or himself,”⁷⁸ he told the Committee. Although Unitarians believe that every person possesses “inherent worth and dignity,” Rev. Kiely outlined how Unitarianism adopted an individualistic approach to this position, an outlook that differed sharply from the communitarianism embraced by orthodox Judaism and Christianity: “[I]f worth and dignity are to be the guides, then neither should society have the power to prevent mentally competent, irreversibly ill persons from choosing to end their lives. In our Unitarian view, only the individual has the ability to make that kind of decision.”⁷⁹ For Rev. Kiely, a law that forbids assisted suicide is both “inequitable and lacks compassion”

⁷⁷ Ibid.

⁷⁸ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 14, 61.

⁷⁹ Ibid.

because it “force[s] someone to live when they no longer wish to continue living.”⁸⁰ He added that Unitarians embrace these normative positions because they “do not accept a credo fraternalism from any scriptural body as being absolute and without question.”⁸¹

Another religious proponent of state-sanctioned euthanasia and physician-assisted suicide was the Rt. Reverend Dr. Bernd Osborg, a retired Bishop of the Liberal Catholic Church. Emphasizing an ethic of self-governance, he commented on how “sanctity of life” was a “vastly over-rated term” because it interfered with “a citizen’s free and conscious decision to take his or her life.”⁸² From his religious perspective, autonomy rights trumped the inviolability of human life: “[I]f an immortal self decides to shorten life or end a given incarnation, we should not interfere with this exercise of the free will.”⁸³ Instead of embracing stewardship, Rev. Osborg submitted that “the whole thing [assisted suicide] comes down to [individual] conscience.”⁸⁴

Speaking on behalf of himself, the Rev. James Dickey attempted to clarify why the Christian Church had difficulty accepting an intentionally hastened death. He explained that in the early days of Christendom, the challenge was to prevent martyrdom: “The idea that everybody wants to go to heaven but nobody wants to die was not held by the early Christians, some of whom went to great lengths to provoke the Roman officials, including the Roman Senate, to martyr them.”⁸⁵ The danger was that there would be no souls to convert if everyone committed mass suicide, so the early theologians mandated restrictions: “They had to point out that it [martyrdom] was wrong, that one should not

⁸⁰ Ibid., 62.

⁸¹ Ibid., 67.

⁸² *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 15, 137.

⁸³ Ibid.

⁸⁴ Ibid., 139.

⁸⁵ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 8, 55.

throw one's life away on a hope of getting to heaven that much faster,"⁸⁶ replied Rev. Dickey. Because enthusiastic martyrs had to be warned off from seeking death too eagerly, it created "an almost superstitious attempt to guard life against all hazards."⁸⁷ Rev. Dickey challenged what he felt were self-evident propositions made by sanctity of life advocates (e.g., "suffering possessing transcendent meaning"). He countered such assertions by offering his own personal interpretation of Scripture:

I see euthanasia as a positive Christian act; a moral act, not something that must be apologized for. "Blessed are the merciful for they shall obtain mercy" weighs far more with me than the intense effort of saying that life and suffering teaches us something. Suffering does teach us something, but there comes a time when there is no more to be learned by the patient or by the people who love the patient. God is not a sadist. The God I know does not teach that way.⁸⁸

Metaphysics Interwoven in Secular Discourse

After examining the religious viewpoints expressed predominantly by Christians, it is interesting to note how similar normative assumptions surrounding an intentionally hastened death permeated secular discourses as a "trace," specifically among ethicists and bioethicists. Dr. Edward W. Keyserlingk, a professor of bioethical law and medicine at the University of Montreal and McGill University, had authored studies for the Law Reform Commission of Canada in the 1980s. However, a decade later he remained cautious toward any change in the law. For example, he supported absolute moral

⁸⁶ Ibid.

⁸⁷ Ibid., 56. Christian views warning against "self-killing" were shaped by the position taken by Augustine in the *City of God*. He broke with the Roman tradition of an honourable suicide and argued that suicide was self-murder, even when enacted to avoid rape (as in the sack of Rome) or in resisting religious domination (as in the case of Donatist martyrs); see J.C. Bauerschmidt, "Suicide," in A.D. Fitzgerald, ed., *Augustine through the Ages: An Encyclopedia* (Grand Rapids: Eerdmans, 1999), 820. Augustine outlawed suicide because of the radical martyrdom practised by the Circumcellions, a prohibitionist stance that was later solidified by Thomas Aquinas in the thirteenth century in his *Summa Theologica*; see Glanville Williams, "The Prohibition of Suicide," in *The Sanctity of Life and the Criminal Law* (New York: Alfred A. Knopf, Inc., 1957), 248–68. For a more comprehensive treatment of the differences between martyrdom and suicide in antiquity, see Arthur J. Droge and James D. Tabor, *A Noble Death: Suicide and Martyrdom among Christians and Jews in Antiquity* (New York: HarperCollins, 1992).

⁸⁸ Ibid., 58.

distinctions, admitting that both withholding and cessation of treatment that is futile were considered “good medical care,” as opposed to euthanasia, which was not.⁸⁹ He also informed the Senate Committee that death-hastening methods under palliative care were excluded from the definition of euthanasia since these involved the doctrine of double effect: “It is also not euthanasia if death is indirectly hastened by appropriate pain control—that is, pain control appropriate for the patient’s pain even though it may indirectly hasten death.”⁹⁰ Keyserlingk further disclosed how doctors were not involved in the chain of causation when treatment was either withheld or withdrawn: “In neither case are we [doctors] killing the patient. We are not causing the patient’s death at all. We are simply either respecting a higher right which is the patient’s right to say no, or we are saying that medicine has come to the limit of what it can do.”⁹¹

When it came to presenting evidence as to why prohibition should be maintained, Keyserlingk’s defence involved the “slippery slope” and social morality. He surmised that the Nazi regime “started out with voluntary euthanasia and then it became involuntary in the sense that mental patients and people with other handicaps were being killed.”⁹² When Senator Lavoie–Roux inquired whether Holland had enough experience with euthanasia to guard against abuse, Keyserlingk replied: “In my view, it [Holland] has not. . . . The problem is that there is no way to determine whether the guidelines are being followed or not, that is, whether there are abuses, and so forth. In my opinion, it is

⁸⁹ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 1 (Thursday February 24th to Tuesday, March 15th, 1994), 28.

⁹⁰ *Ibid.*

⁹¹ *Ibid.*, 31. For a contrasting view of causation and the role responsibility of physicians, see Gerald Dworkin, et al., *Euthanasia and Physician-Assisted Suicide: For and Against*, 17–42; also see Tom L. Beauchamp, ed., *Intending Death: The Ethics of Assisted Suicide and Euthanasia*, 23–41, 104–8.

⁹² *Ibid.*, 38.

too early to decide. I think we will have to study actual practice a little longer.”⁹³

However, when asked by Senator Beaudoin if safeguards against abuse were the key concern, Keyserlingk contradicted his previous claim about Dutch practices, admitting that morality was the larger issue. It is important to quote him at length:

When people say, “We couldn’t legalize assisted suicide or euthanasia because patients would be making decisions from which there is no return, it’s a final decision,” I do not consider that to be a very sound argument because that is already the case when patients are refusing treatment. . . . Therefore, it seems to me that the problem is not about irrevocability but more about whether we feel morally, as individuals, as a society, as a medical profession and so forth, that it is appropriate to respond to certain requests. . . . I think the real issue is more about the morality of it—can we do what is being requested—rather than whether we can devise criteria for when the request can be made.⁹⁴

To guard against “slope” concerns, McGill ethicist Margaret Somerville also supported a communal metaphysic, one that required protection from “intense individualism” in order to further “a new vision and practice of community.”⁹⁵ She likened the debate over euthanasia and assisted suicide to the ripple effect of a stone thrown into a pond: “The pond is our whole society. I think we are only just starting to recognize that, in engaging in this euthanasia debate, we are engaging in determining [which] ripples will be right throughout our whole society in very many ways.”⁹⁶ Professor Somerville suggested that the most important harm was not the prolongation of patient suffering but the possible damage to community norms: “Whatever one’s views about the morality of euthanasia at an individual level . . . euthanasia is unacceptable at

⁹³ Ibid., 39. For critics of the Dutch regime, see Wesley J. Smith, *Forced Exit: The Slippery Slope from Assisted Suicide to Legalized Murder* (New York: Random House, 1997); also see Neil M. Gorsuch, *The Future of Assisted Suicide and Euthanasia* (Princeton: Princeton University Press, 2006); John Keown, *Euthanasia Examined: Ethical, Clinical, and Legal Perspectives* (Cambridge: Cambridge University Press, 1995); John Keown, *Euthanasia, Ethics, and Public Policy: An Argument against Legalization* (New York: Cambridge University Press, 2002).

⁹⁴ Ibid., 42–43.

⁹⁵ *Proceedings of the Senate Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 6 (Wednesday, May 18th, 1994), 9.

⁹⁶ Ibid., 5. Her views opposing euthanasia and assisted suicide are more explicit in Margaret Somerville, *Death Talk: The Case against Euthanasia and Physician-Assisted Suicide* (Montreal and Kingston: McGill–Queen’s University Press, 2001).

the societal level because of the harm it would cause, especially to some of our most important values and symbolism.”⁹⁷ In fact, she claimed the stakes were so high that the morals of future generations would also be jeopardized. Warned Somerville: “The danger of abuse is a concern, but it is the lesser concern. The real harm that we are dealing with here is: What sort of society will we pass on to the future, and what will be the values and symbolism of that society?”⁹⁸ Fearing the debate would inevitably shift from a right to refuse treatment (*qualified* sanctity of life ethos) to a right to die (quality of life ethos), she alerted the Committee to the “troublesome situation” that lay ahead: “This is the next step. Someone else then has a duty to kill you. This is the danger of the right-to-die situation.”⁹⁹

Professor Somerville was also clear about what values she believed were most threatening to communalism, those being individualism and secularism. For example, even though she recognized Sue Rodriguez’s freedom of choice, Somerville supported “limits on these rights in the interests of society itself,” adding: “We have lost touch with what those limits should be.”¹⁰⁰ The McGill ethicist did, however, admit to the difficulty of denying autonomy rights for a consenting, terminally ill adult making an informed choice: “To be on television with her [Rodriguez] was such an experience. She was enormously courageous. She elicited the utmost feelings of compassion. You could not help but feel, ‘Why should I say that I do not think this is what you should have?’ when it seemed to be the only thing she wanted.”¹⁰¹ She reiterated that the ideology supporting legalized euthanasia or physician-assisted suicide was temporal and materialistic rather

⁹⁷ Ibid., 8.

⁹⁸ Ibid.

⁹⁹ Ibid., 17.

¹⁰⁰ Ibid., 9.

¹⁰¹ Ibid.

than metaphysical: “This is a world of affectivity, efficiency, performance, with priority given to cost-effectiveness and consumption, a world of objects, not of subjects; in short, a world stripped of souls and spirit, a world without love.”¹⁰² Ironically, although she sensed that the debate lacked “space for spirit,” Professor Somerville denied her position was based on “any sort of belief in religion.”¹⁰³

Likewise, Danielle Blondeau, a professor and researcher of ethics and death at Laval University, arrived at her position from the philosophical and fundamental perspective of communalism. Fearing what Charles Taylor referred to as the “subjective principle underlying soft relativism,”¹⁰⁴ Ms. Blondeau felt that the principle of autonomy “must be seen as part of a social context that has certain values” and that this communal ethos “give[s] meaning to autonomy.”¹⁰⁵ She suggested that the state needed to address “bankrupt values like solidarity and awareness of others,” principles she felt had “disappeared from our society.”¹⁰⁶ According to Ms. Blondeau, any decision to sanction an intentionally hastened death was “one more symptom of the lack of [community]

¹⁰² Ibid., 19. Presently, Professor Somerville claims she is promoting a “middle ground” position that is different from the “pure mystery” approach and the “pure science” view. However, her preferred position, the secular-sacred or “science-spirit” view, is strongly linked to moral intuitionism. She recognizes that human life consists of “more than just its biological component.” It also involves “a sense of mystery—made up of at least the mystery of the unknown or the mystery of the nameless, or both—of which we have a sense through our intuitions, especially our moral intuitions, and accepts that we should respect this mystery.” See Margaret Somerville, *The Ethical Canary: Science, Society and the Human Spirit* (Toronto: Penguin Books, 2000), 19–20.

¹⁰³ Ibid., 5.

¹⁰⁴ It is somewhat ironic that Charles Taylor would be referenced to support a relativist argument against euthanasia. Taylor is a strong advocate of “the politics of recognition,” which emphasizes a respect for differences. In Taylor’s view: “Our identity is partly shaped by recognition or its absence, often by the *mis*recognition of others . . . Nonrecognition or *mis*recognition can inflict harm, can be a form of oppression, imprisoning someone in a false, distorted, and reduced mode of being.” See Charles Taylor, “The Politics of Recognition,” in *Multiculturalism*, 25.

¹⁰⁵ *Proceedings of the Senate Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 12 (Tuesday, July 5th, 1994), 67.

¹⁰⁶ Ibid., 69, 77. Other authors have noted their concerns over the emphasis on individual values at the expense of communal principles. See Zygmunt Bauman, *Alone Again: Ethics after Certainty* (London: Demos, 1994); also see Anselm Min, *The Solidarity of Others in a Divided World: A Postmodern Theology after Postmodernism* (New York: T & T Clark International, 2004).

values that we are seeing at the present time.”¹⁰⁷ However, when Chairman Neiman asked what could be done to alleviate those experiencing intractable pain, Ms. Blondeau was uncertain as to whether their suffering warranted a change in social/legal norms:

Chairman Neiman: But when it comes to . . . intractable suffering . . . and other forms of suffering, morally and ethically you draw the line there. That is, you do not feel that it [an intentionally hastened death] is appropriate for them [patients], even though they may be terminally ill as well and are suffering just as much or even more than others who have been treated more humanely. A line is drawn there. . . . Would you like to comment on that?

Ms Blondeau: Yes. I think you are referring to people who suffer and for whom pharmacology has little to offer. I certainly sympathize with these people. . . . We can only hope that medical science will find a solution. I do not know whether a small number of people justifies making a law that will apply to everyone in our society. I do not know how we could handle these problem cases. I am very much aware of the issue you raised.

Chairman Neiman: Their suffering is undeniable, but somehow we are still drawing that line there. We say, “Well, we do not know what to do with them.” This issue continues to arise, and we still have this problem today because there are those people out there. . . . [Sue Rodriguez] represents the kind of conundrum that we are facing.¹⁰⁸

In addition, Abbyann Day Lynch, the Director of the Bioethics Department at the Hospital for Sick Kids in Toronto, discounted the ethical viability of both euthanasia and assisted suicide for several reasons. First of all, she claimed such acts went against nature: “Euthanasia makes death occur unnaturally, and by this I mean only ‘before time.’ We say someone dies ‘ahead of his time.’ We have intervened, and we have caused that to happen.”¹⁰⁹ A “good death,” in her opinion, was not based on individual control but on deference to nature: “To think we can dignify it [dying] at the last minute by a control manoeuvre . . . is self-deception. . . . Quality lies in . . . accepting what is inevitable, and accepting it with grace.”¹¹⁰ Mme. Lynch also sought to “re-naturalize” death by linking it to a communal ethos. This implied that dying was “not a matter of

¹⁰⁷ Ibid., 77.

¹⁰⁸ Ibid., 79, 80.

¹⁰⁹ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 11 (Wednesday, June 22nd, 1994), 18.

¹¹⁰ Ibid., 22.

autonomy” but was, in fact, “a social affair.”¹¹¹ She was firm in her belief that “to allow these particular practices [euthanasia and assisted suicide] within the medical profession [was] to trivialize life.”¹¹²

Dr. T. Douglas Kinsella, Professor and Director of the Office of Medical Bioethics at the University of Calgary’s Faculty of Medicine, was forthright with his concerns over the “slippery slope.” From his perspective, euthanasia and assisted suicide would “kill the profession of medicine,” changing its essence “from a profession whose duty it is to heal to a profession whose duties will become to heal and to kill.”¹¹³ He discerned that medicine would be “morally corrupted by the conflicting duties of healing and killing in the name of health care.”¹¹⁴ In Dr. Kinsella’s view, decriminalization of either euthanasia or assisted suicide would lead to one inevitable conclusion: “[M]edicine and the patients it serves would indeed be mortally harmed by such legislation.”¹¹⁵

However, it was Dr. Kinsella’s interpretation of suffering that was most illuminating. He justified the pain and anguish of “hard cases” in utilitarian terms, as a sacrifice for the “greater good.”¹¹⁶ His exchange with Senator Perrault illustrates how Dr. Kinsella defended the sanctity of life as absolute even amidst unbearable suffering:

Senator Perrault: During these interviews, we have heard harrowing and horrible accounts of dying. We have heard about the agonies involved in the final stages of cancer, ALS, and other afflictions. . . . They

¹¹¹ Ibid., 23.

¹¹² Ibid., 21.

¹¹³ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 16 (Wednesday, September 28th, 1994), 6.

¹¹⁴ Ibid.

¹¹⁵ Ibid., 11.

¹¹⁶ Classic views of utilitarianism are most often noted in the philosophical writings of Bentham and Mill. See Jeremy Bentham, *Utilitarianism* (Charleston, South Carolina: Bibliolife, 2010); John Stuart Mill, *The Basic Writings of John Stuart Mill: On Liberty, The Subjection of Women & Utilitarianism* (New York: The Modern Library, 2002). However, other writers have discussed utilitarianism within the realm of euthanasia and assisted suicide, both from a Western and Eastern perspective. See Joseph Fletcher, *Situation Ethics: The New Morality* (London: Westminster John Knox Press, 1966); also see Roy W. Perrett, “Buddhism, Euthanasia, and the Sanctity of Life,” *Journal of Medical Ethics* 22, no. 5 (October 1996): 309–13.

[Committee witnesses] have seen the terminal stages of illness, the pain, the suffering, the inconvenience, the loss of dignity, which has been described to us in such graphic terms, and the sheer misery. . . . What kind of message do you give to the people out there who have gone through this incredible, terrible experience of seeing a loved one die? What do you say to them?

Dr. Kinsella: This is going to sound terrible, and I am sorry, but I do have to say it: There will be cases that we will not be able to handle properly. Those cases will be hard cases. . . . I do not mean to be debonair and cavalier and dismiss the horrors and suffering that these people will endure, but it is a reality. . . . That does not mean that the rare cases should drive the social and moral fibre of this country in terms of its attitudes toward dying, and this is a step that I, personally, simply cannot bridge. We cannot . . . change the ethics of this country for the *occasional dreadful, horrible case that cannot be accommodated by the system* [emphasis mine].¹¹⁷

Ironically, Dr. Kinsella had told the Committee that he objected to free-standing euthanasia or assisted suicide clinics “from the perspective of secular morality and secular ethics,¹¹⁸ but his own research on Alberta doctors indicated that what separates positions for or against euthanasia and assisted suicide was an inherent religious bias: “Physicians who are regularly religiously active oppose any change in the law with respect to legalization of either of these two acts. Physicians who are religiously inactive in the context of the results of our surveys [Dr. Kinsella and Dr. Marja J. Verhoef] are predominantly in favour of the legalization of these two acts.”¹¹⁹

Similarly, Dr. David J. Roy, Director of the Centre for Bioethics at the Clinical Research Institute in Montreal, focused his discussion on the danger of the “slippery slope.” If euthanasia became legally, socially, or ethically acceptable, Dr. Roy held that it would be impossible to “prohibit people from using persuasion, however subtle, on people to request euthanasia when that is probably not what they want.”¹²⁰ Once voluntary euthanasia became the norm, the next logical step, according to Dr. Roy, would be a slide toward eugenics motives: “It would be difficult for a society to withstand for long the pressures . . . to move on and to give euthanasia to those whose lives seem to

¹¹⁷ Ibid., 16-17, 20-21.

¹¹⁸ Ibid., 6.

¹¹⁹ Ibid., 12.

¹²⁰ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 22, 8.

have no sense, no purpose, no worth in the eyes of others.”¹²¹ Dr. Roy also elaborated on “second-order links,” or the possible domino effect from decriminalization:

[W]e could come forth with a beautiful law with all of its conditions, but we do not realize the links that will eventually be made between that law and emerging new ideas, and political and social circumstances that will want to use that law for purposes totally different from the original purpose for which the law was designed.¹²²

When Senator Keon inquired about the “hard cases”—those whose acute pain could not be resolved—Dr. Roy admitted that their suffering was outweighed by “slope” concerns: “I can fully understand some people wanting their death brought about rapidly. . . . However, to change the law to deal with those circumstances would, in my opinion, open the door to great abuse. It is a socially unjustifiable thing to do.”¹²³ Although Dr. Roy admitted that he had no empirical evidence to substantiate such claims, he still wished to maintain the status quo: “It cannot be proved that, if you change the law, we will go down the slippery slope. That is true, but I do not think that it is wise to try that social experiment.”¹²⁴

The University of Sherbrooke’s Ethics Committee was represented by religious, medical, and legal professionals, yet all shared the same Christian normative assumptions despite their diverse backgrounds. From the Faculty of Theology, Dr. Jean Declos proposed that the debates centred on two competing value systems: self-determination and respect for human life. He was concerned that an emphasis on autonomy threatened communitarianism by “exclud[ing] the idea that there are common values and standards . . . which are at the heart of our mutuality and reciprocity as human subjects living in

¹²¹ Ibid., 9.

¹²² Ibid., 11.

¹²³ Ibid., 15.

¹²⁴ Ibid.

society and seeking harmony.”¹²⁵ Professor Declos rejected any belief in the relative value of human life, maintaining instead that “all human deaths are of equal value, as are lives and persons.”¹²⁶ This led to the adoption of a universal ethical assumption: “The prohibition against homicide,” Dr. Declos declared, “appears to us as a normative absolute. A society which cultivates freedom and respect for persons must maintain it as a firm boundary. This prohibition must everywhere be maintained.”¹²⁷

Dr. Declos’s colleague from the Faculty of Medicine, Dr. Pauline Lesage–Jarjoura, interpreted the ethics of suffering as “part of the human condition.” She asserted that it would be “mistaken to want to exclude it completely without ultimately risking the destruction of the entire person.”¹²⁸ In her view, the purpose of suffering was of greater significance than the relief of existential pain. She asked: “Isn’t it not [sic] mainly this absence of a meaning of suffering that is unendurable, much more so perhaps than the suffering itself?”¹²⁹ Her associate from the Faculty of Law, Dr. Suzanne Philips–Nootens, inquired as to the shift away from religious values: “So are we at the point where we are in favour of rapid death as a major social value in defiance of the ‘sanctity’ of life by removing its religious connotation?”¹³⁰ Dr. Philips–Nootens even accepted the inevitable progression of the “slippery slope” from “truly voluntary death to quickly accepted death,” a transition which would eventually lead to “suggested death or even the perception of a duty to die.”¹³¹ A change in the law was simply deemed too risky because “in order to meet the demand of a few patients,” she claimed “our entire

¹²⁵ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 29 (Monday, December 12th, 1994), 25.

¹²⁶ *Ibid.*, 27.

¹²⁷ *Ibid.*

¹²⁸ *Ibid.*, 23.

¹²⁹ *Ibid.*, 25.

¹³⁰ *Ibid.*, 39.

¹³¹ *Ibid.*, 28.

society would quickly be faced with abuses of all kinds to the detriment of its most vulnerable members.”¹³² When questioned by Senator Carstairs as to why society could not support both options—palliative care and euthanasia/assisted suicide—Dr. Philips—Nootens asked the Committee to consider the risk of a “slippery slope”:

And it is always tempting to say “yes” in special cases. We want to say “yes” but the repercussions and danger of that case being extended is there and, in our view, that danger is undeniable. And if we open the door once again to these solutions, why should we stop once under way? Why should we stop at euthanasia on demand? Why should we stop at death with dignity only for those who can request it? . . . The cessation of treatment was originally recognized for competent patients only. It was a withholding of treatment. It was extended to incompetent patients; it was extended to the cessation of treatment both for competent patients and for incompetent patients. And I may not trust us as a society to open the door only partially to assisted suicide and euthanasia.¹³³

Lastly, Dr. Gordon Crelinsten, Chairman of Bioethical Ethics at the Royal College of Physicians and Surgeons of Canada, also shared similar normative assumptions with those of religious organizations. He first admitted that a utilitarian calculus shaped his thinking on the issue over decriminalization for those experiencing intractable pain. As he told the Committee, “[E]ffective palliative care can relieve the vast majority of suffering,” but legalization for “the individual suffering from a horrible condition . . . will affect the whole Canadian picture of the professional practice of medicine. . . .”¹³⁴ Furthermore, Dr. Crelinsten denied that palliative methods should be seen as playing any causal role in death: “[E]ven though the exercise of effective palliative care may hasten death, it should not be viewed as causing death and should not be viewed as a criminal act.”¹³⁵ This meant that omissions were ethically viable because,

¹³² Ibid., 30.

¹³³ Ibid., 37. The promotion of risk and harm to the community is a common technique used to maintain the sanctity of human life as first principle. To see its application in other contexts, see Lori G. Beaman, “Risk and Excess,” in *Defining Harm: Religious Freedom and the Limits of the Law*, 59–99; also see Mariana Valverde, “The Art of Drawing the Line: Judicial Knowledges of Community Morality and Community Harms,” in *Law’s Dream of Common Knowledge* (Princeton: Princeton University Press, 1999), 28–53.

¹³⁴ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 20 (Monday, October 17th, 1994), 36, 47.

¹³⁵ Ibid., 38.

unlike commissions, the former did not entail an intention to hasten death. Therefore, a moral distinction was drawn between the two: “The withdrawal of life-sustaining or life-supporting therapy, such as in the Nancy B. case, is not an example of euthanasia. It is not an example of suicide,”¹³⁶ asserted Dr. Crelinsten.

Vattimian Postmodernists

In contrast to prohibitionists, ethicists and bioethicists who advocated for decriminalization were almost exclusively Vattimian postmodernists, promoting specific non-absolutist beliefs in their discourses (i.e., a self-determined death as a subjective decision, the fluidity of moral distinctions, the relative value of human life, and the workability/flexibility of safeguards). For example, Dr. Eike–Henner W. Kluge, who lectured extensively on biomedical ethics in the United States and Canada, indicated that the individual’s constitutional right to self-determination, dignity, equality, and justice was “fundamentally at variance with a utilitarian approach, that is, a perspective which maintains that an act is right, and a policy appropriate, if, all things being equal, it produces or is likely to produce the greatest amount of good for the greatest number of people.”¹³⁷ For Dr. Kluge, utilitarianism was seen as unconstitutional because it arbitrarily subordinated individual rights: “It strikes me that a utilitarian perspective forces us to see people as quantifiable entities whose autonomy and dignity lose before the good of the majority . . . It seems to me that it makes a mockery of autonomy and respect for persons and of the notion of individual rights.”¹³⁸ What concerned Dr. Kluge

¹³⁶ Ibid., 47.

¹³⁷ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 2 (Thursday March 17th to Tuesday, April 20th, 1994), 10.

¹³⁸ Ibid.

the most was how a communal metaphysic was often anathema to the lived reality of the dying. As Kluge indicated, utilitarianism “fosters an imposition of an externally defined good on the values of the individual person . . . the values that are thus imposed are external to the patient’s own value system.”¹³⁹

In contrast to Edward W. Keyserlingk, Dr. Kluge challenged “objective” metaphysical assumptions, particularly the omission / commission moral distinction. All things being equal, Dr. Kluge asserted that whether an action or non-action occurs does not determine a physician’s role responsibility. Instead, what mattered was whether or not an individual or doctor was “in a position to influence the causal chain of events as it is unfolding and whether the person is ethically obligated to influence it.”¹⁴⁰ Therefore, even with “passive euthanasia” or the “failure to intervene in a lifesaving or sustaining capacity,” the medical practitioner ensures that “the established chain of events will unfold to its fatal outcome.”¹⁴¹ Instead of attributing causation differently for negative and positive acts, Dr. Kluge believed that the same ethical parameters applied to *both* omissions *and* commissions:

In fact, the general philosophy on so-called passive euthanasia, namely, allowing nature to take its course, may be expressed like this: Because the condition of the patient is what it is, because the history and nature of the disease or condition is such and so, and because the medico-social circumstances are what they are, therefore death is expected to occur if treatment is suspended. Physicians who make such a decision expect that only a miracle could alter the chain of events which foreseeably will lead to death. However, this is the same assumption that underlies positive interference. When a physician acts positively, the physician expects that, except for a miracle, the laws of nature, together with their own causal determination, will yield a fatal outcome.¹⁴²

¹³⁹ Ibid.

¹⁴⁰ Ibid., 22. John Stuart Mill examined causation from a multi-faceted perspective. Instead of accepting an inherent distinction between acts of omission and commission, Mill provided an example of a person dying after eating a specific meal. Instead of the cause of death being the eating of the food, Mill felt that the eating of the dish may have caused death when combined with “a particular bodily constitution, a particular state of present health, and perhaps even a certain state of the atmosphere.” Philosophically speaking, the cause of death would be “the sum total of the conditions positive and negative taken together; the whole of the contingencies of every description, which being realized, the consequent invariably follows.” See J.S. Mill, *A System of Logic* (London: Longman’s, 1959), 214, 217.

¹⁴¹ Ibid., 23.

¹⁴² Ibid.

Kluge also insisted that the same logic of causation applied to methods used by the hospice/palliative care community. This implied that, pharmacologically speaking, hospice/palliative care specialists could not cloak their intent to hasten death behind the doctrine of double effect. As Kluge stated, “[C]urrent standards of palliation permit the use of narcotic analgesics and related medicaments even though their use may hasten death. . . . Therefore, the ethical position that permits palliation is the position that it is sometimes ethically appropriate not only to be the causal determinant of death, but also to speed the process on its way.”¹⁴³ Adopting a consequentialist approach, Dr. Kluge argued that palliation was on the same ethical plane as the withdrawal of treatment and euthanasia/assisted suicide:

[I]t follows that the very philosophy which underlies palliation and the philosophy that underlies the cessation of treatment legitimates the ethics of deliberate death. Since active and passive euthanasia are ethically on a par with respect to causality, intent, and responsibility, and since deliberate death is engendered through palliation and the adoption of a passive stance, it follows that active euthanasia must be accepted as ethically defensible as well.¹⁴⁴

In like manner, Professor Bernard Dickens from the Faculties of Law, Medicine, and Bioethics at the University of Toronto addressed how the *qualified* sanctity of life ethos harmed others by sanctioning the prolongation of pointless suffering. First, he recognized that the Supreme Court’s prohibition against assisted suicide “impose[d] hardships on Sue Rodriguez and others, but [the Court] concluded, on balance, that the hardship on those who want to end their lives is justifiable for protection of the vulnerable.”¹⁴⁵ However, Professor Dickens emphasized the dissenting judgment of Chief Justice Lamer to demonstrate how the law’s absolute support of the sanctity

¹⁴³ Ibid., 24.

¹⁴⁴ Ibid.

¹⁴⁵ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 10 (Wednesday, June 15th, 1994), 27.

doctrine was overly burdensome in the Rodriguez case: “[Chief Justice Lamer] accepted that the prohibition of assisted suicide ha[d] a role to defend the vulnerable, but that to impose that burden on Sue Rodriguez, who was competent and not abused, was excessive.”¹⁴⁶ Dickens admitted that although the sanctity of life as absolute increased individual suffering, such hardship was often justified in order to maintain the supremacy of the doctrine: “If one models arguments on a vision of the protection of life or the sanctity of life, if one believes in life at any cost, then one will tolerate the cost that Sue Rodriguez and others are required to bear.”¹⁴⁷

Professor Dickens also inquired as to whether there was an alternative, or “middle way,” to the blanket prohibition against assistance in suicide. He suggested a compromise that would “mediate between compassion for the request of Sue Rodriguez and protection of the vulnerable.”¹⁴⁸ Appropriate safeguards would not only be maintained, but decriminalization would also “accommodate cases to which a judge was sympathetic on the basis that the patient was competent, knew what he or she wanted, and was willing to be assisted in suicide or have another person end life.”¹⁴⁹ In the case of Sue Rodriguez, Professor Dickens believed a balance could be struck, one that prevented abuses, allowed the individual to exit life early, and permitted others to participate legally in an assisted suicide:

I do feel that the law ought to offer more to Sue Rodriguez than it did and should not leave her in the position in which, to realize her goals at the end of her life, she had to jeopardize those who came to the aid that she sought, by leaving them vulnerable to criminal prosecution. That is, I am satisfied that the minority judges in the Rodriguez case had drawn the sort of contrast between protection of the vulnerable and the relief of excessive burden on Sue Rodriguez in an appropriate way.¹⁵⁰

¹⁴⁶ Ibid., 30. For Chief Justice Lamer’s full analysis of the Rodriguez case, see Chapter V under “Sue Rodriguez and the Weakening of Metaphysics.”

¹⁴⁷ Ibid., 34.

¹⁴⁸ Ibid., 27.

¹⁴⁹ Ibid., 32.

¹⁵⁰ Ibid., 36.

However, Dickens was asked to elaborate on several key societal concerns for the Committee. When Senator Keon inquired if euthanasia and/or assisted suicide should be made legal, Dickens acknowledged that such choices were indeed necessary to fill a gap in standard medical practice: “I am satisfied, however, that palliative care has limits. Palliative care may control physical pain, but there can be conditions of moral anguish that make an individual feel that continued living is not appropriate.”¹⁵¹ When Senator Lavoie-Roux reminded Dickens that “a few accidents” could occur before safeguards were in place, Dickens simply reversed the “slippery slope” analogy: “Accidents go both ways. Some may conclude that the Supreme Court majority decision in the *Rodriguez* case was an accident.”¹⁵² Finally, when pressed by Senator Beaudoin to know exactly how he would rule on the *Rodriguez* case, Dickens reiterated his commitment to a compromise: “I would concur respectfully with the judgment of the Chief Justice, but have the Criminal Code amended in ways that would follow from that decision.”¹⁵³

From the Centre for Professional and Applied Ethics, Professor Arthur Schafer attempted to dismantle myths surrounding the “slippery slope” by emphasizing the history of death and dying as one of “eventuation.” He reminded the Committee that accusations of abuse, danger to the medical profession, and damage to societal symbols were previous arguments made against “passive” euthanasia: “Virtually every group who opposes euthanasia now nevertheless accepts what would have been called euthanasia 15 years ago but which is now called, in one case, palliative care.”¹⁵⁴ He added that what was controversial at the time—withholding or withdrawing life-saving medical care—

¹⁵¹ Ibid., 35.

¹⁵² Ibid., 38.

¹⁵³ Ibid., 42.

¹⁵⁴ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 18, 121.

was “now understood as a fundamental human right” and that the term “passive euthanasia” was now referred to as “justified allowing to die.”¹⁵⁵ To help the Committee understand the role omissions play in the intentional hastening of death, he provided a hypothetical scenario:

If, instead of the physician coming in to pull the plug on a patient who could not live without a respirator, a greedy nephew came into the room seeking an inheritance and pulled the plug, no one would be in doubt that the nephew had committed homicide . . . Why is it homicide when a greedy relative pulls a respirator plug, killing a patient, and it is not homicide when a physician does? I suggest to you that, in both cases, the physician is causally participating in the death of the patient. . .¹⁵⁶

Professor Schafer concluded that, if a “slippery slope” had not occurred with the sanctioning of negative acts, there was no reason to believe it would happen in the case of euthanasia or assisted suicide:

[F]ar from the legalization of passive and indirect euthanasia leading to a brutalization of society, far from making us a society which countenances killing rather than caring, I would say the opposite has happened. If there has been a slope, it has been a slope from less towards greater humanity, from less towards greater respect for the autonomy, the liberty, and the wishes of patients.¹⁵⁷

Professor Schafer also wanted to debunk “slippery slope” allegations directed against the Dutch regime. Although he agreed that Holland engaged in nonvoluntary euthanasia (explicit consent unknown), this was misconstrued to imply a hastened death *against* consent: “[T]hese were cases [nonvoluntary euthanasia] in which the patient was suffering horribly and death was imminent and the physician, from a sense of mercy, killed the patient, sometimes at the patient’s request and sometimes without the patient’s request; never involuntarily, never against the patient’s wishes. . . .”¹⁵⁸ It was equally important to remind the Committee that Holland’s open system was the most efficient way to examine potential “wedge” issues, such as nonvoluntary euthanasia:

¹⁵⁵ Ibid., 122.

¹⁵⁶ Ibid., 123.

¹⁵⁷ Ibid., 124.

¹⁵⁸ Ibid., 127.

Do we have any evidence that the incidence of nonvoluntary euthanasia in Holland is increasing? My suggestion to you is that it may well have decreased, but we now have a much greater degree of public accountability. . . . I would suggest that legalizing euthanasia, subject to a variety of important restrictions, gives us much greater opportunity to ensure that abuses do not take place. . .
¹⁵⁹

Professor Schafer finished by reminding the Committee that any application of the “slippery slope” must not be applied arbitrarily:

Every one of your concerns about the difficulty of ascertaining whether a dying patient is competent to request euthanasia or physician-assisted suicide applies with equal weight to the decision to withhold or withdraw medical care, which happens thousands of times every month in Canadian hospitals. . . . There are obviously twin dangers. There is the danger of usurping the autonomy of a competent patient by refusing to respect his or her wishes; and there is the opposite danger of allowing an incompetent patient to request discontinuation of life-saving medical care when it may be the illness speaking rather than the genuine, rational wish of that patient.¹⁶⁰

Metaphysical “Traces” in Quality of Life Discourse

In the Senate Committee reports, only one ethicist who supported the normative assumptions of the quality of life ethos ultimately rejected euthanasia and assisted suicide. University of Manitoba ethicist Barney Sneiderman initially appeared in support of self-determination for agents seeking an intentionally hastened death:

Who are you to say that someone who is afflicted with intolerable suffering cannot resort to euthanasia? How can you, speaking from within the comfort of your intact body, say to one who is sorely afflicted of body and soul that he or she must be denied the merciful release of euthanasia? If you have not undergone the experience of intolerable relentless suffering, then how dare you tell those who have that they must die your way?¹⁶¹

Even when metaphysical principles and individual cases of suffering were presented as competing arguments, Sneiderman agreed that the patient’s lived reality must take precedence:

I keep returning to the view that it really is an existential question, by which I mean you are the person who is doing the suffering. You are the person who is entrapped in the failing body. It seems to me that, if it is you in that position, your view might very well be much different compared to when you simply view the situation abstractly.”¹⁶²

¹⁵⁹ Ibid.

¹⁶⁰ Ibid., 130.

¹⁶¹ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 6, 60.

¹⁶² Ibid., 66.

Sneiderman was even moved by the opinion of legal philosopher Ronald Dworkin, who had offered his perspective on the prolongation of death in *Life's Dominion*: "Making someone die in a way others approve, but he believes a horrifying contradiction to his life, is a devastating, odious form of tyranny."¹⁶³ Unlike Margaret Somerville, Sneiderman rejected principle-based ethics. To know if an act was indeed morally right or wrong, Sneiderman suggested that one must first know the situation: In his words: "It prompts me to reject the 'No, never!' approach to euthanasia, by which I mean the philosophical view that euthanasia is morally wrong in principle. Period. 'Euthanasia is killing. Killing is wrong. Case closed.'"¹⁶⁴

Yet the possibility of the "slippery slope" made Sneiderman reluctant to support the legalization of euthanasia and assisted suicide in Canada. What was disconcerting for Sneiderman was the possibility that "an increasingly aging population [would] bring its own pressures to bear."¹⁶⁵ Because of possible cuts to home care, he felt that that elderly would prefer a "lethal injection" rather than be "trapped" in an institution until they die.¹⁶⁶ Since a scarcity of health care dollars could lead to coercion of the vulnerable, Sneiderman sought the kind of health care system in which "euthanasia could be

¹⁶³ Ibid., 60. For a complete analysis of Dworkin's own views on euthanasia, see Ronald Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom* (New York: Vintage Books, 1993); also see "The Philosophers' Brief," Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls, Thomas Scanlon, and Judith Jarvis Thomson as Amicus Curiae, in Support of Respondents, in *Bioethics: An Introduction to the History, Methods, and Practice*, 2nd ed., edited by Nancy S. Jecker, Albert R. Jonsen, and Robert A. Pearlman (Toronto: Jones and Bartlett Publishers, 2007), 490–502. Dworkin and five other moral philosophers submitted an Amicus Curiae Brief to the U.S. Supreme Court in support of physician-assisted suicide as an individual right in 1997.

¹⁶⁴ Ibid.

¹⁶⁵ Ibid., 72.

¹⁶⁶ Ibid.

practised as the medical measure of last resort,” adding: “I certainly do not feel that way in the Canada of the 1990s.”¹⁶⁷

Sneiderman was equally troubled over which types of patients would qualify for such death-hastening methods. A clear distinction was made between a hastened death for terminally versus non-terminally ill patients:

One concern I have, if euthanasia is legalized, is that, unless we have a clear boundary, it opens things up. Then there are no boundaries. At least if the boundary is terminal illness, we can say we are putting a protective cover on so that only those who are terminally ill can qualify for euthanasia.¹⁶⁸

When Senator Keon asked Sneiderman to confirm his position that “euthanasia should be legalized” and “limited to the terminally ill,”¹⁶⁹ Sneiderman was reluctant to commit to any form of decriminalization: “I do not believe that is what I said. What I said was that, if we do legalize euthanasia, it should be restricted to the terminally ill; but I do not think we should [legalize], not in this century. Perhaps in the next century.”¹⁷⁰

¹⁶⁷ Ibid., 71.

¹⁶⁸ Ibid., 70.

¹⁶⁹ Ibid., 71.

¹⁷⁰ Ibid.

Chapter IV: Medicine's Rejection of Euthanasia and Assisted Suicide

This section presents a discourse analysis of the Canadian medical profession's attitudes toward euthanasia and assisted suicide, with an emphasis on physicians, hospice/palliative care workers, and those representing major health organizations. The methodology is threefold: an examination of doctors' editorials, essays, journal articles, and letters to the editor located in the archives of the *Canadian Medical Association Journal (CMAJ)*; witness testimony during the *Proceedings of the Special Senate Committee on Euthanasia and Assisted Suicide* in Canada; and supplemental research located in other secondary sources. The main temporal period runs from 1988–95, with particular emphasis on the years 1991–94. In this time frame, there was an explosion of discussion containing the fullest expression of what Canadian medical professionals were thinking and feeling about an intentionally hastened death. High-profile cases involving Nancy B., Sue Rodriguez, and Robert Latimer no doubt triggered nationwide debate over the hastening of death, as did a Royal Commission on Health Care in British Columbia that recommended the Criminal Code be amended to permit physician-assisted suicide.¹ In addition, controversial American figures, such as Derek Humphry, Jack Kevorkian, and Timothy Quill, fuelled discussion that eventually entered Canadian ethical and medical discourses.² Thus, it is within this context that the majority of Canadian medical practitioners maintained support for the criminalization of an intentionally hastened death.

¹ BC Royal Commission on Health Care and Costs, *Closer to Home: the Report of the BC Royal Commission on Health Care and Costs* (Victoria: Crown Publ., 1991), c–183.

² See ethicist Daniel Callahan's remarks in S. Cromwell Crawford, *Dilemmas of Life and Death: Hindu Ethics in a North American Context* (Albany: State University of New York Press, 1995), 79.

In the archives of the *CMAJ*, the evidence suggests that doctors who embraced the *qualified* sanctity of life ethos as first principle—as metaphysics—emphasized two normative assumptions: (1) the inevitability of the “slippery slope” and (2) the acceptance of absolute moral distinctions. In contrast, those physicians gravitating toward the quality of life ethos argued against such positions, claiming that the “slippery slope” and inherent moral distinctions were misleading and arbitrary. In the Senate Committee reports, the normative assumptions of medical practitioners who supported the sanctity of life ethos (i.e., hospice/palliative care workers and health care representatives) were strikingly similar to those of Christian religious organizations/individuals. These assumptions included (1) stewardship (life as “a loan,” as “sacred,” or of “infinite worth”); (2) value in prolonged suffering; and (3) the inevitability of the “slippery slope.” In contrast, medical professionals supporting the quality of life ethos believed in the following: (1) self-determination; (2) the relative value of human life; and (3) the workability/flexibility of safeguards.

This chapter begins, then, with a brief history of the Canadian Medical Association (CMA) to demonstrate how ethical boundaries related to death and dying were never fixed but, in actuality, shifted over time. This will be followed by a discourse analysis of the two most common rhetorical patterns expressed by physicians within the CMA. Finally, an overview of the normative assumptions made by hospice/palliative care workers and representatives of major health care institutions will also be provided. A summary of the discourse not only highlights how religious “traces” still exist within so-called secular institutions, but a marked rhetorical difference between metaphysicians and Vattimian postmodernists is also revealed.

The CMA Code of Ethics: A History of “Eventuation”

Specific historical factors/events helped mould an interpretation of the CMA’s *Code of Ethics* in either a relativist or absolutist direction. The core of the Hippocratic Oath—“Whatever houses I may visit, I will come for the benefit of the sick, remaining free from all intentional injustice”—pertains to the physician’s obligation to the patient; therefore, it is worth emphasizing that this obligation is the *foundation* of the CMA’s *Code of Ethics*.³ This implies a fundamental bond whereby “physician and patient together seek to relieve suffering.”⁴ This perspective on medical care is more in line with the Greek tradition of eudaimonistic ethics, which aimed at “making the moral agent a good spirit—one who acquires well-being.”⁵ Yet those who invoke the *Oath* for contemporary help in the debate over euthanasia and assisted suicide may only exacerbate the dilemma, since “its [the Oath’s] injunction to relieve suffering may well be felt to be at odds with its parallel requirement to prolong and protect life.”⁶

This conflict of interpretations occurred because the Greek eudaimonist orientation of medicine was eventually challenged by Christian theological doctrine. The West’s religious heritage—from Christendom, throughout the Middle Ages, and well into the twentieth century—helped shape and sustain Christian morality within medical

³ Nuala P. Kenny, “The CMA Code of Ethics: More Room for Reflection,” *Can Med Assoc J* 155, no. 8 (15 October 1996): 1064. No one doubts that the Hippocratic Oath has shaped medical ethics and therefore the general moral code of physicians for centuries. Where uncertainty prevails is in the Oath’s applicability as a universal standard. This is because there is no consensus as to when the Oath was composed or on its specific purposes. There is even doubt as to whether or not the entire Hippocratic Collection—more than sixty books—contains even a single volume written by Hippocrates himself. See Chester R. Burns, ed., *Legacies in Ethics and Medicine* (New York: Science History Publications, 1977), 12; also see Paul Carrick, *Medical Ethics in the Ancient World: Philosophical Perspectives on Abortion and Euthanasia* (Washington: Georgetown University Press, 1995), 79–80.

⁴ *Ibid.*, 1065.

⁵ Paul Carrick, *Medical Ethics in Antiquity: Philosophical Perspectives on Abortion and Euthanasia*, 100.

⁶ David M. Forrest, “Euthanasia and the American Medical Association,” *Can Med Assoc J* 131 (15 September 1984): 629.

orthodoxy, particularly in the area of death and dying.⁷ In addition, World War II brought with it the reality of Nazi concentration camps, solidifying both the Oath's mythological power and the Christian church's hegemony over matters of life and death. According to John R. Williams, PhD, "The revulsion that followed reports of Nazi 'euthanasia' programs and of physician participation in them further strengthened the belief that physicians should never participate in or even support euthanasia or suicide."⁸ Thus, in the post-WW II era, Christian morality was instrumental in shaping the direction of bioethics, particularly in the 1960s and '70s.⁹ For those doctors who rejected the legalization 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.¹⁰

That said, it is important to remember that the CMA *Code of Ethics* never formally subscribed to objectivistic metaphysics. In fact, medical ethics was considered situational, a point made clear in a report by the Committee on Ethics to the CMA's General Council in 1963:

The medical profession does not now subscribe to all that was laid down in the original Oath of Hippocrates. Our own Code of Ethics was written in 1868, just ninety-five years ago, and in the interval many changes have been made—changes that are attempts to place it in harmony with the "changing sentiments of the world" and the resulting changes in the conditions surrounding practice and the relations that exist between the profession, its patients and society.¹¹

Hence, emerging social trends triggered changes to the *Code of Ethics*. In the milieu of competing bioethical claims and the interpretative history of medicine,

⁷ Ian Dowbiggin, *A Concise History of Euthanasia: Life, Death, God, and Medicine*, 7–26.

⁸ John R. Williams et al., "Canadian Physicians and Euthanasia: 1. An Approach to the Issues," *Can Med Assoc J* 148, no. 8 (15 April 1993): 1294.

⁹ John R. Williams, *Christian Perspectives on Bioethics: Religious Values and Public Policy in a Pluralistic Society* (Ottawa: Novalis, 1997), 1–28.

¹⁰ Edward J. Larson and Darrel W. Amundsen, *A Different Death: Euthanasia and the Christian Tradition* (Downers Grove, Illinois: InterVarsity Press, 1988); also see Helga Kuhse, *The Sanctity of Life Doctrine in Medicine: A Critique* (Oxford: Oxford University Press, 1987).

¹¹ John Sutton Bennett, *History of the Canadian Medical Association, 1954–1994* (Ottawa: Canadian Medical Association, 1996), 209.

principles were merely helpful tools, not absolute foundations to be taken as self-evident.¹² As different contexts and competing value systems posed new challenges, the *Code* became an “unfinished reflection on the meaning of being a good physician” and “[could not] be regarded as the single source for assistance in clarifying complex ethical issues.”¹³ The CMA’s *Code of Ethics*, therefore, is consistent with the Vattimian concept of eventuation in which “Being is temporality.”¹⁴ In other words, historical circumstances, or “events of being,” shape and reshape our normative assumptions.

In the late 1960s, methods used within standard medical practice, such as widespread application of life-support and other extraordinary measures, forced physicians to rethink the importance of vitalism, the belief that biological life is of ultimate value, something to be preserved at all costs.¹⁵ The extraordinary use of technology had many questioning the need to keep patients alive indefinitely, so much so that by 1969 the CMA General Council issued the following statement: “An ethical physician will allow death to occur with dignity and comfort when death of the body appears inevitable. He will support the body when clinical death of the mind has occurred, but need not prolong life by unusual or heroic means.”¹⁶ In 1974, a further weakening of the vitalist principle emerged with the legal acceptance of do-not-

¹² K.D. Clouser and B. Gert, “A Critique of Principlism,” *J Med Philos* 15 (1990): 219–36.

¹³ Nuala P. Kenny, “The CMA Code of Ethics: More Room for Reflection,” 1064, 1065.

¹⁴ Vattimo, *Not Being God: A Collaborative Autobiography*, 63.

¹⁵ Keown, *Euthanasia, Ethics, and Public Policy: An Argument against Legalization*, 41.

¹⁶ John R. Williams et al., “Canadian Physicians and Euthanasia: 1. An Approach to the Issues,” 1294. As previously mentioned in Chapter II (“Global Trends”), the CMA’s acceptance of brain death was influenced by a new criterion first established as ethically viable in 1968 by the Harvard Brain Death Committee under the chairmanship of Henry Beecher. Declaring someone “brain dead” resolved the crisis over organ donation in that it was not practical to wait for the patient’s circulation to stop, declare the patient dead, and watch potentially good organs go to waste. To resolve such a dilemma, the patient would be declared deceased when there was an “irreversible loss of the capacity for consciousness.” See Henry Beecher, “The New Definition of Death: Some Opposing Viewpoints,” 120–21; also see David Rothman, *Strangers at the Bedside*, 160–61; Peter Singer, *Rethinking Life and Death: The Collapse of our Traditional Ethics*, 38–56.

resuscitate orders for the terminally ill. The CMA recognized that “there [were] conditions of ill health and impending inevitable death where an order on the order sheet by the attending doctor of ‘no resuscitation’ [was] appropriate and ethically acceptable.”¹⁷

Even with these shifts in medical ethics, discourses condemning euthanasia and physician-assisted suicide were rare in the *Canadian Medical Association Journal* (CMAJ) from the 1970s to the early 1980s. Those that were published, however, manifested a Christian bias. In late 1975, Dr. Colin P. Harrison stated that health was a sacred matter. For Dr. Harrison, health represented “a pristine order of well-being such as might have existed only in the Garden of Eden before the Fall,” adding that “man who was once said to have been created in the image and likeness of God is to be recreated in the current idiom of well-being.”¹⁸ Rejecting quality of life considerations, Dr. Harrison warned that the physician “must not presume to be able to weigh the value of continued life against death. . . .”¹⁹ Another article addressing euthanasia and physician-assisted suicide was written in August of 1979 by J. Arthur Boorman, PhD, an associate professor of Christian ethics at McGill University. Emphasizing a communal and metaphysical outlook, he criticized modernity’s “preoccupation with individual rights and personal freedom; a certain softness in the face of hardship or pain; [and] a preference for the tangible and the useful.”²⁰ Professor Boorman felt that a profound truth was derived

¹⁷ Ibid., 1295.

¹⁸ Colin P. Harrison, “Euthanasia, Medicine, and the Law,” *Can Med Assoc J* 113 (8 November 1975): 834.

¹⁹ Ibid., 833.

²⁰ J. Arthur Boorman, “To Live or Not to Live: The Moral and Practical Case against Active Euthanasia,” *Can Med Assoc J* 121 (18 August 1979): 483.

from the sanctity of life ethos in that “human life is a gift” and that “every human life is therefore precious.”²¹

In the early 1980s, euthanasia and assisted suicide were also dismissed for reasons that reflected what Vattimo refers to as “objectivistic metaphysics.” Dr. David M. Forrest, a fourth-year student in medicine at the University of Alberta, outlined the sanctity of life position. Individuals were said to have “absolute worth simply as persons,” meaning that the self was “infinitely valuable.”²² Evidence of this truth, Dr. Forrest claimed, rested in “the supreme value we place upon a loving attitude towards persons.”²³ This principle possessed a transcendent quality and could be reinforced socially by “seeing ourselves and others as a community bound together in the service of something beyond all its members.”²⁴

However, a shift began to emerge. The Law Reform Commission of Canada issued its *Report on Euthanasia, Aiding Suicide, and Cessation of Treatment*, noting an increasing emphasis on quality of life concerns.²⁵ The government’s proposed amendments now struck a balance between competing paradigms. The state still maintained “the presumption in favour of life” for patients who could not consent or who were unconscious, yet concluded that people “must remain masters of their fate.”²⁶ Most important, the Commission’s *Report* indicated that “if a patient’s decision is more concerned with his quality of life than his staying alive as long as possible, such a

²¹ Ibid., 485.

²² David M. Forrest, “Euthanasia and the American Medical Association,” 629.

²³ Ibid.

²⁴ Ibid.

²⁵ Law Reform Commission of Canada, *Report on Euthanasia, Aiding Suicide and Cessation of Treatment* (Ottawa: Minister of Supply and Services Canada, 1983).

²⁶ “Newsbriefs,” *Can Med Assoc J* 129 (1 December 1983): 1213.

consideration should be respected by the physician.”²⁷ Yet the sanctity of life ethos could only be weakened to a point. The *Report* concluded that Canada could not tolerate euthanasia “without violating its social traditions and history,” warning that legalization “would be open to serious abuse.”²⁸

As a result of medico-legal changes—namely, the redefinition of death, rising dependency on technology, and the burgeoning influence of the quality of life ethos—the CMA’s General Council recommended that there be “increased coverage of ethical issues in the *CMAJ* and increased awareness and coverage of ethical and bioethical issues at meetings of affiliate societies.”²⁹ Consequently, by the late 1980s, the CMA’s Department of Ethics and Legal Affairs was established “to provide leadership and advice to physicians, other health professionals, policymakers and the general public on the ethical and legal aspects of health and health care.”³⁰ To summarize, the CMA could accept as medically and ethically viable the withholding or withdrawal of treatment (acts of omission), but it could not sanction an intentionally hastened death in the form of either euthanasia or physician-assisted suicide (acts of commission). Thus, by the end of the decade, the transition from vitalism to the *qualified* sanctity of life ethos was a *fait accompli*.

This paradigmatic shift was also influenced by the opinions of several global medical bodies. In 1987, the World Medical Association approved the following declaration on euthanasia: “Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient’s own request or at the request of close relatives, is unethical.

²⁷ Ibid.

²⁸ Ibid.

²⁹ John Sutton Bennett, *History of the Canadian Medical Association, 1954–1994*, 211.

³⁰ Ibid., xii.

This does not prevent the physician from respecting the desire of a patient to allow the *natural process of death* to follow its course in the terminal phase of sickness [emphasis mine].”³¹ Likewise, in 1988, the British Medical Association concurred with the World Medical Association, declaring the sanctity of life ethos as *the* foundation of medicine:

An active intervention by anybody to terminate another person’s life should remain illegal. . . . The rejection of a change in the law to permit doctors to intervene to end a person’s life is . . . an affirmation of the supreme value of the individual, no matter how worthless and hopeless that individual may feel.³²

In 1991, the American Medical Association’s Council on Ethical and Judicial Affairs took a position similar to that of its British cousin; however, the “slippery slope” became an additional concern: “Physicians must not perform euthanasia or participate in assisted suicide. . . . [T]he societal risks of involving physicians in medical interventions to cause patients’ deaths are too great in this culture to condone euthanasia or physician-assisted suicide at this time.”³³

Consequently, by 1991, the CMA’s Committee on Ethics adopted five topics of study—one being euthanasia—and by 1993, a series of background papers on euthanasia was prepared by the Department of Ethics and Legal Affairs. In total, five papers appeared in the *CMAJ* between April and June of 1993, followed by educational and strategic issue sessions on the subject of an intentionally hastened death.³⁴ From these sessions, doctors required more certainty that procedures permitted within standard medical practice would not result in criminal prosecution, particularly the use of drugs leading to death (the doctrine of double effect) and the withholding/withdrawal of treatment (acts of omission). A report surfaced in 1993 recommending that the *Criminal*

³¹ John R. Williams et al., “Canadian Physicians and Euthanasia: 1. An Approach to the Issues,” 1295.

³² *Ibid.*, 1295–96.

³³ *Ibid.*, 1296.

³⁴ John Sutton Bennett, *History of the Canadian Medical Association, 1954–1994*, 214.

Code be amended to state clearly that “physicians administering palliative care [were] not criminally responsible for *accelerating the patient’s death* unless the patient refuse[d] such care” (i.e., unless the patient refused pain medication that could hasten death) [emphasis mine].³⁵ In other words, it was not the hastening of death that was problematic; it was the protection of physicians from criminal liability that mattered more. Nevertheless, because of the historico-cultural influences that shaped CMA policy, any proposed amendment in support of an intentionally hastened death was going to face stiff opposition. The ability to implement such radical reform was summed up in November of 1993 by the CMA’s then president, Dr. Bruno L’Heureux:

A change in the legal status of [physician-assisted death] in Canada would represent a major shift in social values and behaviour. For the medical profession to support such a change and participate in physician-assisted death would require a fundamental reconsideration of traditional medical ethics.³⁶

In 1994, the CMA held firm to an absolute moral distinction between acts of omission used within standard medical practice and acts of commission, such as euthanasia/physician-assisted suicide. Euthanasia meant that an agent “commits an act with the primary intention of ending that person’s life;” physician-assisted suicide referred to “knowingly and intentionally providing a person with the knowledge and/or means of committing suicide;” and ethical methods under standard medical practice involved “the withholding or withdrawal of inappropriate medical treatment or the provision of compassionate palliative care, even when life is *shortened by such measures*” [emphasis mine].³⁷ Such an ethical stance—life can be shortened as long as one does not *intend* to hasten death—left physicians divided on the issue of prohibition. This was evidenced by the fact that in 1994, when the CMA’s General Council took a

³⁵ Ibid., 216.

³⁶ Ibid., 217.

³⁷ Ibid., 216.

vote 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).³⁸

What the polarized vote and medical opinion indicated was that an intentionally hastened death was not a normative stance the CMA was ready to accept. In fact, even with the flexible mandate inherent in the *Code of Ethics*, as well as suggestions for further debate, centuries of entrenched values—namely, the Hippocratic tradition, the physician as healer, and the Christian sanctity of life ethos—could not be abandoned by the majority of the profession. As Dr. Fred Lowy, 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.”³⁹ Because the majority of CMA members eventually rejected euthanasia and physician-assisted suicide, a discourse analysis is required to highlight the normative assumptions that shaped sanctity of life advocates (metaphysicians) and quality of life supporters (Vattimian postmodernists).

Holland’s “Slippery Slope” and the Nazi Analogue

During debates within the *CMAJ* from 1988–95, one of the most common “wedge” issues dealt with the Dutch medical profession’s acceptance of euthanasia and physician-assisted suicide. The greatest fear among Canadian doctors was that legalizing acts of commission would result in a “slippery slope,” either in the form of abuse or worse—a return to Nazi eugenics. Consequently, the majority of CMA members maintained the reigning metaphysic by supporting the *qualified* sanctity of life ethos.

³⁸ 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.

³⁹ J. Rafuse, “CMA Continues Development of Euthanasia Policy after Supreme Court’s Rodriguez Ruling,” *Can Med Assoc J* 149, no. 9 (1 November 1993): 1305.

Fears over the Dutch regime 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 euthanasia by administering an overdose of morphine sulphate for a twenty-year-old woman named Debbie without personally knowing the patient.⁴⁰ The story caused nothing short of a media sensation. As journalist Anne Mullens acknowledged, “The letter mark[ed] the beginning of a constant stream of articles and opinion pieces that still hasn’t ceased.”⁴¹ Undoubtedly, the American controversy began to influence mainstream medical opinion across the border.

In June 1988, an editorial in the *CMAJ* by Dr. Peter A. Singer, 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 physician-assisted suicide: “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.”⁴² 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

⁴⁰ Jonathan D. Moreno, ed., *Arguing Euthanasia: The Controversy over Mercy Killing, Assisted Suicide, and the ‘Right to Die’* (Touchstone: New York, 1995), 31–32. Different moral philosophers have called into question the rhetoric surrounding the “Debbie” incident. Similar to Vattimo’s concept of the “event of being,” 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.

⁴¹ Anne Mullens, *Timely Death: Considering our Last Rights*, 162.

⁴² Peter A. Singer, “Should Doctors Kill Patients?” *Can Med Assoc J* 139 (1 June 1988): 1000.

thousands of vulnerable people will be in danger if active euthanasia is legalized.”⁴³ He also highlighted two main reasons for his position, one medical and one historical. First, he confessed that “physician-mediated killing” was unprincipled because “it erode[d] the moral mission of medicine. . . . The Hippocratic Oath speaks unequivocally about active euthanasia: ‘I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect.’”⁴⁴ Second, Dr. Singer 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 [medical practice] is much like Germany in the ’20s and ’30s. The barriers against killing are coming down.”⁴⁵ Overall, Singer condemned physicians who supported euthanasia, stating that “a doctor who injects a patient with a lethal dose is simply not behaving like a doctor.”⁴⁶

Several Canadian physicians replied favourably to Dr. Singer’s editorial. In December 1988, Dr. Albert J. Kirshen wrote the *CMAJ*, claiming that in Holland, autonomy and informed consent were not being universally safeguarded: “Apparently dementia sufferers in nursing homes are now subject to active euthanasia.”⁴⁷ In June 1989, Dr. Kirshen wrote again to clarify his position on the issue of patient consent in the Netherlands:

⁴³ Ibid., 1001.

⁴⁴ Ibid.

⁴⁵ Ibid.

⁴⁶ Ibid.

⁴⁷ Albert J. Kirshen, “Should Doctors Kill Patients?” *Can Med Assoc J* 139 (1 December 1988): 1041. Kirshen’s claims elicited counterarguments from the Dutch. 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.

If euthanasia is being practised in a hospital or a nursing home [in Holland], 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?⁴⁸

For Dr. Kirshen, the reported use of *involuntary* euthanasia in Holland was evidence of “the ‘can of worms’ we open when talking about active euthanasia. . . .”⁴⁹

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 of Nazi physicians who participated in the Third Reich’s mandate. Dr. Fritz Stern 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.”⁵⁰ Canadian physicians agreed. Dr. Frederick Lowy, 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.”⁵¹ 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.”⁵²

⁴⁸ Albert J. Kirshen, “Euthanasia in the Netherlands,” *Can Med Assoc J* 140 (1 June 1989): 1258.

⁴⁹ Ibid. 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*, 9; Peter Singer, *Rethinking Life and Death: The Collapse of our Traditional Ethics*, 151.

⁵⁰ Michael O’Reilly, “Nazi Medicine: ‘The Perversion of the Noblest Profession,’” *Can Med Assoc J* 148, no. 5 (1 March 1993): 819.

⁵¹ Ibid., 820.

⁵² Ibid.

A group of Alberta doctors concurred with Lowy's anxieties 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 judgments, Dr. W. Joseph Askin et al. 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.⁵³

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 position 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.”⁵⁴

Affirming the views of the Alberta physicians, several doctors used the Nazi analogue as a form of “slippery slope.” For instance, Dr. Willi D. Gutowski 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. . . .”⁵⁵ However, to avoid a downward spiral, Dr. Gutowski's solution was to reject any tempering of the sanctity doctrine by negating subjective interpretation of the issue. Society, he claimed, must “maintain objectivity in dealing with this emotional problem [euthanasia]. When patients ‘feel’ that they want to die we must be objective

⁵³ W. Joseph Askin et al., “Nazi Medicine,” *Can Med Assoc J* 148, no. 11 (1 June 1993): 1866.

⁵⁴ Ibid. As John Stuart Mill acknowledged, utilitarianism implies 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*, 250.

⁵⁵ Willi D. Gutowski, “Nazi Medicine,” *Can Med Assoc J* 148, no. 11 (1 June 1993): 1866.

and scientific. The best answer may be no.”⁵⁶ In similar fashion, Dr. William E. Goodman 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.”⁵⁷ Dr. Wena V.P. Hyde-Williams 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.’”⁵⁸

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.⁵⁹ It was at this time that Canadian doctors became increasingly vocal about comparisons between Dutch practices and Nazi experiments. Dr. Ted Boadway, 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 assistance in suicide because if they did, “they [would] be compared to Nazis, even by colleagues.”⁶⁰ 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, Chair of the CMA’s

⁵⁶ Ibid.

⁵⁷ William E. Goodman, “Nazi Medicine,” *Can Med Assoc J* 148, no. 11 (1 June 1993): 1866.

⁵⁸ Wena V.P. Hyde-Williams, “Nazi Medicine,” *Can Med Assoc J* 148, no. 11 (1 June 1993): 1866.

⁵⁹ *Rodriguez v. British Columbia* (Attorney General), 3 S.C.R. 519 September 30, 1993, Docket: 23476 (1993). <<http://scc.lexum.umontreal.ca/en/1993/1993rcs3-519/1993rcs3-519.html>>

⁶⁰ Patrick Sullivan, “Take Stand on Euthanasia, Assisted Suicide, MDs Tell CMA in Survey Released during Annual Meeting,” *Can Med Assoc J* 149, no. 6 (15 September 1993): 858.

Committee on Ethics, the link was used to “inhibit many who might want to speak in favour of PAD [physician-assisted death].”⁶¹

The Nazi taint continued well into 1994. Dr. Howard Bright felt that it was “sadly ironic that Dutch physicians, who resisted Hitler so heroically a generation ago, now embrace[d] the utilitarian view of life and death.”⁶² Dr. Bright also noted the key source of anxiety among the elderly and the terminally ill: “Fear of physicians is understandable in light of the Rummelink Report, which documented widespread *involuntary* euthanasia in the Netherlands [emphasis mine].”⁶³ Comments made by Dr. L. Le Baron de Veber also supported Dr. Bright’s findings. Dr. Le Baron de Veber cited as evidence of Dutch medical abuses “any decisions to withhold or withdraw lifesaving treatment without the patient’s request (25,000 times a year or 19% of all deaths),” adding that when morphine was administered “‘in such a way that it nearly certainly shortened life,’ in 27% of the cases ‘the decision was not discussed with the fully competent patient.’”⁶⁴

Other physicians disagreed with any comparison between Canadian medical practices and Nazi eugenics. Contradicting Dr. Bright’s opinions, Dr. Arnoldus J. Verster replied that such connections to Nazism were a result of “pamphlets from the anti-euthanasia lobby that tell horror stories about the terrible things that can happen in a hospital” and that the doctors he knew “certainly [did] not go around with a syringe

⁶¹ Douglas M. Sawyer, “What Do Canadian MPs Think about Euthanasia? An Update Following the CMA Annual Meeting,” *Can Med Assoc J* 150, no. 3 (1 February 1994): 396.

⁶² Howard Bright, “Dutch Health Care,” *Can Med Assoc J* 151, no. 3 (1 August 1994): 273.

⁶³ Howard Bright, “Euthanasia in the Netherlands,” *Can Med Assoc J* 151, no. 10 (15 November 1994): 1396.

⁶⁴ L. Le Baron de Veber, “Physicians and Euthanasia,” *Can Med Assoc J* 150, no. 2 (15 January 1994): 124.

killing old people.”⁶⁵ As an overall critique of these remarks, Dr. Sawyer 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].⁶⁶

Although scarce, there were some doctors that supported Dutch medical practices. In April 1991, Dr. Morley J. Tuttle gravitated toward the Dutch medico-legal approach for euthanasia and physician-assisted suicide because it balanced freedom of choice with concerns over abuse: “Reasonable cases [of euthanasia and physician-assisted suicide] will not attract the attention of public prosecutors, and in other cases the court decisions will in time provide appropriate guidelines.”⁶⁷ In February 1992, Dr. Frances S.H. Dartana hoped that “the terminally ill . . . [would] be given alternatives, as they were in Holland.”⁶⁸ Further support for Holland’s approach was provided by the aforementioned Dr. Verster. He highlighted how euthanasia in the Netherlands was “subject to very strict controls” and was “not a ‘quick fix’ that had been found in desperation.”⁶⁹

However, the majority of Canadian physicians would not be swayed by such opinions, and divisions within the CMA became further entrenched. One either sided

⁶⁵ Arnoldus J. Verster, “Euthanasia in the Netherlands,” *Can Med Assoc J* 151, no. 10 (15 November 1994): 1393.

⁶⁶ Sawyer, “What Do Canadian MDs Think about Euthanasia? An Update Following the CMA Annual Meeting,” 396–97. Philosopher Michael Stingl also claims that the Nazi analogue is a weak one. 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.

⁶⁷ Morley J. Tuttle, “Ethics of Euthanasia,” *Can Med Assoc J* 144, no. 8 (15 April 1991): 956.

⁶⁸ Francis S.H. Dartana, “Ethics of Euthanasia,” *Can Med Assoc J* 146, no. 4 (15 February 1992): 445.

⁶⁹ Arnoldus J. Verster, “The Death of Bill C–203,” *Can Med Assoc J* 147, no. 12 (15 December 1992): 1748.

with palliative care and methods established under standard medical practice (i.e., acts of omission), or one sought to change the status quo and support the decriminalization of euthanasia, physician-assisted suicide, or both. At the CMA's annual meeting in 1994, the campaign against participation in euthanasia and physician-assisted suicide was led by a British Columbia delegation headed by Dr. Daniel MacCarthy of West Vancouver. Dr. MacCarthy was worried about the potential threat to the integrity of medicine: "The healers of Canada and an honourable profession should not be vulnerable to being misrepresented as the killers of Canada."⁷⁰ Dr. Augustin Roy of Montreal sided with Dr. MacCarthy: "We shouldn't fall into the trap of discussing an issue which is not medicine . . . The role of the physician is to help people live, not help them die. . . . [Assisting death] would be a flagrant contradiction of our role [as healers]."⁷¹ Dr. Boadway supported Drs. MacCarthy and Roy: "I feel strongly that doctors are not for killing. There is alternative care, palliative care."⁷² In addition, Dr. Jim Lane of Port Coquitlam, BC, warned that doctors "must not lose the trust of [their] patients"⁷³ by compromising on good palliative care.

Nevertheless, other physicians at the annual meeting took either opposing or neutral positions. Dr. Michael Wyman, president of the Ontario Medical Association, commented that "specific exclusion of euthanasia is not one of the generally accepted principles of palliative care."⁷⁴ Highlighting the CMA's ambivalence toward change, the aforementioned Dr. Sawyer admitted that the Committee on Ethics "did not intend to take a stand for or against physician-assisted death because the issue presented a moral

⁷⁰ J. Rafuse, "CMA Rejects Neutral Stand, Comes out Firmly against MD Participation in Euthanasia," 854.

⁷¹ Ibid.

⁷² Ibid.

⁷³ Ibid., 853.

⁷⁴ Ibid.

dilemma for many doctors.”⁷⁵ Yet Sawyer hinted at what he felt was an integral part of living in a pluralistic society: “We [physicians] have to be prepared to live with diversity and to be tolerant of other positions.”⁷⁶ Dr. Sawyer also addressed the medical dilemma if a firm stand were taken against euthanasia and physician-assisted suicide: “[I]f the law is changed, the CMA would be in the awkward position of prohibiting its members from participating in a legal act.”⁷⁷

One last series of discussions was generated as a result of a vote (August, 1994) by the CMA’s General Council to exclude physician participation in euthanasia and assisted suicide. In December 1994, Dr. Eugene Leduc reminded readers of the importance of a communal ethos: “The issue of whether physicians should participate in the active killing of a patient is central to our purpose in society and should never be left to individual conscience.”⁷⁸ Dr. Leduc’s reasoning behind the prohibitionist stance lay in the possible weakening of the doctor-patient relationship: “Fortunately, good sense in the form of a rational argument and a return to the traditional role of physician as healer and comforter prevailed at this [CMA General Council] meeting. . . . The issue for physicians is not one of individual ethics but of professional limits.”⁷⁹ In rebuttal, Dr. Harry E. Emson countered both the views of Dr. Leduc as well as those advocating for the sanctity of human life as absolute: “I believe that physician-assisted suicide is a moral right which, with proper safeguards, should also be a legal right.”⁸⁰ His perspective centred on a rights-based discourse, emphasizing a Millian form of liberty: “I do not wish to force

⁷⁵ Ibid., 854.

⁷⁶ Ibid.

⁷⁷ Ibid.

⁷⁸ Eugene Leduc, “Euthanasia and Physician-Assisted Suicide,” *Can Med Assoc J* 151, no. 12 (15 December 1994): 1691.

⁷⁹ Ibid.

⁸⁰ Harry E. Emson, “Euthanasia and Physician-Assisted Suicide,” *Can Med Assoc J* 151, no. 12 (15 December 1994): 1691.

my beliefs upon others who do not share them; likewise, I require that observance of the beliefs of others, which I do not share, not be forced upon me.”⁸¹

Nonetheless, Dr. Arnold Voth suggested the “slippery slope” argument as 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.”⁸² 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 Robinsons of this nation do not visit them or trumpet their cause aloud on television. They are disenfranchised.⁸³

Consistent with the Vattimian understanding of history as “eventuation,” the CMA’s *Code of Ethics* had indeed changed with the “sentiments of the world”⁸⁴ but only to a point. Medical acceptance of euthanasia and assisted suicide was simply considered too radical a shift. Hence, the *qualified* sanctity of life ethos maintained its status as first principle. Because Canadian doctors could not intentionally hasten death, their rhetoric also centred on another absolute: the inherent moral distinction between acts of omission and commission.

⁸¹ Ibid.

⁸² Arnold Voth, “Euthanasia and Physician-Assisted Suicide,” *Can Med Assoc J* 151, no. 12 (15 December 1994): 1691.

⁸³ Ibid., 1691–92. As a controversial member of the New Democratic Party at the time, Svend Robinson was not only an advocate of physician-assisted suicide but was also present when Sue Rodriguez chose to have her death hastened with the aid of an anonymous physician.

⁸⁴ John Sutton Bennett, *History of the Canadian Medical Association, 1954–1994*, 209.

The Omission / Commission Moral Distinction

Canadian doctors also focused on maintaining absolute medico-legal distinctions, in particular the difference between “passive” and “active” euthanasia. In August 1988, the question of absolutes was posed by freelance writer Hans Goddard in the *CMAJ*. Paraphrasing Marylinne Seguin, cofounder and executive director of Dying with Dignity, Goddard debated whether there was a difference between “active” euthanasia (lethal injection) and “passive” euthanasia (withdrawal of treatment) since “‘the intention and the result [were] the same.’”⁸⁵ Almost a year later, freelance writer Ann Silversides quoted Dr. Peter Admiraal, a Dutch anesthetist and presenter at the First International Conference on the Palliative Care of the Elderly in Toronto. Admiraal dismissed any reliance on absolute moral distinctions, arguing that “the discontinuation of medical treatment can in fact lead to a ‘cruel death’” and that “[t]he only thing passive about it is the physician.”⁸⁶

However, it was not until February of 1991 that opinions appeared more frequently about the need to maintain absolute moral distinctions. The views expressed in two *CMAJ* articles by freelance writer Mina Gasser Battagin and medical ethicist Eike-Henner Kluge, the CMA’s director of medical ethics and legal affairs, sparked serious debate among physicians on the validity of such distinctions. Battagin made one poignant observation: “What a strange world we live in that we are kinder to our animals than to human beings. Had our dog been ill or in pain we would have taken him to the veterinarian and had him put gently to sleep. . . . Why do we not gently and lovingly put

⁸⁵ Hans Goddard, “‘Voluntary Euthanasia Declaration’ Goes Step beyond Living Will,” *Can Med Assoc J* 139 (1 August 1988): 246.

⁸⁶ Ann Silversides, “Passive Euthanasia Simply Means Cruel Death, Dutch MD Maintains,” *Can Med Assoc J* 140 (15 June 1989): 1482, 1484.

people to sleep in the same way?”⁸⁷ Battagin elaborated on how the concept of stewardship was the source of resistance to euthanasia: “Many with strong religious or moral convictions believe that any form of unnatural [intentionally hastened] death is a type of homicide. This comes from the premise that if we trust in God, we would not end our existence.”⁸⁸

Eike–Henner Kluge added that the euthanasia issue was imminent. He believed the process would involve physicians “either as providers of the drugs that bring about death, or as direct agents of death.”⁸⁹ Moreover, Kluge highlighted cases within standard medical practice and asked how such scenarios differed ethically from euthanasia and physician-assisted suicide:

Is what he [Jack Kevorkian] made possible [the “suicide machine”] really so much different from the prescriptions for narcotic analgesics that physicians give patients—prescriptions that are appropriate and should last a week, except the doctor knows full well the patient will take the entire prescription at once because he wants to die? Is it really so much different from what physicians do when they know a patient is hoarding medication because he wants to take an overdose, and yet take no steps to stop him?⁹⁰

Because Kluge felt that doctors had not critically assessed the omission/commission distinction, he asked: “If the medical profession thinks a physician might become responsible for a patient’s death through inaction, but without automatically bearing moral guilt, why does it insist that a physician who becomes responsible for the death of a patient through action automatically becomes morally

⁸⁷ Mina Gasser Battagin, “Giving Death a Helping Hand,” *Can Med Assoc J* 144, no. 3 (1 February 1991): 358.

⁸⁸ *Ibid.*

⁸⁹ Eike–Henner Kluge, “Euthanasia and Related Taboos,” *Can Med Assoc J* 144, no. 3 (1 February 1991): 359.

⁹⁰ *Ibid.*, 360. Jack Kevorkian’s “suicide machine,” the “Mercitron,” was used by Oregon resident Janet Adkins in 1990 after she was diagnosed with Alzheimer’s disease. It involved an intravenous injection that the patient self-administered. At a time of the patient’s choosing, a hair-trigger switch is pressed, which stops a saline solution and activates a rapid infusion of concentrated potassium chloride. The patient would be dead within minutes. See Jack Kevorkian, *Prescription: Medicide, The Goodness of Planned Death*, 208–10.

guilty? Is the difference between doing and failing to do really that great?”⁹¹ In reply to these viewpoints expressed above, Dr. Philip G. Ney felt that airing such differences [pro-choice euthanasia views] would lead “ethical physicians” to champion a separate association. Stated Dr. Ney: “A Canadian Ethical Medical Association (CEMA) would be founded on principles of progressive science and enduring ethics” so that “neither governmental coercion nor ethical guile would sway them from basic principles.”⁹²

By June 1991, arguments also focussed on permissible scenarios for omissions. Because stewardship, or the “sanctity of life” as first principle, was foundational to the moral positions of metaphysicians, it followed that for death-hastening acts—including negative methods—intent must always be denied as one’s primary motivation. For example, Dr. Donald G. Jansen initially emphasized what he called the “first principles” of care in medicine: “All life is inviolable,” he stated, and it “continues to have equal worth throughout its existence.”⁹³ These principles led Dr. Jansen to believe in an absolute moral difference between “passive” euthanasia (making someone die) and “natural death” (allowing someone to die). The former implied the intent to hasten death based on the quality or kind of life, while the latter act was based on removing extraordinary treatment. Clarified Jansen:

. . . [A] decision against a mode of treatment because it will offer the patient no appreciable benefit must not be confused with a decision to withhold further treatment because a patient should no longer live. The former decision is based on the fact that the treatment, not the continuation of life, will be burdensome. Such decisions are not examples of euthanasia. The latter decision is passive euthanasia.⁹⁴

Jansen’s letter was critiqued by the aforementioned Dr. Kluge, who argued that “the distinction between intent and motive . . . is not quite as clear as Jansen makes

⁹¹ Ibid.

⁹² Philip G. Ney, “Ethics of Euthanasia,” *Can Med Assoc J* 144, no. 8 (15 April 1991): 956–57.

⁹³ Donald G. Jansen, “Questioning the Taboo,” *Can Med Assoc J* 144, no. 11 (1 June 1991): 1383.

⁹⁴ Ibid., 1382.

out.”⁹⁵ However, after Nancy B.’s precedent-setting case in 1992, the purity of a physician’s intent during an act of *omission* was no longer a major concern among CMA members.

Yet from 1992 to 1993, debate over the omission/commission distinction became even more pronounced. In one familial incident, Vancouver doctor Tom Perry told a reporter that he had given a final dose of morphine to his father, who was dying of prostrate cancer. The headlines not only sparked controversy but also responses to the *CMAJ*. Dr. Jacqueline Fraser, medical director of the palliative care unit at St. Paul’s Hospital (Vancouver), felt that Dr. Perry’s actions must not be confused with euthanasia: “If you are giving morphine for comfort care and people happen to die, that’s totally different. His father was probably on morphine for months. Somebody has to give that last dose.”⁹⁶ Clarifying the issue a year later in one of a series of position papers for the *CMAJ*, Dr. Douglas Sawyer et al. argued that distinctions exist to separate euthanasia and the intent to hasten death from acts of omission within standard medical practice: “We do not use the term ‘passive’ in relation to euthanasia and regard the withholding or withdrawal of treatment as a separate issue that can be debated on its own merits.”⁹⁷ The authors confirmed that some physicians will not cross a specific line—the intentional ending of a life—for both secular and religious reasons: “The belief on which this argument [on moral distinctions] is based is that human life is fundamentally good (also

⁹⁵ Dr. Eike-Henner Kluge, “Dr. Kluge Responds,” *Can Med Assoc J* 144, no. 11 (1 June 1991): 1383.

⁹⁶ Elizabeth Godfrey, “Patients’ Right to Die Becoming Major Issue for MDs and MPs,” *Can Med Assoc J* 146, no. 4 (15 February 1992): 608.

⁹⁷ Douglas M. Sawyer, John R. Williams, and Frederick Lowy, “Canadian Physicians and Euthanasia: 2. Definitions and Distinctions,” *Can Med Assoc J* 148, no. 9 (1 May 1993): 1464.

known as the ‘sanctity-of-life’ principle). Although often identified with religion this belief is also firmly embedded in traditional secular medical ethics.”⁹⁸

Yet in the summer of 1993, at the CMA’s 126th annual meeting in Calgary, Alberta, Dr. Ted Boadway challenged the significance of absolute moral distinctions. He was of the opinion that “Canadian doctors are already hastening patients’ deaths ‘in one way or another’ every day in Canada, but those actions are taking place without any direction or guidance.”⁹⁹ At the same meeting, Dr. Patrick Hewlett of Toronto disagreed. He felt that Ontario did not require institutionalized euthanasia. Instead, it “‘desperately need[ed] hospice care’ and ‘old-fashioned things like love and caring.’”¹⁰⁰ In December 1993, Dr. Boadway’s view was also critiqued by Dr. Daniel M. Fleming, who believed that palliation was not only morally distinct from euthanasia and physician-assisted suicide, but that blurring the distinction would lead to a “slippery slope”:

It is alarming that Dr. Ted Boadway, the Ontario Medical Association’s director of health policy, would have us believe that many Canadian doctors hasten patients’ deaths without any direction or guidance. . . . Any misinformed acceptance of euthanasia and physician-assisted suicide will turn back the bioethic clock, compromise the health care professional’s traditional role and integrity . . . as well as suppress corporate investments and research commitments to superior standards of care and cure.¹⁰¹

From 1993-94, physicians continued to support the distinction between omissions (negative acts in which death was *foreseen*) and commissions (positive acts in which death was *deliberately* hastened). Dr. James McGregor of the Ontario Palliative Care Association argued in front of the Senate Committee on Euthanasia and Assisted Suicide for clear distinctions to be maintained: “Cessation and non-intervention of treatment have

⁹⁸ John R. Williams, Frederick Lowy, and Douglas Sawyer, “Canadian Physicians and Euthanasia: 3. Arguments and Beliefs,” *Can Med Assoc J* 148, no. 10 (15 May 1993): 1700.

⁹⁹ Patrick Sullivan, “Take Stand on Euthanasia, Assisted Suicide, MDs Tell CMA in Survey Released during Annual Meeting,” 858.

¹⁰⁰ *Ibid.*, 859.

¹⁰¹ Daniel M. Fleming, MD, “Euthanasia, Physician-Assisted Suicide,” *Can Med Assoc J* 149, no. 12 (15 December 1993): 1772.

been considered passive euthanasia; in fact, we believe that they simply represent non-interventionist actions allowing the *natural history of the illness to progress*. These acts are not considered to be euthanasia or physician-assisted suicide [emphasis mine].”¹⁰²

Dr. McGregor justified his position by attributing the cause of death for omissions to “nature” rather than direct this cause to any role played by the physician. In 1994, when the CMA’s Committee on Ethics had prepared a draft policy on euthanasia for the association, doctors once again pointed out that specific types of acts—ones that explicitly hastened death—differed ethically from other methods within standard medical practice. One letter sent to John R. Williams, PhD, was signed by four Alberta physicians:

Only in the last 25 years have we seen demands for the physician to also accept the role as executioner. . . . There is no doubt that we re-evaluate carefully, in light of new technology, when it is appropriate to withhold futile therapies that serve only to extend the dying process. This is quite a different issue from the question of active and deliberate steps to terminate the lives of those who are terminally ill, handicapped, or simply tired of life.¹⁰³

Overall, the CMA itself made it clear that it did not support euthanasia, even for sympathetic motives. Euthanasia meant “knowingly and intentionally performing an act that is explicitly intended to end another person’s life . . . [even if] the act is undertaken with empathy and compassion. . . .”¹⁰⁴ However, if doctors used legal methods that hastened death, the CMA did not categorize these acts as “breach of duty” because these procedures were performed by doctors routinely: “Physician-assisted death . . . does not include the withholding and withdrawal of appropriate, futile or unwanted medical

¹⁰² Charlotte Gray, “Is the Pendulum of Public Opinion Swinging in Favour of Euthanasia?” *Can Med Assoc J* 152, no. 6 (15 March 1995): 957.

¹⁰³ Patrick Sullivan, “Ethics Committee Inundated by Mail during Development of Policy on Euthanasia,” *Can Med Assoc J* 150, no. 6 (15 March 1994): 950. It is important to note that the majority of the letters received by John R. Williams, PhD, were from patients, not doctors. Most of the letters opposed legalization of physician-assisted suicide, and the write-in campaign was organized by right-to-life organizations. Many of the letters cited religious beliefs as their reason for supporting prohibition.

¹⁰⁴ “Physician-Assisted Death,” *Can Med Assoc J* 152, no. 2 (15 January 1995): 248A.

treatment or the provision of compassionate palliative care, *even when these practices shorten life* [emphasis mine].”¹⁰⁵

Hospice / Palliative Care Workers: The Metaphysical/Postmodern Divide

The discourse of hospice and palliative care workers testifying before the *Special Senate Committee on Euthanasia and Assisted Suicide* was strongly polarized between metaphysicians (sanctity of life advocates) and Vattimian postmodernists (quality of life supporters). Whether religious or secular in affiliation, metaphysicians consistently supported the following normative assumptions: (1) stewardship (life as a “loan,” as sacred, and of infinite worth); (2) value in prolonged suffering; and (3) the inevitability of the “slippery slope.” It is also important to note that the normative assumptions of hospice/palliative care workers closely resembled the discourses of various Christian organizations discussed in chapter three (“Ethical and Religious Discourses in Canada”). Although rare among hospice/palliative care experts, a minority of Vattimian postmodernists emphasized quality of life considerations, adopting such normative positions as (1) self-determination; (2) the relative value of human life; and (3) the workability/flexibility of safeguards.

Metaphysicians in Hospice / Palliative Care

Dr. Elizabeth Latimer, director of palliative care at Henderson General Hospital in Hamilton, opposed euthanasia and assisted suicide, admitting that the prolongation of death and/or suffering served a higher purpose:

¹⁰⁵ Ibid.

If people are well cared for as they are dying, they will often tell us [palliative care staff] they do their finest living at that time. . . . There is not a waiting time for death, but rather an active and positive opportunity to live. Euthanasia and assisted suicide may rob individuals of this opportunity, and that is a concern.¹⁰⁶

Dr. Latimer also questioned an individual's ability to understand the significance of suffering, claiming it was too subjective a concept to fully appreciate: "We know far too little about suffering and life's quality to be able to say when a life has no quality and in what situations suffering is senseless."¹⁰⁷ She further suggested that euthanasia served no logical purpose in the relief of acute suffering since the patient could not experience his/her own extinction:

Euthanasia is often put forward as a solution to problems of severe, intractable pain relief, as a release from "senseless suffering," as a benefit to the patient, and a release from a life of poor quality. I would propose to [the Committee] that these are all false assumptions. . . . To say that someone can benefit from their death is a form of oxymoron in that they no longer exist to perceive the benefit of the death that has been inflicted upon them.¹⁰⁸

The risk of the "slippery slope" was also a pressing matter for Dr. Latimer. If euthanasia and assisted suicide were legalized, others may feel obligated to exit earlier than previously planned: "[W]e have grave concerns that people would begin to feel that the most valiant way [to cope] would be to ask to have their lives ended. Subtle pressures may ensue in this way."¹⁰⁹ Dr. Latimer insisted that there was an increased risk to vulnerable groups, particularly the frail and incapacitated, which "introduces the notion of risk to others should a euthanasia, assisted suicide law come into being."¹¹⁰ The possibility that limited resources could help facilitate death-hastening measures was also problematic for Dr. Latimer. She asked the Committee to consider the following ethical dilemma: "How long might our health care delivery system be able to care for the frail

¹⁰⁶ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 4 (Wednesday, May 4th, 1994), 6.

¹⁰⁷ *Ibid.*, 7.

¹⁰⁸ *Ibid.*

¹⁰⁹ *Ibid.*

¹¹⁰ *Ibid.*, 8.

and the dying before we would come to see it as a more expedient option to offer them euthanasia or assisted suicide?”¹¹¹ When pressed by Senator Grafstein to explain the basis of her “slope” allegations, Dr. Latimer relied on a utilitarian calculus. Community morality, she claimed, overshadowed minority rights in order to guard against the potential danger of abuse:

Senator Grafstein: Doctor, you set out the notion of justice. I want to deal with your notion. I want to know what you are talking about.

Ms Latimer: . . . [T]he ethical concept of justice . . . is described as the greatest good for the greatest numbers, which is an ethics sort of principle.

Senator Grafstein: Let me go at two cases once again to see if there is a difference: Richard Nixon and Sue Rodriguez. Richard Nixon says to his family, or in a living will, as reported in the paper, “The most important thing to me is my mind. If somehow my mind is not there and I am not able to function mentally, please do not treat me.” Sue Rodriguez says, “I can’t function mentally or physically. Please help me.” Now, characterize for me, in terms of justice, the difference between those two.

Ms Latimer: [T]he continued safety and protection of large numbers of frail people in Canada or any other country depends on the maintenance of the law the way it is. That would be justice. . . . To change the law on the basis of perhaps the rights of autonomy of a few people who would want to be killed places others at such high risk that the ethical notion of justice says we keep the law the way it is and that we do not allow killing of each other.¹¹²

Dr. Latimer’s views resembled those of her colleague, Dr. James McGregor, a board member of the Ontario Palliative Care Association. Dr. McGregor described the sanctioning of euthanasia and assisted suicide as a “superficial and perhaps simplistic response” because decriminalization “[did] not solve the problem of intractable pain and suffering.”¹¹³ If Dr. McGregor could not relieve the suffering of the terminally ill, he claimed he would “suffer along with the patient and family.”¹¹⁴ He even maintained that purpose in suffering could often be found in the terminal phase of illness: “The patient, in the final stages of living, has gone on to find new meaning out of the darkness and

¹¹¹ Ibid.

¹¹² Ibid., 17, 18.

¹¹³ Ibid., 53.

¹¹⁴ Ibid., 59.

despair through the shared journey of exploration of meaning and reinforcement of their value as individuals.”¹¹⁵ Euthanasia was depicted as the antithesis of dignity, since not only does the “taking of a life devalu[e] that life and its meaning,” but according to Dr. McGregor, “true meaning has little to do with incontinence or physical dependence on others and everything to do with the whole person, including the spiritual dimension.”¹¹⁶ Therefore, euthanasia was to be rejected because it was “a cry for validation of life and life’s purpose and meaning.”¹¹⁷ Ironically, he contradicted himself by admitting that suffering was, in actuality, a relative term: “. . . [W]e have no good way to measure suffering,” he told the Committee. “What is suffering to me may not be suffering to you.”¹¹⁸

Dr. McGregor’s philosophical beliefs were also guided by “slope” concerns. To protect the common good from any potential danger, Dr. MacGregor justified his utilitarian position for the Committee:

Society has long supported the value of life and the value of the individual in the context of the whole of society. A recent disturbing trend has been to value individual autonomy more than the good of the whole. It seems that the push for euthanasia and assisted suicide reflects this trend, that the part is greater than the whole. Although individual autonomy is important, perhaps of greater importance might be the autonomy of the whole. Society has a responsibility to protect the whole. Euthanasia and assisted suicide may devalue human life and thus all of society.¹¹⁹

Despite possessing no statistics to prove his assertion of a “slippery slope,” Dr. McGregor still believed that “euthanasia [could] be abused, the result being involuntary euthanasia.”¹²⁰ Any legalized precedent, he feared, was without limits and would

¹¹⁵ Ibid., 54.

¹¹⁶ Ibid.

¹¹⁷ Ibid., 53.

¹¹⁸ Ibid.

¹¹⁹ Ibid., 54–55.

¹²⁰ Ibid., 55. It is important to note that allegations of a “slippery slope” cannot be conjecture. To be credible, they must be *both* modest *and* detailed. The ‘One Great Slippery-Slope Argument’ is highly immodest and lacking in detail. For a comparison between a valid “slippery slope” argument and the ‘Great Argument,’ see J.A. Burgess, “The Great Slippery-Slope Argument,” *Journal of Medical Ethics* 19 (1993):

eventually lead to “sanctioned killing of the most vulnerable members of society, the newborn, the aged, and the mentally incompetent.”¹²¹

Belief in the inevitability of the “slippery slope” was also evident in the testimony of another palliative care expert, Dr. Margaret Scott. Her primary focus was on the Dutch regime and the danger of adopting its mandate on euthanasia and assisted suicide. Dr. Scott viewed the Remmelink Report’s “1000 cases of nonvoluntary euthanasia” as “irrefutable evidence that the [Dutch] guidelines were not working then.”¹²² She was also apprehensive about the effect legalization would have on other vulnerable populations, accusing the Dutch of terminating “the lives of incompetent patients, specifically severely defective newborns, comatose patients, demented elderly and severely mentally handicapped.”¹²³ As proof of further social dilemmas, Dr. Scott stated that tolerance of euthanasia and assisted suicide in the Netherlands had created a moral panic: “95 per cent of nursing home inhabitants in Holland are afraid,” she insisted, and “[c]itizens in Holland now carry cards in their wallets when they reach 60 years of age saying that they do not want euthanasia.”¹²⁴ However, Dr. Scott never quoted her sources for such alarming figures, informing the Committee instead that one needed to “[g]et expert advice . . . on the Holland experience” since she herself had “never been to Holland.”¹²⁵ Nevertheless, Dr. Scott was adamant that the “wedge” issue would eventually become a

169-174. Also see Hugh LaFollette, “Living on a Slippery Slope,” *The Journal of Ethics* 9, no. 3/4 (2005): 475-499; Danny Scoccia, “Slippery Slope Objections to Legalizing Physician-Assisted Suicide and Voluntary Euthanasia,” *Public Affairs Quarterly* 19, no. 2 (2005): 143-161.

¹²¹ *Ibid.*, 57.

¹²² *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 6, 49, 50.

¹²³ *Ibid.*, 50.

¹²⁴ *Ibid.*, 54.

¹²⁵ *Ibid.*

Canadian reality: “We have a slippery slope; first, it will be our grandmothers and mothers and then, in a few years, it will be ourselves.”¹²⁶

Other representatives of the Canadian Palliative Care Association pleaded their case using the rhetoric of the “danger” and “risk” to the community. Dr. Paul Henteleff stated that his association was “against the proposal to legalize euthanasia, largely to protect vulnerable individuals.”¹²⁷ Included were those who were “not competent to speak for themselves or because they [were] disabled in their decision-making by the pressure of being seen as a burden.”¹²⁸ Dr. Henteleff also feared that euthanasia and assisted suicide would be used on patients who were not of sound mind: “[T]he desire for death [by such patients] . . . is usually on the basis of a separately existing psychiatric condition, something psychiatrists call a clinical depression.”¹²⁹ When pressed for statistics by Senator Keon, Dr. Henteleff noted surveys that showed when ten percent of terminally ill patients desired death, two-thirds of them had been categorized as “psychiatrically depressed.”¹³⁰ However, no comparison study was provided to describe the mental incapacity of patients seeking the withholding or withdrawal of treatment. According to Dr. Henteleff, only acts of commission were deemed risky: “. . . [L]egalized euthanasia . . . may turn out to have less benefit than palliative care could offer and consequences of a much higher frequency, such as bringing death to people who were not competent to ask for euthanasia. . . .”¹³¹

¹²⁶ Ibid.

¹²⁷ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 5 (Wednesday, May 11th, 1994), 9.

¹²⁸ Ibid., 10.

¹²⁹ Ibid., 11.

¹³⁰ Ibid., 11–12.

¹³¹ Ibid., 16.

The views of Dr. Balfour Mount, chair of palliative care medicine at McGill University, were also indicative of metaphysicians. Initially, Dr. Mount agreed that a crucial dilemma existed in how best to deal with suffering. He had performed a study that showed the “unmet needs and the unacceptable suffering” at the Royal Victoria Hospital, a first-rate McGill teaching centre.¹³² In another study of four Canadian provinces, he found that cancer patients were given “low use of pain-management medications, even in the presence of extreme pain.”¹³³ Dr. Mount concluded that there exists in Canada “an important burden of unnecessary suffering in terminal illness and the burden is increasing.”¹³⁴ Of all pain that he himself could control, he estimated that about two per cent fell into the category of “total pain,” which is “uncontrolled in a consecutive fashion.”¹³⁵

However, when euthanasia was introduced as a possible solution to pain and suffering, Dr. Mount relied on the “slippery slope,” asserting that “wider social considerations make that practice undesirable.”¹³⁶ He felt that the benefit of allowing this choice must be “weighed against the possible abuse of euthanasia affecting the frail, disabled and economically disadvantaged members of society.”¹³⁷ Dr. Mount further indicated that, if doctors were allowed to kill patients, it would “substantially change the fabric of the patient-family relationship,” adding: “A physician should not provide interventions that will intentionally cause the death of a patient.”¹³⁸

¹³² *Ibid.*, 28.

¹³³ *Ibid.*

¹³⁴ *Ibid.*, 29.

¹³⁵ *Ibid.*, 35.

¹³⁶ *Ibid.*, 32.

¹³⁷ *Ibid.*

¹³⁸ *Ibid.*

Nonetheless, Dr. Mount admitted that religion shaped one's stance on prohibition: "[R]eligious beliefs and values influence the views of many—indeed all of us in one way or another—when addressing these issues. . . ."¹³⁹ Although he was mindful of the "pluralistic nature of our society and the importance of not imposing personal values on those of other traditions,"¹⁴⁰ he still insisted on solutions for the dying that included "something more," specifically, the spiritual dimensions of "meaning, values, and purpose."¹⁴¹ Despite his own research on the "unnecessary suffering," "extreme pain," and "total pain" experienced by dying patients, he maintained that a physician "should not provide interventions that will intentionally cause the death of the patient," especially the "quick fix of euthanasia and assisted suicide."¹⁴²

Dr. Louise Dionne, a specialist in oncology and palliative care at Quebec City's Hôtel-Dieu hospital, felt that euthanasia should be excluded as an option because it ran counter to the sanctity doctrine: "Life is more important . . . than death. The final days must be lived out. Our whole practice and all of our principles are based on the dignity of life, respect for what is left of life."¹⁴³ Her metaphysical beliefs shaped another major objective of palliative care: "to transform human suffering so as to give it meaning and significance and make it bearable."¹⁴⁴ However, Dr. Dionne agreed that "in about 3 to 4 per cent of cases the pain cannot be alleviated," that "[n]eurological pain . . . can become unbearable," and that "from time to time . . . the dying process seems endless."¹⁴⁵ For instance, lung cancer patients may suffer from respiratory distress, which she admits "can

¹³⁹ Ibid., 28.

¹⁴⁰ Ibid.

¹⁴¹ Ibid., 40–42.

¹⁴² Ibid., 32, 33.

¹⁴³ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 13 (Wednesday, July 6th, 1994), 7.

¹⁴⁴ Ibid., 5.

¹⁴⁵ Ibid., 6, 10.

be quite painful, both for the patient and for his caregivers and family.”¹⁴⁶ However, Dr. Dionne believed that euthanasia should still be prohibited because of society’s collective authority: “We are individuals living in a society, a community, and the community has rights when it comes to an individual member’s behaviour.”¹⁴⁷

Because she gravitated toward communalism, Dr. Dionne concurred that the “slippery slope” was inevitable if voluntary euthanasia were legalized as a form of individual choice. She maintained that “confidence in medicine would erode once euthanasia was practised on a larger scale,” creating what she called “a backlash that [would] kill palliative care.”¹⁴⁸ By funding palliative care adequately, the Senate Committee would be “ward[ing] off the spectre of euthanasia.”¹⁴⁹ Finally, she suggested that the Dutch model was proof enough of the dangers inherent in sanctioning an intentionally hastened death: “You have only to look at Holland to see where this slippery slope would lead us,” claimed Dr. Dionne.¹⁵⁰

Lobbying for the Nova Scotia Palliative Care Association, Dr. Ina Cummings and Ms. Judith Fuller deliberated on the perils of decriminalization. Dr. Cummings believed that a change in the legislation to permit euthanasia or assisted suicide would not only “reduce efforts to provide palliative symptom management and support to those who face progressive and terminal disease” but would also “reduce the choice for those who are weak, elderly and the most vulnerable. . . .”¹⁵¹ Ms. Fuller remarked that legalization would “pressure elderly, dependent people . . . to feel that they [were] expected to die

¹⁴⁶ Ibid., 10.

¹⁴⁷ Ibid., 12.

¹⁴⁸ Ibid., 19, 20.

¹⁴⁹ Ibid., 22.

¹⁵⁰ Ibid., 19.

¹⁵¹ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 23 (Wednesday, November 16th, 1994), 29.

rather than [become] a burden on their families.”¹⁵² As well, she perceived the ramifications of autonomous choice on society as too great to risk legalization: “The issue goes far beyond the individual to the very nature and essence of the health care system of the future in Canada.”¹⁵³ Senator Corbin concurred with both witnesses about the gravity of the situation if one tampered with the sanctity doctrine: “It seems to me that the emphasis should be, and must be, on respect for life. If we lose that and lose that once, then all other values decline.”¹⁵⁴

Representatives from the Quebec Association of Palliative Care, a priest and a physician, both exhibited similar religious sensibilities. Father Robert Dagenais believed that “the true relief of suffering entaile[ed] something more than easy solutions.”¹⁵⁵ He explained that his organization’s moral responsibility was “to try everything within socially permitted limits to provide the patient with relief,” admitting that “those limits should not be expanded to the point of directly and quickly provoking a patient’s death.”¹⁵⁶ Father Dagenais’s solution to pain was simply to suffer along with the patient: “. . . [W]hen someone tells me that he no longer wants to live, that is a terrible cry of suffering. For that person, life has become intolerable. I must at least bear that suffering in order to show him that there is perhaps an alternative to dying.”¹⁵⁷

Moreover, Father Dagenais insisted that the “slippery slope” was inescapable. He opined that the “dangers of abuse [were] all too clear to consider decriminalizing such a matter [assisted suicide and voluntary euthanasia].”¹⁵⁸ An additional concern was for

¹⁵² Ibid., 32

¹⁵³ Ibid., 36.

¹⁵⁴ Ibid., 40.

¹⁵⁵ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 24, 6.

¹⁵⁶ Ibid., 7.

¹⁵⁷ Ibid., 18.

¹⁵⁸ Ibid., 6.

vulnerable patients who would be “at the mercy of those around them.”¹⁵⁹ By weighing the relative risks, Father Dagenais concluded that “the potential social damage is definitely greater than the good thus sought” and that “if we open the door either to euthanasia or to assisted suicide for a certain number of problems which we think are insoluble, we will be opening the door wider to problems that would be even greater, much more numerous and much harder to solve.”¹⁶⁰ He warned the Committee that “[w]e are all too well aware of the arbitrary and subjective nature of human judgment on individuals’ quality of life to be able to take such a risk.”¹⁶¹

Father Dagenais’s colleague, Dr. Maurice Falardeau, agreed that the *qualified* sanctity of life ethos overshadowed quality of life concerns. This implied that one cannot intentionally hasten death because “nature must take its course.”¹⁶² Furthermore, Dr. Falardeau was resistant to any change in the law to accommodate a few suffering patients. An exchange between himself and Senators Beaudoin and Carstairs illustrates this point:

Senator Beaudoin: . . . [W]hat is the best medical remedy if we want to eliminate suffering?

Dr. Falardeau: Do we pass a law for one or two or five per cent of the people at a given time, at one minute or one day or one month of their lives instead of in a perspective of respect for life?

Senator Beaudoin: . . . [I]f he [the terminal patient] is suffering a great deal, you try to relieve his suffering. You apparently manage to relieve patients in 95 per cent of cases, which is remarkable. It’s all well and good to say that it works for 90 per cent of cases, but if you are in the 10 per cent of cases where people are not relieved. . . .

Dr. Falardeau: We have now reached 95 per cent. Let’s put a halt to our efforts; let’s move toward mediocrity. All right! You are going to return to 60 per cent. You are going to return to suicides where, at the first setback, people are going to say to themselves that they can’t go on.

Senator Carstairs: They [some dying patients] want to die now; they want to end it; they want it over. What do we say to those people?

¹⁵⁹ Ibid.

¹⁶⁰ Ibid., 7, 16.

¹⁶¹ Ibid., 7.

¹⁶² Ibid., 10.

Dr. Falardeau: But the real question is this: is Sue Rodriguez one case in thousands or are there millions of Sue Rodriguezes?

Senator Carstairs: But the fact is that we had one, Sue Rodriguez. As a society, are we to say that we can offer nothing to such a person? . . . Here, the dilemma we are faced with as a committee is whether we must turn our backs on those cases.¹⁶³

Likewise, others working in pain management—whether religiously affiliated or not—excluded euthanasia and assisted suicide as legitimate options to relieve suffering. Barbara O'Connor, Executive Director of the Hospice of All Saints in Ottawa, assumed that hospice and palliative care alone would benefit the terminally ill: “The legalization of euthanasia would do nothing to solve the problem of pain and suffering in terminal illness. . . . This is only possible through palliative care.”¹⁶⁴ Yet when confronted by Senator Lavoie-Roux with the “hard cases”—those whose suffering could not be relieved—Ms. O'Connor questioned why the law should have to change for a minority experiencing “total pain”:

Senator Lavoie-Roux: Are there cases where you have tried everything to relieve pain, whether it was pain or suffering, yet the patient said, “I have had enough. I am grateful to you for what you are doing, but I want it to end”? Can you always provide enough moral support to dissuade them from carrying out their wish for euthanasia?

Ms O'Connor: Obviously there are those types of cases. Everyone who has worked in this field knows of cases where there are people who have suffered, for whatever reason. There are reasons, not only intractable pain, but total pain and mental anguish, as well as spiritual pain. . . . We try to give them medication and try as much as possible to alleviate their suffering. Most of the time we do, but there are times we do not. That is a sad thing. But I do not think those few cases can justify the legalization of euthanasia.¹⁶⁵

Her arguments even contained a certain irony. She favoured palliative care as a solution to pain and suffering but told the Committee that there existed “very little government funding for palliative care anywhere in Canada.”¹⁶⁶

¹⁶³ Ibid., 9–11, 18–19.

¹⁶⁴ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 12, 53, 54.

¹⁶⁵ Ibid., 58.

¹⁶⁶ Ibid., 52.

Dr. David Kuhl, representing the British Columbia Hospice/Palliative Care Association, also opposed euthanasia and assisted suicide. When it came to suffering, Dr. Kuhl informed the Committee that his organization “pull[s] out all the stops” and that patient suffering “is what the person says it is.”¹⁶⁷ However, euthanasia and assisted suicide were exceptions to this general approach because, in Dr. Kuhl’s view, they “[do] not end suffering,” but only “transfe[r] the patient’s suffering to the survivors.”¹⁶⁸ When asked by Senator Lucier why a patient could not choose between palliative care and an intentionally hastened death, Dr. Kuhl felt that palliation was sufficient, in spite of unrelieved pain:

I never want to pretend that we are going to eliminate suffering from the face of the earth. It will always be there. . . . At present, society does not have the skills to address the emotional or spiritual pain at the same level or with the same intensity [as physical pain]. Is that reason to change the legislation? I do not know, but I would think not.¹⁶⁹

Dr. Linda Kristjanson of the Manitoba Hospice Foundation was equally clear with her organization’s position. Decriminalization represented specific risks to the community that must be abated: “We believe that any changes to Canadian law would be dangerous and uncontrollable,”¹⁷⁰ she told the Committee. Dr. Kristjanson also cited the Netherlands as an example of a nation not only “proceeding down the slippery slope at an accelerating pace,” but that the “risks of abuse and inability to safeguard use of this policy [were] mounting.”¹⁷¹ The disclosure of the 1,000 cases of nonvoluntary

¹⁶⁷ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 16, 41, 42.

¹⁶⁸ *Ibid.*, 42.

¹⁶⁹ *Ibid.*, 44.

¹⁷⁰ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 17 (Thursday, September 29th, 1994), 42.

¹⁷¹ *Ibid.*, 47.

euthanasia in the Rummelink Report was, in her opinion, a clear indication that abuse had become both “frightening” and “uncontrollable.”¹⁷²

However, Dr. Kristjanson acknowledged that palliative care was not a perfect solution for pain relief: “[S]ome patients do suffer. They suffer because of uncontrolled pain, shortness of breath, nausea, weakness, and spiritual and psychological issues. Some suffering cannot be alleviated by drugs or interpersonal bonding. . . . Despite the best use of palliative care measures, some suffering may continue.”¹⁷³ In spite of these symptoms, she still maintained that “suffering along with the patient” was a more appropriate alternative to euthanasia: “[W]e argue that those whose suffering is most difficult to witness do not require a quick answer such as euthanasia . . . The challenge to health professionals . . . is to understand the patient suffering, to attend to the patient suffering, and to not abandon or deny the person *as he or she suffers* [italics mine].”¹⁷⁴ When asked by Chairman Neiman why AIDS patients could not choose the time and manner of their death, Dr. Kristjanson would not temper her support of the sanctity of life ethos, even if it resulted in prolonged suffering for this cohort:

Our stance may in some ways appear not as merciful to those particular individuals [AIDS patients], but we have compassion for the suffering they endure. However, even in extreme individual circumstances, while we understand at one level that kind of suffering—or try to—it does not lead us to change our position that the overall rule should be changed though there may be those exceptional circumstances.¹⁷⁵

Dr. Michel R. Morissette, a palliative care expert from the Centre hospitalier de l’Université Laval and Maison Marc Simon in Quebec City, issued a caution to the Committee regarding the loss of communal values: “Our societies are becoming increasingly utilitarian. What is more, we do not have a vision of society and the social

¹⁷² Ibid., 43, 46.

¹⁷³ Ibid., 43.

¹⁷⁴ Ibid., 44.

¹⁷⁵ Ibid., 59.

contract is breaking down.”¹⁷⁶ An increased emphasis on the individual right to hasten death led Dr. Morissette to ask: “Would we be pushing the principle of self-determination beyond its limits, where it might well paradoxically compromise certain achievements in society, and possibly even the protection of the most vulnerable members of society?”¹⁷⁷ Because of the precariousness of legalization, Dr. Morissette insisted that not only do “we hold Pandora’s box in our hands,” but decriminalization would have “an insidious effect” on society.¹⁷⁸

However, Dr. Morissette’s testimony contained one inherent contradiction pertaining to absolute moral distinctions. Initially, he explained how omissions and commissions were morally distinct acts, consistent with the *qualified* sanctity of life principle: “[T]here is a clear difference between allowing death to occur naturally and causing it. . . . [W]e are allowing a natural phenomenon to take its course. It is not the same thing as saying that I arrive with my injection of potassium chloride and in 30 seconds it’s all over.”¹⁷⁹ However, when Dr. Morissette discussed the use of terminal sedation within palliative care, he agreed that its purpose was, in fact, to intentionally hasten death. Addressing the Committee, he replied: “Some places . . . are already using artificial sleep [terminal sedation]. Naturally, some ethicists will tell you that we are very close to euthanasia when we resort to this procedure and yes, in effect, this is true. However, I believe that this could be a valid option.”¹⁸⁰ He added that this “artificial sleep” would be his chosen solution if he were “totally unable to control the symptoms

¹⁷⁶ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 32 (Friday, January 13th, 1995), 9.

¹⁷⁷ *Ibid.*

¹⁷⁸ *Ibid.*, 10, 23.

¹⁷⁹ *Ibid.*, 14.

¹⁸⁰ *Ibid.*, 15.

with the narcotics [hypnotics, sedatives, and barbiturates] and other analgesics currently used.”¹⁸¹

Vattimian Postmodernists in Hospice / Palliative Care

One of the few palliative care physicians to reject the sanctity of life as absolute was Dr. Marcel Boisvert, a physician from the Royal Victoria Hospital in Montreal and an Assistant Professor of Medicine (Oncology Division) at McGill University. He proposed that the intrinsic value of human life was a competing value among others:

Is life a transcendental value? Is it a value that literally transcends everything. The simple, clear-cut answer to that is “No” . . . [W]e allow people to refuse medical treatment that will bring about their death in a short while. . . . We recognize that to be alive is just not enough. . . . The autonomy of persons, or of patients, can be greater than life.¹⁸²

Dr. Boisvert suggested that the reason for this shift from the metaphysical to the secular was due to a decline in absolute religious values: “[W]e have gone from a society that was essentially very religious to a society where, although it has remained a believer and has not put religion aside, religious dogma has regressed or has become a less important concept.”¹⁸³ What this transition meant was that there was now less emphasis on life as a stewardship. As Dr. Boisvert explained, “We have taken away the religious concept that made life a transcendent value—that is, life belonged to God—for many people in our culture.”¹⁸⁴ Undoubtedly, he felt that the lived reality of the dying could not be subordinated to metaphysics: “For many people, however, life does not belong to God. Life is theirs—that is, they feel that they are a life, and are alive. You cannot

¹⁸¹ Ibid., 19.

¹⁸² *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, No. 6, 29. Moral philosopher James Rachels acknowledges the difference between “biological life” and “biographical life,” emphasizing the latter’s importance in the intentional hastening of death for the terminally ill. See James Rachels, *The End of Life: Euthanasia and Morality*, 25–27.

¹⁸³ Ibid.

¹⁸⁴ Ibid.

discourse about life as though it was an entity on a shelf somewhere. You cannot discuss life if you do not discuss people. . . .”¹⁸⁵ Consequently, Dr. Boisvert agreed that the sanctity doctrine could not be applied universally, especially to the non-religious: “The very phrase ‘sanctity of life,’ in short, implies religious beliefs. It is totally obvious. It is very hard to build a case on the sanctity of life vis-à-vis someone who has no religious beliefs.”¹⁸⁶

Dr. Boisvert placed additional emphasis on intractable suffering, which for him was the crux of the matter: “The question is—and it is to me, again, the only question that deserves to be asked—are there circumstances, however rare, where the life, the suffering of the patient are such that it would justify or legitimize the shortening of a life?”¹⁸⁷ Concurring with other medical experts, he stated that “there are circumstances where shortening the life of somebody could be ethically justified.”¹⁸⁸ Since death had now been taken “out of God’s hands,” Dr. Boisvert was suggesting that in rare cases patients should have the freedom to choose euthanasia or assisted suicide to hasten their deaths: “The mandate should be, ‘Let us look at possible ways to open a legal window, however small, that would not jeopardize some patients whose end of life is totally intolerable; for whom religious and moral principles are not in the way.’”¹⁸⁹ For those who would delimit such an approach, Dr. Boisvert asked, “Why is it that we are more comfortable with painful death, be it natural . . . rather than painless inflicted death? Again I believe that the problem there is our covert religious beliefs.”¹⁹⁰

¹⁸⁵ Ibid.

¹⁸⁶ Ibid., 36.

¹⁸⁷ Ibid., 31.

¹⁸⁸ Ibid.

¹⁸⁹ Ibid., 32.

¹⁹⁰ Ibid., 33.

The only other palliative care professional to reject the sanctity doctrine was Dr. Robert Buckman from the Bayview Regional Cancer Centre in Toronto. He advanced the idea that quality of life considerations were both subjective and relative. Patients who requested euthanasia were not necessarily in pain but felt that their future dignity would be too eroded. As Dr. Buckman explained, “In many respects, the greatest drive to request euthanasia may be for existential reasons. People may not want the existence ahead of them. It may be their way of evaluating their own existence, rather than because of poor symptom control.”¹⁹¹ He informed the Committee that many patients seeking a hastened death experience pain beyond the physical: “Genuinely speaking, the requests which I have received from patients wanting euthanasia were not from those patients who suffered uncontrolled pain. In the Dutch experience, again, in 5 per cent of acts of euthanasia, the prime motive [was] pain. In 95 per cent of cases, it [was] something else.”¹⁹² In one specific instance, one of Dr. Buckman’s female patients wanted her death intentionally hastened because she “loathed and detested being immobile, not being at home and having her family come in and visit her.”¹⁹³ Of three cases that he felt were genuine requests, Dr. Buckman told the Committee that what impressed him the most was “their motivation of assessing their own quality of life and their desire to end a life which they now regarded as not worth living.”¹⁹⁴

Unlike sanctity of life advocates, Dr. Buckman also rejected the “slippery slope” as inevitable. His solution was to be proactive with safeguards, filling out any paperwork

¹⁹¹ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 26 (Thursday, November 24th, 1994), 5.

¹⁹² *Ibid.*, 9. Other studies show similar results in that the main reasons dying patients seek death were for autonomy and existential issues (e.g., loss of dignity). See Linda Ganzini, “The Oregon Experience,” in *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice*, edited by Dr. Timothy E. Quill and Margaret P. Battin, 165–83.

¹⁹³ *Ibid.*, 10.

¹⁹⁴ *Ibid.*, 11.

“before the act of euthanasia” so that “the public, the patient, the family and the doctor are all certain that the act which is planned is congruent to all the guidelines.”¹⁹⁵ Similar to the Dutch model, the physician would not be charged with murder, “[p]rovided that the current guidelines [were] actually met and documented, and provided that whatever need[ed] to be done ha[d] been done in order to prove the conditions in the guidelines . . . truly represent[ed] the medical facts of the situation.”¹⁹⁶ If a vicar of the Crown Attorney’s office were to examine the documentation, Dr. Buckman proposed that there should be “no judgment from this person, only verification that the doctor [was] not lying.”¹⁹⁷

Health Care Representatives as Metaphysicians

Those representing major health care organizations also figured prominently as witnesses before the Senate. Whether religious or secular in affiliation, doctors and nurses supporting the sanctity of life ethos offered similar normative assumptions in the form of objectivistic metaphysics when discussing an intentionally hastened death. Dr. André Lafrance, representing Ottawa and District Physicians Who Respect Human Life, reminded the Committee of the tragic events that occurred when “doctors chose to be killers instead of healers.”¹⁹⁸ Dr. Lafrance noted that the German euthanasia program was planned and supervised not by Nazi officials but by members of the German medical community, leading to the active *involuntary* euthanasia of “275,000 . . . patients, most of

¹⁹⁵ Ibid., 5.

¹⁹⁶ Ibid., 6.

¹⁹⁷ Ibid., 12.

¹⁹⁸ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 7 (Wednesday, May 25th, 1994), 5.

whom were mentally or physically handicapped.”¹⁹⁹ He added that other dangers were also apparent, such as “diagnostic error,” the convenience of the “killing option,” “procedural abuse,” and the risk of targeting society’s most vulnerable—“the elderly, the uneducated, the poor, the retarded.”²⁰⁰ Moreover, Dr. Lafrance informed the Committee that absolute moral distinctions, particularly between palliation and euthanasia/assisted suicide, were founded in Catholic moral theology: “If the dose of morphine that [a patient] receives is the amount required to control pain, then it could certainly not be considered euthanasia, even if it is large enough to carry the risk of respiratory failure and death. That is the position of the Catholic Church, and that is also our position.”²⁰¹ Although Lafrance agreed that motive was crucial for such a distinction, he noted that “[o]nly the doctor prescribing the morphine really knows what the intention behind the treatment is. That is why it is impossible to prove. There is no way of reading someone’s innermost thoughts.”²⁰²

Several doctors from Canadian Physicians for Life also expressed how their religious convictions shaped their medical views. Dr. H. Robert C. Pankratz, the president, explained that his organization was committed to “maintaining respect for the dignity and inherent goodness of human life at all stages.”²⁰³ Pankratz’s colleague, Dr. Jim Lane, felt that the Netherlands was a prime example of the “slippery slope.” He indicated that in one particular study controls regarding “persistent and enduring request” had been ignored since “59 per cent of patients requesting euthanasia were euthanized

¹⁹⁹ Ibid.

²⁰⁰ Ibid., 6–7.

²⁰¹ Ibid., 13.

²⁰² Ibid.

²⁰³ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 14, 21.

within 24 hours, and 11 per cent were euthanized within an hour.”²⁰⁴ Dr. Willard P. Johnston, the Secretary-General of the organization, believed that the freedom to choose assisted suicide would “constitute a mortal danger to many more inarticulate, weak, and vulnerable patients” and would become a “danger to the larger community.”²⁰⁵ However, Senator Lucier turned the conversation toward suffering, asking: “[H]ow would her [Sue Rodriguez] living another week or another day or another hour have benefited society, especially if she did not want to do that [prolong her life]?”²⁰⁶ Dr. Pankratz replied that intentionally hastening death was “stepping over the line” and that “it is a line that we must continue to draw.”²⁰⁷ He added that Rodriguez’s decision to hasten her own death was psychologically troubling because it would eventually create feelings of guilt in her own son:

She has a nine-year-old son who is mentioned in the book, the biography, called: *Uncommon Will: The Death and Life of Sue Rodriguez*. There is a description . . . of him [Cole] pushing her in her wheelchair. When he pushes her quickly and the wheelchair starts bumping across the grass, she becomes upset with him, and tells him to stop. He . . . refuses to stop. She, in her impotence at that moment, decides that she will commit suicide; her decision has been made. When Cole comes to the realization that he participated in the death of his mother . . . do you think that will have a major impact on that child?²⁰⁸

From the Manitoba Physicians for Life, Dr. Paul V. Adams emphasized the communal ethos surrounding his organization’s beliefs. Although his group’s opposition to euthanasia and assisted suicide did not “lessen [its] sympathy for those who [were] dying, afflicted by pain, or suffering from loneliness and despair,” it was still felt that

²⁰⁴ Ibid., 25.

²⁰⁵ Ibid., 27.

²⁰⁶ Ibid., 37.

²⁰⁷ Ibid., 40.

²⁰⁸ Ibid., 34. Any negative effect Rodriguez’s actions may have had on Cole, her son, are questionable. Rodriguez also mentioned that she wanted her assisted suicide to be legal out of concern for Cole: “I have a son. I want him to respect the law. I don’t want my last action on earth to be tainted by illegality. But if I can’t obey the law in the end, I’ll know at least I did all I could to change it. So will he.” See Lisa Hobbes Birnie and Sue Rodriguez, *Uncommon Will: The Death and Life of Sue Rodriguez*, 48.

“the good of society as a whole must be considered.”²⁰⁹ He elaborated on precisely how the common good would be diminished by any tempering of the sanctity doctrine: “When human life is no longer considered to have intrinsic value and becomes subject to interventions causing death, we all suffer. Our individual integrity is lessened, and society is liable to become less caring and less respectful of human life.”²¹⁰ In fact, he considered dangerous any attempt to condone euthanasia and assisted suicide because it would have “a negative impact upon the present regard accorded to the elderly, the physically handicapped, the mentally ill, the infirm, and the seriously impaired newborn.”²¹¹

Normative assumptions surrounding objectivistic metaphysics were also endorsed by non-religiously affiliated medical institutions. Dr. John S. Senn of the Sunnybrook Health Science Centre in north-central Toronto was of a similar mindset to physicians within pro-life groups. He believed that religious morality still played a major part in shaping medico-ethical beliefs: “It [the Judeo-Christian belief system] says that life is not something that we arrange for ourselves, that it is a gift and that we have no more right to take it away ourselves than we did to demand it to start with.”²¹² On the issue of suffering, Dr. Senn could not condone any act that hastened death—even for reasons of compassion: “It may be that you have to support them [the terminally ill] through suffering, but not support them by causing their death so that they do not suffer. That is a big difference.”²¹³ In fact, he believed that those suffering were incapable of making a

²⁰⁹ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 18, 40.

²¹⁰ *Ibid.*

²¹¹ *Ibid.*, 45.

²¹² *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 9 (Wednesday, June 8th, 1994), 6.

²¹³ *Ibid.*, 14.

rational decision to end their lives: “Even with the voluntary wish of a suffering person to die, I find it difficult to say that that is informed consent in either legal or medical terms, the reason being that, when people are suffering, they are emotionally unstable.”²¹⁴

When asked by Senator Lavoie–Roux what should be done with those whose pain cannot be relieved, Dr. Senn replied that new legislation “does not protect the individual, because the individual at that stage is unable to make a rational decision.”²¹⁵

A cautionary approach was also offered by Dr. Brian Mishara, the founding president of the suicide prevention centre Suicide-Action Montréal. Speaking for the centre, he felt that the risk of abuse was a real possibility: “Our concern is that as soon as the act involves other people—call them ‘helpers,’ or whatever—there is a risk that . . . the right of the person to change his or her mind or put off the suicide may be compromised.”²¹⁶ He linked this anxiety over coercion to the principle of irreversibility. If one legalized euthanasia or assisted suicide, the patient would have no chance to amend future treatment decisions. Stated Mishara: “So one of the problems—and this is one of the challenges for your committee—is how to protect the rights of individuals to change their mind. . . . [O]ne should take the prospect of dying prematurely quite seriously and not try to deny in any way that it is a final prospect.”²¹⁷ That said, both coercion and irreversibility applied equally to cases within standard medical practice (e.g., permitting surgery, withdrawing respirators, and refusing life-saving interventions, such as blood transfusions). The patient may be pressured to accept the above choices by family or physicians, making any decision equally irreversible. As Dr. Eike–Henner W.

²¹⁴ Ibid.

²¹⁵ Ibid., 15.

²¹⁶ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 2, 33.

²¹⁷ Ibid., 41, 43.

Kluge had indicated to the Senate, claims over control and irreversibility “fail as ethical defences in the prohibition against euthanasia and assisted suicide.”²¹⁸

Dr. Gilles Voyer, Director of Professional Services at Hôpital Youville, Sherbrooke, identified the “slippery slope” as central to the debate over euthanasia and assisted suicide. Although he agreed that patients could suffer without assistance in suicide, his overriding concern was the threat to medicine’s reputation as a healing profession: “As much as I cannot avoid being sensitive to Sue Rodriguez’s argument . . . the question of the impact on the medical profession concerns me equally greatly.”²¹⁹ As an example of the potential risks facing society, Dutch medical policy was presented as a dangerous precedent: “When I saw those figures of the Remmelink Commission [20,000 cases of euthanasia a year],” remarked Dr. Voyer, “I couldn’t believe it. Holland, in my view, showed us what we must not do. That is my judgment on the Dutch experience.”²²⁰ Dr. Voyer even cited studies showing that, when Dutch patients requested euthanasia, “the act [was] administered 24 hours after the initial request.”²²¹

From the Izaak Walton Killam Hospital for Children, Dr. Nuala P. Kenny outlined what she viewed were inherent social risks associated with decriminalization. She was concerned that, if autonomy and individualism became further entrenched as values, Canada would “fragment further into sets of individuals who claim rights, rather than responsible interdependence, as the basis for human community.”²²² Dr. Kenny also emphasized that legalization would have “possible ramifications to non-consenting

²¹⁸ Ibid., 18.

²¹⁹ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 19 (Wednesday, October 5th, 1994), 46.

²²⁰ Ibid., 51.

²²¹ Ibid., 52.

²²² *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 20, 22.

populations,” meaning “all populations that in fact do not have legal competence to consent or refuse on their own behalf.”²²³ Thus, decriminalization would have “profoundly negative effects . . . on the research into more effective palliative care” as well as on “the fundamental trust inherent in the physician-patient relationship.”²²⁴ She also believed that once an intentionally hastened death was accepted, it would move beyond its original parameters of self-determination: “Circumstances never considered appropriate with the original change in a moral norm are now ordinary. In ethical terms, this is the concept of the slippery slope. . . . While the assumption of competence is the starting point, it is clear that many persons do not fulfil the criteria for competence, and others must decide for them.”²²⁵ Dr. Penny finished by linking communal concerns with the basis of Judeo-Christian belief. Paraphrasing St. Paul, she noted that “the life and death of each of us has an effect on all of us.”²²⁶

As with other metaphysicians, Dr. Robert Elgie of the Health Law Institute at Dalhousie University was adamant about the promotion of absolute moral distinctions. In his opinion, death could never be intended in a medical context. This is why “passive” euthanasia—for example, the removal of artificial nutrition and hydration or mechanical ventilation—only served to “confuse the debate over euthanasia and physician-assisted suicide” because it implied that such methods “ha[d] something to do with actions that [were] specifically intended to end life rather than respond to a patient’s expressed wish.”²²⁷ He also rejected the term “double-effect euthanasia” since “the intent of the treatment [was] to relieve pain and suffering” even though “the patient’s death [was] a

²²³ Ibid., 21.

²²⁴ Ibid., 24.

²²⁵ Ibid., 25–26.

²²⁶ Ibid., 25.

²²⁷ Ibid., 56.

foreseeable potential effect of that treatment or treatments.”²²⁸ While claiming euthanasia and assisted suicide directly caused death and, thus, were unethical, Dr. Elgie considered it ethically acceptable if a physician “gradually increase[ed] the morphine dosage for patients to relieve cancer pain, realizing that large doses may depress respiration and ultimately cause death.”²²⁹

Even the Hon. Diane Marleau, the Minister of Health, agreed with the dire warnings of other health care professionals. She pointed out that society “cannot overlook the vulnerable, the elderly, the disabled, the chronically ill, and those who lack the capacity to make informed decisions about the future.”²³⁰ According to the Hon. Minister, there was “a real risk that these populations [would] be made to feel more insecure if the social emphasis [were] on euthanasia and assisted suicide.”²³¹ Marleau further claimed that, by giving too much consideration to euthanasia and assisted suicide, “research into other areas of pain management and so on [would] fall by the wayside,” something she considered to be “a very big mistake on our part as a society.”²³²

The viewpoints of Mr. Randy Bottle, Chairman of the Alberta Indian Health Care Commission, resembled those of other metaphysicians, particularly Christians. Mr. Bottle relied on nature and a respect for life as guiding principles for his tribe’s attitudes toward euthanasia and assisted suicide. Initially, he agreed that Sue Rodriguez’s “tragic struggle with a painful and terminal disease moved all Canadians” and that “the legal considerations which faced Sue Rodriguez and others in her situation [were] not

²²⁸ Ibid., 57.

²²⁹ Ibid.

²³⁰ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 29, 5.

²³¹ Ibid.

²³² Ibid., 8.

acceptable.”²³³ However, for most First Nations peoples, “intervention to alter the natural time of death raises the most serious questions about spirituality and belief.”²³⁴ He told the Committee that elders from his Blood Tribe of southern Alberta would never condone euthanasia or assisted suicide for a dying member: “It is not part of our culture to actually approve of someone taking their own life. They [elders] do not want to alter nature. When it comes to terminally ill people, they [elders] leave that in the hands of the Creator.”²³⁵ In the case of the elderly facing death, he wanted to be certain that “they never feel even the most subtle pressure to consider ending their lives unnaturally. . . .”²³⁶

From the vantage point of nursing care, the normative assumptions of both religious and secular health care representatives were again strikingly similar. For instance, Mary-Lynn Mcpherson from Nurses for Life countered with arguments supporting the sanctity doctrine. Ms. Mcpherson described her organization of nurses as “dedicated to the defence of human life from conception to natural death,” believing that “the destruction of human life is in direct contradiction to the moral and ethical responsibilities of our profession.”²³⁷ She also found it “impossible to accept that there is dignity in being killed,” claiming that death with dignity was “inhuman and humiliating.”²³⁸ Likewise, Ms. Mcpherson believed there was a danger in making living wills legally binding because they would “advance societal acceptance not only of the

²³³ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issue No. 30 (Tuesday, December 13th, 1994), 19, 22.

²³⁴ *Ibid.*, 20–21.

²³⁵ *Ibid.*, 23. Not all Canadian indigenous peoples would leave death in “the hands of the Creator.” In fact, the attitudes of some Aboriginal tribes toward an intentionally hastened death were in complete opposition to Christian normative assumptions. For clarification, see Anne Mullens, “Of ‘Savages’ and ‘Saviours,’” in *Timely Death: Considering Our Last Rights*, 52–75.

²³⁶ *Ibid.*, 21.

²³⁷ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 8, 5.

²³⁸ *Ibid.*, 6.

right to die, but of the duty to be killed.”²³⁹ This would lead to two possible scenarios: “[D]octors who may not wish to participate in killing their patients may be legally compelled to do so,” and eventually, “killing for no reason [would become] acceptable.”²⁴⁰ Ms. Mcpherson wanted the Committee to understand that “society cannot afford to slide any farther down the slippery slope to utilitarianism.”²⁴¹

In similar fashion, Eleanor Ross, president of the Canadian Nurses Association, emphasized why death could not be intentionally hastened. She found that in general, nurses “believe that there is value in living life to its natural end.”²⁴² Ms. Ross clarified how acts of omission and commission differed morally. Death by the latter was caused by human agency; whereas, death by the former was caused by nature: “Active and passive euthanasia are terms meant to convey the difference between committing an act that causes death and omitting to take a life-sustaining act, allowing death to ensue.”²⁴³ Therefore, her organization could not support “passive” euthanasia, because the term implied a causal relationship between the withdrawal of treatment and the death of the patient: “If the meaning were blurred [between active and passive euthanasia], it could be seen as assisted suicide where, even with the client’s consent, you withdraw or discontinue, for example, a ventilator. . . . Discontinuing a ventilator or a dialysis machine is stopping treatment.”²⁴⁴

²³⁹ Ibid., 7.

²⁴⁰ Ibid., 8.

²⁴¹ Ibid., 9.

²⁴² *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 19, 5.

²⁴³ Ibid., 4.

²⁴⁴ Ibid., 7.

Health Care Representatives as Vattimian Postmodernists

Outside of hospice and palliative care, quality of life supporters were far more prominent, preferring to adopt the normative assumptions of postmodern pluralism. From the Toronto's Children's Hospital, Dr. Kenneth F. Walker told the Committee that to understand the reality of terminal illness and intractable suffering, the "real experts" should be present as witnesses: "[T]he person who should be talking to you today is not me; it should be the people who are currently dying in agony, right across this land."²⁴⁵ When discussing Lou Gehrig's disease, an infliction from which Sue Rodriguez suffered, Dr. Walker perceived any prolongation of suffering as pointless: "[T]hey [ALS sufferers] have lost the ability to expel mucous from their chests, and they drown. You can say, 'Well, we will give them medication.' To what avail in the last days? Why make them suffer?"²⁴⁶ He also used the example of bone cancer to demonstrate how palliative care cannot relieve all suffering: "That person [with bone cancer] might have a dozen broken bones from metastatic disease—every movement causes pain—and there is nothing you can do to ease that pain."²⁴⁷

As well, Dr. Paul Landry, Assistant and Vice-President of the Association des d'hôpitaux du Québec, reminded the Committee of the shifting values attached to suffering: "[T]raditional values have been called into question, particularly in our society in Quebec where these matters used to be settled on the basis of religious values in another way, one in which suffering had a meaning that was given to it."²⁴⁸ He broadened the concept of suffering beyond a religious framework, admitting that it now

²⁴⁵ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 11, 5.

²⁴⁶ *Ibid.*, 7.

²⁴⁷ *Ibid.*

²⁴⁸ *Proceedings of the Senate Special Committee on Euthanasia and Assisted Suicide*, Issue No. 19, 31.

“encompasse[d] psychological, cultural and more personal aspects.”²⁴⁹ Dr. Landry also noted that new experiences, or what Vattimo calls “events of being,” had changed the thinking of Quebecers on the issue of death and dying: “We in Quebec were particularly sensitive or impressed by the Nancy B. affair . . . [and] were also shaken by the decisions of the Supreme Court judges in the Sue Rodriguez affair. Whether we like it or not, these two cases called our values into question, more particularly those of our health sector.”²⁵⁰ This led Dr. Landry to conclude that “hard cases” may require an intentionally hastened death: “[C]ertain persons are at the mercy of incurable diseases. . . . Despite all our efforts and the advanced technology for relieving pain, these people still suffer, in many cases intolerably, and often conscientiously and lucidly request and ask for help in ending that suffering.”²⁵¹

As President of the Ontario Medical Association, Dr. Michael Wyman recognized that suffering was strictly a personal, existential concern. He informed the Committee that nihilism, as non-existence, may be a more valued choice for some terminally ill patients than prolonged death: “There are times when cure is not possible, and function is so severely impaired that it cannot be restored. It is at these times that many patients may decide that the quality of life is so limited that extension of life for even a very short time is more painful than death.”²⁵² From this, he submitted that the decision to intentionally terminate life was an individual, rather than a social, decision: “The idea that death might not only be inevitable but desirable may be unacceptable to some, but it exists, and it is

²⁴⁹ Ibid., 33.

²⁵⁰ Ibid.

²⁵¹ Ibid., 39.

²⁵² *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 20, 69.

the patient who faces death who must be involved in that choice.”²⁵³ He concluded, therefore, that the choice to hasten death came down to the subjective, lived reality of those dying: “The unbearable suffering of living must be put in context with the value to some of a quick and peaceful death.”²⁵⁴

Dr. Wyman also found that the “slippery slope” argument was spurious. He informed the Committee that specific acts within standard medical practice—namely, removal of nutrition and hydration, disconnecting life-preserving equipment, and titrating morphine—all hastened death, yet the community’s interests were still safeguarded: “I would suggest to the members of the committee that we have indeed been on this slope for some time, and have managed to traverse it with considerable skill.”²⁵⁵ He added that after legalization the state would have “ongoing opportunity to review and modify the checks and balances to ensure that societal values and medical ethics are always considered.”²⁵⁶ In closing, Dr. Wyman viewed the rhetoric of “danger” and “risk” to the community as a way of maintaining the metaphysical status quo indefinitely: “If we do not make appropriate changes because of the fear they will cause other changes to happen, then nothing will ever change. The answer to the slippery slope theory is that one can only make change by doing so.”²⁵⁷

Dr. Ted Boadway, the Director of Public Health at the Ontario Medical Association, concurred with his colleague Dr. Wyman. If physician-assisted suicide and euthanasia remained hidden underground, there would be no way to regulate such acts. Addressing the Committee, he claimed: “They [doctors] will not admit to you that they

²⁵³ Ibid., 74.

²⁵⁴ Ibid., 76.

²⁵⁵ Ibid., 75.

²⁵⁶ Ibid., 77.

²⁵⁷ Ibid., 80.

are doing it [euthanasia and assisted suicide]. They will not discuss where they are doing it. That is not very safe, either.²⁵⁸ An interesting exchange then ensued between Dr. Wyman, Senator Lavoie–Roux, and Dr. Boadway over the hidden practice of death hastening in Canada. In the opinions of Drs. Wyman and Boadway, medical practitioners were simply ignoring acts of commission already occurring in Canadian hospitals:

Dr. Wyman: I have spoken with physicians who have been involved directly in the process [of euthanasia and assisted suicide]. I know for a fact that it does occur on a regular basis. Those who say that it does not are either not talking with many physicians or deliberately turning a blind eye to the numbers.

Senator Lavoie–Roux: You differentiate between the analgesic that you give in palliative care when people know that it will hasten death and that which relieves pain. Do you differentiate between that situation and the doctor who leaves out medication that will cause death if taken in large doses?

Dr. Boadway: Senator, in today's society, it is best if you do not admit it to yourself.

Senator Lavoie–Roux: Pardon?

Dr. Boadway: It is best if you do not admit to yourself that that is what happened. You do not need to admit it to the hospital. You do not need to admit it to anybody. You can just quietly go home.²⁵⁹

From the Department of Community Health Services at the University of Calgary, Marja J. Verhoef, PhD, provided opinions in stark contrast to her research colleague, the aforementioned Dr. T. Douglas Kinsella. Although Verhoef fully supported palliative care, she admitted that it could not alleviate all instances of suffering: “[T]here are cases for who the most frightening aspect of death is not only the physical pain and suffering, but is also the prospect of losing control and independence and dying in an undignified and existentially unacceptable condition.”²⁶⁰ Instead of deferring to stewardship in matters over life and death, Verhoef felt that the decision to hasten death should be a subjective one, founded on the importance of an individual's *biographical* life: “This [one's quality of life] can only be defined by patients themselves, because they would

²⁵⁸ Ibid.

²⁵⁹ Ibid., 81.

²⁶⁰ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 18, 81–82.

like to die in a way that is consistent with the way they have chosen to live.”²⁶¹ She suggested that physician-assisted death could become a legitimate option “only after standard measures for palliative care [had] been found unsatisfactory by competent patients in the context of their own situation and values.”²⁶²

Members from the College of Family Physicians also remarked on how an evolution was occurring that was weakening the sanctity of life ethos as absolute. Dr. Richard MacLachlan commented on this moral revolution: “We are not saying what we said a decade or two decades ago, when the status quo was that it was morally and ethically reprehensible under all circumstances to consider acts such as physician-assisted suicide and euthanasia . . . [T]here are valid ethical arguments on many sides of the issues of every case.”²⁶³ In addition, Dr. Paul Rainsbury explained to the Committee how this shift in medical opinion—from prohibition to possibility—had recently gained momentum: “When the original policy was defined, the issue of euthanasia and physician-assisted suicide was not the public debate it is today. . . . It is just that the debate has become very public.”²⁶⁴ Dr. Eugene Bereza admitted how specific “events of being” were decisive factors in this transition toward possible decriminalization: “There has been an evolution. The reason for the evolution is the prominence that the debate has taken in our society, whether it is the Nancy B. case or the Sue Rodriguez case. These cases have brought to the forefront the issue of euthanasia and assisted suicide and made

²⁶¹ Ibid., 82. Philosopher Paul Carrick links the subjective and individualistic desire to hasten death with the Greek concept of *eudaimonistic ethics*, an ethic that “aims at making the moral agent a good spirit—one who requires well being.” Thus, the moral agent as a whole was accorded the greatest attention in Greek medical theories. See Paul Carrick, *Medical Ethics in Antiquity: Philosophical Perspectives on Abortion and Euthanasia*, 100.

²⁶² Ibid.

²⁶³ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 23, 8.

²⁶⁴ Ibid., 11.

people talk about it a great deal more.”²⁶⁵ When Senator Corbin asked how doctors reconciled the sanctity of life ethos with “the possibility of physicians administering death,” Dr. Bereza clarified how ethical principles were situational and contested, not absolute: “One of the other sections of our code of ethics is to do everything possible to relieve suffering and always to place the patient’s well-being first. And, I feel, these two principles are always open to interpretation.”²⁶⁶

As with other postmodern pluralists, Dr. Kevin Hall, president of the Canadian Pharmaceutical Association, viewed the existential being of the patient as crucial in developing policy. Addressing Senator Corbin, Dr. Hall explained how the problem for dying patients was not just physical pain: “Many terminal illnesses have other side effects. It may be loss of bowel control or spasticity or constant cramping. Some of those things are equally dissatisfying. However, there are patients who believe that their quality of life is still unacceptable, despite the fact they are pain free.”²⁶⁷ When Deputy Chairperson Lavoie–Roux inquired as to whether palliative care was the answer, Dr. Hall was blunt: “There would still be patients who, even with adequate palliative care, would find that their living conditions [were] not acceptable to them as individuals. The issue will still have to be grappled with even with palliative care.”²⁶⁸ Noting the subjectivity and life histories that shape individual cases, Dr. Hall admitted that any universal meaning attributed to suffering was unrealistic. An exchange between Dr. Hall and Senator Beaudoin expands on this issue:

Dr. Hall: What is intolerable for one individual may not seem like it should be intolerable to another. Those are the roads you begin to travel when you discuss euthanasia. Does someone who

²⁶⁵ Ibid., 16.

²⁶⁶ Ibid., 9–10.

²⁶⁷ Ibid., 27.

²⁶⁸ Ibid., 28.

does not seem to be suffering have the same rights if they believe they are suffering? . . . Do they have the right to decide regardless of what you think their quality of life is?

Senator Beaudoin: Are we able to say that a person is suffering or not, or is the person himself the only one who can say whether he is suffering?

Dr. Hall: How do you define suffering? Suffering is not necessarily the presence or absence of pain. There are many people who have adequate pain relief but are suffering intolerable symptoms of another nature. Some patients are not prepared to live with a situation where they do not have bladder control or do not have bowel control.²⁶⁹

The testimony of Marilynne Seguin, a nurse representing Dying with Dignity, was in stark contrast to nurse practitioners promoting the sanctity doctrine. She emphasized the lived reality of dying patients, noting that although palliative care was “a superb service,” it was “not the answer for everyone,” since approximately “three per cent” of patients still chose an “early death.”²⁷⁰ Seguin was asking the Committee to empathize with the individual sufferer since only he/she could really understand the subjective reality of the situation:

I have to believe that only the person can tell what suffering is for them. I cannot crawl into their skin and say, “Come on, you can make it another day, you can make it another week.” They know it will not only be another day or another week. They know it will be another year or two years. Can I say, “Well, you have to put up with it.”?²⁷¹

However, Seguin’s remarks were sharply rebuked by Senator Corbin, whose discourses resembled those of religious and secular opponents of decriminalization. He told Ms. Seguin that “once you’ve crossed the threshold of death, there is no turning back.”²⁷² Although Ms. Seguin never suggested involuntary euthanasia, Senator Corbin accused her of promoting an idea “full of violence,” something that “brought back memories of Nazi Germany and other similar situations.”²⁷³ Instead of humans taking

²⁶⁹ Ibid.

²⁷⁰ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 7, 33.

²⁷¹ Ibid., 38.

²⁷² Ibid., 34.

²⁷³ Ibid., 35.

responsibility for hastening death, Senator Corbin suggested that “nature” already provided solutions to this ethical dilemma:

I believe that in the act of death itself, nature has given us ways of making the crossing of that threshold easier and less of a burden. . . . [I]t seems to me that nature, in its wisdom, has provided us with some “pain relievers,” if I can call them that. . . . It seems to me that our society is too quick to opt for the easy way out.²⁷⁴

²⁷⁴ Ibid., 34.

Chapter V: The “Weakening” of the Sanctity of Life Ethos in Law

This section begins by highlighting the findings of the Law Reform Commission of Canada (the “Commission”) from 1976 to 1986. To show how secular legal opinion often harboured “traces” of religious beliefs, I will demonstrate how the Commission consistently supported Christian normative assumptions—namely, stewardship, value in prolonged suffering, and the “slippery slope”— which, in turn, maintained the *qualified* sanctity of life ethos as first principle. In the Vattimian sense, the Commission’s conclusions helped to maintain “traces” of the Christian metaphysical tradition within legal matters dealing with euthanasia and assisted suicide, particularly in the cases of Sue Rodriguez and Robert Latimer.

This chapter will also examine how the Rodriguez and Latimer cases exposed the presence of objectivistic metaphysics (absolute values, immutable principles) within the Canadian justice system from 1992 to 2001. By requesting physician-assisted suicide as a sane, conscious, and consenting adult, Sue Rodriguez opposed the hegemonic status of the sanctity of life ethos that had previously dominated Canadian legal discourse. Although Rodriguez was fated to die from suffocation, she was denied a constitutional exemption for physician-assisted suicide because of the potential risk/danger to communal values. Rodriguez’s request would have negated the basis of the *qualified* sanctity of life principle by nullifying the omission / commission distinction. Likewise, when Robert Latimer intentionally ended the life of his daughter Tracy, a debate surrounding intractable suffering and the limits of medical intervention ensued. Robert Latimer eventually lost his final appeal in the Supreme Court of Canada because his actions directly challenged the taboo against intentional killing, especially when explicit

consent was unknown. Rodriguez, Latimer, and their supporters gravitated toward a postmodern *quality of life* ethic. This paradigm adopted a situation ethics approach for euthanasia and assisted suicide, emphasizing self-determination, the relative value of human life, and the workability/flexibility of safeguards.

A discourse analysis will demonstrate that both Sue Rodriguez's and Tracy Latimer's "ontology of actuality" (lived reality) threatened to create a paradigmatic shift from metaphysics to what Gianni Vattimo calls "weak thought" (conflict/play of interpretations). In other words, further weakening of the sanctity doctrine would eventually lead to the decriminalization of an intentionally hastened death for the terminally and chronically ill. When confronted with the possibility that the sanctity of life ethos would no longer be the ultimate foundation for life-terminating decisions, the Canadian legal system relied on objectivistic metaphysics in an effort to legitimate its prohibition against acts of commission. In other words, secular law only *appeared* secular.

Metaphysics and the Law Reform Commission of Canada

In 1976, the Law Reform Commission of Canada (the "Commission") submitted its report to Parliament titled, *Our Criminal Law*. In the report, the Commission stated that not only were morality and law intertwined, but the sanctity doctrine was foundational to collective justice: "In truth, the criminal law is fundamentally a moral system . . . When acts occur that seriously transgress essential values, like the sanctity of life, society must speak out and reaffirm those values. This is the true role of criminal

law.”¹ This implied that any act that weakened the sanctity of life ethos was prohibited since it would be “revolting to the moral sentiments of society.”² Thus, communal morality was pivotal in shaping the criminal law’s regulatory scheme. As the report stated,

To count as a real crime an act must be morally wrong. . . . The real criminal law should be confined to wrongful acts seriously threatening and infringing fundamental social values. . . . To share a fundamental value genuinely, society must . . . react publicly when it is violated, condemn the violation and take steps to reaffirm the value. One way of doing this is by the criminal law.³

Three years later, Edward W. Keyserlingk’s background paper, *Sanctity of Life or Quality of Life in the Context of Ethics, Medicine and Law*, set out to encourage this same interaction between law and morality. He suggested that law-making and legal reform played a metaphysical function by “directing attention to questions of meaning, purpose, and responsibility.”⁴ Keyserlingk noted that the sanctity of life ethos played an important role in this process. It symbolized a kind of faith in a supraempirical level of reality, a belief in the “objective, absolute value of human life and worth.”⁵ Consequently, “sanctity of life” acquired universal moral appeal, and those evoking it stood by a single set of normative assumptions: “[L]ife is precious, should be respected and protected, treated with consideration, and is a principle basic to . . . society.”⁶

However, it was the interpretation of human worth as relative that became problematic. Keyserlingk asked: “[W]ould morality (and therefore potentially law as well) have to abandon the commitment to the sanctity of life principle if it were to

¹ Law Reform Commission of Canada, *Our Criminal Law* (Ottawa: Crown Copyrights, 1976), 16.

² *Ibid.*, 5.

³ *Ibid.*, 20, 27.

⁴ Law Reform Commission of Canada, *Sanctity of Life or Quality of Life in the Context of Ethics, Medicine and Law*, Protection of Life Series by Edward W. Keyserlingk (Ottawa: Minister of Supply and Services Canada, 1979), 2.

⁵ *Ibid.*, 49.

⁶ *Ibid.*, 42.

recognize the validity of some quality of life concerns . . . ?”⁷ Although he attempted to reconcile the difference between sanctity and quality of life positions, Keyserlingk declared the reigning metaphysic absolute:

For ethics, medicine, or law, to acknowledge and articulate the validity and importance of quality of life concerns need imply itself no threat to a commitment to the sanctity of life; it need not involve either making the sanctity of life a “relative” value or positing “exceptions” to the principle of the sanctity of life.⁸

Normative assumptions were also promoted as immutable and “objective.” For Keyserlingk, an absolute moral difference existed between “allowing to die” (an act of omission) and euthanasia (intentional killing or act of commission). The two acts could not be equated, since, in the latter scenario, the physician was considered the moral agent causing the patient’s death.⁹ In fact, Keyserlingk remained steadfast over the decision to prohibit assistance in suicide, a policy he would not change “even in the face of cases of excruciating and intractable pain and suffering.”¹⁰ To buffer his stance against euthanasia and assisted suicide, Keyserlingk also relied on the “slippery slope.” For example, if a medical diagnosis were inaccurate, a hastened death would preclude any chance of recovery by the patient. Moreover, once one exception for an intentionally hastened death was granted, other motives would become socially acceptable, a trend which could lead to “unknown social consequences.”¹¹ Moving medical ethics from foundational certainty into the terrain of uncertainty was a step Keyserlingk simply could not take. Therefore, the overall justification for maintaining the traditional metaphysic—even amidst intractable suffering—was framed in utilitarian terms: “Though killing a particular patient could possibly be beneficial to that patient, the consequent risk of

⁷ Ibid., 3.

⁸ Ibid., 4.

⁹ Ibid., 120, 122, 126.

¹⁰ Ibid., 129.

¹¹ Ibid., 126–127.

gradually eroding society's respect for the sanctity of life may ultimately be more non-beneficial to more people than the continued suffering of this one patient."¹²

In 1982, the Commission's report on *Euthanasia, Aiding Suicide and Cessation of Treatment* ("Working Paper 28") not only acknowledged the link between stewardship and the sanctity of life ethos, but *human* life was also singled out as unique among all animal life. In the Commission's words,

For our society recognizes that, morally, religiously, philosophically, and socially, human life merits special protection. This recognition of life's fundamental importance has often been expressed through the concept of the sanctity of human life. One expression of this concept is that because life is God-given and we merely hold it in trust, we should not then interfere with it or put an end to it.¹³

At the metaethical level, stewardship implied that death could only be hastened by God or "nature," not human beings. To sustain such a premise in law, a clear moral distinction was required between acts of omission and commission. In the former, death was merely foreseen; whereas in the latter, death was intended:

This distinction [between acts of omission and commission], which of course is fundamental, finds a parallel in morality and medical ethics. Wilful, deliberate killing means the direct elimination of all hope, all opportunity, all possibility, however remote, of recovery or a possible prolongation of life. . . . Allowing to die . . . does not necessarily deprive the patient of these possibilities. Cessation of treatment may simply restore the situation that existed before treatment was undertaken and allow *nature to take its course* [italics mine].¹⁴

¹² Ibid., 132. As John Stuart Mill acknowledged, utilitarianism implies 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*, 250.

¹³ Law Reform Commission of Canada (Working Paper 28), *Euthanasia, Aiding Suicide and Cessation of Treatment* (Ottawa: Minister of Supply and Services Canada, 1982), 3–4.

¹⁴ Ibid., 19. Other moral philosophers have disagreed with any inherent moral distinction between acts of omission and commission. In 1975, James Rachels challenged the distinction, claiming that such rhetoric was misleading for two reasons: first, in both instances, the motive, intent, and result can be identical; and second, an act of omission (e.g., turning off a respirator) may endorse an option that leads to more suffering rather than less. In other words, if the humanitarian motive for an act of omission is "relief of suffering," then the logical assumption would be to choose the method that causes the least amount of pain and anguish. According to Rachels, euthanasia may be a morally preferred option if it is more humane. See James Rachels, "Active and Passive Euthanasia," in *Bioethics: An Introduction to the History, Methods, and Practice*, 2nd ed., edited by Nancy S. Jecker, Albert R. Jonsen, and Robert A. Pearlman (Toronto: Jones and Bartlet Publishers, 2007), 64–69.

Belief in inherent moral distinctions between negative and positive acts meant that the Commission was unequivocal in its opposition to legalized euthanasia:

There is a fundamental difference . . . between causing death by a positive, deliberate act and stopping treatment at a patient's request. The first is morally and legally unacceptable and should continue to be subject to criminal penalties. The second, however, is perfectly justified in the name of personal autonomy and the right to self-determination.¹⁵

In addition, the Commission felt it had to make a firm presumption in favour of life based on the danger of the “slippery slope.” The “problem” of euthanasia was assumed to create more harm than good for the community: “[W]e believe that legislation legalizing voluntary active euthanasia would be quite unacceptable. Legalizing euthanasia, given current social conditions, would mean far too great a risk in relation to any possible benefit to our society and its members.”¹⁶ The Commission also admitted that it was safeguarding against even the remote possibility of medical oversight:

First of all, there is the risk of error and accident, since an incorrect diagnosis is always a possibility. In addition, there remains the possibility that a new treatment or the refinement of a known treatment, which will permit either survival or recovery, can never be completely ruled out.¹⁷

However, according to the Commission, the “slippery slope” was not the most persuasive claim, since no record existed of a single conviction in Canadian case-law involving euthanasia, palliative care, or “passive” euthanasia (e.g., withdrawal of life support).¹⁸ Even without criminal convictions spanning decades, the protection of the vulnerable was still of gravest concern. In the Commission's words, “There is, first of all, a real danger that the procedure developed to allow death of those who are a burden to themselves may be gradually diverted from its original purpose and eventually used as well to eliminate those who are a burden to others or to society.”¹⁹

¹⁵ Ibid., 57.

¹⁶ Ibid., 46, 47.

¹⁷ Ibid., 46.

¹⁸ Ibid., 8.

¹⁹ Ibid., 46.

A year later, the follow-up report was supposed to provide “clarifications in the area of euthanasia, aiding suicide and the cessation of treatment” since “the present *Criminal Code* provisions [were] ambiguous and vague, and much in need of revision.”²⁰ As with its previous conclusions, the Commission could not sanction an intentionally hastened death. It simply felt that permitting euthanasia or assisted suicide would open “a door to a number of problems and abuses,” thereby resulting in a “devaluation of human life.”²¹ In its conclusions, the Commission rejected the decriminalization of both euthanasia and assisted suicide, recommending instead that “*the existing prohibitions of the Criminal Code concerning homicide be maintained.*”²² In general, the Commission felt that there were neither “wrongs nor needs sufficiently great to justify overturning a well-established tradition based on time-honoured morality.”²³

In 1986 euthanasia and assisted suicide were again deemed prohibited acts, based largely on the popularity of the “slippery slope” argument. According to the Commission,

Active euthanasia, even with the consent of the person concerned, is unacceptable. Its legitimization or direct or indirect recognition by the criminal law is dangerous because it may lead to serious abuses. It could only result in a significant reduction of the area of protection provided by the criminal law for the integrity of the person.²⁴

The Commission felt that aiding or abetting of suicide was also dangerous because “suicide remains an act which is fundamentally contrary to *human nature* [italics mine].”²⁵

²⁰ Law Reform Commission of Canada, *Report on Euthanasia, Aiding Suicide and Cessation of Treatment* (Ottawa: Minister of Supply and Services Canada, 1983), 9.

²¹ *Ibid.*, 18, 19.

²² *Ibid.*, 68.

²³ *Ibid.*, 48.

²⁴ Law Reform Commission of Canada, *Some Aspects of Medical Treatment and Criminal Law*, Report 28 (Ottawa: Minister of Supply and Services Canada, 1986), 13.

²⁵ *Ibid.*

Eventually, Christian normative assumptions already interwoven in legal discourse would become even more apparent in the case of Sue Rodriguez. Because of her unique circumstances, Rodriguez was asking the Canadian legal system to respond to a new interpretation of a “good death.” However, as the authority of metaphysics became challenged by what Gianni Vattimo calls an “event of being,”²⁶ the reaction by sanctity of life advocates was a more consistent dependence on absolutes, further justifications for prolonged suffering, and a greater reliance on the “slippery slope.” In point of fact, Sue Rodriguez would eventually become the maelstrom in the battle to expose absolute values within Canadian law.

Sue Rodriguez and the Weakening of Metaphysics

Before discussing the competing values, ethical principles, and legal arguments that shaped this unique “event,” this section will begin by illustrating Sue Rodriguez’s lived reality. As a sufferer of a motor neuron disease known as amyotrophic lateral sclerosis (Lou Gehrig’s disease, or “ALS”), Rodriguez began to realize that her quality of life was in decline. When the transition from living to dying commenced, her wish was to exit life early. Stated Rodriguez: “[A]s I lose the ability to move, to speak, to eat and to breathe, the time will come when life is no longer joyful for me, a time when living ends and dying begins. I see no point in making this final transition.”²⁷ Absent from her philosophico-ethical framework were any metaphysical assumptions pertaining to stewardship or value in prolonged suffering. Once her quality of life had depreciated

²⁶ In the context of postmodern pluralism, Vattimo defines Being as “event.” Consequently, truth is not a reflection of objective norms and values but rather “a historical message that must be heard and to which we are called to respond.” For Vattimo, Being as event “transforms the existence of the person who receives the announcement.” See Vattimo, *After Christianity*, 6, 7.

²⁷ Sue Rodriguez, “Death with Dignity: Reflections by Sue Rodriguez,” *Ottawa Citizen*, 20 February 1993, B3.

significantly, she wished “to die quickly, painlessly, and with [her] dignity and spirit intact.”²⁸ In contrast to a belief in stewardship, self-determination became central to Rodriguez’s value system. Making a blunt appeal to Members of Parliament in Ottawa, she inquired: “[I]f I cannot give consent to my own death, then whose body is this? Who owns my life?”²⁹ In a special editorial to the *Ottawa Citizen*, Rodriguez again asked: “Do I have the right to die on my own terms in accordance with my own beliefs and values or must I die as the medical/religious establishment says I should?”³⁰ In fact, she was puzzled by the argument made by the Canadian Conference of Catholic Bishops, one of seven interveners, which claimed her life was owned by God. As she herself clarified: “I’m Sue Rodriguez and I have my own values and rules and I really can’t relate to why someone would want to impose their value system on me.”³¹

Prior to acquiring ALS, Rodriguez was described as “active and self-reliant,” but after being afflicted with the disease, she had to “rely on others for every need, even for the most intimate acts of personal hygiene . . . [T]he illness that had deprived her of command over her own body was both irreversible and incurable.”³² In a taped message to a parliamentary committee, she outlined her future prognosis: “There is much worse to come. I will be unable to breathe without a respirator. I will be unable to eat or swallow, unable to move without assistance.”³³ Her fear was not pain but “a drugged-out twilight of total dependency and hopelessness.”³⁴ Philosophically speaking, Rodriguez was anti-

²⁸ Ibid.

²⁹ “Police Investigate Sue Rodriguez’s Death,” *Ottawa Citizen*, 13 February 1994, A1.

³⁰ Sue Rodriguez, “Please Answer the Question,” *Ottawa Citizen*, 18 January 1993, A7.

³¹ Justine Hunter, “Discussing My Life: Sue Rodriguez Watches Court Debate Her Right to Die,” *Ottawa Citizen*, 21 May 1993, A1.

³² Chris Wood, “The Legacy of Sue Rodriguez,” *Maclean’s* 107, no. 9, 28 February 1994, 22.

³³ Ibid., 23.

³⁴ Birnie, Lisa Hobbes and Sue Rodriguez, *Uncommon Will: The Death and Life of Sue Rodriguez*, 37.

vitalistic; *quantity* of life was simply subordinate to *quality*: “[T]he quality of life is the essence of life, and that a life deprived of quality is not worth living,”³⁵ she asserted.

Sue Rodriguez’s lawyer, Chris Considine, also described his client’s lived reality as one of daily suffering. Considine clarified that Rodriguez was experiencing long-term psychological anguish: “[S]he did suffer, mentally, a great deal because of what she saw happening to her body as a result of the disease. From her perspective, she was living a very undignified way of life.”³⁶ This emotional pain was also due to the fact that “she could no longer hug her son; she could no longer play with him, or run around with him.”³⁷ In the few months leading up to her death, Considine described what she endured physically: “She required 24-hour bowel care and feeding assistance. Her voice was very fragile. Her respiratory function was impaired. . . . She was fed with fluids and gruel-like substances. Her shoulders were permanently dislocated. She had virtually no movement in her legs or arms. . . .”³⁸ Considine also wanted Canadians to understand why “natural” death could not fulfill all of Rodriguez’s personal and familial needs: “[S]he wished to die and to bring it about herself rather than being forced to endure ongoing mental and physical suffering needlessly. She felt that the suffering would affect her, her family, and her friends; and it did.”³⁹

There were also important values and principles that drove Sue Rodriguez to seek the legalization of physician-assisted suicide. She interpreted ethical principles—such as dignity, autonomy, and beneficence—as situational, not absolute. Rodriguez had made it public record that “the manner of dying that faced her, its quality and nature, and the state

³⁵ Ibid., 37.

³⁶ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, No. 14, 8.

³⁷ Ibid.

³⁸ Ibid., 7.

³⁹ Ibid., 9.

of utter dependence that it involved, were unacceptable to her. They violated her fundamental values and her sense of dignity as a person.”⁴⁰ What was essential to human dignity, in Rodriguez’s view, was “control over one’s physical and psychological integrity.”⁴¹ Because of the absolute moral/legal distinctions posited between acts of omission and euthanasia/assisted suicide, Rodriguez was left with methods of death-hastening which she viewed as demeaning. For example, refusing food and water would have

violated the very principles that underlay the reason for her choice in the first instance. . . . the means [removal of food and water] necessary for carrying out her purpose would have contradicted the nature of the purpose itself. Therefore, acceptance of alternative and adherence to the law would have entailed a violation of her sense of dignity and of her fundamental values.⁴²

Furthermore, the principle of autonomy was central to Rodriguez’s existential being. Since *R. v. Morgentaler*,⁴³ the law has increasingly recognized that “conscience, beliefs, aspirations, and values of an individual shape the life of that person, and that the right to adhere to one’s conscience, beliefs, aspirations, and values in self-regarding actions is integral to the autonomy of a person in a free and democratic society.”⁴⁴ Rodriguez could have legally committed suicide by her own hand before becoming physically unable to do so; however, “she would have had to end her life before she wanted to,” and such an option would have “forced her to buy her autonomy at the price of an accelerated death.”⁴⁵ According to Considine, Rodriguez was not willing to dictate her views to others but expected the same consideration of self-determination in return:

⁴⁰ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, No. 2, 13.

⁴¹ Hazel Biggs, *Euthanasia: Death with Dignity and the Law* (Portland, Oregon: Hart Publishing, 2001), 151.

⁴² *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, No. 2, 14.

⁴³ *R. v. Morgentaler*, 1 S.C.R. 30 (1988).

⁴⁴ *Proceedings of the Senate Special Committee on Euthanasia and Assisted Suicide*, No. 2, 15.

⁴⁵ *Ibid.*, 14.

Ms Rodriguez recognized that many people might wish to make another choice for themselves, that they might not wish to have physician-assisted suicide, that they may wish to have palliative care, or they may wish to have heroic measures. She felt that those choices were legitimate for those individuals, but that their choices should not be imposed upon her.⁴⁶

The concept of beneficence⁴⁷ was also applicable to the Rodriguez case.

According to bioethicist Dr. Eike-Henner W. Kluge, the usage of beneficence implies a stricter constitutional application. In his words, “Everyone has an obligation to assist others in advancing their good, where the nature of this good is defined by the individual whose good is to be advanced, or where this good is consonant with the values of that person.”⁴⁸ Sue Rodriguez defined “the good” by her quality of life, meaning that “suffering should not be protracted beyond the ability of the individual to bear.”⁴⁹ This is why palliative care was not considered a complete solution in Rodriguez’s case. What she would not accept was any suggestion that she “allow herself to be kept alive and palliated until she slid into an insensate death” or that she “accept a mode of existence that would be burdensome for her. . . .”⁵⁰ What was beneficent for Rodriguez was “to provide her with options that would allow her to end her suffering in keeping with her values.”⁵¹

Irrespective of her lived reality, Sue Rodriguez would soon realize that her affinity for the quality of life ethos and the normative assumptions this entails (e.g., self-determination) was in direct opposition to normative positions adopted by justices at both the provincial and federal level (e.g., the sanctity doctrine and communal authority). In

⁴⁶ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, No. 14, 10.

⁴⁷ For this dissertation, beneficence is defined as “an obligation to help others further their important and legitimate interests.” See Tom L. Beauchamp and James F. Childress, *The Principles of Biomedical Ethics* (Oxford: Oxford University Press, 2001), 166.

⁴⁸ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, No. 2, 15.

⁴⁹ *Ibid.*

⁵⁰ *Ibid.*

⁵¹ *Ibid.*, 16.

the 1990s, shifting from the *qualified* sanctity of life ethos to the quality of life ethos was a moral revolution too radical for Supreme Court judges to accept.

The Metaphysical-Postmodern Divide in the Courts

From 1992 to 1993, Supreme Court justices (at both the provincial and federal level) not only supported “sanctity of life” as first principle, but they also relied on other “objective” claims, such as the following: (1) the omission / commission distinction as absolute; (2) justifications for prolonged suffering; and (3) the “slippery slope.” In contrast, Sue Rodriguez was arguing that s. 7 of the Canadian Charter of Rights and Freedoms, with its reference to “security of the person,” implied self-determination when dealing with cases of an intentionally hastened death. Her application for physician-assisted suicide was dismissed, however, by the British Columbia Supreme Court, the British Columbia Court of Appeal, and the Supreme Court of Canada. For those justices residing for this particular matter, the existential suffering experienced by Rodriguez was not as grave as the possibility of harm to society (i.e., the theoretical possibility of abuse against “vulnerable populations,” such as the old, sick, and disabled). Therefore, the case centred around two competing Charter arguments: s.7’s life, liberty, and security of the person (along with s.15’s equality provision for the disabled) and s.1’s limits on such rights in accordance with principles of fundamental justice.

Applying initially to the British Columbia Supreme Court in December 1992, Rodriguez’s petition was dismissed by Justice Allen Melvin. In his legal analysis of the case, Justice Melvin acknowledged that “rights to life, liberty and security of the person may be lost as a result of state interference when that interference is in accordance with

the principles of fundamental justice.”⁵² Therefore, he rejected Rodriguez’s request for physician-assisted suicide because suicide was “diametrically opposed to the underlying hypothesis upon which a Charter of Rights and Freedoms is based, namely, the sanctity of human life.”⁵³ Justice Melvin also maintained the prohibition against assistance in suicide as outlined in s. 241(b) of the *Criminal Code*. The legislation was specifically designed “to protect those who may in a moment of weakness, or when they are unable to respond or unable to make competent value judgments, may find themselves at risk at the hands of others who may, with the best or with the worst of motives, aid and abet in the termination of life.”⁵⁴ Justice Melvin asserted that s. 241(b) was necessary as it “protects the young, the innocent, the mentally incompetent, [and] the depressed” from abuse, and although Sue Rodriguez did not fall within these parameters, the prohibition against assistance in suicide remained a “*reasonable* limit demonstrably justified in a free and democratic society [italics mine]”⁵⁵

In the British Columbia Court of Appeal (1993), Rodriguez’s lived reality was reconstructed by Justice C.J. McEachern in dissent. He made a point of emphasizing the opinions of the Appellant’s general practitioner, Dr. McGlynn, whose comments hark back to what Gianni Vattimo calls “the metaphysics of pain.”⁵⁶ In other words, the law’s reliance on metaphysical abstractions and absolute principles, such as the sanctity of human ethos, could only result in prolonged suffering for Rodriguez. Dr. McGlynn

⁵² *Rodriguez v. British Columbia* (Attorney General). British Columbia Supreme Court (SCBC) No. 4040/92, Victoria Registry 29 December 1992, Melvin J, 6.

⁵³ *Ibid.*, 10.

⁵⁴ *Ibid.*, 11–12.

⁵⁵ *Ibid.*, 12.

⁵⁶ Because Vattimo defines metaphysics as “will to power, violence, and destruction of liberty,” he asserts that “pain is the very essence of metaphysics, that there is no metaphysics except the metaphysics of pain.” See Gianni Vattimo, *Nihilism and Emancipation: Ethics, Politics, and Law*, 54; also see Richard Rorty and Gianni Vattimo, *The Future of Religion*, 71.

stated that she would continue to have “increasing difficulties with speech, chewing and swallowing,” run the risk of “respiratory infections and choking on either food or secretions,” and “require tubes . . . for feeding and tracheotomy tubes for breathing.”⁵⁷ McGlynn concluded that because Rodriguez’s muscles were atrophying—particularly those for breathing and swallowing—she would either “aspirate and choke to death on food . . . [, or] the muscles used for breathing may simply become so weak that they cannot breathe well enough to maintain life.”⁵⁸ He admitted that the effects of ALS would lead to two different types of suffering: “The patient has not only the emotional anguish of knowing they have an invariably fatal illness, but also must suffer more and more in an immediately physical sense.”⁵⁹

Justice McEachern concurred with Dr. McGlynn’s findings, noting Rodriguez’s own sense of vulnerability. She did not wish to face “the indignity which will accompany being forced to endure life in such a condition and fears that she will be unable to cope with what will surely be a mentally agonizing death.”⁶⁰ What Rodriguez was seeking to avoid was “present and future stress and loss of dignity caused by the prospect of palliative care as well as dependence upon a regime which will lead, inevitably in her case, to death by starvation or choking.”⁶¹ McEachern concluded that s.7 of the Charter (“security of the person”) was violated when the state imposed prohibitions that have the effect of “prolonging the physical and psychological suffering of a person” and that “any provision which imposes an indeterminate period of senseless

⁵⁷ Court of Appeal for British Columbia, No. V01800, Victoria Registry, 8 March 1993, McEachern C.J., Proudfoot J., and Hollinrake J., 3.

⁵⁸ *Ibid.*, 4.

⁵⁹ *Ibid.*

⁶⁰ *Ibid.*, 5.

⁶¹ *Ibid.*, 11–12.

physical and psychological suffering upon someone who is shortly going to die anyway cannot conform with any principle of fundamental justice. Such a provision, by any measure, must clearly be characterized as the opposite of fundamental justice.”⁶²

Justice McEachern concluded that the prohibition against assisted suicide in this particular case had not passed the Oakes test set out in *R. v. Oakes*.⁶³ The test requires that the state must have “an objective or pressing and substantial concern in a free and democratic society” and that “there must be a proportionality between the objective and the impugned measure.”⁶⁴ For McEachern, s. 241 did not satisfy the minimum impairment established by the test: “By preventing others from assisting the Appellant, in her circumstances, to assert and enjoy the liberty and security of her person to which she is entitled, the section substantially ‘overshoots’ its purposes. By its operation, it therefore offends against her constitutional rights.”⁶⁵ Although legally defended to protect the vulnerable from abuse, the sanctity of life ethos also contributed to the suffering of other vulnerable populations (i.e., consenting, terminally ill adults).

In opposition to Justice McEachern, the majority relied on normative assumptions similar to those of other metaphysicians. For instance, Justice J.A. Hollinrake declared that the prohibition against physician-assisted suicide “has always been absolute,”⁶⁶ and the guiding principle underlying society’s approach to this issue “ha[s] always been, and continue[s] to be, the sanctity of life.”⁶⁷ Referencing the Law Reform Commission of Canada’s Working Paper 28, Justice Hollinrake reiterated the hypothetical possibility of a

⁶² *Ibid.*, 19; also see *Rodriguez v. British Columbia* (Attorney General), 3 S.C.R. 519 Docket: 23476 (1993), 25–26. <<http://scc.lexum.umontreal.ca/en/1993/1993rcs3-519/1993rcs3-519.html>>

⁶³ *R. v. Oakes*, [1986] 1 S.C.R. 103. 1985: March 12; 1986: February 28, Docket: 17550.

⁶⁴ Lori G. Beaman, *Defining Harm: Religious Freedom and the Limits of the Law*, 62–63.

⁶⁵ Court of Appeal for British Columbia, No. V01800, 11–12.

⁶⁶ *Rodriguez v. British Columbia* (Attorney General) (1993), 30.

⁶⁷ *Ibid.*, 30–31.

“slippery slope,” yet no evidence was provided. Hollinrake explained that “[t]he probable reason why legislation has not made an exception for the terminally ill lies in the *fear* of the excesses or abuses to which liberalization of the existing law *could lead* [italics mine].”⁶⁸

Moreover, Justice Hollinrake subscribed to absolute moral distinctions. With reference to global medical authorities, he described the difference between withdrawing treatment and ending a patient’s life as a distinction based on motive: “According to the Canadian, British, American, and World Medical Association, the withdrawal of treatment is to lessen suffering . . . while active euthanasia . . . is to cause death.”⁶⁹ Hollinrake emphasized that “motive” and “intent” were indeed relevant when explaining the inherent moral distinction between the doctrine of double effect and physician-assisted suicide: “Administering drugs to alleviate pain *knowing* that death will be hastened has a different intent than setting up an intravenous system which the patient can activate when he or she wants to die. In the former, the drugs are given to *lessen pain*; in the latter, the treatment is made available to *cause death* [italics mine].”⁷⁰ The distinction, however, creates two clear dilemmas in the legal sense. Firstly, when deciding on a charge of culpable homicide, even the Law Reform Commission of Canada admitted that the law does not rely on motive but intent, having already warned against

⁶⁸ Court of Appeal for British Columbia, No. V01800 (1993), 27. If perfectionism is required for safeguards, a myriad of hospital practices—from operations to routine checkups—would also have to be cancelled for fear of possible abuses. The same abuses that could potentially result from physician-assisted suicide apply equally to methods used in standard medical practice, but the “slippery slope” is only applied to the former. For clarification, see R.G. Frey, “The Fear of a Slippery Slope,” in *Euthanasia and Physician-Assisted Suicide: For and Against*, edited by Gerald Dworkin, et al., 43-63; also see Jocelyn Downie, *A Case for Decriminalizing Euthanasia & Assisted Suicide in Canada*, 9, 10, 12, 68, 84, 88, 96–99, 132, 142.

⁶⁹ Ibid., 28.

⁷⁰ Ibid., 32–33.

using motive as a legal defence.⁷¹ According to the Commission, the theoretical inclusion of motive as a mitigating circumstance in the intentional hastening of death would prove difficult to ascertain due to the “precise determination of the ‘purity’ of the motives of the accused.”⁷² Therefore, in establishing culpability and *mens rea*, the agent only needs to *know* his act is likely to cause death; motive is irrelevant.⁷³

Yet Hollinrake could not concur with Justice McEachern that Rodriguez’s security interests were being deprived. In Hollinrake’s opinion, “[T]he appellant is one of the very persons that it is the focus of s. 241(b) to protect.”⁷⁴ However, a paradox existed. The paternalistic intent of s. 241(b) was meant to protect the vulnerable against coercion, but as previously mentioned, it was simultaneously contributing to Rodriguez’s eventual suffocation. Although Hollinrake could “appreciate the irony of it” [the prolongation of her suffering], he remained steadfast that Rodriguez’s deprivation of the security of her person “is one that accords with the principles of fundamental justice” and that s. 241(b) was “in keeping with the concept of the sanctity of life.”⁷⁵

The majority opinion was also supported by Justice J.A. Proudfoot. Justice Proudfoot could only reiterate “slope” concerns using hypothetical situations: “[T]o decriminalize the act of aiding, abetting or counselling suicide would therefore not be a valid legislative policy” because one could incite “mass suicides” or take advantage of an “adolescent’s suicidal tendencies.”⁷⁶ Proudfoot was not convinced that any critical mass

⁷¹ Law Reform Commission of Canada (Working Paper 28), 48.

⁷² Law Reform Commission of Canada, *Report on Euthanasia, Aiding Suicide and Cessation of Treatment*, 19.

⁷³ Law Reform Commission of Canada (Working Paper 28), 18;

⁷⁴ Court of Appeal for British Columbia, No. V01800 (1993), 34.

⁷⁵ *Ibid.*, 35.

⁷⁶ *Ibid.*, 39. It is interesting to note that after Canada decriminalized suicide in 1972, “mass suicides” did not occur. In 1972, the suicide rate was 13.4 per 100,000 deaths, but by 1999 the rate had fallen to 13.0 per 100,000 deaths. See *Statistics Canada*, “Suicide Death Rates (x 100,000): Canada and the Provinces: Both

of support existed for acts of commission, insisting that “we are in no position to assess the consensus in Canada with respect to assisted suicide.”⁷⁷ However, this was not completely accurate. When Sue Rodriguez lost her Supreme Court battle in 1993, seven out of ten Canadians supported physician-assisted suicide for the terminally ill.⁷⁸

In late 1993, the Supreme Court of Canada further acknowledged the dilemma between compassion for Rodriguez’s lived reality and the desire to safeguard communal values. Rodriguez’s condition was described as “rapidly deteriorating,” meaning that she would “soon lose the ability to swallow, speak, walk, and move her body without assistance.”⁷⁹ Worse still, she would “lose the capacity to breathe without a respirator,” and her life expectancy was “between 2 and 14 months.”⁸⁰ Therefore, the prohibition against assisted-suicide caused the Appellant “physical pain and psychological stress in a manner which impinges on the security of the person.”⁸¹ It was a fate *Montreal Gazette* columnist William Johnson termed “worse than death.”⁸² Even with irrefutable evidence of the physical and psychological anguish to come, the sanctity of life’s communitarian force would not be easily repelled.

The importance of the sanctity doctrine began to emerge as the legal drama unfolded. Although everyone had the right to life, liberty, and security of the person under s. 7 of the Charter, one could only be deprived of this right “in conjunction with the

Sexes,” Vital Statistics Mortality Database from 1950 to 1999, Historical Death Shelf Tables for Summary List of Causes (Ottawa: Health Statistics Division). <www.stats.can.gc.ca.>

⁷⁷ Ibid., 39, 41.

⁷⁸ Juliet O’Neill, “Majority of Canadians Want to Legalize Doctor-assisted Suicide, Poll Shows,” *Ottawa Citizen*, 10 June 2007, A5.

⁷⁹ *Rodriguez v. British Columbia* (Attorney General) (1993), 2–3.

⁸⁰ Ibid.

⁸¹ Ibid., 4.

⁸² William Johnson, “Rodriguez Shouldn’t Be Condemned to Slow Death,” *Ottawa Citizen*, 22 May 1993, A8.

principles of fundamental justice.”⁸³ Hence, the Court’s majority—Justices John Sopinka, Gerard La Forest, Charles Gonthier, Frank Iacobucci, and Jack Major—emphasized that human life should not be depreciated by allowing life to be taken, a collectivist claim based on the construct “sanctity of life.”⁸⁴ Speaking for the majority, Justice Sopinka emphasized that the Court’s interpretation of the sanctity doctrine was based on Ronald Dworkin’s book *Life’s Dominion* (1993). Sopinka stated that he was interpreting “sacred” in the “non-religious sense” directly from the book.⁸⁵ However, the majority of the Court had actually co-opted a religious model of the sacred from Dworkin’s text, not a secular interpretation as had been claimed by Sopinka. This meant that the Court’s secular justifications surrounding the sanctity of human life had, in fact, contained “traces” of the Christian religious tradition.

Dworkin had outlined two distinct positions regarding the responsibility of government in safeguarding human life. From a secular viewpoint, the state supported the *derivative* objection by protecting those who have established rights and interests derived from the constitution. However, Dworkin’s second position, the *detached* objection, meant that if human life possesses intrinsic, innate value, abortion and euthanasia could be argued as legally and morally *unjustifiable*.⁸⁶ In the case of the *detached* objection, moral authority is not derived from a secular constitution but from the “sanctity of life” itself. From this standpoint, sanctity of life advocates would adopt *a priori* the position that human life possesses sacred value, a philosophical premise that

⁸³ Margaret Smith, *The Rodriguez Case: A Review of the Supreme Court of Canada Decision on Assisted Suicide* (Ottawa: Law and Government Division, Research Branch, 1993), 2.

⁸⁴ “The Rodriguez Decision: Majority Says Ban on Assisted Suicide Doesn’t Violate Charter,” *Ottawa Citizen*, 1 October 1993, A11.

⁸⁵ *Rodriguez v. British Columbia* (Attorney General) (1993), 80–81.

⁸⁶ Ronald Dworkin, *Life’s Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom*, 11.

“does not depend on or presuppose any particular rights or interests.”⁸⁷ Simply put, life—irrespective of quality or kind—is intrinsically valuable. This particular interpretation of “sacred” was, in actuality, religious in nature, something that presupposed stewardship. If Canadian justices (the majority) were truly siding with Dworkin’s non-religious interpretation, then only a *derivative* objection—one that depended on constitutional rights—was valid since this was truly Dworkin’s bias.⁸⁸

To justify their metaethical stance, the majority also relied on the “slippery slope” as self-evident. Those subscribing to this premise assume that euthanasia and assisted suicide are threatening to the greater community. Basically, “society’s value systems would be deeply affected, and there would always be a lingering problem of erroneous diagnosis, abuse, and neglect, and undue risks for society’s most vulnerable members.”⁸⁹ For the majority, this implied that human life must be respected because any weakening of the sanctity of life ethos as first principle would lead to abuse, create targets of the vulnerable (sick, elderly, and disabled), and fail to provide the necessary safeguards for physician-assisted suicide.⁹⁰ Justice Sopinka was initially concerned with the legalization of both euthanasia and physician-assisted suicide in Holland, fears based largely on the claim that patients were being killed *against* their consent. According to Sopinka, “Critics of the Dutch approach point to evidence suggesting that *involuntary* active euthanasia (which is not permitted by the guidelines) is being practised to an increasing

⁸⁷ Ibid.

⁸⁸ Ibid., 217. In Dworkin’s own words, “Making someone die in a way that others approve, but he believes a horrifying contradiction to his life, is a devastating, odious form of tyranny.”

⁸⁹ Beauchamp, Tom L., *Intending Death: The Ethics of Assisted Suicide and Euthanasia*, 15.

⁹⁰ *Rodriguez v. British Columbia* (Attorney General) (1993), 80–81.

degree. This worrisome trend supports the view that a relaxation of the absolute prohibition takes us down ‘the slippery slope.’”⁹¹

However, the human reality of Rodriguez’s suffering was not lost on Justice Peter Cory in dissent. Dismissing any value in suffering, he declared: “State prohibitions that would force a dreadful, painful death on a rational but incapacitated terminally ill patient are an affront to human dignity.”⁹² Cory also rejected the belief in inherent moral distinctions between acts of omission and commission, claiming:

There is no difference between permitting a patient of sound mind to choose death with dignity by refusing treatment and permitting a patient of sound mind who is terminally ill to choose death with dignity by terminating life preserving treatment, even if, because of incapacity, that step has to be physically taken by another on her instructions. Nor is there any reason for failing to extend that same permission so that a terminally ill patient facing death may put an end to her life through the intermediary of another.⁹³

Since Rodriguez was condemned to a slow death, and by means she had not chosen,⁹⁴ Cory’s remarks were anything but hypothetical. Nevertheless, the majority’s affinity for liberal communitarianism⁹⁵ meant walking a fine line between justifying the prolongation of suffering to protect society and denying that such suffering was too excessive or burdensome. According to the majority, s. 241(b) of the *Criminal Code* “deprive[d] the appellant of autonomy” and “cause[d] her physical pain and psychological stress,” but such deprivation was “not contrary to the principles of fundamental justice” nor was the Appellant subjected by the state to “any form of cruel

⁹¹ Ibid., 100.

⁹² Ibid., 11.

⁹³ Ibid., 12.

⁹⁴ William Johnson, “Rodriguez Shouldn’t Be Condemned to Slow Death,” A8.

⁹⁵ Ezekiel J. Emanuel, *The Ends of Human Life: Medical Ethics in a Liberal Polity*, 8. According to Emanuel, liberal communitarianism means that those arriving at foundational principles are “guaranteed rights necessary for participation in democratic deliberations”; moreover, such a resolution is communitarian in that deliberations aim to articulate “a common conception of the good life that informs laws and policies.”

and unusual treatment or punishment.”⁹⁶ When any first principle is embraced as absolute, suffering will be rationalized to protect its “sacredness.” The symbolic—and, thus, objectivistic metaphysics—becomes more important than one’s lived reality. This is what Gianni Vattimo means when he refers to the “neurotic mindset of metaphysics.”⁹⁷

Justices Claire L’Heureux–Dubé and Beverly McLachlin also confronted the limitations of the sanctity of life ethos as absolute. As with Justice McEachern previously, their comments addressed how a blanket prohibition failed the Oakes test: “A particular limit will be arbitrary if it bears no relation to, or is inconsistent with, the objective that lies behind the legislation.”⁹⁸ If the objective was to prevent abuse and protect the vulnerable, Justices L’Heureux–Dubé and McLachlin questioned how this could be accomplished by prolonging the suffering of a vulnerable patient afflicted with ALS. Moreover, L’Heureux–Dubé and McLachlin pointed out that the Court could not rely on liberal communitarianism as a democratic compromise, let alone a legal measure, since “[t]he principles of fundamental justice require that each person, considered *individually*, be treated fairly by the law. . . [emphasis mine].”⁹⁹

Chief Justice Lamer also questioned the validity of the “slippery slope” and its communal foundations. Recalling the repeal of the offence of attempted suicide in 1972, Lamer suggested that this was due to Parliament’s “unwillingness to enforce the protection of a group containing many vulnerable people (i.e., those contemplating suicide) over and against the freely determined will of an individual set on terminating

⁹⁶ *Rodriguez v. British Columbia* (Attorney General) (1993), 4, 6.

⁹⁷ Vattimo, *After Christianity*, 118.

⁹⁸ “The Rodriguez Decision: Majority Says Ban on Assisted Suicide Doesn’t Violate Charter,” A11.

⁹⁹ *Ibid.*

his or her life.”¹⁰⁰ In his view, this was a strong indication that “[s]elf determination was now considered the paramount factor in the state regulation of suicide.”¹⁰¹ As well, if no external interference or coercion could be demonstrated to have occurred, then “the act of attempting suicide could no longer give rise to criminal liability.”¹⁰² This led the Chief Justice to ask: “[C]an it be said that the intent of Parliament in retaining s. 241(b) after repealing the offence of attempted suicide was to acknowledge the primacy of self-determination for physically able people alone?”¹⁰³ While Justice Lamer did “share a deep concern over the subtle and overt pressures that may be brought to bear on such persons if assisted suicide is decriminalized,” he admitted to a major weakness in relying on the theoretical possibility of abuse: “I do not think legislation that deprives a disadvantaged group of the right to equality can be justified solely on such speculative grounds.”¹⁰⁴ Justice Lamer concluded that “fear of a ‘slippery slope’ cannot . . . justify the over-inclusive reach of the Criminal Code to encompass not only people who may be vulnerable to the pressure of others but also persons with no evidence of vulnerability, and, in the case of the appellant [Sue Rodriguez], persons where there is positive evidence of freely determined consent.”¹⁰⁵ In his final analysis of the situation, Lamer stayed with the evidence, that being Rodriguez’s lived reality: “What we do know and cannot ignore is the anguish of those in the position of Ms. Rodriguez.”¹⁰⁶

The Chief Justice also addressed the viability of safeguards. He agreed that Rodriguez was eligible for a constitutional exemption as long as certain guidelines were

¹⁰⁰ Chief Justice Lamer, C. J., in Michael Stingl, ed., *The Price of Compassion: Assisted Suicide and Euthanasia*, 64.

¹⁰¹ *Ibid.*

¹⁰² *Ibid.*

¹⁰³ *Ibid.*

¹⁰⁴ *Ibid.*, 66.

¹⁰⁵ *Ibid.*

¹⁰⁶ *Rodriguez v. British Columbia (Attorney General)* (1993), 59–60.

followed. The exemption implied that s. 241(b) of the Criminal Code “violate[d] [Rodriguez’s] constitutionally guaranteed rights and that, upon compliance with certain conditions, neither the Appellant nor any physician assisting her to attempt to commit, or to commit suicide, will by that means commit any offence against the law of Canada.”¹⁰⁷ Lamer was not suggesting an “anything goes” form of strong relativism¹⁰⁸ or some alternate metaphysic to replace the sanctity doctrine. However, he noted having been “unpersuaded by the government’s apparent contention that it is not possible to design legislation that is somewhere in between complete decriminalization and absolute prohibition.”¹⁰⁹ Therefore, Chief Justice Lamer summarized the conditions for a constitutional exemption: (1) the patient must be competent and make the choice to end his/her life freely; (2) the applicant maintains the continuing right to change his/her mind; (3) at least one doctor must be present; (4) the act causing the death of the applicant must be that of the applicant him/herself, not anyone else; and (5) the Regional Coroner must be notified.¹¹⁰ Lamer added that these tenets were indeed flexible, “tailored to the particular circumstances of Ms. Rodriguez, and that “each application must be considered in its own individual context.”¹¹¹ He acknowledged that safeguards could even be

¹⁰⁷ Ibid., 70.

¹⁰⁸ Roy Bhaskar notes the dilemma over *strong relativism*. Its acceptance means that “all beliefs (statements) are equally valid, in the sense that there can be no (rational) grounds for preferring one to another.” Vattimo also warns of the trap in which one absolute is replaced by any number of objectivistic metaphysical premises. In his words, “There is a risk attached to taking a step backward, distancing ourselves from the concrete alternatives, which . . . may lead to the adoption of a relativistic metaphysics. Relativism [strong] can perfectly well be described as metaphysical because only from a position strongly anchored in some universal point of view can (should we) gaze on multiplicity as multiplicity. Relativism [strong], one might say, is the (self-contradictory and impractical) metaphysical rigidification of finitude.” See Roy Bhaskar, *The Possibility of Naturalism: A Philosophical Critique of the Contemporary Human Sciences* (Brighton: The Harvester Press, 1979), 73–74; also see Vattimo, *Nihilism and Emancipation: Ethics, Politics, and Law*, 42.

¹⁰⁹ Chief Justice Lamer, C. J., in Michael Stigl, ed., *The Price of Compassion: Assisted Suicide and Euthanasia*, 67.

¹¹⁰ *Rodriguez v. British Columbia* (Attorney General) (1993), 73–74.

¹¹¹ Ibid., 74.

developed for other death-hastening scenarios, hinting that perhaps euthanasia could become a viable option: “[W]hy should [Sue Rodriguez] be prevented the option of choosing suicide should her physical condition degenerate to the point where she is no longer even physically able to press a button or blow into a tube? Surely it is in these circumstances that assistance is required most.”¹¹²

To summarize, the Supreme Court’s majority could have declared that laws concerning euthanasia and assisted suicide belonged to the jurisdiction of Parliament, implying that they were not in the business of “making law.” However, their discourses indicate that another kind of reasoning was at play, one that went beyond a legal framework. Because of their affinity for the *qualified* sanctity of life ethos, the Supreme Court’s majority deemed an intentionally hastened death socially harmful and decriminalization too risky. A grand narrative was posited—the “slippery slope”—without any detailed evidence to substantiate such a claim. As well, the metaphysical construct “sanctity of life” took precedence over Rodriguez’s self-determination. The 5/4 split by the Supreme Court of Canada guaranteed not only the constitutionality of the law, but also maintained a Vattimian form of *metaphysics* that was called into question by an “event of being” (i.e., Rodriguez’s lived reality). This absolutist bias, one that had been reinforced by the Law Reform Commission of Canada, was once again secure.

However, the status quo meant real consequences for the terminally ill. Essentially, Rodriguez was left with two options: defer to the law and die of suffocation or defy the law and ask a physician to hasten her death. In the end, she chose the latter.¹¹³ Nonetheless, Rodriguez had hoped her quest for legalized physician-assisted suicide

¹¹² Ibid., 72.

¹¹³ Chris Wood, “The Legacy of Sue Rodriguez,” 23.

would serve some practical purpose. In her words: “I hope that my going public with my request for physician-assisted suicide will help others in the future.”¹¹⁴ From a Vattimian perspective, Rodriguez’s unique circumstances entered the collective consciousness of a nation as an “event of being.” According to Vattimo, eventuation allows “new senses of experience, new ways for the world to announce itself.”¹¹⁵ Rodriguez was attempting to reemphasize the importance of *eudaimonistic* ethics in which death decisions are made by evaluating an individual’s entire life in a holistic manner.¹¹⁶ She believed that citizens not only shaped their own destinies but also their own deaths, according to how they lived and what they believed.¹¹⁷ Therefore, Rodriguez was challenging the reigning absolute—the *qualified* sanctity of life ethos—as well as the “objective” normative assumptions that maintained it, namely, stewardship, justifications for prolonged suffering, and the “slippery slope.”

The Supreme Court of Canada’s majority simply could not acknowledge two possibilities: first, that the sanctity of life ethos was a competing principle in law, rather than an absolute one; and second, that the sanctity doctrine could also be, in the Vattimian sense, a source of suffering and/or violence. As painful and as unbearable as Rodriguez’s condition would eventually become, the Court’s majority sided with Vattimo’s concept of *metaphysics* over the lived experiences that call absolutes into question. Dennis Kaye, an acquaintance of Rodriguez’s and victim of ALS, made a direct link between a communal metaphysic preferred by the Supreme Court and maleficence: “By ruling as they did, the judges in effect told Canadians that it’s

¹¹⁴ Sue Rodriguez, “Death with Dignity: Reflections by Sue Rodriguez,” B3.

¹¹⁵ Vattimo, *After Christianity*, 67.

¹¹⁶ Paul Carrick, *Medical Ethics in Antiquity: Philosophical Perspectives on Abortion and Euthanasia*, 100.

¹¹⁷ Lisa Hobbes Birnie and Sue Rodriguez, *Uncommon Will: The Death and Life of Sue Rodriguez*, 154, 169–170.

acceptable for individuals to suffer, so long as we appease the collective conscience.”¹¹⁸

Rodriguez understood the impact of metaphysics on her lived reality. After her defeat in the Supreme Court, she declared: “I have decided to end my life . . . because the suffering from ALS is unbearable *to me* [emphasis mine].”¹¹⁹ In the end, it was Rodriguez herself who directed the discussion away from metaphysics and toward a “quality of life” ethic by asking, “[D]o you *really* understand what it’s like to live in a body that is already dead?”¹²⁰

Facta of the Interveners: Religious Opposition

Facta of the interveners in the Rodriguez case initially reveal how religiously affiliated lobby groups—those advocating for the sanctity of life ethos as first principle—embrace the rhetoric surrounding stewardship, value in prolonged suffering, and the “slippery slope.” Two Christian organizations, the Canadian Conference of Catholic Bishops and the Evangelical Fellowship of Canada, lobbied to bring “a moral, philosophical and spiritual perspective to a number of critical public policy issues” and to promote “a life affirming ethic within Canadian culture.”¹²¹ Referencing the Law Reform Commission of Canada from 1976, both religious bodies admitted that criminal law was, in actuality, a system of applied morality: “When acts occur that seriously transgress essential values, like the sanctity of life, society must speak out and affirm those values.”¹²² The interveners asserted that the supremacy of God was “a fundamental

¹¹⁸ Wood, “The Legacy of Sue Rodriguez,” 23.

¹¹⁹ Ibid.

¹²⁰ Hobbes Birnie and Rodriguez, *Uncommon Will: The Death and Life of Sue Rodriguez*, 154.

¹²¹ Factum of the Interveners, *Rodriguez v. British Columbia*, No. 23476, Canadian Conference of Catholic Bishops and the Evangelical Fellowship of Canada (10 May 1993), 1.

¹²² Ibid., 4.

aspect of the Charter and should be expressly recognized and applied by the courts in interpreting and shaping the fundamental rights and freedoms guaranteed by the Charter.”¹²³ What followed, therefore, was both an unwavering belief in stewardship and the normative assumptions this encompasses: “The Interveners believe that human beings, created in the image of God, have inherent worth and dignity. Human life, therefore, must be valued, respected and protected throughout all its stages. We are stewards of what God has entrusted to us.”¹²⁴

Supporting an ethic of communalism, the Interveners argued that risks to the majority outweighed minority or individual concerns. Hence, the dilemma over euthanasia and assisted suicide was not about “a single person not to have continuing pain and psychological trauma imposed on her” but whether or not sanctioning physician-assisted suicide “helps or hinders the common good.”¹²⁵ Since the sanctity doctrine implied a “basic trust that human life and dignity be respected and protected,” the Interveners suggested that euthanasia and assisted-suicide “erode[d] this trust and undermine[d] the community’s commitment to life and responsibility to care and comfort.”¹²⁶ As a specific example of potential social danger, the image of Nazi eugenics was conjured up to make a case against physician-assisted suicide: “Such a law would indeed effect a slippery slope. How long would it be before we would move from seeing old people deciding to eliminate themselves to watching society deciding to eliminate them, together with the handicapped, the powerless, the gullible, and the uneducated?”¹²⁷

¹²³ Ibid., 5.

¹²⁴ Ibid., 6.

¹²⁵ Ibid., 13, 14.

¹²⁶ Ibid., 15.

¹²⁷ Ibid., 16.

Objectivistic metaphysics was also central to the rhetoric of the Pro Life Society of British Columbia and the Pacific Physicians for Life Society (“the Interveners”), organizations devoted “to promoting respect for the sanctity of human life.”¹²⁸ Initially, both lobbyists stressed how physician-assisted suicide was a threat to metaphysics: “The commencement of state sanctioned physician-aided suicide would signal a dramatic weakening in our society’s commitment to the sanctity of life. The intrinsic worth of a human life, independent of utilitarian calculations as to its value or ‘quality,’ has always been a guiding principle and fundamental belief of our society.”¹²⁹ The Interveners also stipulated that Rodriguez, like any other Canadian, could not ask the judiciary to sanction an intentionally hastened death. The *qualified* version of the sanctity doctrine meant that the omission/commission distinction was absolute; thus, a “natural” death was her only option: “The Appellant [Sue Rodriguez] enjoys the same right as all Canadians to live with dignity to the fullest that her *natural condition and circumstances permit* [emphasis mine].”¹³⁰ As with other “objective” claims, the killing/allowing to die distinction was upheld. The Interveners clarified that while “no one was required by law to extend his or her life beyond its natural duration by artificial means (i.e., by accepting or sustaining treatment), attempting by a specific act to directly and intentionally end one’s life was unlawful and criminal.”¹³¹

¹²⁸ Factum of the Interveners, *Rodriguez v. British Columbia*, No. 23476, Pro Life Society of British Columbia and the Pacific Physicians for Life Society (14 May 14 1993), 1.

¹²⁹ Ibid, 6. The Interveners were so protective of the sanctity of life ethos that they performed an “ontological substitution.” Sue Rodriguez’s lived reality was actually decentred in favour of the empirical results of other dying patients. Quoting two studies at an ALS hospice in England, case histories of over 200 ALS patients were used to counter Rodriguez’s claim that she would eventually suffocate to death. “Nearly all the patients died peacefully (choking attacks ‘are rarely a cause of death’).” See page 12 of the factum.

¹³⁰ Ibid., 2.

¹³¹ Ibid., 3.

The Interveners then presented Canada's per capita suicide rates as evidence of a "slippery slope," suggesting that suicide rates "[had] been rising in Canada since 1945" and that the rate "remain[ed] at its highest level in history."¹³² The Interveners added that the incidence of suicide was affected by external factors, one of which was its social acceptance: "Any change in the law demonstrating a greater tolerance of suicide has the potential to increase its frequency."¹³³ Although the highest suicide rates in Canada occurred in the 1970s, the Interveners neglected to mention that these rates had been in a slow, steady decline since the decriminalization of suicide in 1972. Thus, liberalization of the law coincided with lower rates of suicide on the per capita basis in Canada.¹³⁴ Nonetheless, the Interveners were convinced that a domino effect existed:

"[C]ondonation of physician-aided suicide diminishes respect for the worth of an individual's life, which in turn leads to a loss of self-respect, which in turn leads to an increased risk of suicide, [which] could well affect groups other than the elderly such as the mentally or physically handicapped."¹³⁵ That said, the Interveners were quick to admit that claims of social danger and risk were speculative at best: "It is virtually impossible," they admitted, "to predict the impact . . . of the unprecedented triumph of 'autonomy' over the state interest in protecting life in the area of suicide. This is especially true of the criminal law."¹³⁶

¹³² Ibid., 8–9.

¹³³ Ibid.

¹³⁴ Suicide rates on a per capita basis in Canada went from 13.4 per 100,000 in 1972 to 13.0 per 100,000 in 1998. See Stéphanie Langlois and Peter Morrison, "Suicide Deaths and Attempts," *Canadian Social Trends* (Autumn 2002): 21; also see *Statistics Canada*, "Suicides, and Suicide Rate, by Sex and by Age Group," <www40statscan.ca/01/cst01/health01/htm>

¹³⁵ Factum of the Interveners, *Rodriguez v. British Columbia*, Pro Life Society of British Columbia and the Pacific Physicians for Life Society, 11.

¹³⁶ Ibid., 13.

Secular Opposition and “Civil Rights” Discourse

In rare cases, secular organizations opposed physician-assisted suicide under a “civil rights” discourse or “equality metaphysic.” For instance, People in Equal Participation Incorporated (PEP) were dedicated to “enhancing the quality of life for the disabled.”¹³⁷ Although there was “no question that the Appellant’s circumstances [were] compelling,” so were “the concerns of disabled persons who [were] being denied adequate resources to live independently in the community.”¹³⁸ This led PEP to conclude that “the severely disabled [were] not going to be given the appropriate opportunities . . . before choosing death,” and therefore would not be “afforded equal protection under the law.”¹³⁹

Supporting a communal ethos, PEP’s members considered themselves “a vulnerable group in Canadian society . . . concerned about the broad social policy implications” if section 241(b) were declared invalid.¹⁴⁰ Furthermore, PEP’s general position was utilitarian in that preventing an intentionally hastened death was regarded as a maximum good. Although section 241 (b) of the *Criminal Code* had an “indirect effect” on Sue Rodriguez, her individual request for assistance in suicide must be denied because “a declaration of invalidity [would] have a very substantial impact on a much broader constituency of vulnerable persons in need of protection.”¹⁴¹ Ironically, PEP did acknowledge that section 241(b) “ha[d] the effect of discriminating against [Rodriguez] by virtue of the degree of her physical disability” and that the Appellant’s “degree of

¹³⁷ Factum of the Interveners, *Rodriguez v. British Columbia*, No. 23476, People in Equal Participation Incorporated (10 May 1993), 1.

¹³⁸ *Ibid.*, 3.

¹³⁹ *Ibid.*, 4.

¹⁴⁰ *Ibid.*, 1.

¹⁴¹ *Ibid.*, 7

disability [would] prevent her from ending her life in a quick and painless manner—an option which [was] available to others in society.”¹⁴² However, section 241(b) was saved, and the prolongation of Rodriguez’s suffering justified, “by the operation of section 1 of the Charter.”¹⁴³

Although the Right to Die Society of Canada (“the Society”) adopted the rhetoric of quality of life advocates, it too embraced a civil rights discourse in the form of absolute equality. The Society reminded the Court that although the Law Reform Commission of Canada had advocated prohibition, citing “concerns over possible abuses,”¹⁴⁴ the Commission had indicated that the criminal provision involving aiding and abetting was “very rarely involved in practice.”¹⁴⁵ If section 241(b) was meant to preserve the sanctity of life ethos, the Society pointed out that in 1972 “the offence of attempted suicide would have been maintained.”¹⁴⁶ Moreover, the evidence indicated that rigid application of the sanctity of life ethos created more suffering for those afflicted with ALS, such as Sue Rodriguez. According to the Society, “Serious state-imposed psychological stress may also constitute a breach of security of the person” as it had with the prohibition of abortion.¹⁴⁷

Autonomy and self-determination were also of paramount importance to the Society’s mandate. It claimed that, although abortion and assisted suicide were different issues, they were the same in principle: “By denying a group of individuals the right to control the circumstances of their dying, section 241(b) of the Criminal Code, both in its

¹⁴² Ibid.

¹⁴³ Ibid.

¹⁴⁴ Factum of the Interveners, *Rodriguez v. British Columbia*, No. 23467, The Right to Die Society of Canada (18 May 1993), 4.

¹⁴⁵ Ibid.

¹⁴⁶ Ibid., 14.

¹⁴⁷ Ibid., 6.

purpose and in its effect, violates each of the rights guaranteed by section 7 of the *Charter* in a manner which is contrary to the principles of fundamental justice.”¹⁴⁸ As a result, the individual is “denied control over his or her bodily integrity, possibly at great physical pain, but without doubt, at great emotional pain.”¹⁴⁹ The Society also claimed that choice over when and under what circumstances one wished to die was paramount to liberty: “Without the freedom to choose and control these factors, the liberty to choose to die is meaningless.”¹⁵⁰ By protecting the life, liberty, and security of the person, s. 7 of the *Charter* was based on a “respect for personal autonomy and individual self-determination” because such traits “relate[d] to an individual’s physical or mental integrity and the individual’s control over these.”¹⁵¹

Ironically, even with their rejection of the sanctity of life ethos as first principle, and the consistent use of quality of life rhetoric, the Right to Die Society still could not accept a constitutional exemption for Rodriguez. Three reasons dominated the Society’s thinking: (1) any drafting considerations would fail to take into account other individual situations as compelling as Rodriguez’s; (2) no readily definable criteria for physician-assisted suicide existed that would provide the appropriate degree of certainty and predictability; and (3) legal considerations for physician-assisted suicide were best left to Parliament.¹⁵² With respect to the first reason, the Right to Die Society shared a similar

¹⁴⁸ *Ibid.*

¹⁴⁹ *Ibid.*, 7.

¹⁵⁰ *Ibid.*, 8. Frithjof Bergmann notes that “an act is free if the agent identifies with the elements from which it flows; it is coerced if the agent disassociates himself from the element which generates or prompts the action.” This means that “identification is logically prior to freedom, and that freedom is not a primary but a derivative notion.” Therefore, the primary condition of freedom, according to Bergmann, is “the possession of an identity or a self—freedom is the acting out of that identity.” See Frithjof Bergmann, *On Being Free* (Notre Dame, Indiana: University of Notre Dame Press, 1977), 37.

¹⁵¹ *Ibid.*, 6.

¹⁵² *Ibid.*, 19–20.

absolutist metaphysic—*equality*—with People in Equal Participation Incorporated (PEP).

Intervenors as Vattimian Postmodernists

In contrast, those groups which supported the Appellant's constitutional argument focused on Rodriguez's self-determination, questioned the value of prolonged suffering, and suggested a more open approach to safeguards. In direct opposition to PEP above, the goal of the British Columbia Coalition of People with Disabilities ("the Coalition") was "to facilitate the full participation of people with disabilities in society by promoting independence and self-help."¹⁵³ Preferring a subjective evaluation of human worth, the Coalition emphasized the impact of ALS on Rodriguez's lived reality:

S. 241(b) adversely affects the Appellant because she suffers from Amyotrophic Lateral Sclerosis (Lou Gehrig's disease) and her condition will at some point deteriorate until she will be physically incapable of ending her own life without assistance. She wants to be able to determine the timing and manner of her death, so that it is consistent with her conception of human dignity.¹⁵⁴

Rather than rely on hypothetical scenarios involving "slope" possibilities, the Coalition highlighted Rodriguez's ontology of actuality: "S. 241(b) has the effect of imprisoning the Appellant . . . who no longer wish[es] to continue living in what for [her] has become a life of unbearable and unrelenting physical or mental suffering."¹⁵⁵

As well, the Coalition adopted the position of the "slippery slope" by using its own logic against it: "[S. 241(b)] converts [Rodriguez's] 'right to life' into a burden or 'duty to live,' and thereby deprives [her] of equality before and under the law, which allows able-bodied persons the choice of ending their suffering."¹⁵⁶ The Coalition elaborated on a further irony. The metaphysical construct "sanctity of life" created an

¹⁵³ Factum of the Intervenors, *Rodriguez v. British Columbia*, No. 23476, British Columbia Coalition of People with Disabilities (May 13, 1993), 1.

¹⁵⁴ *Ibid.*, 2.

¹⁵⁵ *Ibid.*, 6.

¹⁵⁶ *Ibid.*

equally harmful stereotype in that “persons with disabilities [were] inherently less capable than others of being entrusted with fundamental decisions about their lives.”¹⁵⁷

In general, a constitutional exemption for Rodriguez did not imply the negation of all safeguards for “vulnerable” populations but, rather, flexibility for ontological difference within the *Criminal Code*. As the Coalition admitted, “If the objective of s. 241(b) is to protect the vulnerable, a personal exemption for the Appellant could not be inconsistent with that purpose.”¹⁵⁸

Support from the Coalition of Provincial Organizations of the Handicapped (COPOH) proved that the concepts of disability and vulnerability could not be essentialized under the banner of communalism. Instead, COPOH intervened for “the purpose of supporting autonomy and self-determination of persons who, because of physical disabilities, are unable to commit suicide without some assistance.”¹⁵⁹ Their mandate of choice was “a testament to which self-determination and autonomy are seen . . . as essential components of true equality.”¹⁶⁰ Therefore, Sue Rodriguez could not be labelled as “vulnerable” because she was a “highly competent individual,” one who had “consistently requested control over her own body,” and “there [did] not appear to be anyone in a position of trust or authority . . . who [was] exercising undue influence over her decision.”¹⁶¹

COPOH admitted that their position on autonomy was in no way absolute. They still wanted procedural safeguards in place “to ensure that assisted suicides . . . [were] in

¹⁵⁷ Ibid., 14.

¹⁵⁸ Ibid., 19.

¹⁵⁹ Factum of the Interveners, *Rodriguez v. British Columbia*, No. 23476, Coalition of Provincial Organizations of the Handicapped (17 May 1993), 1.

¹⁶⁰ Ibid., 19.

¹⁶¹ Ibid., 18.

fact as a result of informed mentally competent decision-making, free from coercion or undue influence.”¹⁶² Even for those in Rodriguez’s predicament, COPOH realized that vulnerability could potentially exist, but they concluded that an open system with strict guidelines “should enhance rather than displace the decision made by a person who might require assistance to commit suicide.”¹⁶³ Therefore, the tension between vulnerability and autonomy was not an either/or dilemma. According to COPOH, “Statutory and procedural safeguards can be designed which will strengthen protections against vulnerable people from being pressured or coerced into committing suicide, while still enabling mentally competent persons to exercise self-determination and achieve independence.”¹⁶⁴

Finally, Dying with Dignity focused on the autonomy rights of the individual. Quoting Madam Justice Wilson in *R. v. Morgentaler*, emphasis was placed on self-determination over perfectionism:

The idea of human dignity finds expression in almost every right and freedom guaranteed in the Charter. Individuals are afforded the right to choose their own religion and their own philosophy of life . . . the state will respect choices made by individuals and, to the greatest extent possible, will avoid subordinating these choices to any one conception of the good life.¹⁶⁵

¹⁶² Ibid., 1–2.

¹⁶³ Ibid., 14.

¹⁶⁴ Ibid., 12.

¹⁶⁵ Factum of the Interveners. *Rodriguez v. British Columbia*, No. 23476, Dying with Dignity (11 May 1993), 3. There can be more than one interpretation of perfection as “the good.” The Aristotelian version highlighted by Joseph Heath becomes problematic because it is believed that there is “a specific set of virtues common to all of us as humans, and that our goal should be to cultivate these virtues to the highest degree.” Other authors, such as Michael J. Hyde, define perfection as an ideal or sense of excellence. For Hyde, perfection can be both a benefit and a burden. If taken to an extreme, one can be “rotten with perfection.” However, if no sense of excellence is desired, one can become “rotten with imperfection.” Even Hyde admits that when taken to a god-like ideal, perfection can “condition its possessors to marginalize what is other than itself and to see this otherness and its difference as being threatening, perhaps requiring extermination.” See Joseph Heath, *The Efficient Society: Why Canada Is as Close to Utopia as It Gets* (Toronto: Viking Press, 2001), 27; also see Michael J. Hyde, *Perfection: Coming to Terms with Being Human*, 1–17.

Referencing an American Supreme Court case, *Re Conroy*, in which life-sustaining treatment could be withdrawn from terminally ill, incompetent patients,¹⁶⁶ Dying with Dignity expanded on this case to include the liberty interests and self-determination of competent individuals. From a religious perspective, although an intentionally hastened death ran contrary to the sanctity of life ethos, the “sacredness” of life was also cheapened without freedom of choice in dying: “Indeed, in so far as the ‘sanctity of individual free choice and, self-determination (are) fundamental constituents of life,’ the value of life may be lessened rather than increased ‘by the failure to allow a competent human being the right of choice.’”¹⁶⁷ Dying with Dignity also argued that Section 7 of the Charter of Rights and Freedoms “include[d] a right to commit suicide” and “a ‘right to make fundamental personal decisions without interference from the state.’”¹⁶⁸ The implication was that such liberty extended to assistance in suicide. Using the abortion issue as a link to physician-assisted suicide, Madam Justice Wilson once again referenced *R. v. Morgentaler*: “Liberty . . . is a phrase capable of a broad range of meaning . . . [and], properly construed, grants the individual a degree of autonomy in making decisions of fundamental personal importance.”¹⁶⁹

In addition, Dying with Dignity made specific recommendations for cases of physician-assisted suicide that reflected the lived reality of ALS patients. For example, courts could utilize guidelines similar to the Dutch model, such as (1) mental competence; (2) medical evidence respecting a prognosis; (3) repeated requests by the Appellant; (4) an unassisted final act; and (5) a full recording of the circumstances

¹⁶⁶ *Re Conroy*, 486 A. 2d 1209 (N.J. 1985).

¹⁶⁷ Factum of the Interveners, *Rodriguez v. British Columbia*, Dying with Dignity, 8.

¹⁶⁸ *Ibid.*, 9.

¹⁶⁹ *Ibid.*, 10.

assessed by the Attorney General.¹⁷⁰ In order to protect physicians, Death with Dignity recommended that “criminal proceedings not be commenced under Section 241 of the Criminal Code against a physician who assists the Appellant provided that such criteria as may be considered appropriate by the Court are met.”¹⁷¹

Overall, an analysis of the interveners indicates an affinity either for normative assumptions that reflected objectivistic metaphysics and the sanctity of life ethos or Vattimian postmodernism and a quality of life ethic. In rare cases, a third voice was heard, that being quality of life supporters (i.e., People in Equal Participation Incorporated and the Right to Die Society of Canada) that rejected physician-assisted suicide. Using a “civil rights” discourse, these two lobby groups promoted an alternate metaphysic—equality—claiming it was threatened by Rodriguez’s desire for state-sanctioned physician-assisted suicide. For the former, the disabled would be treated differently since they would not be *equally* protected under the law. For the latter, if helping others to die in similar circumstances to Rodriguez’s could not be achieved, a change in the law was then considered inadequate (unequally applied). That said, these two exceptions highlighted one key aspect of the Vattimian perspective, namely, that objectivistic metaphysics leads to more suffering. These lobby groups were, however, exceptions to the rhetoric of quality of life advocates, who generally support an intentionally hastened death.

Similar patterns would eventually emerge in the case of Robert Latimer. As normative assumptions underlying the sanctity of life ethos began to weaken, the intrinsic value of human life, value in prolonged suffering, and the “slippery slope” became

¹⁷⁰ Ibid., 25.

¹⁷¹ Ibid., 26.

consistent rhetorical devices used to prevent any paradigmatic shift away from the *qualified* sanctity of life ethos toward a quality of life ethic. Moreover, the sanctity of human life as first principle had to be protected at all costs, even if it meant the prolongation of intractable suffering for Tracy Latimer.

Tracy Latimer, Suffering, and the Sanctity of Life Ethos

Tracy Latimer's suffering became the main focus of concern for her father, Robert Latimer, at his original trial, in the Saskatchewan Court of Appeal, during his re-trial, and in the Supreme Court of Canada. Tracy was not only born with a severe form of cerebral palsy and brain damage, but she was a quadriplegic, bedridden, and in continuous pain. She required back operations, amputations, and hip surgeries that caused tremendous suffering and complications. Even with anti-seizure medication, she still experienced five to six seizures a day.¹⁷² Consequently, Robert Latimer informed the police that her suffering had left him no alternative but to perform a mercy killing by poisoning Tracy with carbon monoxide in a truck inside his barn. In Latimer's words, "My priority was to put her out of her pain. . . . She's been in pain for years. Ever since she's been born she's had trouble. . . . Each time you moved her there was pain."¹⁷³ When Robert Latimer was asked by authorities how he felt after Tracy's death, he replied: "I'm much happier for her now."¹⁷⁴ His wife, Laura Latimer, concurred: "That was the best thing for Tracy, the best thing that happened to her."¹⁷⁵

¹⁷² *Latimer v. Her Majesty the Queen*, The Court of Appeal for Saskatchewan, C.A. 6515 (18 July 1995); Justices Bayda, Tallis, and Sherstobitoff, 1.

¹⁷³ *Ibid.*, 7, 8.

¹⁷⁴ *Ibid.*, 12.

¹⁷⁵ Sharon Doyle Driedger, "Should Latimer Go Free?" *Maclean's*, 17 November 1997, 14.

However, at Latimer's first trial by judge and jury, there was a line the judge would not cross, that being the intentional hastening of death for compassionate motives. The trial transcripts indicate clearly that intending death was *absolutely* prohibited under all circumstances—even for a case of extreme suffering:

The Court: Mr. Latimer, is there anything you want to say?

Mr. Latimer: I feel that I did what was right.

The Court: Yes, anything else?

Mr. Latimer: Well, my wife mentioned that it's not a crime to cut off her [Tracy's] leg, not a crime to stick a feeding tube in her stomach, not a crime to let her lay there in pain for another twenty years. I don't think—I don't think you people are being human.

The Court: I know you believe you did the right thing and many people will agree with it; however, the criminal law is unremitting when it comes to the taking of human life for whatever reason. Life was not kind to Tracy but it was a life that was hers to make of it what she could.¹⁷⁶

The trial judge refused to accept the defence of necessity—a defence which holds that the Appellant's decision to break the law was inescapable and unavoidable. In fact, the trial judge withdrew such a defence, claiming that there was indeed an alternative to Tracy's suffering: "There was an option, albeit not a particularly happy one. The option was to persevere in the attempts to make Tracy comfortable in her life, however disagreeable and heartwrenching those attempts might have been."¹⁷⁷

To prevent any weakening of the sanctity of life ethos, the majority in the Saskatchewan Court of Appeal also relied on objectivistic metaphysics. Justice Tallis asserted that any judgement placed on human life should not be based on the quality or kind of person involved but on the property of intrinsic value: "Our law does not authorize such surrogate decision-making based on the assessments of the personal worth or social utility of another's life or the value of that life to the individual involved or to others. . . .Our society, through its criminal law, may . . . simply assert an *unqualified*

¹⁷⁶ *Latimer v. Her Majesty the Queen*, The Court of Appeal for Saskatchewan, 31.

¹⁷⁷ *Ibid.*, 27.

interest in the preservation of *human life* [italics mine].”¹⁷⁸ Thus, Justice Tallis felt that condoning Robert Latimer’s actions could lead to further acceptance of the *relative* value of human life, particularly for the disabled:

In such circumstances it is no defence for a parent to say because of a severe handicap, a child’s life has such diminished value that the child should not live any longer. . . . In this situation it is a fair inference that such a decision would never have been suggested or considered if Tracy were not handicapped and in extreme pain. This difference in approach between handicapped and non-handicapped children directly reflects a sense that the life of a handicapped child is of significantly less value than the life of a non-handicapped child in extreme pain. . . . One would not be so inspired by love and compassion to take the life of the non-handicapped child.¹⁷⁹

As with the trial judge, Justice Tallis justified Tracy’s ongoing suffering. Although he agreed that the evidence “clearly established a bleak future” and that Tracy’s scheduled hip surgery “involved a long recovery period” (one year), there was still the prospect of “some pain alleviation” or the option of “permanent placement in a group home.”¹⁸⁰ However, it was Robert Latimer’s decision to “play God” and directly intend Tracy’s death that Justice Tallis strongly condemned: “Surrogate decision-makers are not entitled to arrogate to themselves the life and death decisions under review in this case. . . . As a self-appointed surrogate decision-maker, he [Latimer] was not entitled to take the criminal law into his own hands and terminate [Tracy’s] life.”¹⁸¹

However, Justice Tallis’ interpretation differed sharply from the dissenting opinion provided by Chief Justice C.J.S. Bayda. He argued that Latimer’s minimum ten-year sentence was, in fact, cruel and unusual punishment under section 12 of the Constitution and that Tracy’s pain and suffering warranted a constitutional exemption. Justice Bayda reiterated that Tracy’s seizures were “severe to the point where her whole

¹⁷⁸ Ibid., 36.

¹⁷⁹ Ibid., 29, 36.

¹⁸⁰ Ibid., 28, 29.

¹⁸¹ Ibid., 36, 37.

body shook.”¹⁸² Her muscles had tightened up so much that operations had to be performed to have muscles cut out of her legs, toes, heels, and knees, and due to the curvature of her back, “stainless steel rods were put on either side of her spine to straighten her body sufficiently to relieve the cramping of her stomach and her lungs.”¹⁸³ Furthermore, since her mental development was between two-three months, she had to be permanently diapered, had no control of her excretory functions, and could not keep food down, often vomiting when fed.¹⁸⁴ Her condition led Chief Justice Bayda to conclude that Robert Latimer possessed “a severe preoccupation or an obsession with that pain.”¹⁸⁵

Bayda also countered several arguments made by the majority in terms of Tracy’s lived reality. By focussing on the dilemma surrounding Tracy’s ongoing suffering, he rejected institutionalization as a legitimate option for the Latimers: “[W]hile it may relieve him [Robert] and the family from having to care for Tracy in the family home, the placement in the nursing home would not relieve her pain.”¹⁸⁶ Bayda further rejected the assertion made by Justice Tallis that Tracy was killed because she was handicapped. The issue was the existential reality of Tracy’s suffering, not her disability: “[S]he was not put into her father’s truck because she was disabled. She was put there because of her pain, something very different from her disability. She was put there because her father loved her too much to watch her suffer.”¹⁸⁷

Bayda even provided four case studies to demonstrate that the state already provided lenient (non-custodial) sentences involving mercy killings. As previously

¹⁸² Ibid., 6.

¹⁸³ Ibid., 7.

¹⁸⁴ Ibid.

¹⁸⁵ Ibid., 9.

¹⁸⁶ Ibid., 11. It is also important to note that Tracy lost a sixth of her body weight when institutionalized. See Sharon Doyle Driedger, “Should Latimer Go Free?,” 15.

¹⁸⁷ *Latimer v. Her Majesty the Queen*, The Court of Appeal for Saskatchewan, 12.

mentioned in Chapter II (Global Trends and the “Eventuation of Being”), *R. v. Mataya* involved a doctor using a fatal dose of potassium chloride on a seventy-eight-year-old patient to shorten his agony after a respirator was pulled. Similarly, in *R. v. de la Rocha*, a doctor used potassium chloride on a seventy-year-old woman dying from lung cancer after an endotracheal tube was removed. In *R. v. Myers and Power*, a husband and wife deliberately killed the wife’s father, who was dying of lung cancer, by placing a pillow over his head and suffocating him. *R. v. Brush* involved an eighty-one-year-old woman who murdered her eighty-one-year-old ailing husband suffering from Alzheimer’s.¹⁸⁸ Although there were dissimilarities to the Latimer case—all involved terminally ill, elderly patients and two scenarios involved doctors performing the final acts—Justice Bayda concluded that the similarities favoured the Appellant: “[E]ach case involve[d] the intentional killing of another human being for an altruistic or compassionate reason: to end the victim’s suffering. . . . There is nothing intrinsically different between those four cases and the present case.”¹⁸⁹

In a twist of fate, however, Latimer was granted a new trial after the Supreme Court of Canada concluded that his constitutional rights had been violated. At the original trial, Crown counsel and an RCMP officer from the Wilkie detachment (Latimer’s home town) prepared a questionnaire asking perspective jurors for their views on religion, abortion, and euthanasia without disclosing such information to the trial judge or the defence.¹⁹⁰ At his re-trial in the late fall of 1997, the focus was once again on Tracy’s suffering. Although Robert Latimer had previously been convicted of second-degree murder, this time the jury recommended leniency—parole eligibility after one

¹⁸⁸ Ibid., 13-20.

¹⁸⁹ Ibid., 20, 29.

¹⁹⁰ *R. v. Latimer*, 1 S.C.R. 217, File No. 24818 (1997).

year—while Justice Ted Noble ordered a sentence of less than two years, one to be served in the community. Justice Noble explained that Latimer was “motivated solely by his love and compassion for Tracy and that, at least in his mind, she should not suffer any more pain.”¹⁹¹ Justice Noble concurred that “[a]ll the evidence points to his [Latimer’s] concern for the pain he saw flowing from her illness.”¹⁹² As with Chief Justice Bayda, Justice Noble rejected the argument that it was Tracy’s disability, rather than her pain, that motivated Robert Latimer to hasten her death: “. . . I could not conclude Mr. Latimer ever considered killing his daughter because she was disabled. In addition the history of his 12-year relationship with her completely negates such a conclusion.”¹⁹³ Justice Noble noted that a forensic psychiatrist testified that Robert Latimer was “was compelled to do what he did out of concern for her [Tracy’s] present and future pain.”¹⁹⁴ After Latimer received what Justice Noble called “the despairing news that her [Tracy’s] pain would continue unremitting,” he decided that it was “his duty as her father to relieve her of that prospect.”¹⁹⁵

As a result of Tracy’s intractable suffering, Justice Noble concluded that in this specific circumstance a new interpretation of murder was warranted: “[W]e have that rare act of homicide that was committed for caring and altruistic reasons. That is why for want of a better term this is called compassionate homicide.”¹⁹⁶ Noble viewed a minimum term of ten years imprisonment as a breach of section 12 of the constitution,

¹⁹¹ *Latimer v. Her Majesty the Queen*, Transcription of Cassettes, No. 26980 (Wednesday, June 14th, 2000, 09:47 hours), 110.

¹⁹² “Judge Noble’s Ruling,” Q.B.J. A.D. 1994 No. 37 J.C.B., In the Queen’s Bench Judicial Centre of Battleford between: Her Majesty The Queen-and-Robert W. Latimer Eric J. Neufeld, Q.C. and Graeme G. Mitchell for the Crown Mark Brayford, Q.C. for Robert W. Latimer Ruling on Defence Motion, Noble J. (December 1, 1997), 5 <www.robertlatimer.net>

¹⁹³ *Ibid.*

¹⁹⁴ *Ibid.*

¹⁹⁵ *Ibid.*, 7.

¹⁹⁶ *Ibid.*

thereby granting Latimer a constitutional exemption: “[The mandatory minimum sentence for second degree [murder] in the circumstances of this case is grossly disproportionate” and “would be unjust, unfair, and far too excessive.”¹⁹⁷ He added that “[i]f Mr. Latimer’s situation does not warrant the granting of a constitutional exemption then it is unlikely that any set of facts will ever arise where this rarely granted remedy can be made available to one who commits an act of compassionate homicide.”¹⁹⁸ However, the Crown appealed Justice Noble’s decision to implement such an exemption. When the case was again brought before the Saskatchewan Court of Appeal in the fall of 1998, Latimer was found guilty of second-degree murder since “the circumstances remain[ed] materially the same” and the previous judgement was “a considered one.”¹⁹⁹

An appeal to the Supreme Court of Canada on June 14th, 2000, brought to light further realities of Tracy’s medical condition. Arguing for the appellant, Mr. Edward L. Greenspan reminded the Court that heavy doses of pain medication counteracted the effect of Tracy’s anti-seizure medication. Thus, Tracy could only use Tylenol since painkillers “put her at risk of aspirating and developing pneumonia.”²⁰⁰ Since strong doses of narcotics interfered with Tracy’s ability to swallow, a feeding tube could be used to mitigate the problem of supplying nutrition, but as Mr. Greenspan made clear, “[I]t doesn’t stop the pain.”²⁰¹ Not only did back surgery in 1992 cause significantly more suffering, but painful bedsores meant that she could only be turned on her dislocated hip. As Mr. Greenspan explained, “A bath now became torture. To bathe her, her legs had to

¹⁹⁷ Ibid., 8.

¹⁹⁸ Ibid., 9.

¹⁹⁹ *Latimer v. Her Majesty the Queen*, No. C.A. 7413, 7416, The Court of Appeal for Saskatchewan (23 November, 1998). Cameron, Vancise and Wakeling, J.J.A., 24.

²⁰⁰ *Latimer v. Her Majesty the Queen*, No. 26980 (2000), 8.

²⁰¹ Ibid., 156.

be held perfectly still because otherwise she would scream in pain.”²⁰² Greenspan added that her hip had “dislocated and degenerated so badly that the only medical option was to remove the top quarter of her thigh.”²⁰³ A doctor had testified that the “post-operative pain after the hip surgery would be incredible and very difficult to manage” and that “there was no medical ability to alleviate her pain.”²⁰⁴

Greenspan also reminded the Court to consider the views of Tracy’s parents. Laura Latimer felt that further operations, particularly the removal of Tracy’s upper leg, would be inhumane: “It just seemed obscene. It just seemed like something that you wouldn’t do to your pet, like you wouldn’t do it to your dog or cat. If you did, you’d probably be charged with being cruel to an animal. It just seemed unthinkable.”²⁰⁵ In fact, Laura Latimer supported her husband’s actions, justifying them as merciful:

Bob did the right thing for Tracy. No doctor was going to say: This little girl can’t take it anymore. No doctor was going to say: No, we can’t mutilate your little girl. The doctors were going to keep working on her and working on her. They wanted to put a feeding tube in her so that they could keep her alive, so that they could torture her and mutilate her some more and keep her going.²⁰⁶

Greenspan added that the most important viewpoint was the interpretation of Tracy’s suffering from those who experienced it daily: “[J]ust because Tracy could not articulate her pain, just because she had to suffer in silence and pain that few of us could even imagine does not mean that she didn’t feel pain, that she wasn’t human. . . . They [Bob and Laura Latimer] heard [her pain]. They heard it, and they saw it, each and every day of Tracy’s life.”²⁰⁷

²⁰² Ibid., 9.

²⁰³ Ibid., 10.

²⁰⁴ Ibid.

²⁰⁵ Ibid., 10-11.

²⁰⁶ Ibid., 12.

²⁰⁷ Ibid., 12.

In contrast to the appellant's emphasis on suffering, arguments of the respondent gravitated toward metaphysics. Kenneth W. MacKay, Q.C., agreed with Greenspan that "Tracy Latimer was subject to pain,"²⁰⁸ but Mr. MacKay felt that this was a reductionist strategy used to portray Tracy's life as nothing but pain. In his view, quality of life judgements were subordinate to a life possessing inherent worth: "Tracy Latimer was a human being, she had a life to live and it was a life to make it what she could."²⁰⁹ Mr. MacKay claimed that Tracy's life "also had value and meaning" and that "[h]er humanity was not diminished because her life was simple and basic, that of a three-month-old child, or because she suffered pain."²¹⁰ He also admitted that "there was no doubt that she would face further surgeries," adding: "That was part of her life."²¹¹ Although Mr. MacKay agreed with Justice L'Heureux-Dubé in that "everyone has sympathy and understands a parent who cannot stand to see his or her child in pain," Robert Latimer's subjective perspective would, he claimed, open the floodgates to other abuses, particularly with regard "to disabled persons, to infirm persons, to elderly persons, where it becomes the perception of the caregiver . . . which rules the day. . . ."²¹²

Another argument of the respondent was provided by Graeme G. Mitchell, Q.C., who compared Tracy's lived reality with the Appellant's sister, Dorothy Harder. The witness, a registered nurse, was also diagnosed with scoliosis (a curved spine) at the age of sixteen. Mr. Mitchell pointed out that the witness had "extensive surgery to correct her condition," and although the procedure was intended to alleviate pain, it was "not the

²⁰⁸ Ibid., 68.

²⁰⁹ Ibid., 69.

²¹⁰ Ibid., 70.

²¹¹ Ibid., 71.

²¹² Ibid., 79.

same procedure that Tracy went through. . . .”²¹³ Following the surgery, Harder said that she had “never had anything like it [the pain] before or since” and that “having two children by Caesarean section was a ‘walk in the park compared to this.’”²¹⁴ Mr. Mitchell concluded that although Harder did not have cerebral palsy, suffer from seizures, or face the prospect of future surgeries, there were “far less . . . drastic options [for Robert Latimer], such as performing the surgery, in attempting to control [Tracy’s] pain.”²¹⁵ He suggested that allowing mercy killing would lead to other dangers as well, such as the involuntary euthanasia of children: “[I]t would mean that any parent, who terminated the life of his or her child, because of that child’s extreme and unremitting pain, is like the Appellant, acting compassionately, *regardless of the child’s wishes*. And, ultimately, that’s where it takes us [*italics mine*].”²¹⁶

In similar fashion, Supreme Court justices divided their arguments between abstract, metaphysical assumptions and Tracy Latimer’s lived reality. Justice Binnie concurred that it was not Robert Latimer’s prerogative to “play God,” even in the case of acute suffering: “[G]iven all of the terrible circumstances in which this fam—family found itself, it wasn’t for Mr. Latimer to make the decision that he did.”²¹⁷ Justice Binnie added that the “slippery slope” was a legitimate concern: “Where are the boundaries? And—and how do you contain it [compassionate killing]. . . .?” However, Madam Justice L’Heureux-Dubé countered Justice Binnie’s arguments by focussing the

²¹³ Ibid., 109.

²¹⁴ Ibid.

²¹⁵ Ibid., 110.

²¹⁶ Ibid., 111.

²¹⁷ Ibid., 52.

discussion on the ontology of pain: “He [Robert Latimer] was a person . . . just like you and me, and he couldn’t endure the suffering of his daughter.”²¹⁸

The Interveners: Religious Organizations

As with the Rodriguez case, it is important to compare the discourse of religious and secular supporters of the sanctity of life ethos with adherents of the quality of life ethos. Once again, there is a marked difference between metaphysicians and Vattimian postmodernists. The former consistently supported rhetoric that involved one of more of the following: stewardship, justification for prolonged suffering, and the “slippery slope”; whereas, the latter promoted self-determination, the relative value of human life, and the workability/flexibility of safeguards.

As Counsel for the Catholic Group for Health, Justice and Life (the “Catholic Group”), William J. Sammon reminded the Court that those comprising the Catholic Group had been consistent advocates for the “protection of human life from its beginning to natural end.”²¹⁹ Mr. Sammon asserted that social objectives involved with mandatory sentencing provisions meant “uphold[ing] a universal respect for the value of all human life by severely punishing all killers, regardless of motive.”²²⁰ It was purported that these communal aims “transcend[ed] the circumstances of the particular case and [were] capable of justifying the punishment under s. 1 of the *Charter*.”²²¹

²¹⁸ *Ibid.*, 78.

²¹⁹ *Factum of the Interveners*, The Catholic Group for Health, Justice and Life, No. 26980, In the Supreme Court of Canada (On Appeal from the Court of Appeal for the Province of Saskatchewan) (28 April 2000), 1.

²²⁰ *Latimer v. Her Majesty the Queen*, No. 26980, (2000), 138.

²²¹ *Factum of the Interveners*, The Catholic Group for Health, Justice and Life, 13.

Since the Catholic Group's foundational premise—the sanctity of human life—precluded any parental right “to decide on death rather than life for a child,” the most dangerous argument advanced by Latimer was his assertion that “he had the right to kill Tracy based on the defence theory of surrogate suicide.”²²² This defence of compassionate homicide was rejected by the Catholic Group, which argued instead that “[l]ove and concern for a child are *normal* human instincts which do not compel parents to kill children in their care for reasons of mercy” [italics mine].²²³ Consequently, Mr. Sammon argued that a constitutional exemption for Robert Latimer would lead to a “slippery slope where the life of any disabled, incompetent or suffering human being would be at serious risk.”²²⁴ Although Mr. Sammon acknowledged that the case was “a tragedy with irrevocable consequences for Tracy,” one that caused “enormous suffering for her family,” other solutions were required that would not “facilitate, condone, or excuse the murder of society's most vulnerable people.”²²⁵

As with the Catholic Group, other religious interveners—the Evangelical Fellowship of Canada (“EFC”), Physicians for Life (“PFL”), and the Christian Medical and Dental Society (“CMDS”)—viewed Tracy Latimer's case from the perspective of divine sovereignty. Representing the three organizations above, David M. Brown argued that because of the supremacy of God, “all human beings enjoy[ed] equal dignity in the face of this higher, creative power.”²²⁶ In the case of Tracy Latimer, the interveners claimed that Tracy possessed “the same qualities and dignity as any other human being

²²² Ibid., 5.

²²³ Ibid., 8.

²²⁴ Ibid., 12.

²²⁵ Ibid., 17.

²²⁶ *Latimer v. Her Majesty the Queen*, No. 26980, (2000), 145.

because she was made in the image of God.”²²⁷ This implied that a person’s value was not relative, meaning that “personhood cannot be lessened by differences in [one’s] physical or mental attributes.”²²⁸ The general consensus was that any person, whether disabled or not, enjoyed what the interveners referred to as “intrinsic worth,” which holds that “a human being must be treated as an end in himself or herself.”²²⁹

Mr. Brown also suggested that capitulating to the defence of necessity would be socially dangerous. Eventually, it would lead to a mentality similar to Nazi eugenics in that “some lives are not worthy of living and, therefore, it is necessary to kill such persons.”²³⁰ His greatest concern was that the death of ultimate foundations would eliminate safeguards for the weakest members of society: “[O]nce the law embarks upon comparing the relative worth of human lives . . . then it rejects any commitment to protect the inherent dignity of all persons and absorbs into itself the insidious principle that will result in the abuse and killing of the most vulnerable in society.”²³¹ Fearing that life would be judged in relative terms, Mr. Brown warned that “the deliberate killing of a disabled child could be necessary because there was something lesser about her life.”²³² This meant that any appeal granted to Robert Latimer would “encourage a culture of death in [Canada].”²³³ All three groups concurred with the Law Reform Commission of

²²⁷ Factum of the Intervenors, *The Evangelical Fellowship of Canada, Christian Medical and Dental Association, and Physicians for Life*, No. 26980, In the Supreme Court of Canada (On Appeal from the Court of Appeal for the Province of Saskatchewan (2 May 2000)), 6.

²²⁸ *Ibid.*, 6.

²²⁹ *Ibid.*, 8.

²³⁰ *Ibid.*, 14.

²³¹ *Ibid.*, 14.

²³² *Ibid.*, 18.

²³³ *Ibid.*, 2.

Canada's conclusions from 1983 in that state-sanctioning of euthanasia would "open the door to abuses, and hence indirectly weaken respect for human life."²³⁴

The Interveners: Secular Organizations

Some form of rhetoric involving stewardship, value in prolonged suffering, and the "slippery slope" was also evident throughout the discourse of secular organizations in support of the sanctity of life ethos. As an intervener for the Attorney General of Canada, Robert J. Frater emphasized that any exception granted to Robert Latimer for compassionate killing would open the floodgates to other love-related defences. Mr. Frater expanded on this idea with reference to conclusions made by the Law Reform Commission of Canada:

Well, what of passionate killers, those presumably who—who kill in a fit of romantic love? Or what about killers who kill in pursuit of the national interest, those presumably who are motivated by love of country. . . . That's the same claim that would be made by each person in these groups. Treat me specially because all I am guilty of is loving too much, whether it be family, country, or whatever.²³⁵

Mr. Frater argued that a ten-year minimum sentence was not a violation of section 12 of the Charter. The Court was reminded of the potential for abuse "if the law's protection for the integrity of human life was diminished by recognizing 'compassionate' homicide as a special category of murder."²³⁶ The Attorney General of Canada emphasized that vulnerable groups—the very old, the very young, the sick, and persons with disabilities—would have "cause to fear from people with non-compassionate motives who seize the opportunity to portray their actions as 'merciful.'"²³⁷

²³⁴ Ibid., 18.

²³⁵ *Latimer v. Her Majesty the Queen*, No. 26980 (2000), 119.

²³⁶ *Factum of the Intervener*, The Attorney General of Canada, No. 26980, In the Supreme Court of Canada (On Appeal from the Court of Appeal for the Province of Saskatchewan) (1 May 2000), 13.

²³⁷ Ibid.

Likewise, as intervener for the Attorney General of Ontario, Mr. Michael Bernstein felt that the mandatory, minimum sentence of ten years in prison was not only about denunciation but was “an expression, an affirmation of the values of the inherent dignity and sanctity of life and the equal worth of all.”²³⁸ Mr. Bernstein supported the view that killing another human being was, in fact, “an assault on the sacred, natural order.”²³⁹ He reminded the justices that since “the disabled and the seriously ill [were] uniquely vulnerable,” it was imperative to “avoid any slide down the slippery slope of relative worth.”²⁴⁰

Representing various disabled groups across Canada (“the Coalition”), Robert G. Richards, Q.C. rejected the notion of surrogate suicide, especially any suggestion that “parents and other caregivers are entitled to decide whether disabled children should live or die.”²⁴¹ Supporting the sanctity of human life, the Coalition felt that it was inappropriate for “one person to assess another person’s life and to determine whether that other person’s life is of sufficient quality to warrant his or her continued existence.”²⁴² It was essential, therefore, that the Court “clearly reject the notion that any person can put himself or herself in a position to make such a judgement.”²⁴³

Expressing the concerns of the Coalition, Mr. Richards viewed any leniency toward Latimer as a threat to the disabled community. He feared that a lesser sentence

²³⁸ *Latimer v. Her Majesty the Queen*, No. 26980 (2000), 123.

²³⁹ *Factum of the Intervener*, Attorney General for Ontario, No. 26980, In the Supreme Court of Canada (On Appeal from the Court of Appeal, for the Province of Saskatchewan) (1 May 2000), 9.

²⁴⁰ *Latimer v. Her Majesty the Queen*, No. 26980 (2000), 125.

²⁴¹ *Factum of the Interveners, Council of Canadians with Disabilities et al.*, No. 26980, In the Supreme Court of Canada (On Appeal from the Court of Appeal for the Province of Saskatchewan) (May 1st, 2000), 9.

²⁴² *Ibid.*, 11.

²⁴³ *Ibid.*, 12-13.

would create the impression that “disabled people have lives of diminished value.”²⁴⁴ In other words, if Robert Latimer were permitted to use the defence of necessity, then it could be used in “scores of other situations” to shield from punishment “those who kill disabled individuals.”²⁴⁵ According to the Coalition, Latimer’s argument about necessity not only involved “a threat to the lives and security of disabled people generally,” but would also “open the door to very real risks [in] that other care-givers [would] kill those in their charge.”²⁴⁶ The Coalition strongly challenged what they felt was the rhetoric of eugenics, stating that the arguments advanced by Robert Latimer “involve[d] a threat to the lives and security of disabled people generally, and to persons with cognitive disabilities in particular.”²⁴⁷ Quoting Wesley J. Smith in *Forced Exit: The Slippery Slope from Assisted Suicide to Legalized Murder* (1997), the Coalition viewed euthanasia as the catalyst for a two-tier system of rights. With a direct analogy to Nazi eugenics, Smith wrote:

Once we accept the idea that some lives are not worth living, once we come to see the intentional ending of lives of the profoundly disabled as proper, once we claim the right to judge who should live and die on the basis of subjective standards such as happiness, quality of life, or dignity, we have created a disposable caste: fellow humans who can be killed without legal consequences, whose deaths do not disturb a good night’s sleep.²⁴⁸

“Civil Rights” Discourse

Only one organization that promoted normative assumptions surrounding the quality of life ethos (e.g., self-determination) lobbied against Robert Latimer’s actions. On behalf of the Canadian AIDS Society (“CAS”), Mr. R. Douglas Elliott emphasized

²⁴⁴ *Latimer v. Her Majesty the Queen*, No. 26980 (2000), 129.

²⁴⁵ *Ibid.*, 132.

²⁴⁶ *Factum of the Interveners, Council of Canadians with Disabilities et al.*, 13.

²⁴⁷ *Ibid.*, 20.

²⁴⁸ *Ibid.*, 13. For more of Wesley J. Smith’s critique of the Dutch medical model and his claims of a link to Nazi eugenics, see Wesley J. Smith, *Forced Exit: The Slippery Slope from Assisted Suicide to Legalized Murder* (New York: Random House, 1997).

the lived reality of AIDS sufferers as central to decriminalizing assisted suicide. The greatest fear of persons living with AIDS was not death but “the loss of control over their mental faculties and the resulting dependency on others. . . .”²⁴⁹ CAS also informed the Court that AIDS was “associated with much suffering and pain,” and for this reason, “many persons with HIV and AIDS seek out means of controlling the end of their lives.”²⁵⁰ CAS revealed that gay men in particular who experienced the death of friends and lovers had become very aware of “the horrible pain and suffering endured in the terminal stages of AIDS.”²⁵¹ Thus, CAS supported the fundamental principle of “self-determination for persons living with HIV, and for all people, including the right to die with dignity.”²⁵²

Mr. Elliott also advised the Court that warnings of risk and danger were a two-way street in that restricting individual freedom can also have an undesired impact on the community: “In truth we are on a slippery slope today. Keeping euthanasia in the closet does not prevent abuse. It does lead to great social harm.”²⁵³ He even reminded the Court that a closed system would lead to “back alley” euthanasia, resulting in “botched suicides and further pain and suffering for the patient.”²⁵⁴ When it comes to AIDS sufferers, Mr. Elliott told the Court that “they do not wish to prolong their pain, nor risk the living oblivion of massive sedation or, worse, depart this life strapped to a hospital bed and convulsed with madness.”²⁵⁵ He surmised that choice denied “does not enhance the dignity of the disabled” because “it degrades them by imposing upon them our moral

²⁴⁹ *Factum of the Intervener*, The Canadian AIDS Society, No. 26980, In the Supreme Court of Canada (On Appeal from the Court for the Province of Saskatchewan) (1 June 2000), 3.

²⁵⁰ *Ibid.*, 4-5.

²⁵¹ *Ibid.*, 5.

²⁵² *Ibid.*, 4.

²⁵³ *Latimer v. Her Majesty the Queen*, No. 26980 (2000), 59.

²⁵⁴ *Ibid.*, 61.

²⁵⁵ *Ibid.*, 60.

choices, rather than allowing them to control their own bodies.”²⁵⁶ The problem, Mr. Elliott maintained, lay in “moral paternalism imposed by the state,” adding: “[N]o one should sit in judgement on the quality of life of another. . . .”²⁵⁷

Although AIDS organizations had previously supported Sue Rodriguez, this was not the case for Robert Latimer. Fearing that one form of paternalism would replace another, Mr. Elliott and the CAS denounced active, nonvoluntary euthanasia, stating that such an act was “not excused and that the Appellant’s [Latimer’s] argument of ‘surrogate suicide’ should be rejected.”²⁵⁸ According to the CAS, since Tracy was never mentally competent, it would have been “impossible to determine her wishes as to whether she would choose . . . to hasten the end of her life in some manner.”²⁵⁹ Even in Tracy’s circumstances, the CAS considered self-determination to be absolute; however, its reasoning surrounding incompetence and negative acts appeared somewhat contradictory. Although critical of Latimer’s decision to substitute his judgement for Tracy’s, the CAS still maintained that parents had a right to “consent to treatment or refuse to consent to treatment for immature minor children or mentally incompetent children” and that parental choice in ‘passive’ non-voluntary euthanasia should be “free from interference of the state through wardship.”²⁶⁰ While rejecting Latimer’s more active method of *nonvoluntary* euthanasia, the CAS admitted that passive *nonvoluntary* euthanasia was already legally permissible in that the life of a mentally incompetent person “may be terminated without his/her consent when in a persistent vegetative state based on the

²⁵⁶ Ibid., 62.

²⁵⁷ Ibid., 67.

²⁵⁸ *Factum of the Intervener*, The Canadian AIDS Society, 2.

²⁵⁹ Ibid., 13.

²⁶⁰ Ibid., 14.

wishes of his/her parents alone”²⁶¹ As with other metaphysicians (i.e., sanctity of life advocates), the CAS claimed an absolute moral distinction existed between acts of omission and commission. In cases of incompetence, a negative act was deemed “not a right to impose death, but a right to choose a course of action which will fail to avert death.”²⁶²

Vattimian Postmodernists

Only one group was unequivocal in its support for Robert Latimer’s actions. As Counsel for the Canadian Civil Liberties Association (“CCLA”), Mr. Kent Roach gravitated toward an individual, rather than a communal, perspective. He stipulated that “Mr. Latimer [was] not a threat to society and [did] not require any rehabilitation.”²⁶³ When it came to children and the disabled being afforded equal protection under the law, Mr. Roach replied that it was up to the state to demonstrate that “the use of an inflexible, severe, mandatory penalty [was] necessary to fulfil these societal objectives” since “there was no rational connection between those societal objectives and the mandatory penalty.”²⁶⁴ Mr. Roach openly admitted that the “slippery slope” was a fallacy since there was “simply no basis to believe that the leniency shown [to Latimer] will open the floodgates.”²⁶⁵ He reminded the Court of what Latimer’s lawyer, Mark Brayford, had said in that “it is not logical to think that you can deter or rehabilitate a compassionate homicide.”²⁶⁶

²⁶¹ Ibid., 16.

²⁶² Ibid., 14.

²⁶³ *Latimer v. Her Majesty the Queen*, No. 26980 (2000), 50-51.

²⁶⁴ Ibid., 52.

²⁶⁵ *Factum of the Intervener*, Canadian Civil Liberties Association, No. 26980, In the Supreme Court of Canada (On Appeal from the Court for the Province of Saskatchewan) (26 April 2000), 17.

²⁶⁶ *Latimer v. Her Majesty the Queen*, No. 26980 (2000), 52.

Metaphysics Maintained in the Latimer Affair

Robert Latimer's last opportunity to declare his minimum sentence of ten years "cruel and unusual punishment" failed in the Supreme Court of Canada in 2001. The debate over the intrinsic value of Tracy's life, how much suffering she could endure, and the justifications for prolonging it highlighted how secular institutions maintained "traces" of the Christian metaphysical tradition. The Supreme Court agreed that Tracy "experienced a great deal of pain" and that Robert Latimer "faced challenges of the sort most Canadians can only imagine."²⁶⁷ Such pain, it was admitted, "could not be reduced by medication since the pain medication conflicted with [Tracy's] anti-epileptic medication and her difficulty in swallowing."²⁶⁸ The Court even highlighted the testimony of doctors who anticipated that Tracy would have to "undergo repeated surgeries" and that her "breathing difficulties had increased."²⁶⁹ With regards to Tracy's scheduled surgery on November 19th, 1993—the surgery that motivated Robert Latimer to end her life—the procedure involved "removing her upper thigh bone," leaving her lower leg "loose without any connecting bone," and "held in place only by muscle and tissue."²⁷⁰ Doctors involved in the procedure "suggested further surgery would be required in the future to relieve the pain emanating from various joints in Tracy's body."²⁷¹

That said, the Court still rejected any defence of necessity. The Appellant's justifications for his actions—namely, imminent peril or danger to Tracy, no reasonable legal alternative or course of action to resolve her suffering, and proportionality between

²⁶⁷ R. v. Latimer, 1 S.C.R. 3, 2001 SCC 1, File No. 26980, 3, 11 (2001).

²⁶⁸ Ibid.

²⁶⁹ Ibid., 12.

²⁷⁰ Ibid., 13.

²⁷¹ Ibid.

the harm inflicted and the harm avoided—were said to have “no air of reality”²⁷² in this particular circumstance and that Latimer’s decision to end his daughter’s life “was an error in judgment.”²⁷³ As in previous trials, Latimer was told he possessed legitimate options. Tracy could have been “fed with a feeding tube into her stomach, an option that would have improved her nutrition and health, and that *might* have also have allowed for more effective pain medication to be administered [emphasis mine].”²⁷⁴ Without reference to the impact stronger pain relief would have on Tracy’s seizures and respiration, the Court maintained that it was “*not reasonable* for the accused to form the belief that further surgery amounted to imminent peril, particularly when better pain management was available [emphasis mine].”²⁷⁵

Moreover, the Court concluded that Latimer possessed other legal options. For instance, “[H]e could have struggled on, with what was unquestionably a difficult situation, by helping T to live and by minimizing her pain as much as possible or by permitting an institution to do so.”²⁷⁶ In terms of proportionality, the Court declared that Tracy’s degree of suffering was not a legitimate motive to hasten her death, especially since she was not terminally ill: “[T]he harm inflicted in this case was immeasurably more serious than the pain resulting from T’s operation . . . Killing a person—in order to relieve suffering . . . is not a proportionate response to the harm represented by the non-life-threatening suffering resulting from [a physical or mental] condition.”²⁷⁷ In fact, the Court suggested that “there was a threshold at which a person must be expected to suffer

²⁷² Ibid., 4.

²⁷³ Ibid., 11.

²⁷⁴ Ibid., 12.

²⁷⁵ Ibid., 4.

²⁷⁶ Ibid.

²⁷⁷ Ibid., 5.

the harm rather than break the law.”²⁷⁸ Yet the Court agreed that Tracy’s pain “was expected to continue, or increase, following the surgery” [on November 19th, 1993] but that “ongoing pain did not constitute an emergency in this case.”²⁷⁹ An emergency had to be imminent and not “an obstinate and long-standing state of affairs.”²⁸⁰ Although the Appellant argued that, for him, “further surgery did amount to imminent peril,” the Court concluded that “it was *not reasonable* for the appellant to form this belief. . . .”[emphasis mine].”²⁸¹

As in prior court decisions, the majority of the Supreme Court relied on objectivistic metaphysics in the form of a collective ethos. The Court admitted that although “most situations fall into a grey area that requires a difficult balancing of harms,” Robert Latimer’s subjective judgment could not be permitted because it was feared that the defence of necessity would become “a mask for anarchy.”²⁸² Necessity was rooted in an *objective standard*, the Court insisted, based largely on the judgment of “society’s expectation of *appropriate* and *normal* resistance to pressure [emphasis mine].”²⁸³ Therefore, Latimer’s punishment mandated a sentence based on a communal response. In short, “a sentence with a denunciatory element represents a symbolic, collective statement,” and as the Court reaffirmed, “the offender’s conduct should be punished for encroaching on . . . society’s basic code of values. . . .”²⁸⁴ In essence, the Court felt that the value of human life was absolute. Even extreme suffering was better—and proportionately less harmful—than non-existence. To exempt Robert Latimer from

²⁷⁸ Ibid., 23.

²⁷⁹ Ibid., 24.

²⁸⁰ Ibid.

²⁸¹ Ibid., 25.

²⁸² Ibid., 19, 21.

²⁸³ Ibid., 22.

²⁸⁴ Ibid., 42.

the moral standards set by the community—and thereby weaken the sanctity of life ethos—was, in the Court’s opinion, to invite harm and danger to the society.

Chapter VI: Political Discourse in Canada

In the Debates of the House of Commons from 1991-2005, several attempts were made by various politicians to either pass or block legislation and/or motions concerning active euthanasia, “passive” euthanasia (i.e., the withholding/withdrawal of treatment), and physician-assisted suicide. As with other discourses, metaphysicians and Vattimian postmodernists supported the sanctity of life ethos and the quality of life ethos respectively; however, a hybrid between the two paradigms was also apparent within the debates, involving a merger between the rhetoric of self-determination and Christian natural law. This “middle path” was indicative of a movement away from vitalism (maintaining biological life at all costs) and toward the *qualified* sanctity of life principle (refraining from any prolongation of death).

As a general rule, the Canadian political spectrum was divided between postmodern leftists in support of euthanasia and assisted suicide and centre-right metaphysicians opposing such methods of death-hastening. More precisely, the Block Québécois and New Democratic Party supported active euthanasia, “passive” euthanasia, and physician-assisted suicide. In contrast, the Liberals, Progressive Conservatives/Conservative Party of Canada, and the Reform Party would only sanction acts of omission, provided that death was not intended. The centre-right simply could not support positive acts since these represented more overt forms of intentional death. Other exceptions to this general pattern, however rare, are highlighted either in the text or footnotes.

Robert Wenman and the *Qualified Sanctity of Life Ethos*

Beginning in March, 1991, Mr. Robert Wenman (Fraser Valley West, PC) first sought to introduce Bill C-351, an act to amend the Criminal Code for terminally ill persons. Mr. Wenman's discourse initially borrowed from the rhetoric of quality of life advocates, as he clearly supported "the right of individuals who are in the latter stages of terminal illness to refuse or withdraw from medical treatment."¹ Foreshadowing the Nancy B. case, Wenman felt that the *Criminal Code* of Canada was unclear in this matter and that "withholding treatment from the terminally ill might constitute a criminal offence."² A legal dilemma occurred in that the *Code* could be interpreted in a vitalistic sense. Section 14 stated that doctors "must provide their patients with full medical treatment regardless of circumstances" and that "[n]o person is entitled to consent to have death inflicted upon him."³ Wenman argued that allowing patients the right to refuse or withdraw treatment gave them "the right to die with dignity" and "preclude[d] unnecessary pain and suffering."⁴ Nonetheless, Bill C-351 died on the *Order Paper* after the end of the parliamentary session.

With a similar mandate in mind, Wenman introduced Bill C-203 to Parliament in May of 1991; however, by second reading in September, Wenman's motivations for the bill appeared equally founded in the *qualified sanctity of life* principle. Influenced by the rhetoric of stewardship, this doctrine implied that one could "allow death to occur" (passive or negative acts) but could not intend it (active, positive acts). In the context of advancing technology, Wenman asked:

¹ Robert Wenman, "Criminal Code: Measure to Amend," *Commons Debates* (2nd Session, 34th Parliament) Vol. IV (March 12th-May 8th, 1991), 19083.

² Ibid.

³ Ibid.

⁴ Ibid.

When will science and the state allow my will and God's will to prevail and allow a natural death? . . . [F]or the Christian ethic, when will technology end and allow the individual to call an end to treatment and suffering and put himself or herself in the hands of God so that the beginning of death leads to the ending of life and the beginning of a new life after death?⁵

Although Wenman hoped the dying process would be “eased from pain and suffering,” this could only be achieved by “allowing natural death to occur.”⁶ The bill also supported the Christian doctrine of double effect. A qualified medical practitioner could administer palliative care “intended to eliminate or relieve the physical suffering of a person where such care or measures will or are likely to shorten the life expectancy of the person.”⁷ In general, Wenman represents a good example of metaphysics in transition. Suffering could only be alleviated “passively” in order to make room for “traces” of the Christian tradition involving stewardship.

Those critiquing Wenman's bill represented three distinct viewpoints: (1) vitalists (one cannot intend death passively *or* actively; (2) *qualified* sanctity of life supporters (one can hasten death passively but *not* actively); and (3) quality of life proponents or Vattimian postmodernists (one can intend death *both* passively *and* actively). Mr. Rey Pagtakhan (Winnipeg North, Lib.) began with rhetoric that mirrored Wenman's initial motives for the bill. Since Pagtakhan was a physician by trade, he acknowledged the doctor's duty to sustain life but questioned the quality of that life:

Is life in a coma, fed intravenously and given breath through a respirator, with brain activity almost non-existent, the kind of life I, myself, would choose before death? What of a life where the body

⁵ Wenman, “Private Members' Business: Criminal Code, Measure to Amend,” *Commons Debates* (3rd Session, 34th Parliament) Vol. II (June 10th-September 24th, 1991), 2664. Like Wenman, some scholars agree that a Christian argument could be made for assisted suicide. Paul Badham argues that since Jesus preached “love thy neighbour as thyself” and the Golden Rule (“always treat others as you would like them to treat you”), these moral principles provide a basis for assistance in suicide for those suffering gravely from a terminal illness; see Paul Badham, *Is There a Christian Case for Assisted Dying?* (London: SPCK, 2009).

⁶ Ibid.

⁷ Wenman, “Bill C-203: An Act to Amend the Criminal Code (Terminally-ill Persons),” *The House of Commons Canada* (3rd Session, 34th Parliament) First Reading, May 16th, 1991, 2.

constantly contorts in pain, racked by spasms of unrelenting agony? I would refuse to live like that unless I was sure at the end I could be healthy once again.⁸

He confirmed that the restoration of health was “not a possibility for terminally ill people at the final stage of their diseases,” and the manner of death required for these patients was “being addressed by this [Wenman’s] bill.”⁹ Pagtakhan supported Wenman’s basic premise of “dying with dignity,” acknowledging that there should be “no case where a person is made to suffer because of heroic treatments which may, in the end, serve no purpose.”¹⁰

Even though he could relate to many of the principles in Wenman’s bill, Pagtakhan also referred to common rhetorical statements made by advocates of the sanctity of life ethos. His greatest concern was the “slippery slope,” specifically the possibility of abuse:

Issues like suicide, death for economic reasons, pressure by family members, the feeling of burdensomeness and that the dying are a strain on the health care system, all must be resisted. I believe the possibility exists that people could be pressured into selecting a quick death and use the medical system to terminate their lives, and that must be resisted too. No one should feel pressured to die for convenience.¹¹

Pagtakhan was also concerned about the reputation of physicians. He warned that the doctor-patient relationship could suffer in three distinct ways: physicians may become too complacent and quickly “dispatch” the terminally ill; patients may no longer trust their doctors’ judgements and “instruct the physicians with living wills;” or there could be an incorrect diagnosis.¹² Firm in his belief that traditional medical ethics precluded euthanasia and assisted suicide, Pagtakhan reminded the Committee that doctors and

⁸ Rey Pagtakhan, “Private Members’ Business: Criminal Code, Measure to Amend,” 2666.

⁹ Ibid.

¹⁰ Ibid., 2667.

¹¹ Ibid.

¹² Ibid., 2666-67.

nurses can “allow death to happen, but must insist not to will death to happen.”¹³

Because of perceived risks to both patients and the integrity of medicine, Pagtakhan sided with Wenman’s belief in absolute moral distinctions and the *qualified* sanctity of life ethos. Addressing the Speaker, he stated: “There is a fine line between allowing terminally ill patients to die with dignity at their request and aiding in that death.”¹⁴

Mr. Svend J. Robinson (Burnaby—Kingsway, NDP) was more openly supportive of Wenman’s bill, discussing it exclusively in postmodern terms. Robinson asserted that there was a fundamental principle at stake in that society “must give people the right to make this decision [an intentionally hastened death], this most basic literally life or death decision.”¹⁵ Robinson admitted that this principle “did not diminish our respect for life” but was, in fact, “a symbol of our respect for the quality of life and a recognition that people should be allowed to die with dignity.”¹⁶ Concurring with the basic values of right-to-die organizations, Robinson not only believed that the individual had the right “to choose the time, place and means of his or her death,” but he also rejected any notion that “human beings [were] to be subjected to the risk of a protracted period of misery and humiliation. . . .”¹⁷ He even suggested that an intentionally hastened death could actually be the lesser of evils: “Surely the far greater crime is not allowing men and women in

¹³ Ibid., 2667.

¹⁴ Ibid., 2668.

¹⁵ Svend Robinson, 2668.

¹⁶ Ibid.

¹⁷ Ibid., 2669. Robinson specifically sided with the philosophy of such right-to-die lobby groups as Dying with Dignity and the Right to Die Society of Canada.

situations [involving a slow, agonizing and painful death] to make the decision for themselves.”¹⁸

In addition, Robinson pointed out that specific changes or “events” had led to a gradual acceptance of an intentionally hastened death. For example, Canadian interest in the debate accelerated with the publication of Derek Humphry’s best seller *Final Exit*.¹⁹ Robinson also noted the results of a Gallup poll showing that “78 per cent of Canadians believe that a doctor should be allowed by law to end the life of a patient who has an incurable disease that causes great suffering, if the patient had made a formal request in writing.”²⁰ Because of shifting global currents, Robinson was willing to go even further and “support the system in Holland which allows for active euthanasia.”²¹

As a rare exception on the political right, Progressive Conservative Stan Wilbee (Delta, PC) supported Wenman’s bill. Mr. Wilbee emphasized the ontological reality of the dying, claiming that many patients have “welcomed the idea of being permitted to leave their pain, suffering and sickness.”²² He then highlighted several conditions that make life intolerable: “Perhaps it is nausea, pain or various types of distress and the patient no longer has the will to live.”²³ According to Wilbee, the patient’s existential being, or his or her lived reality, was at the heart of Wenman’s bill:

I think that this law permits a physician to do what he thinks is the best thing. Perhaps this is to do nothing but to make sure that the patient is relieved of suffering. We are talking in this law today

¹⁸ Ibid. Robinson was making reference to the “slow, agonizing and painful death” of his friend Mitch Jacobson who died of AIDS at the Elizabeth-Bruyère Health Centre in Ottawa.

¹⁹ Ibid., 2668; also see Derek Humphry, *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying* (New York: Random House, 1991). Humphry’s book was particularly controversial because not only did he openly support an intentionally hastened death, something he called “self-deliverance,” but his book even provided graphic descriptions of how to use the most effective methods of death-hastening (e.g., placing a plastic bag over one’s head and filling it with helium, outlining the proper use of drug dosages, and maintaining a checklist to stage the ideal suicide).

²⁰ Ibid., 2669.

²¹ Ibid.

²² Stan Wilbee, 2670.

²³ Ibid.

about passive euthanasia. . . . It is [the patient's] care and comfort that we are looking for, and I believe the quality of life which this bill is protecting is all important.²⁴

In contrast, two members of the House sensed that Wenman's proposal had not considered the potential fallout from the "slippery slope." Mrs. Barbara Sparrow (Parliamentary Secretary to Minister of National Health and Welfare, PC) claimed that there were "some negatives" to the proposed Bill C-203. Although she admitted that, as a nurse, she found herself in certain situations that were "extremely difficult where people certainly did suffer a great deal," she still conceded that "there [were] complications with regard to providing legislation that allows physicians the right to practice [sic] [passive] euthanasia."²⁵ Bill C-203 had to be sent to committee for further discussion because, as Mrs. Sparrow admitted, "the negatives are so great."²⁶ Although Mrs. Sparrow felt that a consensus would have to be found to resolve any "complications" produced by Bill C-203, she suggested that religious organizations were key to this resolution: "There can be criteria worked out that I feel can be accepted, not only by the medical fraternity, but the community in general, all assisting health care institutions and the religious areas. Getting in touch with the church, I think is most important."²⁷

Of all House members, the most resistant to Bill C-203—and the politician whose rhetoric was most indicative of metaphysics—was Mr. Don Boudria (Glengarry—Prescott—Russell, Lib.). Not only was Mr. Boudria "a person who believe[d] very strongly in the sanctity of life,"²⁸ but his major concern was the possible rejection of

²⁴ Ibid., 2670, 2671.

²⁵ Barbara Sparrow, 2672.

²⁶ Ibid.

²⁷ Ibid.

²⁸ Don Boudria, 2673.

stewardship, particularly a society that “would start . . . to play God in any way.”²⁹ As with other sanctity of life advocates, Boudria targeted the Netherlands as a country whose policies were “wrongheaded.” He felt that “too many decisions . . . [were] taken by members of the [Dutch] medical profession to end human life,” adding: “That whole subject disturbs me immensely.”³⁰ Even with such reservations over Bill C-203, both Sparrow and Boudria were, nevertheless, in favour of its referral to committee in order to examine the issues the bill raised. However, following several weeks of hearings, the legislative committee charged with reviewing the bill would not assign a further meeting date, which “effectively halted further parliamentary action on the bill.”³¹

Those on the centre-right who rejected Wenman’s proposal were no doubt bothered by his more open admission that individuals—along with God—could co-govern their own deaths. Using *passive* means, one could lessen the time period associated with prolonged suffering, allow the agent more control over his or her death, and weaken stewardship as a foundational principle in end-of-life care. The fact that Wenman was encountering resistance for a bill on “passive” euthanasia indicated that in the early 1990s, prior to the case of Nancy B., Canadian parliamentarians had not fully resolved the ethical viability of withdrawing/withholding treatment. The line between standard medical practice and intentionally hastening death was still precarious even for acts of omission. Although many politicians had already made the transition from vitalism to the *qualified* sanctity of life ethos, the shift was not universal. This was evidenced by the fact that Wenman’s “middle way” approach—one that positioned itself

²⁹ Ibid.

³⁰ Ibid.

³¹ Marlisa Tiedemann and Dominique Valiquet, *Euthanasia and Assisted Suicide in Canada* (Parliamentary Information and Research Service: Library of Parliament, July 17, 2008), 19.

between vitalism and the quality of life ethos—proved unsuccessful. His attempt to resolve part of the dilemma over patient suffering fell short, and Bill C-203 was dropped from the Order Paper.

Chris Axworthy and the Quality of Life Ethos

In June, 1991, Member of Parliament Chris Axworthy (Saskatoon Clark's Crossing, NDP) introduced Bill C-261, "an Act to legalize the administration of euthanasia under certain conditions to persons who request it and who are suffering from an irremediable condition and respecting the withholding and cessation of treatment and to amend the Criminal Code."³² The bill was more controversial than Wenman's in that it made the method of death more inclusive. Unlike Wenman's emphasis on absolute moral distinctions, Axworthy's bill made no such demarcation. Its main purpose was to legalize active euthanasia while simultaneously protecting from criminal prosecution "doctors involved in euthanasia-like situations," such as pain relief that may possibly hasten death (the doctrine of double effect) and the withholding or withdrawal of treatment.³³ To qualify for active euthanasia (i.e., lethal injection), the candidate must be suffering from a terminal illness, consent must be provided by an adult (or a legal guardian for a minor), and the person must apply to a euthanasia referee for a "euthanasia certificate."³⁴

Axworthy felt that a more complex, pluralistic society had emerged, one that would now sanction euthanasia. Highlighting a broader approach to medical ethics,

³² Chris Axworthy (Saskatoon-Clark's Crossing), "Bill C-261: Euthanasia and Cessation of Treatment Act," *The House of Commons Canada* (3rd Session, 34th Parliament) First Reading, June 18th, 1991, 1.

³³ *Ibid.*, 1a.

³⁴ Marlisa Tiedemann and Dominique Valiquet, *Euthanasia and Assisted Suicide in Canada*, 18.

Axworthy noted that the World Health Organization was utilizing “an holistic definition of health which include[d] spiritual, emotional, family, environmental and physical aspects.”³⁵ From his perspective, there was a shift toward the quality of life ethos, which implied that “[p]eople also deserve[d] a better quality of death.”³⁶ He sensed that more hermeneutic charity had to be given to the sanctity of life ethos in order to expand its meaning beyond vitalism. As Axworthy asserted, “Certainly if as a society we want to preserve the moral value of the sanctity of life, we need to be clear about what is sacred about life. Is it biological existence of [sic] some measure of quality?”³⁷ For Axworthy, the sanctity doctrine was not a “one size fits all” paradigm but rather a general ethos that had to be tailored to fit personal circumstances: “If we do not want to violate the sanctity of life then I believe we are required to respect each individual’s interpretation of life’s meaning and accept that this will necessitate the availability of euthanasia within our health care system.”³⁸

The emphasis on lived reality was most apparent in Axworthy’s discourse. He suggested that euthanasia was preferred by some individuals when “the quality of life defined by the patient ha[d] degenerated to the point of meaninglessness, when the illness ha[d] reached a stage beyond the help of the physician.”³⁹ Axworthy admitted that voluntary euthanasia rested on a fundamental human right, that being “the right to die if death is the only release from suffering.”⁴⁰ Unlike sanctity of life advocates, he saw no point in “sentencing [individuals] to lingering, painful deaths,” adding that for patients

³⁵ Chris Axworthy, “Euthanasia and Cessation of Treatment Act,” *Commons Debates* (3rd Session, 34th Parliament) Vol. III (September 25th-October 25th, 1991), 3992.

³⁶ *Ibid.*, 3992-3993.

³⁷ *Ibid.*, 3994.

³⁸ *Ibid.*

³⁹ *Ibid.*, 3993.

⁴⁰ *Ibid.*

suffering from terminal cancer, “about three per cent will experience pain which is medically untreatable.”⁴¹ Since Axworthy accepted an holistic approach to health, he recognized that “suffering can take many forms beyond physical and terminal manifestations.”⁴²

More importantly, Axworthy outlined how opposition to euthanasia revolved around specific rhetorical patterns. First, he suggested that stewardship played a role in prohibition. In his words: “Some put forth the argument that only God gives life and only God can take it away and thus euthanasia should be opposed.”⁴³ Although the “slippery slope” was worrisome for prohibitionists, Axworthy reminded Parliament that such anxiety was unwarranted: “The concern expressed that voluntary euthanasia would lead to involuntary euthanasia is not warranted if the legislation is carefully developed and crafted.”⁴⁴ For those who argued that the role of the physician as healer would be undermined, Axworthy informed his colleagues that medical history should be viewed as “eventuation” in the Vattimian sense: “[The Hippocratic Oath] was created prior to any possible conception of what health care would become today and it was created in the absence of any real ability to prolong life in the fact of death. Times have changed

⁴¹ Ibid., 3993, 3995.

⁴² Ibid., 3995. That various manifestations of suffering exist is a thesis widely promoted by Eric J. Cassell. Adopting a postmodern perspective, Cassell believes that two people may experience the same circumstances but react differently, adding weight to his thesis that “suffering is *always individual*” and “the loss of a person’s intactness—the hallmark of suffering—is related to the specific nature of that person.” For Cassell, the term “suffering” is a complex phenomenon and relative to context. Therefore, all aspects of personhood—the lived past, the family’s lived past, culture and society, roles, associations and relationships, the body, and the perceived future—can all affect one’s perception of suffering. See Eric J. Cassell, *The Nature of Suffering and the Goals of Medicine* (New York: Oxford University Press, 1991), 30-47; also see Eric J. Cassell, “When Suffering Patients Seek Death,” in *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice*, edited by Timothy E. Quill and Margaret P. Battin, 75-88.

⁴³ Ibid., 3994.

⁴⁴ Ibid.

drastically in this regard and I think we need to address these concerns in a different and more humane way.”⁴⁵

As with Wenman’s bill, Liberal Don Boudria was again a vocal opponent of Axworthy’s proposal. Relying heavily on the Christian metaphysical tradition, Boudria began by summarizing his feelings over a potential shift in social mores. Addressing the Speaker, he declared: “[T]his is one of those sad days when I wonder whether I should be angry or sad; sad about the role we are being asked to play in the House today.”⁴⁶ From Boudria’s perspective, matters over life and death were not the individual’s concern since “no one on earth had the right to decide whether someone may live or die.”⁴⁷ He also remarked how suffering possessed some kind of value, especially towards the latter stages of death: “I believe as well that life becomes even more precious when there is little left to live.”⁴⁸

However, Boudria’s greatest concern entailed the “slippery slope.” At significant risk, he insisted, were “people who have reached a certain age in life.”⁴⁹ The lives of the elderly were particularly in jeopardy in Holland, Boudria claimed, citing anecdotal evidence provided by a British Columbia physician, Dr. Will Johnson:

What has this practice [euthanasia] done to the concept of trust? Rumours abound. One psychiatrist muses that he has a choice of two nursing homes for his elderly patient. One home he feels is involved in fairly aggressive euthanasia of the demented elderly, and he says “my patient would not last half as long if I sent her there.” It has become common knowledge that some physicians take the initiative “you really ought to go to hospital now or I could just give you an injection.” Given widespread fear of hospitals and ignorance of the effective palliation that is available [in Holland], this ominous scenario is now complete.⁵⁰

⁴⁵ Ibid., 3994-3995.

⁴⁶ Don Boudria, 3998.

⁴⁷ Ibid.

⁴⁸ Ibid., 3999.

⁴⁹ Ibid.

⁵⁰ Ibid.

Again citing Dr. Johnson, Boudria highlighted one published case in which a Dutch physician was called to a patient's home and recommended euthanasia after "meeting [the patient] for the first time," giving her only "one hour to think it over."⁵¹ Overall, Boudria rejected what he called "state legislated murder," confessing to his colleagues that "[i]f there is only one mercy killing I want to do right now, it is to kill this bill immediately and put it out of its misery."⁵² On October 24th, 1991, the bill was dropped from the Order Paper.

Ian Waddell, Raymond Skelly, and the Continuing Postmodern Trend

In February, 1993, Mr. Ian Waddell (Port Moody—Coquitlam, NDP) introduced another motion, calling upon the government to consider "the advisability of introducing legislation on the subject of euthanasia and, in particular, of ensuring that those assisting terminally ill patients who wish to die not be subject to criminal liability."⁵³ The reasoning behind the motion was existential in that chronic, degenerative diseases "caused extensive physical and emotional suffering prior to death."⁵⁴ Quoting the president of the Victoria Chapter of the ALS Society of British Columbia, Waddell provided a description of how ALS patients eventually die: "When some people lose the ability to swallow, they refuse to be fitted with a stomach tube and die in about 10 days. That means starving to death."⁵⁵ Quoting Sue Rodriguez, Waddell wanted to emphasize compassion since other Canadians "may some day be in a position similar to

⁵¹ Ibid.

⁵² Ibid.

⁵³ Ian Waddell, "Private Members' Business: Euthanasia," *Commons Debates* (3rd Session, 34th Parliament) Vol. XII (December 8th-February 17th, 1992-1993), 16093.

⁵⁴ Ibid.

⁵⁵ Ibid., 16094.

[Rodriguez's]."⁵⁶ The important question for Waddell was whether the "quality of life in these last days is worth the effort to keep the patient alive."⁵⁷

Waddell was also sceptical of any "slippery slope" allegations. Referencing a book by Derek Humphry and Ann Wickett titled *The Right to Die: Understanding Euthanasia*, Waddell summarized the main concern for sanctity of life advocates: "If euthanasia is permitted in limited ways today, however tightly controlled by law, what is to stop groups and/or governments in the future from taking things a step further and introducing compulsory death for, say, the burdensome, the poor, the handicapped, the sick, and the elderly?"⁵⁸ Waddell countered this claim with a critique provided by Humphry and Wickett:

Where is the sense . . . in telling a dying person of throat cancer that euthanasia cannot be made available because Nazi Germany murdered thousands of people in the 1940s using a method labelled "euthanasia"? The lessons of history are there to be learned, and the Nazi experience has taught society how not to let government slip into the hands of an irresponsible minority.⁵⁹

Waddell agreed that a theoretical possibility of abuse existed; therefore, he insisted on safeguards "to make sure that the choice [to end life with dignity] is not taken advantage of."⁶⁰

⁵⁶ Ibid.

⁵⁷ Ibid., 16093.

⁵⁸ Ibid., 16095; also see Derek Humphry and Ann Wickett, *The Right to Die: An Historical and Legal Perspective of Euthanasia*, 313.

⁵⁹ Ibid. Some critics have questioned the sincerity of Humphry's and Wickett's convictions. Ian Dowbiggin notes that Derek Humphry left his second wife, Ann Wickett, shortly after she had undergone breast cancer. Wickett was so depressed by the desertion that in 1991 she killed herself by taking a lethal overdose of drugs. She left a note stating, "There. You [Derek] got what you wanted. Ever since I was diagnosed as having cancer, you have done everything conceivable to precipitate my death." Wickett even sent a copy of the note to anti-euthanasia activist Rita Marker. To Marker she wrote: "Rita: My final words to Derek. He is a killer. I know." She even accused Humphry of suffocating his first wife, Jean, not just supplying her with medications to end her life as was claimed by Humphry; see Ian Dowbiggin, *A Merciful End: The Euthanasia Movement in Modern America*, 151; also see Rita Marker, *Deadly Compassion: The Death of Ann Humphry and the Case against Euthanasia* (London: HarperCollins Publishers, 1993); Sue Woodman, *Last Rights: The Struggle over the Right to Die* (New York: Plenum, 1998).

⁶⁰ Ibid.

Not surprisingly, Robert Wenman provided some support for Waddell's motion, but only to a degree. The rhetoric of self-determination was once again central to Wenman's view of an intentionally hastened death. As he declared in Parliament,

Surely the ultimate freedom in a free and democratic society is when an educated rational man or woman has become self-actualized in creating, making and living with the results of free choice. Is that not what we are trying to create by law here? . . . When we are mature should we not have the right of free choice to make our own decisions in what might well be our own end times?⁶¹

Wenman became more animated as he pointed out how the dying, in their greatest moment of vulnerability, were being deprived of a fundamental human right: "Why should our right to free choice as rational men and women be stolen from us just because we have become terminally ill? That does not mean we lose our capacity to think, to feel, to suffer. I resent that this right is not my right before the laws of Canada."⁶²

Undoubtedly, paternalism was of grave concern to Wenman since it thwarted the right to self-determination for the terminally ill. In his words: "I must shout right now in this House because of the great fear I have of lying powerless and helpless in an extended terminal care bed somewhere and not being able to shout. Instead the decision would be made for me by well-meaning doctors, by the state, or even a well-meaning family."⁶³

Despite the rhetoric of autonomy, missing from Wenman's discussion was any overt support for active euthanasia and physician-assisted suicide. Instead, he used Waddell's motion to reiterate his support for "passive" euthanasia exclusively: "This is why I brought in Bill C-203. I wanted the right of protection from the state against the

⁶¹ Wenman, 16096. Self-determination or "living with the results of free choice," is a philosophical argument heavily promoted by Michael J. Hyde. Influenced by Heidegger, Hyde believes that because human beings are temporal, finite creatures they are "fated" to hear the "call of conscience," or "truth of Being," which Hyde claims comes to us out of the "uncertainty and contingency of human existence." As a result, the call of conscience "'summons' us to the challenge of assuming the ethical responsibility of affirming our freedom through resolute choice such that we can structure and live out existence in a meaningful and moral way." See Michael J. Hyde, *The Life-Giving Gift of Acknowledgement* (West Lafayette, Indiana: Purdue University Press, 2006), 39-40.

⁶² Ibid.

⁶³ Ibid.

state and against the medical profession and against the technology so that I could make a decision between myself and my God.”⁶⁴ Making explicit religious references, Wenman believed that technology could be used to hasten death, a tool God provided as a release from suffering:

Even at some point in the life and death process it seems science and technology and the state are fighting against death but [sic] prolonging suffering. I do not think that was the intention of God when He gave us medical science. He gave it to us to save our lives, yes, but He gave it to give our lives comfort and He gave it to give us comfort as we pass from death to life again.⁶⁵

Wenman concluded by emphasizing how the existential being of the patient was paramount to understanding the debate over “passive” euthanasia: “I want to preserve my right that should I become terminally ill I might at one point in the suffering process of my death say that enough is enough. . . . Make me comfortable and let me go.”⁶⁶

Mr. Boudria was first to critique Waddell’s original motion, focusing almost exclusively on the dangers of the “slippery slope.” Highlighting the plight of Sue Rodriguez, Boudria suggested that the terminally ill were being coerced to die:

We are debating this because of an unfortunate person who is very ill in British Columbia and who I believe has been used by others in a propaganda campaign on this issue. That is sad for all of us as a society, and it is particularly sad for that woman. Of course I am referring to Mrs. Sue Rodriguez.⁶⁷

Boudria mentioned how Rodriguez was manipulated when John Hofsess of the Right to Die Society betrayed her trust in order to publish a news story: “. . . [H]e [Hofsess] had forged the signature of Mrs. Rodriguez on certain documents. Yet that person [Hofsess] is the one who asks us to trust him or others like him with the life of an individual when he was not even trustworthy enough not to forge the signature of

⁶⁴ Ibid.

⁶⁵ Ibid.

⁶⁶ Ibid.

⁶⁷ Boudria, 16097.

someone else.”⁶⁸ Boudria’s “slope” fears went beyond the Canadian context. He believed that in Holland people were deciding “whether or not to enter a hospital based on their chances of escaping euthanasia if they go there.”⁶⁹ Boudria informed the House that not only were there “10,000 cases of active euthanasia per year” in Holland, but “there [was] a virtual absence of hospices and palliative care.”⁷⁰ Because Boudria perceived a deficiency in palliative resources in the Netherlands, he depicted euthanasia as a “quick fix for the lack of care provided for the dying.”⁷¹

Boudria’s remarks were supported by Mr. Ross Belsher (Parliamentary Secretary to Minister of Fisheries and Oceans for the Atlantic Canada Opportunities Agency, PC). As with Boudria, the rhetoric of the “slippery slope” dominated the discourse. Quoting an article in the *Ottawa Citizen* by Susan Zimmerman, a lawyer involved with the McGill Centre for Medicine, Ethics and the Law, Mr. Belsher posited that vulnerable populations would be at risk if euthanasia were to become state-sanctioned: “Acceptance of euthanasia in any form means that death becomes an option where currently it is not. How will we measure the insidious shift this will entail in social attitudes toward the weak, the infirm, the elderly and the dependent?”⁷² As a national example of the “wedge” issue, Mr. Belsher pointed to Holland where euthanasia was “not just being considered for the terminally or chronically ill, but also for newborns,” something he

⁶⁸ Ibid. Hofsess had signed a newspaper column for the *Vancouver Sun* with a shaky “S.R.,” with the “R” trailing off as if the writer could not hold a pen, an indication that Rodriguez had actually signed it. Hofsess tried to justify the forgery by claiming Rodriguez had reached the point in her disease where she was unable to write her own letters. Rodriguez’s reply to Hofsess’ statement was succinct: “I am sick but I can still talk. No one talks for me but me.” Even with an apology by Hofsess, a trust had been broken, and Rodriguez eventually broke off all ties with Hofsess. She was eventually befriended by New Democrat Svend Robinson; see Lisa Hobbes Birnie and Sue Rodriguez, *Uncommon Will: The Death and Life of Sue Rodriguez*, 90-94, 115.

⁶⁹ Ibid., 16097-16098.

⁷⁰ Ibid., 16098.

⁷¹ Ibid.

⁷² Ross Belsher, 16099.

found “extremely disturbing and something to be feared.”⁷³ Also problematic was the possibility of neglecting alternative treatments for economic motives: “The danger,” according to Belsher, “is that where physicians decide to practice [sic] euthanasia or aid in a suicide, their patients might not be aware of the option of appropriate palliative care. . . . [I]n this sense there is a danger that euthanasia may then be regarded as a cheap substitute for palliative care.”⁷⁴

As with other sanctity of life enthusiasts, Mr. Belsher confirmed that absolute moral distinctions were central to the debate over an intentionally hastened death. He told parliamentarians that “generally approved medical practices such as administering palliative care for pain relief even when it may also have the effect of hastening the death of terminally ill patients is not murder.”⁷⁵ Belsher submitted that various acts of omission did not involve the intention to hasten death because their function was strictly to respect autonomy and relieve suffering:

Removing a respirator at the request of the patient is seen by most as an accepted practice. Withdrawing drugs and food from patients in a persistent vegetative state at the request of a patient’s family has been recognized as an extension of the patient’s own right to refuse treatment. In all these situations, treatment has not been successful and all that remains is to make the patient as comfortable as possible or to grant the request of the patient or his or her family to cease any further attempt to treat.⁷⁶

Overall, Mr. Belsher was succinct with his reasons for maintaining such distinctions and, thus, rejecting Waddell’s motion. His foundational principles led him to believe that intentionally causing death by “playing God” was simply out of the question: “It is an ethical question which forces us to look at ourselves, and I . . . cannot bring

⁷³ Ibid.

⁷⁴ Ibid., 16100.

⁷⁵ Ibid.

⁷⁶ Ibid.

myself to support the motion or the sentiment surrounding it. I do not want to set aside the principle that intentionally taking the life of another is no longer wrong.”⁷⁷

Mr. Tom Wappel (Scarborough West, Lib.) concurred with both Boudria and Belsher in that the possibility of a “slippery slope” presented the greatest threat to society. Since many patients would be suffering when the decision to terminate was made, Mr. Wappel insisted that such patients would be too distraught to make a rational choice: “Are they going to be thinking straight? Are they going to have the ability to determine this [the request for euthanasia] on their own? Of course not.”⁷⁸ Wappel singled out Holland an example of why safeguards did not work. He highlighted a list of serious accusations against the Dutch medical system, especially the use of *involuntary* euthanasia:

What happened in Holland? In 1990, 1,030 Dutch patients’ lives were terminated. They were killed without their consent . . . Of 22,500 deaths due to withdrawal of life support, 63 per cent of them, 14,175 living patients, were denied medical treatment without their consent and 12 per cent of them, 1701, were mentally competent but were not consulted. They were killed without consultation. They were executed without consultation.⁷⁹

To outline his own core beliefs, Mr. Wappel made an explicit religious reference to Christian morality to clarify why euthanasia should be prohibited: “The member for Fraser Valley West [Mr. Wenman] however did mention the word ‘God’ . . . He mentioned his God and I know his God because He is the Christian God. I remind him and people listening of precisely what his God has already said in one of His 10 very simple rules: ‘Thou shalt not kill.’”⁸⁰

Initially supporting Wenman’s bill, Mr. Wilbee (Delta, PC) now wavered. He noted “slope” concerns whenever the topic switched from “passive” euthanasia to the

⁷⁷ Ibid.

⁷⁸ Tom Wappel, 16101.

⁷⁹ Ibid.

⁸⁰ Ibid.

possibility of physician-assisted suicide (i.e., acts of commission). Though Wilbee felt Sue Rodriguez deserved sympathy, coercion was in his opinion a more important consideration than self-determination: “The real question on my mind,” declared Wilbee, “is whether this woman [Rodriguez] is being manipulated. She has expressed a desire to end her life when the time comes. I have a real concern for this woman in that area.”⁸¹ Mr. Wilbee agreed with Boudria in that John Hofsess’ forgery not only highlighted the danger of the “slippery slope,” but also questioned the integrity of the right-to-die movement:

The head of the Right to Die Society [John Hofsess] admitted that he had forged Sue’s initials on a letter. In it he said that [Rodriguez] said that the letter does not represent her viewpoint and was sent without her knowledge. The fellow that did this is the executive director of the Right to Die Society that is backing Rodriguez court challenge [sic] to have the law prohibiting assisted suicide struck down. He admitted: “My actions were both inappropriate and unethical.” I think we need to look at that with care.⁸²

The House resumed on February 26th (1993) for consideration of Mr Waddell’s motion. Mr. Doug Fee (Red Deer, PC) maintained the familiar rhetorical patterns held by sanctity of life advocates, especially normative assumptions surrounding communal danger. Initially, Mr. Fee viewed euthanasia as a direct threat to better pain management: “He [Mr. Waddell] is asking the government in the name of compassion to legalize murder. I want to add my name to those who think our compassion would be better served by expanding palliative care and pain relief rather than endorsing the killing of people.”⁸³ Without quality palliative care, Fee surmised that Canadian hospitals, like those in Holland, would recommend euthanasia as a cost-cutting measure:

There is a real danger that euthanasia will be regarded as a cheap substitute for palliative care. . . . The Netherlands failed to develop hospice programs and as a result is known for its poor standards

⁸¹ Stan Wilbee, 16102.

⁸² Ibid.

⁸³ Doug Fee, “Private Members’ Business: Euthanasia,” *Commons Debates* (3rd Session, 34th Parliament) Vol. XIII, (February 18th-March 23rd, 1993), 16565.

of palliative care and pain relief. In desperation it has turned to euthanasia as a cheap solution to suffering.⁸⁴

In addition, Fee used the example of Jack Kevorkian to demonstrate additional risks to patients: “He [Kevorkian] claims to operate on the basis of compassion. . . . Apparently one of his patients changed his mind at the last minute and the well-meaning doctor proceeded with his procedure anyway and killed him. Is this what we want to open the door to? I think not.”⁸⁵

Absolute moral distinctions were also emphasized by Mr. Fee in order to distinguish between acts of omission and commission. In his opinion, there was an ethical difference between the *qualified* sanctity of life ethos and an intentionally hastened death:

We should not confuse the issues. No one is required to accept medical heroics to maintain life. That principle has been decided. This motion goes beyond that and asks that we open the door to legalizing murder. This is not about turning off respirators. This is not about artificially resuscitating and reviving people. This is not about forcing life into unwilling bodies. This motion asks for permission to kill patients.⁸⁶

Fee also distinguished between the doctrine of double effect and euthanasia/assisted suicide on the basis of legal precedent: “Court decisions have made it

⁸⁴ Ibid. Dutch medical practitioners categorically deny allegations that their hospice and palliative care services are underdeveloped or threatened by alternatives, such as euthanasia or physician-assisted suicide. See Senate of Canada. *Of Life and Death: Report of the Special Senate Committee on Euthanasia and Assisted Suicide*. Ministry of Supply and Services Canada (May 1995), A-115 to A-148.

⁸⁵ Ibid., 16566. The case involved Hugh Gale, someone whom Kevorkian aided in a suicide. There were conflicting reports as to how Gale died. It was initially reported that Gale had asked Kevorkian to “take it [the mask] off.” This report actually came from a right-to-life group, Operation Rescue, known in the United States for its attempts to shut down abortion clinics. One day later, Operation Rescue maintained that Kevorkian could have murdered Gale, admitting that the report it found was located in the trash of the doctor’s assistant. This conflicts with the testimony of Gale’s widow, Cheryl, who maintained that her husband “never abandoned his determination to die.” In a biography of Kevorkian by Nicol and Wylie, they claim the real victim was not Hugh Gale but his loved ones. His wife, Cheryl Gale, was “left alone in a house surrounded by crime scene tape, hounded by ubiquitous reporters, her neighbours badgered by the police.” They reported that Hugh Gale decided that he had had enough of life and told his wife Cheryl that all he wanted for Christmas was a visit from Jack Kevorkian.” See David Osborne, “Kevorkian Patient Tried to Halt Euthanasia, Report Suggests,” *Ottawa Citizen* 27 February 1993, A12; also see “Two Sides Demonstrate at Suicide-MD’s Home,” *Ottawa Citizen* 28 February 1993, B7; also see Neal Nicol and Harry Wylie, *Between the Dying and the Dead: Dr. Jack Kevorkian’s Life and the Battle to Legalize Euthanasia* (Madison, Wisconsin: The University of Wisconsin Press, 2006), 178.

⁸⁶ Ibid.

increasingly clear that generally approved medical practices, such as administering palliative care and pain relief, even when it [sic] may also have the effect of hastening the death of terminally ill patients, is [sic] not murder.”⁸⁷ He also noted that in Canada there has never been criminal responsibility where “a palliative care treatment has had the effect of hastening death” and that “no consensus has developed on issues involving euthanasia and aiding suicide.”⁸⁸ Consequently, Fee concluded that society “cannot let compassion overrule our moral values.”⁸⁹

In opposition to sanctity of life advocates, Mr. Raymond Skelly (North Island—Powell River, NDP) focussed on the existential being of the patient and the feasibility of safeguards. He concurred with Mr. Waddell in that he “would like to see culpable homicide removed from the Criminal Code so that terminally ill patients, suffering tremendously and wishing to end their lives, can be assisted in a reasonable and practical way to do so. That is an element of compassion.”⁹⁰ Moreover, Mr. Skelly did not support the either/or schism between hospice care and an intentionally hastened death; in fact, he recognized both options as beneficial in alleviating suffering:

One of the things that has suffered is funding for palliative care. . . . Let those funds go so that people do not have to die in pain and agony, so that they can make a choice of going to a palliative care unit where they can get decent treatment and can end their last days in relative comfort and dignity. . . . We need more resources in that area, but at the same time the door should not be closed on an individual who says: “I can no longer live in unbearable pain, with a lack of dignity and have no control over myself or my bodily functions. I wish to end my life and I wish to have medical assistance to do so.”⁹¹

⁸⁷ Ibid. Both Canadian and American court cases have been unanimous in supporting the omission/commission distinction. See *Nancy B. v. Hôtel-Dieu de Québec* (Q.C.A.), [1992], 86 D.L.R. (4th) 385, 69 C.C.C. (3d) 450, 1992 CarswellQue 387, J.E. 92-132, EYB 1992-84012 (C.S. Que., Jan 06, 1992) LexisNexis Quicklaw; *Vacco, Attorney General of New York, et al.*, No. 95-1858 v. *Quill et al.*, 117 S.Ct.2293 (1997); *Washington et al., Petitioners* No. 96-100 v. *Harold Glucksberg et al.*, 117 S.Ct. 2258 (1997).

⁸⁸ Ibid., 16556, 16567.

⁸⁹ Ibid., 16567.

⁹⁰ Raymond Skelly, 16568.

⁹¹ Ibid.

According to Skelly, Parliament had a duty to end suffering by seriously considering Waddell's motion. The House, he claimed, had "a responsibility to bring forward and place before the people of Canada a proposal" that would end the pain and anguish of the "terminally ill, those suffering from AIDS or any of the other chronic afflictive illnesses that incapacitate people."⁹²

Mr. Skelly also disputed "slippery slope" allegations. He called any argument "outrageous" that claimed the Netherlands had passed legislation on euthanasia because "it was against palliative care," adding: "That is just unmitigated nonsense."⁹³ He informed the House that the Netherlands did not create legislation based on an "anything goes" relativism but instead "passed into law a limited provision with plenty of safeguards so that there is no abuse to basically deal with the wishes of terminally ill patients."⁹⁴ In general, Mr. Skelly felt that individuals requesting an intentionally hastened death required an open system to perform such an act "safely and effectively" and that there was "a willingness to provide that [assistance] on the part of the medical practitioners."⁹⁵

However, Mr. Fernand Jourdenais (La Prairie, PC) reignited debate over the "slippery slope." According to Mr. Jourdenais, one of the difficult issues raised by Waddell's motion was the possibility of misdiagnosis. As Jourdenais indicated, "[M]any persons initially diagnosed as terminal have continued to live and contribute to society in a meaningful way for many years."⁹⁶ The risk of labelling was also a potential danger

⁹² Ibid., 16569.

⁹³ Ibid., 16568.

⁹⁴ Ibid., 16569. For a more nuanced understanding of the forms of relativism, see Jeppe Sinding Jensen, *The Study of Religion in a New Key: Theoretical and Philosophical Soundings in the Comparative and General Study of Religion* (Denmark: Aarhus University Press, 2003), 353-404.

⁹⁵ Ibid., 15568.

⁹⁶ Fernand Jourdenais, 16569.

that Jourdenais found worrisome. If euthanasia were made available to either the terminally or chronically ill, these groups could “feel pressure from society and family not to remain a burden on scarce resources.”⁹⁷ Jourdenais theorized that economic considerations would impact upon “the allocation of health resources [by reflecting] the value put on individual persons by society’s approval of euthanasia.”⁹⁸ Consequently, the “intrinsic worth of every individual would be breached” since the public would find it easier “to weigh money against life.”⁹⁹ Such utilitarianism, according to Jourdenais, would create a new ethical reality in that “some diagnoses will mark the patient as a possible candidate for euthanasia or assisted suicide.”¹⁰⁰ As a specific example of coercion, Jourdenais highlighted the Dutch context: “There have been reports from that country [the Netherlands] that elderly people fear pressure from society and families to submit to what has become an increasingly prevalent practice [euthanasia].”¹⁰¹

Jourdenais’ perspective was supported by Mr. Jesse Flis (Parkdale—High Park, Lib.). Mr. Flis’ reasoning for rejecting Waddell’s motion was based entirely on the “slippery slope,” specifically the potential for recovery after a terminal diagnosis. Flis used three separate scenarios to demonstrate his apprehension over an intentionally hastened death. In the first instance, a man was hit by a car, sustained severe head injuries, and lapsed into a deep coma. Although given intravenous feeding, he passed away after four years. According to Flis, one could argue that “maybe it was better with modern medical advice to have disconnected the tubes after one year in a coma, or maybe after two years in a coma, because doctors were quite sure that he would not come out of

⁹⁷ Ibid.

⁹⁸ Ibid.

⁹⁹ Ibid.

¹⁰⁰ Ibid., 16570.

¹⁰¹ Ibid., 16569.

this coma.”¹⁰² However, Flis noted another case in which a man had suffered a heart attack and stroke, again lapsing into a deep coma. When Flis asked the doctor what the chances of recover were, the doctor said, ““No, there is no way that he will come out of this.”” Flis then described what he witnessed just three months later:

I will never forget what followed. . . . As we walked into the campaign headquarters to begin our 1984 campaign I thought I saw a ghost in front of me. Here was Takhur [the man in the coma] standing in the entrance, unshaven, skin and bones. This was three months after I had seen him in hospital, and I thought he was already gone . . . The medical doctor had said straight to my wife and I: “No, he will not come out of this.”¹⁰³

Flis’ final example involved his mother-in-law who suffered a severe stroke at the age of seventy-nine:

Well, that woman, my mother-in-law, lived to be 89 years old. Again, professional advice and her own will could have said: “I want to end it at age 79.” She had a will to live. . . . She got herself going to the point where she was walking. She saw more grandchildren grow up and she went on peacefully, but at 89 years of age not at 79 years of age.¹⁰⁴

Flis concluded that because of these specific cases he had to “speak out strongly against any legislation that would assist taking someone’s life” because such lives would have been “snuffed out.”¹⁰⁵

Mr. Bob Horner (Mississauga West, PC) also voted against Waddell’s motion because of the risks associated with the “slippery slope.” Mirroring Mr. Fee’s alarming headlines, Mr. Horner reminded his colleagues of the threat posed by Jack Kevorkian: “. . . [T]he news story this morning was that in Michigan there is a case involving assisted suicide. The allegation is that the chap [Hugh Gale] changed his mind and now there may be murder charges. . . . I would be very worried to see the government act quickly in

¹⁰² Jesse Flis, 16570.

¹⁰³ Ibid., 16571.

¹⁰⁴ Ibid.

¹⁰⁵ Ibid.

such an important area [legislation on euthanasia].”¹⁰⁶ Mr. Horner insinuated that the availability of euthanasia for the dying would lead to “pressure on these individuals to commit suicide in order to be relieved from pain and to relieve their relatives from the burden they impose upon them.”¹⁰⁷ As with Mr. Flis, Horner worried that patients may end their lives prematurely upon receiving news of a terminal diagnosis: “A person who would have committed an assisted suicide after hearing the news and becoming understandably depressed would in such a case have been deprived of meaningful years during which this person could have enjoyed his life to some extent and contributed to society.”¹⁰⁸ Lastly, Horner questioned whether euthanasia could realistically be limited to adults: “What about children who are terminally ill and wish to die? When would they be considered old enough to consent to their own deaths?”¹⁰⁹

As a rare example of right-wing support for acts of commission, the Hon. John Bosley (Don Valley West, PC) indicated that he would vote for Waddell’s motion. His perspective on pointless suffering was shaped largely by personal experiences that differed from Mr Flis’ moving stories. Mr. Bosley told the House about his mother’s terminal illness and that he never forgot her “pleading [him] to kill her when she was dying of cancer.”¹¹⁰ Seeing little value in prolonging the suffering of his mother, Bosley was supportive of the doctrine of double effect for its potential death-hastening effects: “I do not know if the doctor who prescribed the morphine for my mother prescribed such a dosage that it led to her dying sooner [from respiratory failure]. If he did, bless him, because there was nothing being achieved in what she was going through, nothing

¹⁰⁶ Bob Horner, 16572

¹⁰⁷ Ibid.

¹⁰⁸ Ibid.

¹⁰⁹ Ibid., 16573.

¹¹⁰ John Bosley, 16573.

whatsoever.”¹¹¹ Overall, Bosley’s position was that anyone assisting a suicide for those suffering miserably and for whom all hope is lost “would be doing a service, as terrible as that is to think.”¹¹²

Bosley’s perspective was supported by Mr. Lyle Dean MacWilliam (Okanagan—Shuswap, NDP). He did not view euthanasia as murder because, in his opinion, “Euthanasia is about compassion, about an understanding of the needs of those who are terminally ill to face death with dignity . . . an understanding that in many cases those individuals who are facing the end of their lives are doing so in great pain and great suffering.”¹¹³ Similar to Mr. Bosley, Mr. MacWilliam introduced his own personal experiences with dying parents:

The most painful thing that I saw as the son after my mom had passed away and my dad was becoming very ill was to see him, the proud individual that he was, lose the dignity that he had, and how it hurt him to lose that dignity and to understand that he had lost complete control over his own faculties, over his own bodily functions, and how terribly frustrated and embarrassed he was to have to come to that end. As he lay on his bed in his last days I could do nothing as a son except try to comfort him in his last very painful hours.¹¹⁴

Having experienced such a dilemma directly, MacWilliam surmised that “there are situations in our lives when individuals face that choice and want to make that choice, they have the courage of making that choice, because they want to have the chance of dying with dignity, of controlling their lives to the end.”¹¹⁵ Overall, he was convinced that communalism was an inappropriate response to the personal decision to end suffering: “I think it is reprehensible that we as a community, as a society, would deny that choice to our loved ones,”¹¹⁶ claimed MacWilliam.

¹¹¹ Ibid.

¹¹² Ibid., 16574.

¹¹³ Lyle Dean MacWilliam, 16575.

¹¹⁴ Ibid.

¹¹⁵ Ibid.

¹¹⁶ Ibid., 16576.

In March, 1993, one last effort was made to save Mr. Waddell's motion. The first to participate in the debate was Chris Axworthy. He reminded the House of specific "events" that shifted Canadian opinion toward a quality of life ethic, especially cases involving extreme human suffering:

There was the Nancy B. case in which it was felt necessary to have court-sanctioned permission for the physician to remove Nancy B. from her life support systems. Surely that sort of trial and turmoil for a patient, for a person living in great pain and great suffering toward the end of their life is undignified and should not be required in Canada. Most recently, we have seen the case of Sue Rodriguez. I do not think anybody in this Chamber or many Canadians would want to go through the same torture she is going through in trying to get permission to ask a physician to assist her in ending her life when she concludes that her quality of life is such that she can no longer continue.¹¹⁷

Axworthy recognized that such circumstances required acknowledgement from Parliament because their special circumstances had the capacity of disclosing or "showing-forth" some fundamental truth about the death and dying debate. For Axworthy, the case histories of Nancy B. and Sue Rodriguez were "events of being" that challenged previous normative assumptions related to an intentionally hastened death:

I believe our society has progressed to the level at which we can say that it is not a reprehensible act [euthanasia] that should be punished by a criminal penalty and that we should respond in a caring and compassionate way to people like Sue Rodriguez, Nancy B., and the many other Canadians faced with the same tragedy who merely want the opportunity to end their pain and suffering.¹¹⁸

Because Gallup polls consistently favoured some changes to the law dealing with physician assistance in dying, Axworthy insisted that the government had a duty to respond to this turn toward the quality of life ethos: "It is time," demanded Axworthy, "that this Parliament acted on this issue. It is rare that such a large proportion of

¹¹⁷ Chris Axworthy, "Private Members' Business: Euthanasia," *Commons Debates* (3rd Session, 34th Parliament) Vol. XIII (February 18th-March 23rd, 1993), 17322.

¹¹⁸ Ibid. Hyde notes that disclosing or "getting at the truth of things" is a form of epideictic discourse, rhetoric's most important department. According to Hyde, this allows a "showing forth" of what is. See Michael J. Hyde, *The Life-Giving Gift of Acknowledgement*, 75-80.

Canadians [70-75 per cent] are of a common mind about anything, especially an issue of this importance. It is time that this House responded to that very large majority.”¹¹⁹

In contrast, Mr. Dennis Mills (Broadview—Greenwood, Lib.) viewed Waddell’s motion as a threat to the sanctity doctrine. Mr. Mills initially agreed that the suffering of the dying had to be addressed by the living: “The first reaction by those of us who are not suffering is obviously one of care and compassion for the person. We do not want them to continue suffering, and naturally we do not want to be someone who is promoting that.”¹²⁰ However, Mills maintained that, despite such ontological concerns, metaphysical beliefs were of greater importance: “I believe that life, even in its most painful form and at its loneliest moment, is something precious and meaningful and not for us to make a judgment on as to when it should end, especially when the judgment is to be made by someone who in his or her natural state is low and in pain.”¹²¹ Mills clarified that it was not that he lacked compassion for a suffering person, but his underlying values lay in opposition to the intentionally hastening of death. As he stated: “[L]ife . . . is precious and should be supported with all the forces and energies we have [;] we should not be the ones who support an interruption of it.”¹²² Hence, Mills’ reliance on metaphysics led to a single conclusion: “I do not think it is a progressive measure to enshrine into the law of this land a motion that supports euthanasia.”¹²³

Although Mr. Peter L. McCreath (Parliamentary Secretary to Minister of Industry, Science and Technology and Minister for International Trade, PC) concurred with Mr. Waddell that society had moved in a new direction, McCreath concluded it has not turned

¹¹⁹ Ibid., 17321.

¹²⁰ Dennis Mills, 17323.

¹²¹ Ibid.

¹²² Ibid.

¹²³ Ibid., 17322.

enough. For every “event” that created new possibilities for the dying, there were other concerns to counterbalance such emerging trends. For instance, Mr. McCreath was sympathetic to the Rodriguez case in that he hoped it would “stimulate the kind of serious discussion . . . need[ed] on this issue [euthanasia] in Canada.”¹²⁴ McCreath also agreed that medical technology had contributed to renewed dialogue over quality of life considerations: “Sometimes I think we have developed it [medical technology] almost to an industry of keeping people alive no matter how miserable they may be.”¹²⁵ He was also aware of medico-legal shifts in other Western nations: “We are mindful of what is going on at the present time in Holland and the legislative changes taking place there.”¹²⁶

Despite these apparent social transformations, McCreath could not arrive at a clear position on the issue of an intentionally hastened death. He sensed that part of the resistance to euthanasia rested in Christian orthodoxy: “[P]eople will be motivated perhaps by their religious beliefs,” he remarked. “The Bible is fairly explicit: Thou shall not kill.”¹²⁷ He himself questioned whether it was “appropriate for government in a democratic country to authorize citizens to kill each other.”¹²⁸ The dilemma over the physician’s role was another question mark for McCreath. He asked: “If we go back to the Hippocratic oath . . ., is [its mandate] to save life or is it to relieve pain?”¹²⁹ Weighing both arguments, McCreath felt that it was still “premature for Parliament to speak on this issue [euthanasia]” or “vote in an overt direction” because there had not

¹²⁴ Peter L. McCreath, 17324.

¹²⁵ Ibid.

¹²⁶ Ibid.

¹²⁷ Ibid.

¹²⁸ Ibid.

¹²⁹ Ibid. The Oath’s mandate has been critiqued by several scholars. See Paul Carrick, *Medical Ethics in Antiquity: Philosophical Perspectives on Abortion and Euthanasia* (Washington: Georgetown University Press, 1995); also see O. Tempkin and C. Tempkin, eds., *Ancient Medicine: Selected Papers of Ludwig Edelstein* (Baltimore: Johns Hopkins University Press, 1967); Mark G. Kuczewski and Ronald Polansky, *Bioethics: Ancient Themes in Contemporary Issues* (Cambridge, Massachusetts: The MIT Press, 2002).

been “adequate debate in Canadian society on this issue.”¹³⁰ McCreath did, however, leave the door open for future consideration: “The day will come,” he predicted, “when Parliament will in a serious legislative way have to face this issue and make a decision.”¹³¹

Waddell’s motion received a vote of confidence from Mr. Lyle Kristiansen (Kootenay West—Revelstoke, NDP) who, like Axworthy previously, summarized various “events” that had triggered renewed debate over euthanasia. Kristiansen agreed with Axworthy that Sue Rodriguez’s public struggle had “brought to the attention of the Canadian people, from one end of the country to the other, the very agonizing choices people feel compelled to make.”¹³² He further alluded to the fact that medical circumstances had begun to impinge upon Canadians’ sacred beliefs: “. . . [T]echnology has changed to such an extent that some of the religious values that at one time were imposed and generally accepted now have to be called into question. The nature of life itself has changed because of our changing technology.”¹³³ Instead of dying from communicable diseases at home and at a younger age, Kristiansen pointed out that people were now dying from chronic, degenerative diseases in hospital “surrounded by batteries of life-saving equipment.”¹³⁴ He felt it was important to ask “whether we have the right to deny a human being who, being of sound mind, determines that at a given point of artificially induced continuation of life they wish to terminate it rather than continue in a state of existence they find unbearable.”¹³⁵ Such “events” led him to reject stewardship

¹³⁰ Ibid.

¹³¹ Ibid., 17324-17325.

¹³² Lyle Kristiansen, 17325.

¹³³ Ibid.

¹³⁴ Ibid.

¹³⁵ Ibid.

in favour of self-determination: “I have no right to impose my religious or spiritual values upon others of sound mind in the exercise of their judgment on what is surely the most important and most personal decision a person may feel compelled to make: the question of life or death.”¹³⁶

On the other hand, Mr. Don Blenkarn (Mississauga South, PC) reflected the normative positions of metaphysicians. His foundational premise rested on the fact that “life itself [was] sacred, and the taking of life [was] itself a crime.”¹³⁷ When dealing with euthanasia and assisted suicide, he was hesitant to support the feasibility of safeguards, inquiring: “Do they [the terminally ill] really want to end their life or do they only temporarily want to end their life as they go from one state of mind to another?”¹³⁸ Although Mr. Blenkarn accepted that most individuals have had family members who were “exceptionally ill” and “have clearly been in pain,” he concluded that it was “so easy to pull the plug and kill them.”¹³⁹ Reiterating his initial position, he concluded: “I do not think we have the right [to pull the plug]. . . . Belief in life is a sacred and continuing thing.”¹⁴⁰

Closing the debate, Mr. Waddell summarized his own feelings on the motion. He announced to the House that there was a new direction to take, that being the one provided by Sue Rodriguez. As he explained, “We cannot expect sick and dying people to be dragging themselves through the courts. Parliament has to deal with this issue. It belongs to Parliament. That is what we are here for. We have to deal with these tough

¹³⁶ Ibid., 17326.

¹³⁷ Don Blenkarn, 17326.

¹³⁸ Ibid.

¹³⁹ Ibid., 17327.

¹⁴⁰ Ibid.

issues. We have got to do it.”¹⁴¹ Quoting the *Toronto Star*, Waddell reminded elected representatives of Rodriguez’s future impact on other dying patients: “The truth is, Sue Rodriguez’s fight to have doctor-assisted suicide made legal under certain specific, clear and out-in-the-open conditions is not just for her own sake but for the lives of all who may well one day find themselves in a similar situation.”¹⁴² Reemphasizing the lived reality of suffering, Waddell ended the session by quoting Sue Rodriguez herself: “Despite my losses, I do not want pity. All I ask of my fellow Canadians is understanding and compassion. Understanding that they too may some day be in a position similar to mine.”¹⁴³ Even with Waddell’s final plea, the motion was voted down.

In June of 1993, however, another motion was presented by Mr. Raymond Skelly (North Island—Powell River, NDP) to urge the government to consider amending the Criminal Code to permit physician-assisted suicide when (a) it is requested by the patient; (b) the patient is terminally ill and will experience a painful death; (c) two independent physicians certify that the patient's condition is terminal; and (d) the office of the Attorney General for the province has reviewed the case.¹⁴⁴ Like other quality of life advocates, Mr. Skelly’s rhetorical patterns followed a specific logic. He recognized how particular “events” sparked new revelations, particularly the Supreme Court challenge brought forward by Sue Rodriguez. As Skelly stated, “She [was] asking that she be given the right to have her physician assist her in committing suicide rather than face the gruesome death this disease [ALS] will inflict upon her.”¹⁴⁵ In addition, Skelly asked the

¹⁴¹ Waddell, 17327-17328.

¹⁴² Ibid., 17328.

¹⁴³ Ibid.

¹⁴⁴ Raymond Skelly, “Private Members’ Business: Criminal Code, Physician-assisted Suicide,” *Commons Debates* (3rd Session, 34th Parliament) Vol. XVI (June 2nd-June 23rd, 1993), 20419.

¹⁴⁵ Ibid.

House to reconsider the original *Criminal Code* provisions prohibiting assisted suicide. He suggested that such a law “[did] not contemplate the realities of our society today where about 75 per cent of deaths are attributable to chronic degenerative diseases such as cancer, AIDS and a variety of other diseases. . . . [which] are characterized by a complete loss of control and quite often by a very serious and painful death.”¹⁴⁶ Since a reliance on the status quo delimited new interpretations of “events of being,” Skelly maintained that Canadians should “not be bound by an antiquated law that does not recognize the changes in our society.”¹⁴⁷

Skelly also argued that, when suffering from a terminal illness, a person may find him/herself in a situation in which self-determination can improve the quality of life: “It [physician-assisted suicide] can prevent death in great pain and degradation because of the complete loss of control when the individual does not have the ability to control even the simplest of life’s functions.”¹⁴⁸ Consequently, an amendment to the law would help others “to avoid a degrading and painful death” as well as “to avoid the indignity of a complete loss of ability to control any function of life.”¹⁴⁹ Skelly made one further observation in that the reigning metaphysic could only be sustained by downplaying the lived reality of those suffering. The religious conviction of stewardship, in other words, had an ontological cost:

We cannot argue against a religious conviction that says no matter what, God created life and God has the ultimate choice as to when it will end. If a person holds those convictions you cannot deal with the issue if you totally ignore the situation that when a person’s life is going to end anyway, and it is going to end with pain and degradation, we do have an opportunity to control it.¹⁵⁰

¹⁴⁶ Ibid.

¹⁴⁷ Ibid., 20420.

¹⁴⁸ Ibid., 20419-20420.

¹⁴⁹ Ibid., 20420, 20421.

¹⁵⁰ Ibid., 20422.

Furthermore, Skelly was optimistic that safeguards would work. This would entail taking section 241(b), which prohibits aiding or abetting a suicide, and “[adding] a number of clauses to it,” namely clauses that would say that “no one could assist someone to commit suicide unless it was a physician assisting a patient.”¹⁵¹ Skelly suggested that other stringent controls could be set, such as the following: terminal illness, mental competence, repeated requests for assistance in suicide, and a review process by an independent physician and the Attorney General.¹⁵² For Skelly, an open system with safeguards was preferable to a closed system, the reason being that there would be no guidelines “in the arrangement between Sue Rodriguez and her physician or with the next case or the next one.”¹⁵³ He dismissed accusations of a Nazi “slippery slope” as “false and misleading” because Canada was “one of the most sensitive and successful democracies in the world.”¹⁵⁴ Moreover, Skelly did not accept the “less funding for hospice care” argument as credible. Refusing to take an either/or position, he concluded that the issue for Canada was simply good health care. Such a mandate would ultimately result in “properly funding hospices for the same reason it would give Sue Rodriguez empowerment and the right to self-determination.”¹⁵⁵

The aforementioned Mrs. Sparrow, however, disagreed, citing several theoretical possibilities of the “slippery slope.” The role of the physician could be compromised, thought Mrs. Sparrow, since the “proper concern of medicine is with treatment, including palliative treatment to relieve pain.”¹⁵⁶ Moreover, Sparrow indicated that tampering with

¹⁵¹ Ibid., 20420.

¹⁵² Ibid., 20422.

¹⁵³ Ibid.

¹⁵⁴ Ibid.

¹⁵⁵ Ibid.

¹⁵⁶ Barbara Sparrow, 20423.

the omission/commission distinction would undermine the heart of the Hippocratic tradition: “These acts [euthanasia and assisted suicide] go beyond withdrawal of treatment that has proven unsuccessful. They would reverse the ancient injunction to do no harm. They would foist on the medical profession a philosophical position that says killing is better than allowing suffering.”¹⁵⁷ Inevitably, she feared, decriminalization of an intentionally hastened death for consenting patients would affect “the plight of children or other persons who are incapable of requesting assisted suicide or euthanasia.”¹⁵⁸

Mr. Boudria was again vocal about why the “slippery slope” was an ever-present danger to society. Referencing a Dutch department spokesperson, Liesbeth Rensman, Boudria remarked on Holland’s adoption of voluntary euthanasia in 1993. When he discovered that the Dutch were considering “regulation for killing without [explicit] request,” Boudria announced in the House, “If you do not think we are on a slippery slope when we discuss this issue, think again.”¹⁵⁹ He further questioned the implications of an acquittal for a Dutch psychiatrist who injecting a depressed patient with a lethal substance: “How could we tell our fellow citizens that murder is wrong if we were to permit doctors to do it? How could we tell our young and emotionally fragile citizens that suicide is wrong and that life is precious if we allow life to be destroyed in this kind of a cavalier manner?”¹⁶⁰ As with a large contingent of Canadian physicians, Boudria sensed a direct link between the Dutch medical model and Nazi eugenics. He noted that Germany, like the Netherlands, betrayed its moral foundations incrementally by relying

¹⁵⁷ Ibid.

¹⁵⁸ Ibid.

¹⁵⁹ Boudria, 20424.

¹⁶⁰ Ibid., 20425.

on utilitarian, rather than humanitarian, principles. Quoting Dr. Robert Conot, the author of *Justice at Nuremberg*, Boudria explained that Germany's slide "was no plunge to damnation from conscious decision but a step-by-step descent into darkness, each step marking a small erosion of ethics and morality."¹⁶¹

Boudria reiterated that "sanctity of life" was foundational to his opposition against euthanasia and physician-assisted suicide. When addressing the possibility that his "wedge" claims lacked evidence, Boudria responded by relying on metaphysics as first principle: "Some members of this House might disagree with me about the slippery slope, but then what? I believe that euthanasia would still be wrong because it cheapens human life."¹⁶² Individually and collectively, Boudria felt it was important to make a statement in Parliament about "the value and dignity of human life" and that "[w]e must not say things to cheapen it [life] any more than it has been already."¹⁶³

Mr. Wenman ended the debate by emphasizing a shift toward both the *qualified* sanctity of life ethos and self-governance. Recognizing that unique situations were moving the House toward some form of decriminalization, Wenman was essentially outlining Vattimo's belief in history as eventuation: "It [a change in the law] is inevitable because the majority of people, the nature of medical technology and many other factors are driving us in a direction that calls for discussion, reason and resolution. Therefore, I have no doubt that the law will be changed."¹⁶⁴ Wenman believed that a trend toward greater patient autonomy implied "the right of the individual to make a rational, logical choice through access to medical technology," allowing him "to terminate [his] own life

¹⁶¹ Ibid.

¹⁶² Ibid.

¹⁶³ Ibid.

¹⁶⁴ Wenman, 20425-20426.

when there is no further hope.”¹⁶⁵ Wenman was convinced that, as a self-governing agent in a liberal democracy, he was “responsible and intelligent enough to make that choice [hastening death by omission],” and he “resent[ed] that any government or other parliamentarians would deny [him] that right of choice.”¹⁶⁶

Wenman’s gravest concern, however, was existential since he did not believe that value in suffering could be universalized. If sanctity of life advocates supported “prolonging life through and into intense suffering,” Wenman reminded the House that this was “their choice for them and their families,” but he “[did] not agree with that choice for [him] and [his] family.”¹⁶⁷ Wenman noted what he felt was a difference in philosophy between himself and proponents of the traditional sanctity doctrine, that being, how far one was willing to go to relieve suffering. Although both sanctity and quality of life advocates agreed that the terminally ill had “the right to withdraw *from treatment*,” what they could not agree on was whether the dying had “the right to withdraw *from suffering* [italics mine].”¹⁶⁸

Ironically, Wenman never explained how, after treatment withdrawal, one could relieve prolonged suffering entirely without relying on either active euthanasia or physician-assisted suicide. As a result, the omission/commission distinction could not be jettisoned by Wenman at this point in time. Perhaps, this showed that a full transition from the *qualified* sanctity of life ethos to the quality of life ethos was too revolutionary, even for moderate liberals and conservatives. Politicians, such as Wenman, who supported a more ontological and phenomenological approach to suffering still found the

¹⁶⁵ Ibid., 20426.

¹⁶⁶ Ibid., 20427.

¹⁶⁷ Ibid., 20426.

¹⁶⁸ Ibid.

idea of an intentionally hastened death too radical. This is because any state-sanctioning of euthanasia and assisted suicide would result in a negation of stewardship, meaning in prolonged suffering, and the “slippery slope” as inevitable.

Svend Robinson and the Aftermath of the Rodriguez Case

After the death of Sue Rodriguez in February, 1994, New Democrat Svend Robinson introduced Bill C-215, an Act to amend the Criminal Code (aiding suicide). The amendments would allow “a qualified physician, upon the request of a terminally ill person, to assist that person to commit suicide” while ensuring that “a physician who did assist in such a suicide could not be charged with some other offence under the Criminal Code.”¹⁶⁹ Introducing the bill in first reading, Robinson’s motives were twofold. First, he recognized that a closed system was more of a social and individual danger than an open system. As he warned the House, “People with terminal illnesses, some suffering terrible pain or indignity, are now being assisted to die but too often it is being done by secret physicians who perform secret acts or, worse yet, by family and friends with no safeguards whatsoever in place.”¹⁷⁰ Robinson’s other motive was of a more personal nature, that being his intimate knowledge of Sue Rodriguez’s lived reality. He described Rodriguez as someone who “lived her life and approached her death with incredible courage and dignity” in an attempt to persuade Members of Parliament that Bill C-215 would lead to “a more decent and civilized society for all Canadians.”¹⁷¹

¹⁶⁹ Svend Robinson, “Bill C-215, An Act to Amend the Criminal Code (Aiding Suicide),” *The House of Commons Canada* (1st Session, 35th Parliament), First Reading, February 16th, 1994, 1a.

¹⁷⁰ Robinson, “Criminal Code,” *Commons Debates* (1st Session, 35th Parliament) Vol. 133, no. 023 (February 9th-March 16th, 1994), 1434.

¹⁷¹ Ibid.

By second reading, Robinson presented a stark contrast between the ontology of suffering and the metaphysical beliefs that contributed to its prolongation. He admitted that stewardship not only shaped the opposition against physician-assisted suicide, but it was also directly related to any value placed on suffering: “There are those who believe for personal religious reasons . . . that it is unethical or immoral for anyone other than their God to end life. The Catholic Church has stated in its declaration on euthanasia: ‘Suffering during the last moments of life has a special place in God’s saving plan.’”¹⁷² Robinson commented further that the universal application of a particular metaphysic was, in fact, a form of violence: “I would argue that a law which imposes that personal religious philosophy [transcendent meaning in prolonged suffering] on an entire nation is one which is both cruel and inhuman.”¹⁷³

Instead, Robinson preferred situation ethics in which different instances of suffering called for varying responses. Reiterating previous Senate Committee testimony, Robinson summarized what hospice care workers had always known: “there is some suffering, there is some indignity and there is some pain that no amount of palliative care can effectively respond to.”¹⁷⁴ For example, Robinson pointed out that the “wracking pain of bone cancer cannot in all cases be responded to by palliative care.”¹⁷⁵ This implied that in those rare circumstances, or “hard cases,” palliative care was “not appropriate,” leading Robinson to conclude that “the option must surely remain to an individual to put an end to that suffering, that pain and that indignity.”¹⁷⁶

¹⁷² Svend Robinson, “Private Members’ Business: Criminal Code,” *Commons Debates* (1st Session, 35th Parliament) Vol. 133, no. 094 (June 8th-September 27th, 1994), 5968.

¹⁷³ *Ibid.*, 5969.

¹⁷⁴ *Ibid.*

¹⁷⁵ *Ibid.*

¹⁷⁶ *Ibid.*

In contrast to Robinson's ontological and phenomenological perspective, the rhetoric of metaphysics (i.e., stewardship, prolongation of suffering, and the "slippery slope") was embraced by members of the House affiliated with the centre-right. Robinson's postmodern sensibilities were initially countered by the absolutist claims of Mr. Dan McTeague (Ontario, Lib.). He viewed acts of omission and commission as morally distinct based on natural law: "Euthanasia very clearly, categorically and unequivocally rather than allowing people to die naturally makes them die and that is a travesty. I believe that is wrong,"¹⁷⁷ claimed McTeague. Quoting Dr. John Scott, head of palliative care at the Elisabeth-Bruyère Centre in Ottawa, McTeague highlighted the value of life even when death was imminent and suffering at its most intolerable: "When we witness suffering, we also hear complaints. When death is at our door, we raise our hands in horror and sometimes we even call for death, but we must resist the temptation to kill. We must not remain insensitive to the will to live trying to make itself heard above all the moaning."¹⁷⁸ McTeague feared both the potential risks of decriminalization and the idea that human beings were now the arbiters of death, that they alone could "play God." His explanation is worth noting at length:

. . . [W]e are on the slippery slope for something far more pernicious than the intention of the bill [C-215]. Euthanasia is the state actively participating in the death of individuals. . . . What if that right becomes an obligation? I ask the House more emphatically: What if the potential for corruption is there by impatient heirs who want to see that person dead? Handicapped individuals, people in wheelchairs, people who are not genetically perfect according to some, people suffering from Alzheimer's. This is more than a tempest in a teapot. We are opening more than Pandora's box. We are indeed deciding as a state who should live and who should die. . . . I will vote against any legislation which comes before the House which promotes that kind of insidious proposal.¹⁷⁹

The rhetoric of Ms. Roseanne Skoke (Central Nova, Lib.) was also indicative of metaphysics. As she informed the House, "[L]ife begins at the moment of conception

¹⁷⁷ Dan McTeague, 5970.

¹⁷⁸ Ibid., 5971.

¹⁷⁹ Ibid.

and continues until natural death. Respect for the sanctity of life and the dignity of human suffering . . . is well founded in both natural law and Canadian law.”¹⁸⁰ She could not accept “killing as a private matter of individual choice” because it would “diminish respect for human life, dehumanize society, and it [was] unconscionable.”¹⁸¹ Skoke also supported a utilitarian form of communalism by claiming that an individual’s suffering, although unfortunate, served a greater good: “I demand that the existing laws of the Criminal Code respecting assisted suicide be strictly enforced to ensure that our nation’s values and moral conscience with respect to life not be fettered, for not to do so will create a greater injustice to mankind than any human pain or suffering could possibly do.”¹⁸² She concluded that “the laws of nature must be upheld and the values of our society must be protected.”¹⁸³

Mimicking Skoke’s arguments was a member of the Reform Party, Mr. Myron Thompson (Wild Rose, Ref.). He explained how his evangelical background influenced his belief in stewardship. To his fellow colleagues, he admitted that “the most precious thing that you can receive from your creator is your life, and that the giver of life is the only one who should have the authority to take it.”¹⁸⁴ When Mr. Thomson’s sister was dying of terminal cancer and was in “deep pain,” he believed that “through her suffering, there was a benefit to those of us who loved her the most.”¹⁸⁵ Thompson viewed concerns over suicide as an additional reason to prohibit an intentionally hastened death. Worried that decriminalization would affect young people’s attitudes, Thompson claimed

¹⁸⁰ Roseanne Skoke, 5975.

¹⁸¹ Ibid.

¹⁸² Ibid.

¹⁸³ Ibid.

¹⁸⁴ Myron Thompson, 5975.

¹⁸⁵ Ibid., 5976.

that “suicides were taking place far too often than we desired to see as a society” and were “on the increase.”¹⁸⁶ Of greater import was his conviction that something dangerous lie ahead for Canadian society if it followed the example of the Netherlands: “I do not believe for a moment that I would want to engage in some kind of venture that would make me accountable for something that we could very possibly regret, terribly regret, down the road if it turns into the . . . Holland experience. Some terrible tragedies happened there.”¹⁸⁷

In November, 1997, Svend Robinson made one last attempt to sway House opinion with the introduction of Motion-123, calling for “a special committee to be appointed to review the *Criminal Code* provisions dealing with euthanasia and assisted suicide and to prepare a bill.”¹⁸⁸ As with previous debates, postmodernists tended to be on the political left (i.e., New Democrats and Bloc Québécois) while metaphysicians tended to gravitate toward the centre-right (i.e., Liberals, Progressive Conservatives, and Reformers). As a New Democrat, Robinson found the current law supporting prohibition to be “profoundly cruel and unjust” because it delimited the various ways suffering was expressed. He addressed the fact that the “best palliative care in the world [could not]

¹⁸⁶ Ibid. It is important to note that suicides in Canada since decriminalization in 1972 were not on the increase as Reform member Myron Thompson claimed. In fact, on a per capita basis, suicide rates were on a decrease for the country as a whole from 1972-1999 (13.4-13.0 per 100,000 respectively) as well as for both sexes from the 1979-1998 (16.7-14.0 x 100,000 respectively). Moreover, the only youth category that rose from 1979-1998 in terms of per capita suicide rates was the 10-14 age range (1.1-2.2 x 100,000). The suicide rates for all other youth categories declined in the same time period (teens and young adults aged 15-19, 20-29, 30-34). See *Statistics Canada*, “Suicide Death Rates (x 100,000): Canada and the Provinces: Both Sexes,” Vital Statistics Mortality Database from 1950 to 1999, Historical Death Shelf Tables for Summary List of Causes (Ottawa: Health Statistics Division), <www.statscan.ca>; also see Stéphanie Langlois and Peter Morrison, “Suicide Deaths and Attempts,” *Canadian Social Trends*, 21 (Autumn, 2002); also see a further study in *Statistics Canada*, “Suicides, and Suicide Rate, by Sex and by Age Group, 1981-1997.” <www40statscan.ca/01/cst01/health01/htm>

¹⁸⁷ Ibid.

¹⁸⁸ Tiedemann and Valiquet, 19.

respond in all circumstances to all suffering, indignity and anguish.”¹⁸⁹ For instance, some patients did not want heavy sedation as an alternative to euthanasia because they would be “incapable of meaningful interaction with their families,” and some terminally ill people “did not want to live or to die that way.”¹⁹⁰ Consequently, in narrow circumstances in which palliative care was ineffective, the issue for Robinson became one of choice, especially for “the right of competent adults to decide for themselves how their lives will end.”¹⁹¹ As the law stood, the dying and their families were under even more duress because they could not relate to options available to them under standard medical practice. Stated Robinson:

. . . [T]he choice is either to continue that suffering and anguish or to be sedated into a state of pharmaceutical oblivion, or to find a doctor who is prepared to break the law and risk life imprisonment, as in the case of Sue Rodriguez, or if you cannot find a doctor, as we have seen tragically in some circumstances, to leave your own country.¹⁹²

A further recommendation that Robinson’s motion be sent to a special committee for review came from Mr. Michel Bellehumeur (Berthier-Montcalm, BQ). What struck Mr. Bellehumeur as significant were the unique social changes—the “events of being”—that had altered the populace’s thinking over death and dying: “With medical advances and given what is acceptable today, which may not have been acceptable yesterday and evolves over time, a responsible government, a government that wants to reflect the evolution of society, will have to get its act together and deal with this area of responsibility, this admittedly difficult issue.”¹⁹³ He indicated that specific Canadians had transformed the ethical possibilities surrounding euthanasia and physician-assisted

¹⁸⁹ Robinson, “Private Members’ Business: Euthanasia,” *Commons Debates* (1st Session, 36th Parliament) Vol. 135, no. 127 (October 27th-November 7th, 1997), 1559.

¹⁹⁰ Ibid.

¹⁹¹ Ibid.

¹⁹² Ibid. Robinson noted that two dying patients, Austin Bastable and Natverial Thakore, had left Canada to seek assistance in dying from Jack Kevorkian in Michigan.

¹⁹³ Michel Bellehumeur, 1563.

suicide: “Some news stories have advanced our understanding of this new problem. There was the case of Nancy B., Sue Rodriguez, and the most recent, . . . the case of Robert Latimer, a father accused of ending his daughter’s life. . . .”¹⁹⁴ As a result of these controversial figures, Bellehumeur recognized that a polarization had occurred between the traditional sanctity of life ethos and an emerging quality of life ethic: “The present context is not an easy one. Some will say that respect for life is being used as an excuse to outlaw killing. . . . Others, however, will say that the respect for life and the right to die with dignity are personal values and that only the individual who is ill may decide.”¹⁹⁵ Although Bellehumeur admitted that legislating euthanasia and assisted suicide “pose[d] many ethical problems,” he concluded that in light of societal changes a committee should give “very serious consideration to these ethical and medical factors.”¹⁹⁶

Not all of Robinson’s detractors, however, adopted the rhetoric of metaphysicians. Ms. Eleni Bakopanos (Parliamentary Secretary to Minister of Justice and Attorney General of Canada, Lib.) felt that the motion was premature, but her motives for not supporting it were of a more practical nature. She pointed out that although the Senate Committee in 1994-95 had reached a consensus on palliative care, sedation practices, pain control, and the withholding and withdrawal of treatment, there were “no such agreements among committee members when it came to euthanasia and physician-assisted suicide.”¹⁹⁷ Moreover, Ms. Bakopanos outlined how safeguards needed to be more entrenched before any possibility of decriminalization was possible: “[F]ew Canadian provinces and territories have passed legislation on advanced

¹⁹⁴ Ibid.

¹⁹⁵ Ibid.

¹⁹⁶ Ibid.

¹⁹⁷ Eleni Bakopanos, 1561.

directives,” and “at such times, when critical decisions must be made, it is useful and less stressful for those involved to make these decisions if they know the patient’s wishes.”¹⁹⁸

Bakopanos added that an amendment to the *Criminal Code* would be “fraught with difficulties” since, as the Senate report demonstrated, “Canadians are much too divided on these issues [of euthanasia and physician-assisted suicide].”¹⁹⁹ Nowhere in the discourse of Bakopanos were there any overt religious references, nor did any convincing examples exist of the rhetoric of metaphysicians, namely that of stewardship, prolongation of suffering, or the “slippery slope.” The discourse of Bakopanos indicates that the weakening of metaphysics is a process, one that provokes thought and balances the various interpretations available in a given context. In this particular case, the opposition to Robinson’s motion was based in pragmatic, not absolutist, terms.

However, those most opposed to Motion-123—and whose rhetoric was characteristic of metaphysics—straddled the centre-right of the political spectrum. Mr. Gary Brietkreuz (Yorkton—Melville, Ref.) admitted that some Reformers viewed euthanasia and physician-assisted suicide as “a moral issue,” one that “should be handled using a process employed on issues such as abortion and capital punishment and on issues of personal conscience.”²⁰⁰ Brietkreuz even made his own metaphysical views known for the record: “I believe in the inherent value of life and the need to protect the most vulnerable individuals in our society.”²⁰¹ As with other sanctity of life advocates, Brietkreuz believed that “letting die” was considered ethical while “intending death” was criminal: “While I respect every person’s right to refuse medical treatment, I do not

¹⁹⁸ Ibid.

¹⁹⁹ Ibid.

²⁰⁰ Gary Brietkreuz, 1562.

²⁰¹ Ibid.

believe that any changes should be made to the Criminal Code offences of euthanasia, assisted suicide or counselling suicide.”²⁰²

Mr. Grant Hill (Macleod, Ref.) rejected Robinson’s motion because of his perception of Holland’s “slippery slope.” Citing the Rummelink Report, Hill noted that although “about 2000 cases of euthanasia per year” are reported, over 1000 dying patients were “killed involuntarily,” and “8100 were killed by deliberately using pain medication.”²⁰³ For Hill, safeguards were not working in the Netherlands since in 1990 “over 10,000 people [were] euthanized in one year when only 2,700 were reported.”²⁰⁴ Hill’s response to the Dutch medical model was that it was the antithesis of individual freedom: “In Holland doctors have taken over end of life decisions. This has not become an empowering thing for the patient . . . giving the power of life to physicians is bad public policy.”²⁰⁵

Similarly, Mr. Greg Thompson (Charlotte, PC) remarked how his definition of euthanasia was directly influenced by the Campaign Life Coalition, a well-known Christian pro-life lobby group. For Thompson, the “acceptable” definition of euthanasia was, in actuality, synonymous with vitalism, meaning “to act or fail to act so as to cause the death of a human being for the purpose of relieving suffering.”²⁰⁶ In reality, however, Thompson supported the *qualified* sanctity of life ethos because “allowing a terminally ill person at the last stages of life to die a *natural death* is not euthanasia [italics mine].”²⁰⁷

²⁰² Ibid.

²⁰³ Grant Hill, 1563.

²⁰⁴ Ibid.

²⁰⁵ Ibid. It should be noted that Hill’s views on the Dutch medical model may have been influenced by the fact that he was both a medical doctor and religiously affiliated with The Church of Jesus Christ of Latter-day Saints.

²⁰⁶ Greg Thompson, 1564. For clarification on vitalism, see John Keown, *Euthanasia, Ethics, and Public Policy: An Argument against Legalization*, 39.

²⁰⁷ Ibid.

This acceptance of the latter principle was, according to Thompson, “consistent with thousands of years of religious belief and practice.”²⁰⁸ The foundation for Thompson’s beliefs was the sanctity of human life, a doctrine presupposed by stewardship. As he openly admitted in Parliament,

I remember saying in the House that according to my definition if life begins at conception life should be allowed to continue. As a parallel to that, if we are talking about human life and we have accepted that life is there, what right do we have as individuals to determine when that life should end? That goes back to the fundamentals. We are talking about the continuation of human life or the termination of human life. It is no more fundamental than that. It is about life. It is about the preservation of life. It is about the continuation of life.²⁰⁹

The political centre also held reservations about Robinson’s motion. Although Mr. Clifford Lincoln (Lac-Saint-Louis, Lib.) agreed that many Canadians supported Robinson’s views of decriminalization, he reminded the House of how polarized public opinion was over the issue of an intentionally hastened death: “[I]f there is a consensus in our society not to artificially prolong the suffering of the dying through continued use of life support equipment, I do not think this consensus extends to assisted suicide and euthanasia.”²¹⁰ In contrast to Robinson, however, Mr. Lincoln felt that society should not “play God” by sanctioning the intentional hastening of death: “Where I feel we should draw the line and where I disagree fundamentally with those who believe that assisted suicide and euthanasia should be a fact of life is with respect to the deliberate use of whatever means there are to terminate a life. Who are we to decide that we can terminate

²⁰⁸ Ibid. I disagree with Thompson’s view here. The shift away from vitalism and toward the *qualified* sanctity of life ethos is a recent phenomenon of the last four decades, particularly in light of the number of court cases required to resolve issues surrounding the withholding or withdrawal of treatment. Karen Ann Quinlan, Nancy Beth Cruzan, Terri Schiavo, and Nancy B. represent some of the more prominent cases. For detailed accounts of these legal matters, see Peter G. Filene, *In the Arms of Others: A Cultural History of the Right-to-Die in America* (Chicago: Ivan R. Dee, 1998); Arthur L. Caplin, James J. McCartney, and Dominic A. Sisti, eds., *The Case of Terri Schiavo: Ethics at the End of Life* (New York: Prometheus Books, 2006); Michael Schiavo and Michael Hirsh, *Terri: The Truth* (New York: Penguin Books Ltd., 2006); *Nancy. B. v. Hôtel-Dieu de Québec* (Q.C.A.), [1992], 86 D.L.R. (4th) 385, 69 C.C.C. (3d) 450, 1992.

²⁰⁹ Ibid., 1565.

²¹⁰ Clifford Lincoln, 1565.

a life?”²¹¹ Quoting two doctors, Herbert Hendin²¹² and Gerald Klerman, Lincoln deduced that vulnerable populations would also be neglected: “If those advocating legalization of assisted suicide prevail, it will be a reflection that as a culture we are turning away from efforts to improve our care of the mentally ill, infirm, and the elderly. Instead, we would be licensing the right to abuse and exploit the fears of the ill and depressed.”²¹³ When the time required for Private Members’ Business had expired, the motion was dropped to the bottom of the order of precedence on the Order Paper and would not be debated for another four months.

In March of 1998, Robinson’s motion was once again a heated topic of discussion. As with previous debates, there was a noticeable division between leftists and those of the centre-right. Mrs. Pauline Picard (Drummond, BQ) interpreted Robinson’s motion as existential and phenomenological, rather than political, in scope. As she claimed: “Motion-123 is not about amending marketing standards, about increasing or reducing the budget, or about implementing international accords . . . This motion touches on the very essence of who we are and what we believe, on the very essence of life and, since life would not be life without it, death.”²¹⁴ She hoped the majority of parliamentarians would support Motion-123 because, as she asserted, “we

²¹¹ Herbert Hendin had been the founding director of the American Foundation for Suicide Prevention and served as its first president. Dr. Gerald L. Klerman was a psychiatrist who specialized in depression, schizophrenia, and panic and other anxiety disorders. He was appointed head of the Alcohol, Drug Abuse and Mental Health Administration by President Jimmy Carter, holding the post from 1977 through 1980.

²¹² Clifford Lincoln, 1565.

²¹³ Ibid.

²¹⁴ Pauline Picard, “Private Members’ Business: Euthanasia and Assisted Suicide,” *Commons Debates* (1st Session, 36th Parliament) Vol. 135, no. 080 (March 12th-March 25th, 1998), 5353. The term “phenomenological” is used here in the sense that Michael J. Hyde interprets it. He suggests that phenomenology is a way of thinking “devoted to interpreting, analyzing, and describing how the immediate content of experience actually presents itself to human consciousness.” Phenomenology thus offers itself as a “truth-telling activity, for the happening of any truth takes place first and foremost as a disclosing of the world, a revealing or uncovering of the ‘givenness’ of something that is perceived *to be*.” See Michael J. Hyde, *Perfection: Coming to Terms with Being Human*, 16-17.

have a duty to develop frameworks which are fair and which respect human dignity.”²¹⁵

Utilizing the rhetoric of postmodernists, she asked: “Could we really imagine choosing for ourselves and all our loved ones anything but a gentle and humane death with dignity? Anything but the freedom of choice?”²¹⁶

Picard’s rhetoric was countered sharply by Mr. Paul Steckle (Huron—Bruce, Lib.). In support of prohibition, Steckle’s personal stance was based on “life as a sacred gift from the moment of conception to the moment of natural death.”²¹⁷ For that reason, legislators should “never condone or legalize the deliberate *unnatural* taking of life [italics mine].”²¹⁸ Although Steckle recognized that Jack Kevorkian, Sue Rodriguez, Nancy B., and Robert Latimer were tangible reference points for discussion, they could also “distract from and act as a compelling hindrance to our grasping of the deeper moral and spiritual argument surrounding this matter.”²¹⁹

Such explicit religious convictions above also influenced Steckle’s stance toward absolute moral distinctions. As with Progressive Conservative Greg Thompson, Mr. Steckle supported opinions provided by the Campaign Life Coalition, particularly the need to “clearly differentiate between a sound medically based decision to end a life and the practice of euthanasia.”²²⁰ Again concurring with Mr. Thompson, Steckle regarded the omission/commission moral differentiation as “consistent with thousands of years of established religious philosophy.”²²¹ Hence, an act of omission was not euthanasia because it permitted an individual with a terminal illness “to conclude their life in a

²¹⁵ Ibid., 5354.

²¹⁶ Ibid., 5354.

²¹⁷ Paul Steckle, 5356.

²¹⁸ Ibid.

²¹⁹ Ibid., 5355.

²²⁰ Ibid., 5354.

²²¹ Ibid.

natural fashion. . . . [emphasis mine].”²²² That said, Steckle also sympathized with the vitalistic principle. He deemed the passive/active distinction irrelevant if “the intent [was] to kill,” thus making the method of choice “simply a question of strategy.”²²³

What Steckle elaborated on most, however, was the inevitability of the “slippery slope.” State-sanctioning of euthanasia or assisted suicide would not only “seriously jeopardize the continuation of [doctors’] traditional role as healers,” but would also make the physician ““the most dangerous man in the state.””²²⁴ According to Steckle, euthanasia was not an exercise of a basic human freedom but rather “an abandonment of that freedom.”²²⁵ He even alluded to a possible domino effect, fearing that “society would devise an infinite number of uses for death once it [euthanasia] [had] become a legal means for solving human problems.”²²⁶ More specifically, Germany’s “final solution” was cited as a viable example of society’s failure to stop the “slide”:

During one of the world’s darkest time periods, the Nazi party developed and promoted a set of proposals designed to weed out certain people who were considered to have no value to society. The idea was adopted by the general public and the medical community of the day. As a result, the war machine euthanized more than 300,000 mentally handicapped children and adults in addition to the thousands of elderly people who were deemed to be useless by the Third Reich.²²⁷

Steckle drew support from Mr. Jason Kenney (Calgary Southeast, Ref.), a Reform Party member who expressed strong religious beliefs. It was his understanding that liberal democracy was founded on stewardship. Since the Charter recognized the

²²² Ibid.

²²³ Ibid. Various authors have questioned the rhetoric used in the intended/foreseen moral distinction. See Tom L. Beauchamp, ed., *Intending Death: The Ethics of Assisted Suicide and Euthanasia*, 104-105; also see Margaret P. Battin et al., eds., *Physician-Assisted Suicide: Expanding the Debate*, 431-441; Dr. Timothy E. Quill and Margaret P. Battin, eds., *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice*, 118-129.

²²⁴ Ibid., 5355. Steckle was quoting Dr. Christoph Hufeland, a German physician of the late 18th and early 19th century. Over 200 years ago, Dr. Hufeland said: “If a 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.”

²²⁵ Ibid.

²²⁶ Ibid.

²²⁷ Ibid.

supremacy of God and the rule of law, this implied that “we do not grant rights unto ourselves. We do not create ourselves, and we therefore do not create our own rights, but we are created and rights are bestowed upon us.”²²⁸ Kenney insisted that fundamental human rights, such as the right to life, were inalienable. Thus, “[e]ven individuals cannot through the exercise of some radical personal autonomy alienate rights which cleave to the human nature of individuals because they were granted to us by our Creator.”²²⁹ More specifically, the right to intentionally hasten death could never be granted since human life was inviolable. In other words, because life was a “loan from God,” Kenney asserted that “[c]ertain inalienable rights are rights that cannot be alienated by a legislature, rights that cannot be alienated by a doctor whose business is killing and rights that cannot be alienated even by ourselves.”²³⁰ Kenney concluded with what he recognized as the foundational premise of the prohibitionist position: “[W]e are ultimately discussing whether or not parliament will grant to people the right to destroy themselves and the right to destroy the inviolable dignity stamped on them by the Creator of which our constitution speaks.”²³¹ Finally, Kenney pictured morality at a crossroads, as a choice between obedience and the notion of self-governance:

I say that we must never, in this society animated by a profound understanding of the inviolable dignity of the human person, allow a radical notion of personal autonomy or a disordered understanding of human liberty to overcome our most profound obligation as people, as creatures and as legislators to protect human life.²³²

Ms. Aileen Carroll (Barrie—Simcoe—Bradford, Lib.) supported previous Reform arguments with a strong focus on three “slope” issues, namely, the Dutch medical model,

²²⁸ Jason Kennedy, 5357.

²²⁹ Ibid.

²³⁰ Ibid.

²³¹ Ibid.

²³² Ibid. To understand the historical tension between the voluntarist position and self-governance, see J.B. Schneewind, *The Invention of Autonomy: A History of Modern Moral Philosophy* (New York: Cambridge University Press, 1998).

the traditional doctor-patient relationship, and the diminished role of palliative care. Initially, Ms. Carroll viewed the Netherlands as central to the debate over euthanasia and assisted suicide. Although Dutch guidelines previously listed “unbearable pain” to qualify for a hastened death, Carroll stated that the policy had broadened to include “psychic suffering or the potential disfigurement of personality,” a shift she described as a “downward spiral, one on which [Canada] must not embark.”²³³ Furthermore, Carroll noted that the trust inherent in the doctor-patient relationship must be preserved. She hypothesized that by creating a context in which the physician can ethically take a human life, “we cross a threshold and threaten the trust of beneficence that is at the root of the physician-patient relationship.”²³⁴ Lastly, because Carroll had previously worked in hospice care, she viewed any intent to hasten death as a threat to both her former occupation as well as to the sanctity of life in general:

Not only does resorting to euthanasia risk hijacking palliative care in this country . . . it also leads our society on a trajectory we do not want . . . [I]t could become normal to ask to put an end to life and abnormal to want to live despite subtle pressures from all sides. We will have to justify our own survival. The day that an individual must justify his or her own survival must never be allowed to dawn in this country.²³⁵

However, this same alarmist rhetoric did not apply to acts of omission (“passive” euthanasia). For Carroll, support of the *qualified* sanctity of life ethos led to a reliance on absolute moral distinctions: “[N]on-initiation and cessation of medical treatment is distinctly different from a deliberate action taken to bring about the death of a patient. A huge difference exists between allowing to die and killing.”²³⁶ She drew this distinction from *Vacco v. Quill*, an American case which clearly indicated different causes of

²³³ Aileen Carroll, 5359.

²³⁴ Ibid.

²³⁵ Ibid., 5359-5360.

²³⁶ Ibid., 5359.

death—and hence one’s role responsibility—for positive and negative acts: “When a patient refuses life-sustaining medical treatment, he dies from the underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication.”²³⁷ Carroll insisted that this distinction was integral to the debate over euthanasia and assisted suicide: “In the first instance [acts of omission], the patient is allowed to die. In the second instance [acts of commission] the patient is killed. . . . We have rightly accepted the concept of allowing to die. We must not accept the concept of killing.”²³⁸ The rhetoric of metaphysicians finally prevailed. On March 25th, 1998, Robinson’s motion was rejected by a substantial margin.

The Metaphysical / Postmodern Divide in the 21st Century

Svend Robinson’s failed attempts at amending the *Criminal Code*, however, would not spell an end to the debate. After the turn of the century, the metaphysical/postmodern, left/right divide would continue. Ms. Francine Lalonde (La Point-de-l’Île, BQ) introduced Bill C-407, an Act to Amend the Criminal Code (Right to Die with Dignity) in October of 2005. As with Robinson and Axworthy, Lalonde made no moral distinction between acts of omission and commission. This bill simply stated that a person is not guilty of a homicide if the individual seeking to die with dignity (1) is at least eighteen years of age; (2) continues to experience severe physical or mental pain without any prospect of relief; (3) suffers from a terminal illness; and (4) has (while lucid) made to a medical practitioner, or to the person who aids the person to die, two requests more than ten days apart expressly stating the person’s free and informed wish to

²³⁷ Ibid., 5360. Also see *Vacco, Attorney General of New York, et al., No. 95-1858 v. Quill et al.*, 117 S.Ct.2293 (1997).

²³⁸ Ibid.

die.²³⁹ As with previous debates, the political left, particularly the Bloc Québécois, supported the quality of life ethos, utilizing the rhetoric of self-determination, an end to pointless suffering, and the viability of safeguards; whereas, the discourse of the Conservative Party of Canada (CPC) contained strong statements in support of the sanctity doctrine, with poignant references made to stewardship and the inevitability of the “slippery slope.” There were few exceptions to this general pattern.²⁴⁰

Ms. Lalonde’s second reading of the bill was an attempt to remind her political opponents that suffering was a subjective reality that must be addressed. In her words: “Any lucid person facing a very difficult and painful end of life, which they consider degrading, an unfitting end to the life they have led, inconsistent with their condition as a free person, has to be able to decide how they wish to die. . . .”²⁴¹ Recalling both the plight of Sue Rodriguez and the recent Senate Committee report, Lalonde insisted that lawmakers “cannot remain insensitive to the cries of pain and desire for dignity of so many people who are facing death.”²⁴² She concluded by leaving all Members of Parliament with a question to ponder: “Who could object to a person being allowed to decide how they will leave their body to put an end once and for all to relentless pain they are unfairly made to suffer?”²⁴³

Lalonde also informed the House that the sanctity of life ethos was not a universally held concept but was, in actuality, contingent upon one’s socio-cultural

²³⁹ Francine Lalonde, “Bill C-407: An Act to Amend the Criminal Code (Right to Die with Dignity),” *The House of Commons Canada* (1st Session, 38th Parliament), First Reading, June 15th, 2005), 1-2.

²⁴⁰ The only exception on the political left was Mr. Joe Comartin (Windsor-Tecumseh, NDP). His discourse was indistinguishable from the rhetoric of the centre-right, those parliamentarians who consistently rejected attempts to sanction an intentionally hastened death.

²⁴¹ Lalonde, “Private Members’ Business: Criminal Code,” *Commons Debates* (1st Session, 38th Parliament) Vol. 140, no. 144 (Monday, October 31st, 2005), 9219.

²⁴² *Ibid.*, 9221.

²⁴³ *Ibid.*

background. Like Canada, several developed nations—the Netherlands, the United States, and Belgium—did not consider suicide a crime.²⁴⁴ She further noted that Oregon had voted twice to permit physician-assisted suicide (1994, 1997). Their act allowed “any adult suffering from a terminal illness who is a resident of that state and whose diagnosed life expectancy is less than six months to obtain a prescription for drugs to end his or her life.”²⁴⁵ She also compared Switzerland’s policies to those of Canada. Although aiding and abetting suicide in Canada carried a maximum of fourteen years in prison, Switzerland adopted a different approach. Lalonde summarized this more liberal mandate: “[U]nless this [an intentionally hastened death] is done for venal [corrupt or selfish] motives, a person . . . can help someone die. It must be clearly established that the decision to die is that of the dying person.”²⁴⁶

Lalonde was supported by her colleague Ms. Christiane Gagnon (Québec, BQ). Ms. Gagnon wished to highlight that safeguards associated with the bill were directly related to resolving an existential dilemma for the terminally ill, that being intractable pain: “First and foremost, the bill is aimed at lucid people who face a painful end of life, who are suffering, and who have no hope of ever being able to improve their physical condition.”²⁴⁷ Gagnon’s approach was to address the lived reality of the dying, since for these people, “life [was] nothing but physical and mental suffering from terminal and

²⁴⁴ Ibid., 9219.

²⁴⁵ Ibid. It is worth noting that since Oregon made physician-assisted suicide legal in 1997 there has been no evidence of widespread abuse. In fact, no physician or relative of any patient since decriminalization has been charged with “improperly providing assistance or coercing the patient into hastening his death.” See Michael Stigl, *The Price of Compassion: Assisted Suicide and Euthanasia*, 284.

²⁴⁶ Ibid. Lalonde added that in 2004 Manon Brunelle, a former assistant producer with Télé Québec, obtained assistance to end her life from a Swiss organization called EXIT. Brunelle even wanted to televise her death to promote the right to die with dignity.

²⁴⁷ Christiane Gagnon, 9225.

degenerative illness, for which there [was] no prospect of relief and quality of life.”²⁴⁸ In this particular context, Gagnon insisted that “life [for some terminally ill patients] has no more meaning because their bodies have failed them and because they obtain no relief from medication or other palliative care.”²⁴⁹ For these “hard cases,” it was Gagnon’s belief that “[e]nding one’s life may be, for those who ask, an appropriate end to quality palliative care.”²⁵⁰ In closing, Gagnon attempted to calm fears that such legislation reflected an “anything goes” mentality: “Many people believe that this bill gives a blank cheque to decide on someone’s life or death, at any time under any circumstances. This is not the aim of the debate on this bill, quite the opposite.”²⁵¹

As with previous attempts to decriminalize euthanasia and assisted suicide, the centre-left resisted such measures based on a sense of danger to the community. Mr. Gary Carr (Halton, Lib.) noted that his constituents most opposed to Bill C-407 maintained strong religious affiliations. One citizen, Joanne Matters of Halton Pro Life (Burlington, On.), stated that “there is no such thing as an assisted suicide bill with safeguards,” insisting that “we can’t legalize a little bit of killing for those who ask to be killed” because eventually “it will include those who don’t ask.”²⁵² Carr also summarized a letter he received from Reverend Charlie Jordan, a pastor at Mary Mother of God Parish in Oakville, Ontario. Reverend Jordan was “totally opposed to the changes proposed in the bill [C-407],” stating that “human life is too important to permit such a course of action.”²⁵³ Carr also received numerous letters from the Knights of Columbus,

²⁴⁸ Ibid.

²⁴⁹ Ibid.

²⁵⁰ Ibid.

²⁵¹ Ibid.

²⁵² Gary Carr, 9226.

²⁵³ Ibid.

the world's largest Catholic family fraternal service organization. The general feeling from this organization's viewpoint was that "it [was] wrong to take someone's life and that such a change in law would be open to serious abuse."²⁵⁴ As with the opinions of religious individuals/groups, Carr agreed with "slippery slope" allegations directed at Bill C-407: "In an age where we hear a lot about elder abuse, this would not be an acceptable path to take."²⁵⁵

Once again, Jason Kenney (Calgary Southeast, CPC) provided the strongest voice for sanctity of life advocates. Kenney submitted that the truth of the human person can only be understood in theistic terms, meaning that "the human person is created in the image and likeness of God."²⁵⁶ Since stewardship was foundational to his belief system, Kenney viewed state-sanctioning of euthanasia as "the deliberate and lawful taking of innocent human life."²⁵⁷ His more absolutist view of human dignity was, in fact, diametrically opposed to Lalonde's postmodern sensibilities: "Properly conceived, human dignity is not a subjective sense of one's self . . . Dignity is not an ephemeral quality which ebbs or flows based on one's mood or social consensus or anyone's will. Rather, any coherent understanding of human rights . . . is grounded in the inviolable dignity of the human person."²⁵⁸

Kenney rejected the legalization of euthanasia because such a law would result in "dangerous unintended consequences." According to Kenney, any undermining of first principles would "change our social understanding of the human person as a subject with

²⁵⁴ Ibid.

²⁵⁵ Ibid.

²⁵⁶ Kenney, 9223.

²⁵⁷ Ibid., 9222.

²⁵⁸ Ibid.

infinite and inherent value into a disposable object which can be eliminated at will.”²⁵⁹

Most importantly, for Kenney, the weakening of metaphysics was the death knell of a civilized society: “If we say that . . . innocent human life does not have absolute value, then we will embark on a social experiment the consequences of which I am frightened to contemplate.”²⁶⁰ Although it was anticipated that the bill would receive a December vote, the dissolution of Parliament and the call for a federal election meant that the vote did not occur.²⁶¹

Therefore, after more than a decade of deliberation as to the ethical and legal viability of euthanasia and assisted suicide, the metaphysical/postmodern divide continued to polarize the House. Despite the emergence of various “events of being,” political elites reaffirmed their commitment to either vitalism or the *qualified* sanctity of life ethos. To reiterate, for the former one could not intend death using either positive or negative acts. For the latter, however, one could refrain from prolonging death using acts of omission. Permitting an intentionally hastened death would negate the “sanctity of human life” as first principle, thus making this “trace” of Christian moral theology subservient to individual autonomy. Hence, the most controversial aspect of the quality of life ethos—the intentional hastening of death—was rejected by the majority of parliamentarians.

As this dissertation suggests, the main motive behind prohibition is religious in nature. The analysis of discourse shows that Canada remains largely a Christian nation, influenced primarily by a specific metaphysic: the sanctity of human life. Although the quality of life ethos became a more dominant paradigm in the 1990s, its influence was

²⁵⁹ Ibid.

²⁶⁰ Ibid., 9223.

²⁶¹ Tiedemann and Valiquet, 19.

kept in check by advocates of the sanctity doctrine. Whenever an appeal was made to intentionally hasten death for the terminally or chronically ill, the rhetoric of stewardship, meaning in prolonged suffering, and the “slippery slope” countered those promoting self-determination, ending pointless suffering, and the viability of safeguards. In the end, the *qualified* sanctity of life ethos was as far as Canadian elites (i.e., ethicists/bioethicists, medical practitioners, justices, and politicians) were willing to go when it came to death-hastening practices.

Chapter VII: Interrogating the Discourse: The “Slippery Slope” as a Form of Passive-Reactive Nihilism

We now turn to an analysis of discourse to understand how two specific claims made by sanctity of life advocates were unsustainable. These included (1) the omission / commission moral distinction; and (2) the inevitability of the “slippery slope.”

From a Vattimian perspective, both claims involved the use of “masks or “disguises” to maintain the authority of the reigning metaphysic (the sanctity of life ethos) and, thus, should be considered forms of passive-reactive nihilism. In other words, a distortion of evidence and/or its nondisclosure was used as a technique to discredit arguments made by quality of life advocates in order to avoid further weakening of the sanctity doctrine.

An analysis of discourse is divided into four sections. It begins with the claim that a shift toward the quality of life ethos would lead to abuse of the vulnerable, particularly if Canada adopted Dutch medical policy pertaining to euthanasia and physician-assisted suicide. Within the various discourses, sanctity of life advocates, particularly medical practitioners, claimed that decriminalization would lead to increased “risks” or “danger” for the community, either in the form of Dutch medical practice or a return to Nazi eugenics. Therefore, it is pivotal to understand to what degree such claims functioned as “illusions” to sustain the sanctity of human life as first principle. This analysis will be followed an overview of the “slippery slope” from the Dutch viewpoint. The attitudes of Dutch physicians toward an intentionally hastened death were in stark contrast to those of Canadian doctors who viewed such an act as unethical and criminal. Third, this chapter looks “behind the mask” to reveal what shapes attitudes toward prohibition. In spite of quantitative and qualitative evidence that challenges the premise

of the “slippery slope,” sanctity of life advocates consistently claimed that the community would suffer serious harm if euthanasia or assisted suicide were decriminalized. By examining the discourse of one group of elites—doctors—it was found that religious values do, in large part, shape their attitudes toward euthanasia and assisted suicide. This section finishes with a challenge to the claim that an absolute distinction exists between acts of omission and commission. It is here that the case of Nancy B. will be featured to demonstrate how “masks” or “disguises” help to maintain such a distinction and, thus, the *qualified* sanctity of life ethos.

The Dutch “Slippery Slope” Unmasked

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 involved “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.”¹ The Remmelink Report focused particularly on “Medical Decisions Concerning the End of Life,” (“MDEL’s”), 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.”² MDEL’s were given wide parameters, comprising the administration, supply or prescription of a drug, the withdrawal/withholding of treatment (including

¹ P.J. van der Maas, J.J.M. van Delden, and L. Pijnenborg, *Euthanasia and Other Medical Decisions Concerning the End of Life: An Investigation Performed upon Request of the Commission of Inquiry into the Medical Practice Concerning Euthanasia*, 4.

² *Ibid.*, 19-20.

resuscitation and tube-feeding), and the refusal of a request for euthanasia and assisted suicide.³ Moreover, euthanasia was differentiated from other MDEL's. 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."⁴ Methodology aside, it is the controversial elements that need to be addressed, particularly the claim that permitting an intentionally hastened death would inevitably lead to a "slippery slope."

According to the Rummelink Report, only a small percentage of those who died actually received euthanasia and physician-assisted suicide. Out of 129, 000 deaths in 1990, "2300 [1.8%] resulted from euthanasia and 400 [0.3%] were physician-assisted suicides,"⁵ the latter providing lethal medication 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). The majority of controversy centred on these "1000 cases," specifically concerns over abuse of the vulnerable. However, an examination of the quantitative and qualitative data sheds some considerable light on the contingent circumstances surrounding the use of active *nonvoluntary* euthanasia.

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."⁶ 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

³ Ibid., 20.

⁴ John Keown, *Euthanasia Examined: Ethical, Clinical, and Legal Perspective*, 270.

⁵ Mullens, "The Dutch Experience with Euthanasia: Lessons for Canada?," 1347.

⁶ Ibid.

[explicit] request.”⁷ In cases where there was no discussion, this was not possible since the patients were “permanently unconscious” or in a state of “reduced consciousness.”⁸ Consistent with the doctrine of double effect, 80% of the deaths were caused by increased doses of morphine.⁹ Moreover, in 71% of the cases, “the medical decision [to use active nonvoluntary euthanasia] had shortened life by less than a week.”¹⁰

The more worrisome of the trends, active *involuntary* euthanasia, occurred *zero* times. In other words, according to the Rummelink Report’s own findings, no one’s death was intentionally hastened *against* his or her consent in Holland in 1990.¹¹ To summarize, of all deaths that occurred in Holland in 1990, no acts 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 2002.¹² 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.”¹³ In fact, when a Dutch study was finally made available comparing 1990 euthanasia figures with those in 1995, active *nonvoluntary* euthanasia had dropped by 0.1 per cent (0.8% to 0.7% of all deaths), physician-assisted suicide had remained static at 0.3% of all deaths, and active *involuntary* euthanasia was still non-existent (see

⁷ Ibid.

⁸ Singer, *Rethinking Life and Death: The Collapse of our Traditional Ethics*, 153.

⁹ Mullens, “The Dutch Experience with Euthanasia: Lessons for Canada?,” 1347.

¹⁰ Singer, *Rethinking Life and Death: The Collapse of our Traditional Ethics*, 153.

¹¹ P.J. van der Maas, J.J.M. van Delden, and L. Pijnenborg, *Euthanasia and other Medical Decisions Concerning the End of Life*, 66-7, 181-2; also see J.J.M. van Delden, Loes Pijnenborg and Paul J. van der Maas, “The Rummelink Study: Two Years Later,” *Hastings Centre Report* 23, no. 6 (Nov.-Dec. 1993): 24.

¹² Michael Petrou, “A Time to Die: Is the Dutch Model of Euthanasia—Even for Infants—The Solution When Suffering Can’t Be Relieved?,” *Maclean’s*, 5 September 2005, 23.

¹³ J.J.M. van Delden, Loes Pijnenborg and Paul J. van der Maas, “The Rummelink Study: Two Years Later,” 24, 26.

appendix).¹⁴ Although active voluntary euthanasia had increased from 1.8% to 2.4% (see appendix), it is unclear whether this increase, in combination with other statistics, is significant.

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.¹⁵ Since public regulation may actually reduce, rather, than increase the incidence of nonvoluntary euthanasia, ethicist Helga Kuhse 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.”¹⁶ Still, other critics disagreed with Holland’s liberal approach.

John Keown, Senior Lecturer in the Law and Ethics of Medicine at the University of Cambridge, has been a vocal critic of euthanasia and physician-assisted suicide in Holland. His figures, as a percentage of all hastened deaths, indicated 10 558 [8.2%] in 1990 and 25 900 in 1995 [19.1%] for all acts where “the explicit purpose is to shorten life (see appendix).”¹⁷ Since Keown’s own figures included acts of omission (i.e., the withholding/withdrawal of treatment) and the administration of palliative drugs (the intensification of pain and symptom treatment), he was admitting that methods within

¹⁴ Keown, *Euthanasia Examined: Ethical, Clinical, and Legal Perspectives*, 270; Keown, *Euthanasia, Ethics, and Public Policy: An Argument against Legalization*, 126.

¹⁵ P.J. van der Maas, J.J.M. Delden, and L. Pijnenborg, “Euthanasia and Other Decisions Concerning the End of Life,” *Lancet* 338 (1991): 669-74.

¹⁶ Helga Kuhse, “Why Terminal Sedation is No Solution to Euthanasia Debate,” in Torbjörn Tännsjö, *Terminal Sedation: Euthanasia in Disguise?* (Dordrecht: Kluwer Academic Publishers, 2004), 66.

¹⁷ Keown, *Euthanasia Examined: Ethical, Clinical, and Legal Perspectives*, 270; Keown, *Euthanasia, Ethics, and Public Policy: An Argument against Legalization*, 126. A minority pro-life breakaway group called Nederlands Artsenverbond (NAV or Dutch Physicians Association) also condemned euthanasia, claiming that the annual tally for euthanasiast acts was closer to 16, 000 when one included “patients who refused lifesaving treatment or asked for analgesics that may shorten their life [sic]. . . .” See Mullens, “The Dutch Experience with Euthanasia: Lessons for Canada?,” 1847.

standard medical practice were explicitly used to hasten death. In other words, they were *euthanasiast* acts. Using Keown's methodology, such acts would be morally symmetrical to euthanasia and physician-assisted suicide. If so, one may ask: Why then were such medically/legally sanctioned methods not likewise feared for their potential "slippery slope" ramifications? A disconnect remained between allegations of danger and risk using acts of commission (i.e., euthanasia and physician-assisted suicide) and the absence of such fears when an intentionally hastened death occurred using acts of omission. It was an irony that went largely unnoticed by sanctity of life advocates when discussing the Netherlands.

Still, Keown was adamant that the "wedge" issue was inevitable if euthanasia or physician-assisted suicide were ever to become state-sanctioned:

In its empirical form, the "slippery slope" argument runs that even if a line can in principle be drawn between voluntary and non-voluntary euthanasia [explicit consent unknown], a slide will occur in practice because the safeguards to prevent it [non-voluntary euthanasia] cannot be made effective.¹⁸

Yet even Keown was forced to admit that intentionally hastening death in instances of standard medical practice was "inconsistent with . . . continued opposition to the active, intentional killing of patients."¹⁹ Keown was being coherent with his analysis in one sense: the method used, whether a negative or positive acts, was irrelevant if one not only hastened death but did so with explicit intent.

Overall, there were five points of fact established by the Dutch comparison studies: (1) the Rummelink Report found that no concrete evidence of a "slippery slope" exists; (2) a decline in active *nonvoluntary* euthanasia occurred by 0.1% over five years; (3) no cases of *involuntary* euthanasia in Holland were recorded from 1990-95; (4) the

¹⁸ Keown, *Euthanasia Examined: Ethical, Clinical, and Legal Perspectives*, 262.

¹⁹ Keown, *Euthanasia, Ethics, and Public Policy: An Argument against Legalization*, 215.

Dutch, by their own admission, performed very few acts of euthanasia and assisted suicide annually as a percentage of deaths; and (5) the majority of cases of *nonvoluntary* euthanasia contained mitigating circumstances (i.e., patients lapsing into comas before explicit consent reached). Moreover, one anomaly in the empirical data had not been addressed by sanctity of life advocates. When comparing figures from 1990-95, withdrawing or withholding treatment without the explicit consent of the patient rose from 2.1% of all deaths to 10.5%, a five-fold increase over five years (see appendix).²⁰ Whether this dramatic shift represented a crisis for traditional medical ethics or was representative of an upward or downward interpretation of the “slippery slope” remained largely unexamined by prohibitionists.

However, Dr. Robert Dillmann, secretary of medical affairs for the Royal Dutch Medical Association, asserted 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 physician-assisted suicide], the increases in the number of doctors reporting and the increased awareness of the inappropriateness of life termination without [explicit] request.”²¹ Dr. E. Borst-Eilers, chair of the Health Council and former medical director of the Academic Hospital at the University of Utrecht, noted that a cultural difference existed between Holland’s medico-ethical standards and those of other nations. In situations of unbearable suffering, Dr. Borst-Eilers claimed that euthanasia becomes “the ultimate act in good terminal care.”²² Even the CMA concluded

²⁰ Ibid., 126.

²¹ Mullens, “The Dutch Experience with Euthanasia: Lessons for Canada?,” 1848.

²² Maurice A. M. de Wachter, “Euthanasia in the Netherlands,” *Hastings Center Report* 22, no. 2 (March-April 1992): 24.

in January 1995 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.”²³

The “Slippery Slope” from the Dutch Viewpoint

The *Special Senate Committee on Euthanasia and Assisted Suicide* held a video conference on October 25th, 1994, with a number of Dutch legal and medical experts to help clarify any concerns over a “slippery slope.” Dr. Gerrit van der Wal, the Medical Inspector of Health with the Royal Dutch Medical Association, began by explaining how fears over the demise of palliative care were unwarranted: “The arguments that the Dutch practice of euthanasia is fuelled by scarcity of health care resources . . . has no support” because “[m]ost cases of euthanasia take place in the home and concern patients who . . . have a life expectancy of less than a month.”²⁴ Dr. J.J.M. van Delden, the Principal Investigator for the Rummelink Committee, noted that palliative care would not suffer from financial support if euthanasia were made a legal option because palliative medicine in the Dutch system was already “integrated into other existing forms of health care.”²⁵ From the Department of Obstetrics and Gynecology at the University Hospital in Utrecht, Netherlands, Dr. A.P.M. Heintz suggested that since the number of patients who actually receive euthanasia is fairly low, this indicated a “high standard of palliative care both in the hospital and in the home situation.”²⁶ There were also concerns expressed over the standard of pain treatment in Holland and whether or not terminally ill patients would be

²³ “Physician-Assisted Death,” *Can Med Assoc J*, 248B.

²⁴ Senate of Canada, *Of Life and Death: Report of the Special Senate Committee on Euthanasia and Assisted Suicide*, A-115.

²⁵ *Ibid.*, A-120.

²⁶ *Ibid.*, A-121.

forced into euthanasia or assisted suicide. Dr. van der Wal did not view such an opinion as significant “since in only 5 per cent of cases is pain the most important reason for requesting euthanasia.”²⁷

The Committee also heard testimony concerning treatment of the poor and the possibility that a lack of resources would leave them no choice but to accept an intentionally hastened death. Dr. Dirkjan Bakker, a surgeon and member of the Medical Ethical Committee for Patient Care at the University Hospital in Amsterdam, mentioned that “[t]here is no economic consideration in decisions concerning the end of life because 100 per cent of the people in the Netherlands are insured for their medicare and all other kinds of care.”²⁸ Dr. van der Wal agreed with Dr. Bakker in that “[t]here [were] no financial incentives for hospitals, physicians, or family members to stop care or to shorten life of a particular patient.”²⁹ Dr. van Delden clarified that “[t]here is a legal duty imposed on all health care professionals to provide necessary care” and that “[r]efusing or discharging a patient for economic reasons is a criminal offence.”³⁰ In fact, when Dutch physicians were asked their most important motives for performing a life-termination act, economic considerations ranked last (1%).³¹

Abuse of the elderly was an additional “slope” concern addressed by Dutch physicians. As for the rumours of frightened senior citizens in nursing homes, Dr. Paul van der Maas, the lead author of the Rummelink Report, indicated that these came from a single newspaper item about a survey initiated by pro-life physicians within the Dutch

²⁷ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide* (First Session, Thirty-fifth Parliament) Chairperson: Joan Neiman, Issue No. 21 (Tuesday, October 25th, 1994), 11.

²⁸ *Of Life and Death: Report of the Special Senate Committee on Euthanasia and Assisted Suicide*, A-118.

²⁹ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, Issue No. 21, 7.

³⁰ *Of Life and Death: Report of the Special Senate Committee on Euthanasia and Assisted Suicide*, A-118.

³¹ *Ibid.*, A-141-2.

Physicians' League (NAV). The survey was not considered scientific since it was given to a selected group of the League's own members. In actuality, only two per cent of nursing home residents responded that they were afraid,³² not the ninety-five per cent previously quoted by Dr. Margaret Scott during the Senate Committee hearings. As for rumours of "Do-Not-Kill-Me" cards, Canadian journalist Anne Mullens spent six weeks in Holland performing extensive interviews, looking for anyone who possessed such identification, but she could not locate a single case.³³

Dutch medical practitioners also challenged concerns surrounded the effectiveness of safeguards. The Committee had previously been informed that "59 per cent of patients undergoing euthanasia died on the same day they had requested euthanasia, and 11 per cent died in the same hour."³⁴ However, this gave the impression that consent had not reached the explicit stage. Dr. van der Wal informed the Committee that "the day on which they died was the last time they requested it [euthanasia]. . . .It was not the first request; it was the last request."³⁵ There was also concern that not all physicians were following the reporting procedure for euthanasia and assisted suicide as required by law. An exchange between Dr. Robert J.M. Dillmann, Secretary of Medical Affairs of the Royal Dutch Medical Association, and Senator Desmarais helped to illuminate the complexities surrounding mandatory reporting:

Dr. Dillmann: In practice, the reporting rates are presently estimated at between 50 and 60 per cent. That figure is too low and should be improved upon.

Senator Desmarais: You are telling me that "mandatory" does not mean anything. Doctors are not responding to that in large numbers.

³² Anne Mullens, *Timely Death: Considering Our Last Rights*, 145.

³³ *Ibid.*, 146. After journalist Anne Mullens phoned Dr. E. Th. Droop, the secretary of the Dutch Physicians League (NAV), even he could not recommend a single person who possessed such identification cards, stating that Amsterdam was a "very socialist, liberal, un-Christian place."

³⁴ *Of Life and Death: Report of the Special Senate Committee on Euthanasia and Assisted Suicide*, A-146.

³⁵ *Ibid.*

Dr. Dillmann: You must take into account the legal situation, which is not satisfactory from the point of view of the physicians and does not add to the willingness of doctors to report cases of euthanasia. The Royal Dutch Medical Association has stated that since 1984 each physician performing euthanasia should be clear about it and should report to the legal system that he or she is guilty of performing an act which is in the Criminal Code. That in itself is quite remarkable and might fully explain the position. . . . They [physicians] do not feel as though they are criminals. . . . That is the problem.³⁶

The gravest area of concern pertained to the “1000 cases” of nonvoluntary euthanasia. Dr. H.J.J. Leenen, Professor of Social Medicine and Health Law at the University of Amsterdam, clarified that in 600 of these cases “the will of the patient was known,” even though it had not reached the explicit stage.³⁷ The actual number of cases of euthanasia in which consent was unknown and no prior request was made was between 300-400 cases or 0.2-0.3 per cent of all deaths in 1990.³⁸ Professor Leenen also explained how the policy of consent excluded other “vulnerable” populations: “Severely defective newborns cannot ask for euthanasia. Newborns cannot ask for euthanasia, therefore they are not eligible. The same thing applies to comatose patients and patients with Alzheimer’s.”³⁹ An exception, however, could be granted under the principle of *force majeure*, or the defence of necessity, due to conflicting duties. According to Professor Leenen,

The doctor’s duties are in conflict. The baby is suffering severely from unrelenting pain, yet the doctor is not allowed to terminate the life of that severely handicapped baby. The doctor can appeal, citing the necessity rule . . . when he is unable to assist or relieve the pain. This happens in the Netherlands about four times a year.⁴⁰

To address nonvoluntary euthanasia more effectively, Professor Leenen remarked on the difference between an open and closed system of reporting: “There are two things to consider here: first, we know about it [nonvoluntary euthanasia]; we know what is

³⁶ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, No. 21, 56-57.

³⁷ *Of Life and Death: Report of the Special Senate Committee on Euthanasia and Assisted Suicide*, A-140.

³⁸ *Ibid.*, A-141.

³⁹ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, No. 21, 18.

⁴⁰ *Ibid.*

happening concerning these cases, but many countries do not know what is happening. Second, there is now the possibility for us to develop a new policy towards these patients.”⁴¹

Dutch court rulings were also investigated by the Committee for their potential contribution to a “slippery slope.” One of the most famous was the *der Terp* case, which involved a doctor killing patients in a nursing home without consent. The physician was acquitted only because the prosecution erred by bringing in files which were not admissible due to a policy of medical secrecy. According to Professor Leenen, “The court had to dismiss the case, not because they accepted the actions of the doctor, but because the requirements of law were not met.”⁴² However, the doctor was still brought before a medical disciplinary court where he was convicted and suspended.⁴³ The *Chabot* case, however, was more controversial because it involved an assisted suicide for someone experiencing unbearable mental suffering. Hilly Boscher, a fifty-year-old social worker, lost two sons, one to suicide and the other to cancer. On the day the latter died, she attempted suicide.⁴⁴ Her psychiatrist, Dr. Chabot, and seven experienced colleagues reviewed the transcript of her therapy sessions with Dr. Chabot and concluded that “it was a hopeless case.”⁴⁵ Dr. Chabot helped his patient obtain an overdose of barbiturates, believing he had chosen “the lesser of two evils.”⁴⁶

Although the Dutch Supreme Court accepted the principle that “mental suffering could be sufficient to justify assisted suicide,” it reversed Dr. Chabot’s initial acquittal

⁴¹ *Of Life and Death: Report of the Special Senate Committee on Euthanasia and Assisted Suicide*, A-140.

⁴¹ *Ibid.*

⁴² *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, No. 21, 35.

⁴³ *Ibid.*, 35, 61.

⁴⁴ *Of Life and Death: Report of the Special Senate Committee on Euthanasia and Assisted Suicide*, A-131.

⁴⁵ *Ibid.*, A-132; also see *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, No. 21, 47.

⁴⁶ *Of Life and Death: Report of the Special Senate Committee on Euthanasia and Assisted Suicide*, A-132.

and instead entered a conviction because “none of the consulting psychiatrists had personally examined the patient.”⁴⁷ Under the circumstances, however, the Court waived any punishment, noting that “suffering can be as exhaustive and unbearable when it has psychiatric roots, as when it is caused by terminal cancer.”⁴⁸ Professor Leo C.M. Meijers, Attorney-General of the Supreme Court of the Netherlands, warned that assisted suicide for psychiatric patients was the borderline: “We do not have to go further, and we cannot go further.”⁴⁹ However, the aforementioned Dr. Dillmann added that the *Chabot* case was not about any perceived moral difference between somatic and non-somatic sources of suffering: “The nature and cause are not considered important; only the degree of suffering is considered important.”⁵⁰ That said, Dr. Leenen felt that the *Chabot* case was an exceptional circumstance, one that “[did] not represent the actual euthanasia debate in the Netherlands.”⁵¹

Cultural differences and their relation to the “slippery slope” were also addressed. The Committee had been informed by Dr. Karl Gunning, the Secretary of the Palliative Care Association of Rotterdam, that there were 16,000 cases in which “either treatment was slow, started, or stopped, or an overdose of drugs was given with the intention to shorten the patient’s life.”⁵² The Committee was told that such statistics were plausible because of the nuanced way Dutch physicians interpret “intent.” Instead of relying on the doctrine of double effect—separating what is intended from what is foreseen—Dutch physicians embrace a consequentialist ethic. They assume that “if you know the effect of

⁴⁷ Ibid.

⁴⁸ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, No. 21, 52.

⁴⁹ Ibid., 55.

⁵⁰ Ibid., 58.

⁵¹ Ibid., 54.

⁵² *Of Life and Death: Report of the Special Senate Committee on Euthanasia and Assisted Suicide*, A-140. Witnesses for the Committee actually reported intentional deaths ranging from 9,000-20,000.

certain actions is to shorten the patient's life, then you should describe that as at least partially your intent."⁵³ Dr. van Delden went on to explain how one can oversimplify a moral evaluation if the sole criterion for judgement is "intent":

Intentions cannot carry the full weight of a moral evaluation for several reasons. First, intentions are primarily private matters. Ultimately, only the agent decides what his intentions are. Different agents may describe the same action in the same situations as being performed with different intentions. . . . [N]o physician, in my opinion, performs euthanasia with the sole intent to kill the patient. His intention can always be described as trying to relieve suffering of his or her patient. . . . It is our opinion that moral evaluations should take into account all of the following factors: the type of physician; the intent; consultation with the patient; consultation with others; the competence of the patient; reasons for the decision; and, the extent of life-shortening as a result of the decision.⁵⁴

Finally, the Committee heard the role religious beliefs play in Dutch culture and how these shape one's perspective on euthanasia and assisted suicide. When Senator Carstairs began with statistical reports that "up to 60 per cent of people in the Netherlands are terrified of the prospect that they will be euthanized without their permission,"⁵⁵ Dr. van Delden identified the religious source of the information:

There was a telephone survey conducted by a Christian organization for elderly people. There were 2,000 people who volunteered to answer questions. Of those 2,000, 73 per cent were members of that Christian organization. There was no question about euthanasia or assisted suicide in the survey. . . . The results of the survey have been interpreted wrongly.⁵⁶

This did not mean that all religious groups in Holland were opposed to euthanasia and assisted suicide. Members of the Roman Catholic Church were, in actuality, quite liberal in their beliefs about an intentionally hastened death. In a 1993 survey, 67 per cent of Roman Catholics were in favour of euthanasia compared to 78 per cent of the general population; however, according to Dr. van Delden, members of the Dutch

⁵³ Ibid., A-145.

⁵⁴ Ibid., A-146.

⁵⁵ *Proceedings of the Senate: Special Committee on Euthanasia and Assisted Suicide*, No. 21, 24.

⁵⁶ Ibid., 25.

Reform[ed] Church remained more restricted in their beliefs, and members of the Calvinist Church were the most restricted.⁵⁷

As with other elites, the Senate Committee was philosophically divided between metaphysicians and Vattimian postmodernists. Despite the counter evidence from Dutch physicians and legal experts, the majority of the Committee (4-3) would not decriminalize either euthanasia or assisted suicide. Their reasoning contained rhetoric that was strikingly similar to that of religious organizations in support of the sanctity of life ethos. Those Committee members opposed to changes in the existing law were primarily concerned with “maintaining the fundamental social value of respect for life.”⁵⁸ Even in a pluralistic society such as Canada, the majority of the Committee believed that “respect for life is a societal value that transcends individual, religious or diverse cultural values.”⁵⁹ They were also concerned with the potential danger involved with any modernization of the law: “[L]egalization could result in abuses, especially with respect to the most vulnerable members of society.”⁶⁰ There were additional anxieties over the “slippery slope,” particularly in the Netherlands, since “guidelines [were] not always followed.”⁶¹ The majority also admitted that a utilitarian bias was necessary to safeguard societal values: “[W]hile disallowing assisted suicide may seem unfair or harsh in an individual circumstance, this is outweighed by the negative impact that decriminalization would have on the popular conscience.”⁶² Overall, the Committee was of the opinion that

⁵⁷ Ibid., 30.

⁵⁸ Ibid., 71.

⁵⁹ Ibid.

⁶⁰ Ibid.

⁶¹ Ibid.

⁶² Ibid, 72.

legalizing euthanasia would “create serious risks for the most vulnerable and threaten the fundamental value of life in society.”⁶³

Committee members in favour of changing the existing law emphasized concerns that were the antithesis of objectivistic metaphysics. Their rhetoric focused on self-determination, ending pointless suffering, and the effective use of safeguards. Their main concern was “the loss of autonomy experienced by many individuals because of their condition.”⁶⁴ Those in support of the quality of life ethos also rejected the omission/commission moral distinction. They added that, if the principle of autonomy applied to methods of death-hastening within standard medical practice (e.g., withholding or withdrawing treatment), then the same principle “also justifie[d] permitting voluntary euthanasia.”⁶⁵ Sue Rodriguez’s equality argument under section 15 of the Charter also proved influential for those in favour of decriminalization. Since the minority accepted physician-assisted suicide, voluntary euthanasia would also have to be decriminalized “in order to avoid the unequal treatment of those who are physically incapable of committing assisted suicide.”⁶⁶ The minority was also influenced by the testimony and letters of those “describing the pain and suffering of persons with debilitating and irreversible illnesses.”⁶⁷ Finally, in terms of a “slippery slope,” they believed that “there is more potential for abuse because there is a greater risk to the vulnerable from unregulated medical assistance at the end of life, than from legislative changes accompanied by appropriate safeguards.”⁶⁸ Despite evidence rebutting the danger and risk to vulnerable

⁶³ Ibid., 86.

⁶⁴ Ibid., 72.

⁶⁵ Ibid., 87.

⁶⁶ Ibid.

⁶⁷ Ibid., 72.

⁶⁸ Ibid., 73.

populations, those Committee members espousing the sanctity of life human life as first principle would not be swayed.

“Behind the Mask”: How Religion Shapes Attitudes toward Prohibition

Because quantitative and qualitative evidence existed that challenged the premise of the “slippery slope,” it is important ask why opposition against Dutch policy was so charged. One possibility lies with the presence of religious beliefs, especially among physicians. In a survey conducted by Marja J. Verhoef, PhD, and Dr. T. Douglas Kinsella, 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 access the determinants of potential changes in opinion.”⁶⁹ 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. . . .”⁷⁰ In fact, “religious activity” was the “most important characteristic associated with changes in opinion.”⁷¹ 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%.⁷² They concluded that “religious affiliation was significantly related to changes in opinion

⁶⁹ Marja J. Verhoef and T. Douglas Kinsella, “Alberta Euthanasia Survey: 3-year Follow-up,” *Can Med Assoc J* 155, no. 7 (1 October 1996): 885.

⁷⁰ *Ibid.*, 885.

⁷¹ *Ibid.*

⁷² *Ibid.*, 887.

about willingness to practise euthanasia if it were legalized.”⁷³ However, the research only targeted Alberta physicians, not Canadian doctors in general.

When Verhoef and Kinsella 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.”⁷⁴ 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).⁷⁵ Overall, 57% of doctors nationwide rejected the personal practice of assisted suicide.⁷⁶ Ironically, Kinsella and Verhoef 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.⁷⁷ 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

⁷³ Ibid.

⁷⁴ T.D. Kinsella and M.J. Verhoef, “Determinants of Canadian Physicians’ Opinions about Legalized Physician-Assisted Suicide: A National Survey,” *The Annals of the Royal College of Physicians and Surgeons* 32, no. 4 (Jun., 1999): 211-214. Opinions against personal participation in legalized assisted suicide were also significantly associated with older age, geographic region, professional time spent in terminal care, and country of graduation but not gender (57% of both male and female doctors opposed physician-assisted suicide).

⁷⁵ Ibid., 213.

⁷⁶ Ibid., 211, 213.

⁷⁷ Ibid., 213.

perceived to reflect different standards of care for physicians . . . and their patients in end-of-life decisions.”⁷⁸

These Canadian surveys were consistent with medico-ethical research performed in other nations. Baume, O’Malley, and Bauman studied doctors’ attitudes in New South Wales, Australia, 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’).⁷⁹ 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,”⁸⁰ especially those of Catholic and Protestant affiliation.

Similar results were found in Belgium. Broeckaert et al. noted that Flemish palliative care physicians 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.”⁸¹ 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

⁷⁸ Ibid., 214.

⁷⁹ Peter Baume, Emma O’Malley and Adrian Bauman, “Professed Religious Affiliation and the Practice of Euthanasia,” *Journal of Medical Ethics* 21 (1995): 49.

⁸⁰ Ibid., 50. It is important to note that although Catholic practitioners were the most opposed to euthanasia and physician-assisted suicide, “18% of Catholics who had been asked to hasten death acknowledged that they had practised [voluntary euthanasia]. . . . [page 52].”

⁸¹ B. Broeckaert et al., “Palliative Care Physicians’ Religious/World View and Attitude towards Euthanasia: A Quantitative Study among Flemish Palliative Care Physicians,” *Indian J Palliat Care* 15, no. 1 (Jan.-Jun., 2009): 41. Of significance was the fact that the majority of the physicians in the study self-identified as either Christian or Catholic.

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.”⁸² 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.⁸³

Lisker et al. also examined the influence of religion on Mexican physicians’ attitudes toward doctor-assisted suicide. Physicians 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; (3) asking their own physician to help them die if they had intolerable suffering due to a terminal illness.⁸⁴ Doctors with strong religious beliefs saying “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).⁸⁵ Part of the resistance to doctor-assisted suicide may be attributable to the influence of Christian normative assumptions. The authors note that by far the most common religion in Mexico is Catholicism, and recent studies confirm the authors’ suspicions. Emanuel 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

⁸² Ibid., 44-45.

⁸³ Ibid.

⁸⁴ Rubén Lisker et al, “Physician-Assisted Death. Opinions of a Sample of Mexican Physicians,” *Archives of Medical Research* 39 (2008): 453, 456.

⁸⁵ Ibid., 457.

“significantly less likely to support euthanasia or patient-assisted suicide than others.”⁸⁶

The influence of other factors, such as gender, specialty, and years of medical practice, were minimal.⁸⁷

What these studies demonstrate is that, despite claims by doctors that decriminalization would lead to “slippery slope,” what often undergirds such an assumption is the presence of religious beliefs. Allegations of “risk” and “danger” to the community are, from a Vattimian perspective, “masks” that cloak what is actually a deeper motive—a religious motive—that lies beneath the rhetoric of prohibition. For the majority of Canadian physicians, the illusion of the “slippery slope” prevailed over empiricism whenever the intentional hastening of death was discussed, particularly in the tension-filled period of the 1990s.

“Masking Causation”: Nancy B. and Absolute Moral Distinctions

The claim by metaphysicians that absolute distinctions exist between acts of omission and commission is well established in the literature. Active euthanasia implies that the doctor “purposely causes the patients death by a direct act of commission,” meaning that the physician “deliberately interrupts the disease process by an act that unequivocally kills the patient.”⁸⁸ To reiterate: the physician, rather than the disease, causes death. In contrast, “passive” euthanasia, or an act of omission, occurs when death results from the withholding or withdrawal of life-prolonging treatment. In this instance,

⁸⁶ E.J. Emanuel, “Euthanasia and Physician-assisted Suicide: A Review of the Empirical Data from the United States,” *Arch Inter Med* 162 (2002): 142-152.

⁸⁷ Rubén Lisker et al., “Physician-Assisted Death. Opinions of a Sample of Mexican Physicians,” 454. The only variable that played any other significant role in shaping Mexican doctors’ attitudes toward physician-assisted death was “familiarity attending terminally ill patients.”

⁸⁸ B. Sneiderman, J. Irvine, and P. Osborne, eds. *Canadian Medical Law: An Introduction for Physicians and Other Health Professionals* (Toronto: Carswell, 1989), 228-9.

death ensues from “natural causes,” meaning that “it is the disease process that kills.”

Although an omission “enables the patient to die sooner rather than later,” the physician in this situation “has not killed the patient” but has “let the patient die a natural death.”⁸⁹

Some consider any weakening of this distinction significant because it could lead to a growing tolerance for euthanasia and assisted suicide.⁹⁰

The first major “event” in Canada to challenge absolute moral distinctions—one that threatened “sanctity of life” as first principle—was that of Nancy B. (Nancy Bolduc) in 1992. Her scenario is often contrasted with that of Sue Rodriguez in that the former’s death was sanctioned under standard medical practice (i.e., refusal of treatment) while the latter’s request was categorized as physician-assisted suicide (i.e., a criminal act).⁹¹ As previously discussed, Nancy B. was a twenty-five year-old woman suffering from Guillain-Barré syndrome, a condition in which the body’s immune system attacks the nervous system. In June, 1989, her condition deteriorated rapidly. She became completely paralyzed, requiring a ventilator to breathe. Two and a half years later, her condition remained unchanged. Because she was conscious and of age of consent, she was able to provide a persistent request that her ventilator be withdrawn. A psychiatrist who examined her four times found her to be competent with her petition.⁹² However, not all hospitals had made a paradigmatic shift toward the *qualified* sanctity of life ethos and its inherent omission/commission distinction. At Hôtel-Dieu de Québec, Nancy B.’s physician, Dr. Daniel Marceau, refused to honour her request to end life-sustaining

⁸⁹ Ibid, 229.

⁹⁰ David Orentlicher, “The Legalization of Physician-Assisted Suicide: A Very Modest Revolution, *Boston College Law Review*, 38 (1997): 443-475.

⁹¹ Harry E. Emson, “Defining Physician-Assisted Suicide and Euthanasia,” *Can Med Assoc J* 152, no. 12 (15 June 1995): 1961.

⁹² Arthur Fish and Peter A. Singer, “Nancy B.: The Criminal Code and Decisions to Forgo Life-Sustaining Treatment,” *Can Med Assoc J* 147, no. 5 (1 September 1992): 637.

treatment on the grounds that “compliance was not only unethical but also illegal.”⁹³ Dr. Marceau was supported by the hospital’s general director who claimed that Marceau’s stand was compelled by *Criminal Code* provisions against euthanasia and assisted suicide.⁹⁴ The hospital’s apprehension demonstrated that the *qualified* sanctity of life ethos was not ethically viable in all medical circles.

What is important to understand about the Nancy B. case was how medical and legal experts made concerted efforts to distinguish between it and cases of physician-assisted suicide. If life-prolonging treatment had to be withdrawn, any legal intent to hasten her death was denied, seeing as this would make the omission morally equivalent to assistance in suicide. Yet the facts of the case reveal several “disguises” surrounding causation whenever Nancy B.’s death was hastened. All in charge of her care agreed that her illness was incurable, and when asked how soon she would die if the ventilator were removed, Nancy B.’s doctor, Danièle Marceau, indicated “within minutes.”⁹⁵ Nancy B. died seven minutes after the removal of the respirator by the physician, the third party performing the final act.⁹⁶ This would indicate not only foresight in the likelihood of causing death, but because of one’s medical understanding of Nancy B.’s disease, the intent to hasten death to some degree would also be apparent. Even with prior knowledge that Nancy B.’s death would immediately ensue following the removal of the ventilator,

⁹³ Barney Sneiderman, “The Case of Nancy B.: A Criminal Law and Social Policy Perspective,” *Health Law Journal* 1 (1993): 25.

⁹⁴ “Woman Sues for Right to Die,” *The Winnipeg Free Press* (28 November 1991), A15.

⁹⁵ CBC News in Review, VHS, “Nancy B.: The Right to Decide” (Ottawa: Canadian Broadcasting Corporation, February 1992).

⁹⁶ CBC Archives, “Nancy B Dies after Winning the Right to Refuse Treatment,” Broadcast Date: February. 13, 1992; accessed September 22, 2010. <archives.cbc.ca/politics/rights_freedoms/clips/6406/>

the cause of death was still attributed to “her underlying illness rather than the disconnection of the respirator.”⁹⁷

Moreover, during Nancy B.’s Quebec Superior Court trial, Justice Dufour concluded that “the person [physician] who stops Nancy B.’s respiratory support, and lets *nature take its course* is in no way committing a crime. . . [italics mine].”⁹⁸ Justice Dufour even differentiated between acts of commission, such as homicide and suicide, and acts of omission, stating that the former were “not natural deaths,” unlike the removal of respiratory support.⁹⁹ Raphael Cohen-Almagor nicely summarizes the connection between this form of “legal” causation and the religious foundations central to the sanctity of life ethos: “Those who believe life is intrinsically valuable object to taking life . . . because the end of life is something granted only to *nature*, and is not a decision that is incumbent upon human beings [italics mine].”¹⁰⁰

What has to be asked is whether Justice Defour’s reasoning surrounding causation was arbitrary. Had Nancy B. consistently expressed her willingness to live and refused consent to turn off the respirator, any doctor who disobeyed this request would be held responsible for her death. In a case of non-consent, “[N]o one would deny that the patient’s death was *caused* by the disconnection of the respirator [italics mine].”¹⁰¹ R. G. Frey, professor of philosophy at Bowling Green State University, acknowledges that, although methods may vary, physicians cannot direct the cause of death away from their

⁹⁷ Arthur Fish and Peter A. Singer, “Nancy B.: The Criminal Code and Decisions to Forgo Life-Sustaining Treatment,” 639.

⁹⁸ *Nancy B. v. Hôtel-Dieu de Québec*, 11.

⁹⁹ *Ibid.*

¹⁰⁰ Raphael Cohen-Almagor, “The Right to Die with Dignity: An Argument in Ethics and Law,” *Health, Law & Policy* 2, no. 1 (30 October 2008): 2. Available at SSRN: <<http://ssrn.com/abstract=1292302>>

¹⁰¹ Arthur Fish and Peter A. Singer, “Nancy B.: The Criminal Code and Decisions to Forgo Life-Sustaining Treatment,” 639.

actions by relying on a foreseen/intended distinction. Medical practitioners are, in fact, part of the chain of causation:

Turning off or unplugging machines, withdrawing tubes, and the like, are all actions the doctor performs, and over the decision to perform them or not the doctor retains causal responsibility, with the result that he is causally responsible for what ensues as a result of how he makes this decision. He may not be the whole cause of death, for it may well be . . . that he acts at the request of the patient; but he certainly is a part of the cause of death and for what he causes he is *prima facie* morally responsible.¹⁰²

Judith Jarvis Thomson makes a similar point. She argues that causation in death can be established irrespective of one's views on moral distinctions. Her analogy is worth quoting at length:

If I fire a gun out the window, and the bullet lodges in Alfred's head, and I thereby cause him to die, then my intentions in firing the gun may be thought relevant to the question whether I decided to kill Alfred; but my intentions are irrelevant to the question whether I actually did kill him—indeed, I did kill him no matter what my intentions were, whether I fired the gun to kill him or merely thought it would be fun to fire a gun out the window, not caring the least whether I shot anyone. Similarly, if I can but do not save the life of someone I have no connection with, and who therefore dies, I do not kill him; I merely let him die, whatever my intentions are in refraining—I merely let him die whether I refrain from saving him in order that he die, or merely can't be bothered to save him.¹⁰³

From Jarvis' perspective, one cannot escape role responsibility simply by referring to one's actions as an omission or commission, as "killing" or "letting die," as "intended" or "foreseen." From a consequentialist viewpoint, one's actions contributed to a specific result, that being the death of the individual.

James Rachels makes a similar argument. He does not believe any absolute moral difference exists between "intending death" and "letting die." In other words, a physician that "masks" intent does not change the role responsibility of his/her act. The following scenario illustrates Rachels' point:

Smith stands to gain a large inheritance if anything should happen to his six-year old cousin. One evening while the child is taking a bath, Smith sneaks into the bathroom and drowns the child. . . . Jones also stands to gain if anything should happen to his six-year old cousin. Like Smith, Jones sneaks in planning to drown the child in his bath. However, just as he enters the bathroom Jones

¹⁰² Gerald Dworkin et al., eds. *Euthanasia and Physician-Assisted Suicide: For and Against*, 24-25.

¹⁰³ Judith Jarvis Thomson, "Killing and Letting Die: Some Comments," in *Intending Death: The Ethics of Assisted Suicide and Euthanasia*, edited by Tom L. Beauchamp, 105.

sees the child slip, hit his head, and fall face-down in the water. Jones is delighted; he stands by, ready to push the child's head back under if necessary, but it is not necessary. With only a little thrashing about, the child drowns all by himself, "accidentally," as Jones watches and does nothing.¹⁰⁴

Rachels asks, from a moral point of view, if either man behaved better simply because one intended death while the other "merely" let the child die. If there was an absolute distinction between "killing" and "letting die," then one would say that Jones' behaviour was less reprehensible than Smith's; however, Rachels remains unconvinced. Even if the scenario involved a choice by a physician between an act of omission or commission, Rachels argues that either method is irrelevant in moral terms:

[T]he difference between killing and letting die does not, *in itself*, make a difference, from the point of view of morality. If a doctor lets a patient die, for humane reasons, he is in the same moral position as if he had given the patient a lethal injection for humane reasons. If the decision was wrong—if, for example, the patient's illness was in fact curable—then the decision would be equally regrettable no matter what method was used to carry it out. And if the doctor's decision was the right one, then the method he used is not itself important.

Yet in the case of Nancy B., Justice Dufour's dependence on the omission/commission distinction may not have been completely due to a religious "trace" connected to the *qualified* sanctity of life ethos. For practical reasons, he could not admit that Nancy B.'s death was "caused" by a physician with her consent because this would have openly contradicted the *Criminal Code*, which provides that a victim's consent nor a compassionate motive can justify such an act.¹⁰⁵ However, in 1992 this did not stop Drs. Arthur Fish and Peter Singer from calling Justice Defour's legal reasoning "patently artificial" for negating any role responsibility a physician may have played in Nancy B.'s death.¹⁰⁶ In contrast, Bernard M. Dickens explains that technically speaking, although Nancy B.'s death did "result from the patient's inability to breathe spontaneously," the doctor who disconnected the respirator "does not in law cause the death that follows . . .

¹⁰⁴ James Rachels, *The End Of Life: Euthanasia and Morality*, 112-113.

¹⁰⁵ Fish and Singer, "Nancy B.: The Criminal Code and Decisions to Forgo Life-Sustaining Treatment," 640.

¹⁰⁶ *Ibid.*, 639.

Death is caused not by the disconnection of the respirator *per se*, but by breach of duty to maintain connection until the patient consents to disconnection.”¹⁰⁷ Basically, causation is attributed to the doctor only if he/she pulls the respirator without consent. When consent is granted, the cause of death reverts to *nature*. Professor Dickens admits that the principles of legal causation in the case of Nancy B. “may appear patently artificial from a purely scientific and mechanical perspective of cause and effect, but they are well established in law.”¹⁰⁸

Leslie Burkholder also challenges absolute moral distinctions in the case of Nancy B. by comparing her situation to four similar cases (some involving science fiction). Nancy B. had a mechanical ventilator outside her body and wanted this “mechanical lung” turned off. Burkholder asks if there would be any moral difference if “Nancy C” had “mechanical ventilators” or “artificial lungs” inside her body that hospital staff turned off by “remote control.” In both cases, the ability to breathe would be mechanical, and a third party would have to interrupt a mechanical breathing apparatus. Take it one step further. What if “Nancy D” had the same “internal mechanical ventilators,” but hospital staff used a “chemical agent strong enough to stop the action of her implanted artificial lungs”? As with Nancy C, “artificial breathing” is terminated so that *nature can take its course*. What, if again, “Nancy E” received “cadaveric lung transplants” and medical personnel used “a dose of morphine strong enough to stop the action of her transplanted lungs,” a case similar to that of Nancy D? Finally, “Nancy F” has a muscle-wasting disease affecting her own lungs, and the disease will eventually cause her to die. She prefers instead to have a doctor administer enough morphine “to

¹⁰⁷ Bernard M. Dickens, “Medically Assisted Death: Nancy B. v. Hotel-Dieu De Quebec,” *McGill Law Journal* 38 (1993): 1059, 1063-64. Available at SSRN: <<http://ssrn.com/abstract=1226060>>

¹⁰⁸ *Ibid.*, 1064.

stop the action of her lungs” before she “rapidly worsens.” Does the method—an act of omission or commission—constitute a morally significant difference when either will stop the patient from breathing permanently? Burkholder claims that what this reasoning proves is that one cannot call Nancy B.’s case “ethical” while depicting Nancy F’s scenario as “unethical” (or any of the other intermediate cases).¹⁰⁹

However, as previously noted, the killing/letting die distinction is often based on deference to *nature* as the ultimate cause of death, not individuals, and it is here that aspects of a religious bias are implied. Daniel Callahan, an ethicist who founded the Hastings Institute, is adamant that doctors must maintain a clear distinction between acts of commission, such as euthanasia/physician-assisted suicide, and “allowing to die.” For Callahan, eliminating the distinction is a clear admission that man is the sole arbiter over life and death:

Consider one broad implication of what the erasure of the distinction between these two categories implies: That death from disease has been banished, leaving only the actions of physicians in terminating treatment as the cause of death. Biology, which used to bring about death, has apparently been displaced by human agency; doctors end life, not nature.¹¹⁰

Callahan fears that any admission by doctors as causal agents in death within standard medical practice opens up Pandora’s Box. Humans would then accept their role in the causation of death rather than deferring this responsibility to an external source (i.e., “nature”). Such a shift in the interpretation of legal causation would not only lead to the irrelevance of absolute moral distinctions, but it would result in a final weakening of the *qualified* sanctity of life ethos as first principle. Thus, euthanasia and physician-assisted suicide would become one set of means among others within standard medical

¹⁰⁹ Leslie Burkholder, “Discussion Article: Nancy B and Nancy F,” *Journal of Applied Philosophy* 18, no. 2 (2001): 193-195.

¹¹⁰ Daniel Callahan, “Self-Extinction: The Morality of the Helping Hand,” in *Physician-Assisted Suicide*, edited by Robert F. Weir (Bloomington: Indiana University Press, 1997), 78.

practice. Ironically, the intentional hastening of death would, in some cases, be more ethical than palliation or withholding/withdrawing of treatment. States Callahan:

If we fail to maintain the distinction between killing and allowing to die, moreover, there are some disturbing possibilities. The first would be to confirm . . . that when patients die or when physicians stop treatment because of the futility of continuing it, they are somehow both morally and physically responsible for the deaths that follow. . . . The second possibility would be that in every case where a doctor judges medical treatment no longer effective in prolonging life, a quick and direct killing of the patient or assisting the patient to commit suicide would be seen as the next most reasonable step on grounds of both humaneness and economics. I do not see how that logic could easily be rejected.¹¹¹

Other forms of “death-hastening” permitted under standard medical practice also challenge the relevance of absolute moral distinctions. One of these methods, terminal sedation, had been discussed by the Canadian government in a report by the *Special Senate Committee on Euthanasia and Assisted Suicide* in 1994-1995. In their conclusion, all seven members of the Committee indicated that terminal sedation was a legitimate practice as long as the patient provided consent.¹¹² With terminal sedation, the patient is “put definitely into a state of unconsciousness (supposed to go until the patient is dead) while, at the same time, artificial nutrition and hydration of the patient are withheld.”¹¹³

Pharmacologically speaking, the type of drug used in terminal sedation is often an indicator of the physician’s intent. As stated in *The Washington Report* on “Assisted Suicide and Euthanasia,” pain relief (and thus the doctrine of double effect) can be distinguished from intent to hasten death based on the choice of drugs:

To provide pain relief, the primary action of the drug chosen must be to lessen the perception of pain . . . Narcotics (opioids) and other analgesics do this. . . . The primary action of barbiturates, in contrast, is not to lessen the perception of pain in those who are conscious, but to provide sedation and loss of consciousness. Barbiturates are well known for their capacity to cause death; they have been used to kill patients intentionally. . . . [T]heir pharmacology speaks against almost all intent of those using them other than to cause death of those receiving them.¹¹⁴

¹¹¹ Ibid., 80.

¹¹² Mullens, *Timely Death: Considering our Last Rights*, 215-216.

¹¹³ Torbjörn Tännsjö, *Terminal Sedation: Euthanasia in Disguise?*, xvi.

¹¹⁴ Washington Report, *The, Assisted Suicide and Euthanasia: Christian Moral Perspectives*, 15.

Likewise, Swedish philosopher Torbjörn Tännsjö believes that barbiturates cannot be used in terminal sedation because the drugs themselves indicate the intent to suppress respiration and, therefore, hasten death intentionally. Consequently, the patient would not die from the underlying disease but from the action of the physician:

I agree that, if a patient is given drugs that suppress respiration, and hence dies, it is euthanasia, not terminal sedation. But terminal sedation, as I define it, and as it is usually administered, doesn't include barbiturates. The medication typically used is Dormicum (Midazolam) and, when it is given to a patient, the intention is to sedate the patient into oblivion, not to kill him.¹¹⁵

However, in Tännsjö's own book on terminal sedation, Dr. Timothy E. Quill contradicts the author, claiming that, when receiving terminal sedation, the patient does indeed receive barbiturates.¹¹⁶ The cause of death, therefore, is no longer the underlying disease. After artificial nutrition and hydration are removed, the patient dies from either dehydration, starvation, or some other intervening complication.¹¹⁷ The result of making a moral distinction between terminal sedation and euthanasia/physician-assisted suicide is that the intend/foresee distinction becomes harder to justify. As Quill et al. argue, "[I]t seems implausible to claim that death is unintended when a patient who wants to die is sedated to the point of coma, and intravenous fluids and artificial nutrition are withheld, making death certain."¹¹⁸ Another difficulty in distinguishing terminal sedation from other acts of commission is that their ethical differences appear redundant. In both cases, death is hastened, death is certain, the doctor performs the final act with a needle, and the drug of choice (barbiturates in the case of Dr. Quill) indicates an intent to hasten death. It is no wonder Helga Kuhse calls terminal sedation "slow euthanasia" or "euthanasia in

¹¹⁵ Communication with Torbjörn Tännsjö by e-mail. Topic: Terminal Sedation. Sent: Wed 16/01/2008 3:20 PM. It is important to also note that many types of pain-killing drugs, given in the right quantity, can suppress respiration.

¹¹⁶ Timothy E. Quill, in *Terminal Sedation: Euthanasia in Disguise?*, edited by Torbjörn Tännsjö, 3.

¹¹⁷ Torbjörn Tännsjö, *Terminal Sedation: Euthanasia in Disguise?*, 3, 22.

¹¹⁸ Timothy Quill et al., in *Terminal Sedation: Euthanasia in Disguise?*, edited by Torbjörn Tännsjö, 21.

disguise.”¹¹⁹ From a Vattimian perspective, what is being “masked” is the intent to hasten death since such an admission would completely nullify the omission/commission distinction as well as the *qualified* sanctity of life ethos as first principle. For prohibitionists, the result is obvious: There would no longer be a need to distinguish between cases such as Nancy B. and Sue Rodriguez.

David Orentlicher also argues that reliance on terminal sedation presents a constitutional dilemma for those supporting the omission/commission moral distinction. This is because courts in both the United States and Canada have rejected physician assistance in suicide in favour of a form of “euthanasia”—terminal sedation. But the two are not equivalent in quality, though they may be equivalent in ends. With terminal sedation, the dying process takes longer than euthanasia—perhaps hours, days, or weeks longer—thereby creating a lingering death for the patient and family.¹²⁰ In the case of physician-assisted suicide, patients are more likely to relate to the choice of means, preserve their dignity, and ultimately decide when they will die and by their own hand.¹²¹ Most significantly, other options not permitted under standard medical practice, such as euthanasia and physician-assisted suicide, are arguably less worrisome from a medico-ethical point of view because the result is less suffering.¹²² However, for metaphysicians,

¹¹⁹ Helga Kuhse, in *Terminal Sedation: Euthanasia in Disguise?*, edited by Torbjörn Tännsjö, xviii, 59. It is interesting to note that “slow euthanasia” is also used in instances of palliative care where the foreseen/intended distinction disappears and intent is clearer. When doses of palliative medications are increased, “slow euthanasia” is used “not for the purpose of easing identifiable discomfort but with the expectation of hastening death gradually.” See J. Andrew Billings and Susan D. Block, “Slow Euthanasia,” *Journal of Palliative Care* 12, no. 4 (1996): 21-30.

¹²⁰ David Orentlicher, “The Supreme Court and Terminal Sedation: An Ethically Inferior Alternative to Physician-Assisted Suicide,” in *Physician-Assisted Suicide: Expanding the Debate*, edited by Margaret P. Battin, Rosamond Rhodes, and Anita Silvers, 303.

¹²¹ *Ibid.*, 306.

¹²² Communication with Dr. Timothy E. Quill by e-mail. Topic: Terminal Sedation. Sent Wed 04/03/2009 4:22 PM. Dr. Quill confirmed that had terminal sedation been more prominent in the literature at the time of *Vacco v. Quill* when he argued for the legalization of physician-assisted suicide, he would have used it to persuade the U.S. Supreme Court of the arbitrary use of absolute moral distinctions. In his words,

the “masking” of causation—even when the means is, effectively, the same, as when barbiturates are administered—solidifies in law, medicine, and philosophy absolute distinctions (i.e., omission/commission, intend/foresee, killing/letting die) while maintaining the *qualified* sanctity of life ethos as supreme principle.

“Terminal sedation was not being practiced when the case [*Vacco v. Quill*] was being brought; we probably would have made these arguments [comparing terminal sedation with physician-assisted suicide] if it [terminal sedation] was being practiced.”

Conclusion

An Overview of the Vattimian Perspective

A Vattimian analysis of the sanctity of life ethos in Canada was adopted because it was felt that Vattimo's philosophical ethics provided an appropriate framework for such an inquiry. It was particularly his nihilistic approach—"the history of how objective truth gradually dissolves"¹—that helped illustrate how religious normative assumptions operate within the death and dying issue in Canada, specifically the controversy surrounding euthanasia and assisted suicide. Vattimo's main themes—*metaphysics* (fixed, eternal values), "*event of being*" (lived experiences that call absolute values into question), and *passive-reactive nihilism* (the use of "masks" or "disguises" to sustain the reigning metaphysic)—were selected to highlight the reaction of ethicists, doctors, justices, and politicians whenever competing interpretations or "events" challenged the authority of absolute values (i.e., the *qualified* sanctity of life ethos). What Vattimo's theoretical perspective demanded was an overview of immutable principles, an observation of their weakening, and a resolution in terms of either the "death of God" (death of absolutes) or the perpetuation of objectivistic metaphysics.

Through the incorporation of Vattimo's concepts in ethical, medical, legal, and political discourses, a philosophical conflict was apparent between metaphysicians and postmodernists. In other words, there was a marked difference in the rhetoric of those who either gravitated towards the sanctity of life or quality of life ethos. According to Bernard Dickens, the former belief system "limits human intervention in the natural or divinely mandated processes of life and death"; whereas, the latter concerns "the

¹ Vattimo with Paterlini, *Not Being God: A Collaborative Biography*, 24.

entitlement of human beings to exercise decisive control over these vital processes in order to regulate the quality of human and social experience and achieve a world of their own design.”² As a general rule, metaphysicians—religious and secular proponents of the sanctity of life ethos—emphasized the rhetoric of stewardship, value in prolonged suffering, and the “slippery slope” whenever euthanasia and assisted suicide were presented as viable options. By comparison, Vattimian postmodernists—religious and secular advocates of the quality of life ethos—felt that self-determination, the relative value of human life, and the workability/flexibility of safeguards were key arguments in support of an intentionally hastened death. In rare instances, secular organizations adopted absolutist positions (“civil rights” discourse) whenever the principles of “equality” or “autonomy” appeared to weaken as first foundations. Lastly, the rhetoric of “sanctity of life” and “quality of life” was sometimes interwoven, resulting in a hybrid of Christian/metaphysical and secular/postmodern positions.

The dissertation began with an examination of euthanasia and assisted suicide from a global perspective. The historical evidence demonstrated that no single value system or metaphysic has ever held universal appeal. The cultural context dictated the degree of emphasis placed on one of three competing paradigms: vitalism (no intentional hastening of death by act *or* omission); the *qualified* sanctity of life ethos (acts of omission permitted in the hastening of death); or the quality of life ethos (*both* acts of omission *and* commission permitted in the intentional hastening of death). As the historical context evolved, countries and/or states encountered paradigmatic shifts influenced by specific “events of being.” For example, from a Western perspective,

² Bernard M. Dickens, “The Continuing Conflict between Sanctity of Life and Quality of Life: From Abortion to Medically Assisted Death,” *Annals of the New York Academy of Sciences* 913 (September, 2000): 88-89.

death occurred when one's heart and lungs stopped, but as the late 1960s approached, this was no longer practical. Because of the demand for transplants, "brain death" became a more suitable standard to better facilitate the demand for organ donation. Thus, even the criteria for death were subject to change.

In terms of death-hastening practices, even these evolved significantly in the post-World War II era. The state of Missouri eventually allowed the removal of artificial nutrition and hydration, something the Cruzan "event" facilitated. Prior to Cruzan, the state of Missouri considered food and water "medical treatment"; therefore, their removal constituted a homicide. Cruzan was significant because it produced a disjuncture in American society's conviction over the "right way" to die. Eventually, absolute moral distinctions between methods of *omission* were questioned as to their situated and contested nature. As well, the precedent-setting cases of Karen Ann Quinlan and Nancy B. ushered in a new ethical approach to the withdrawal of life-prolonging treatment in the United States and Canada. Even if the removal of a ventilator resulted in a hastened death, the state's interest in the sanctity of human life was overridden by the patient's and/or family's interest in informed choice.³ As a result of these cases, the vitalist perspective weakened due to growing support for the *qualified* sanctity of life ethos as first principle. This paradigmatic shift represented a "middle path" that most Western nations eventually accepted as ethically viable.

³ Barney Sneiderman, "The Case of Nancy B.: A Criminal Law and Social Policy Perspective," 38; also see Trudo Lemmens, "Towards the Right to be Killed?: Treatment Refusal, Assisted Suicide and Euthanasia in the United States and Canada," *British Medical Bulletin* 52, no. 2 (1996): 341-53; Arthur Schafer, "The Great Canadian Euthanasia Debate," *The Globe and Mail* 5 November 2009. <theglobeandmail.com>; accessed 11 November 2009. Shafer discusses how doctors in the 1970s used to worry about the ethics and legality of hastening a patient's death using acts of omission or "pulling the plug." By 1992, the case of Nancy B. helped establish that, in Canada, a competent adult now had the right to refuse life-prolonging treatment. Because of this "event," a hot-button issue had shifted in interpretation. Initially perceived as a homicide, the withdrawal of a respirator was now labelled "appropriate care."

Very few regions in the world (e.g., Holland, Switzerland, Oregon) have adopted the quality of life ethos by accepting euthanasia, physician-assisted suicide, or both. However, there is some evidence that more jurisdictions, such as Washington State and Montana, have made a marked transition in medico-legal standards.⁴ As a result of these fluid moralities, Joane Martel suggests that “a certain stir is occurring in long-standing schemas of thought in many countries around the globe.”⁵ I suggest that, irrespective of one’s philosophico-ethical framework, a global analysis of death and dying is consistent with the Vattimian nihilistic perspective of “history as eventuation” and the “interminable weakening of Being.”⁶ By exposing historical turning points within the metaphysical tradition, one distorts any concept of fixed, immutable principles that, according to Vattimo, “exercise domination.”⁷ Essentially, this was the purpose of chapter II (Global Trends and the “Eventuation of Being”).

An analysis of discourse began with those religious groups and/or individuals (sanctity of life advocates) appearing before the *Special Senate Committee on Euthanasia and Assisted Suicide*. The normative assumptions of Christianity, especially those inherent in Catholic moral theology, dominated religious discussions over euthanasia and assisted suicide. Since life is considered “a gift to us from the Creator,” this makes it intrinsically valuable. Therefore, as stewards, human beings are forbidden to intentionally hasten death. Catholic witnesses affirmed the “value of heroic suffering,”

⁴ William Yardley, “Report Finds 36 Died under Assisted Suicide Law,” *New York Times* (4 March 2010). <www.newyorktimes.com>; accessed 19 October 2010; also see Kirk Johnson, “Montana Court to Rule on Assisted-Suicide Case,” *New York Times* (31 August 2009). <www.newyorktimes.com>; accessed 19 October 2010. Washington State decriminalized physician-assisted suicide in 2009, and Montana began a constitutional challenge of the issue in 2009 in the case of Robert Baxter.

⁵ Joane Martel, “Examining the Foreseeable: Assisted Suicide as a Herald of Changing Moralities,” *Social and Legal Studies* 10, no. 2 (2001): 167.

⁶ Gianni Vattimo, *Beyond Interpretation: The Meaning of Hermeneutics for Philosophy*, translated by David Webb (Cambridge: Polity Press, 1997), 13.

⁷ Vattimo, *Not Being God*, 111.

claiming that it “builds character,” “produces endurance,” and “provides opportunities for reconciliation both to God and to men.” The *Special Senate Committee* was also warned that any weakening of the sanctity of human life would cause civilization to “fall apart in dispute.” The implication was that “if killing goes, anything goes.”⁸

Moreover, the research showed that ethicists and bioethicists who supported prohibition used rhetorical patterns similar to religious organizations. Emphasizing stewardship, Toronto bioethicist Abbyann Day Lynch claimed that euthanasia made death occur “unnaturally” or “before time.” University of Montreal ethicist Dr. Edward W. Keyserlingk gave credence to absolute moral distinctions, claiming that for acts of omission, doctors were “not causing the patient’s death at all.” Although prolonged suffering or intractable pain was the result of maintaining the *qualified* sanctity of life ethos as first principle, Calgary bioethicist Dr. T. Douglas Kinsella did not want the law changed for “the occasional dreadful, horrible case that cannot be accommodated by the system.” In terms of the “slippery slope,” Montreal bioethicist Dr. J. Roy warned of the spectre of eugenics. Euthanasia may become necessary for those whose lives have “no sense, no purpose, no worth in the eyes of others.” McGill ethicist Margaret Somerville added that decriminalization would not only cause harm to society’s “most important values and symbols,” but it would eventually lead to a “duty to kill.”⁹

In contrast, only two religious bodies—Unitarians and the Liberal Catholic Church—lobbied for euthanasia and assisted suicide. Their normative assumptions corresponded with quality of life advocates that also supported decriminalization.

⁸ For Catholic viewpoints surrounding the decriminalization of euthanasia and assisted suicide, see Chapter III: Ethical and Religious Discourse under “The Religious as Metaphysicians.”

⁹ For previous comments made by ethicists and bioethicists, see Chapter III: Ethical and Religious Discourse under “Metaphysics Interwoven in Secular Discourse.”

Witnesses for the Unitarian Church felt that a law that forbids assisted suicide “lacks compassion.” In opposition to metaphysics, Unitarians did not accept scriptural interpretation as “absolute and without question.” One representative from the Liberal Catholic Church even commented on how “sanctity of life” interfered with “a citizen’s free and conscious decision to take his or her life.” In other words, society should not interfere with this “exercise of the free will.”¹⁰

As with the “religious exceptions” above, ethicists and bioethicists who advocated for decriminalization were almost exclusively Vattimian postmodernists. Prominent among these was Dr. Eike-Henner W. Kluge. He noted how prohibition not only made “a mockery of autonomy” and the notion of “individual rights,” but such an imposition was also “external to the patient’s own value system.” Dr. Kluge rejected absolute moral distinctions because, all things being equal, active and passive euthanasia were “ethically on a par with respect to causality, intent, and responsibility.” Specializing in bioethical issues at the University of Toronto, Professor Bernard Dickens also recognized how a belief in prolonged suffering was only feasible if one believed in “life at any cost.” Lastly, ethicist Arthur Schafer dismantled myths surrounding the “slippery slope” by critiquing absolute moral distinctions. As he told the *Special Senate Committee*, “Every one of your concerns about the difficulty of ascertaining whether a dying patient is competent to request euthanasia or physician-assisted suicide applies with equal weight to the decision to withhold or withdraw medical care.”¹¹

¹⁰ For a detailed reasoning of the Unitarian and Liberal Catholic Church’s positions, see Chapter III: Ethical and Religious Discourse under “Religious Exceptions.”

¹¹ For further comments by ethicists and bioethicists in support of euthanasia and assisted suicide, see Chapter III: Ethical and Religious Discourse under “Vattimian Postmodernists.”

There was, however, one exception to this general polarization. University of Manitoba ethicist Barney Sneiderman promoted a quality of life ethic but could not commit to decriminalization, fearing the possibility of a “slippery slope.” Although he agreed that prolonging death against a patient’s wishes was “a horrifying contradiction” and rejected the approach that euthanasia was “morally wrong in principle,” he worried that “an increasingly aging population” would bring its own “pressures to bear.” The elderly may prefer a “lethal injection” rather than be “trapped” in an institution until they die. Interestingly, Sneiderman’s concerns did not apply to acts of omission, a clear indication that “traces” of the *qualified* sanctity of life ethos as first principle still influenced his thinking.¹²

The general history of the Canadian Medical Association (CMA) was also indicative of the Vattimian concept of “eventuation.” Not only did its *Code of Ethics* change with the “sentiments of the world,” but the philosophy of medical ethics had shifted away from vitalism and toward the acceptance of the *qualified* sanctity of life ethos. Acts of omission (i.e., withholding or withdrawal of treatment) were eventually considered part of standard medical practice; however, acts of commission (i.e., euthanasia and assisted suicide) were still equated with homicide. In fact, when discussion focused on the possibility of an intentionally hastened death, the majority of physicians within the CMA rejected decriminalization of euthanasia and physician-assisted suicide.¹³

¹² For an elaboration of Sneiderman’s views, see Chapter III: Ethical and Religious Discourse under “Metaphysical ‘Traces’ in Quality of Life Discourse.”

¹³ For an overview of “changing sentiments” expressed within the CMA’s *Code of Ethics*, see Chapter IV: Medicine’s Rejection of Euthanasia and Assisted Suicide, 1970s-1990s under “The CMA Code of Ethics: A Brief History.”

Generally speaking, Canadian physicians relied on normative assumptions typically associated with metaphysicians. For example, the “slippery slope” was viewed as self-evident. Many doctors were concerned about betraying the Hippocratic tradition, the doctor-patient relationship, and the role of doctors as healers.¹⁴ Decriminalization was said to “erode the moral mission of medicine.” There was serious concern that the “healers of Canada” would become “misrepresented as the killers of Canada.” Other physicians felt that “the lives of thousands of vulnerable people will be in danger” if active euthanasia were ever legalized. Of all “slope” concerns, the most frequently mentioned were the adoption of Dutch policies and a return to Nazi eugenics. The Remmelink Report’s citing of “1000 cases” of nonvoluntary euthanasia was taken as evidence of “‘the can of worms’ we open when talking about euthanasia.” If Canada embraced the Dutch mandate concerning euthanasia and assisted suicide, it was feared that incompetent, nonconsenting patients would fall prey to the “killing treatment.” Dr. Ted Boadway, the CMA’s Director of Health Policy, added that if members discussed assisted suicide openly, they were “compared to Nazis.” It was also recognized that, although the sanctity of life as absolute “caused people with terminal illnesses . . . to suffer,” the maintenance of this principle would “prevent the repetition of past horrors.”¹⁵

¹⁴ The debate over the role of doctors in postmodern bioethics has led to a return to ancient conceptions of medical philosophy, particularly Aristotle’s concept of *phronesis* or “practical wisdom.” Because of postmodernism’s suspicion of all philosophical systems, its recognition of cultural pluralism, and its rejection of “objective” morality, *phronesis* is a possible way out of a foundational dilemma for bioethics. The concept implies making prudent judgements for the good of others, oneself, and the community. The justification of norms and standards does not rely on theories of ethics but on the “practical realm of ‘doing’ medicine, the doctoring and patienting activities that bring about healing.” *Phronesis* is seen as a virtue because “it requires practice, and it signifies an habituation toward and development of one’s standards and norms.” See David Thomasma, “Aristotle, *Phronesis*, and Postmodern Bioethics,” in *Bioethics: Ancient Themes in Contemporary Issues*, edited by Kuczewski and Polansky, 67-91.

¹⁵ For a complete overview of physician opinion on the “slippery slope,” see Chapter IV: Medicine’s Rejection of Euthanasia and Assisted Suicide, 1970s-1990s under “Holland’s ‘Slippery Slope’ and Nazi Analogue.”

As well, moral distinctions between acts of omission and commission were deemed absolute by members of the CMA. The physician was said to have played no role in the death of the patient whenever treatment was withheld or withdrawn. The doctrine of double effect was considered ethical because the primary motive in palliative care was to treat the dying patient's pain, not to intend his/her death. The cause of death was attributed to "the natural history of the illness," not the actions of medical practitioners. Therefore, physicians in general have supported an absolute distinction between euthanasia and assisted suicide and the withholding/withdrawal of treatment "even when these [latter] practices shorten life." Dr. Douglas Sawyer, Chair of the CMA's Committee of Ethics, even admitted that the CMA preferred not to use "passive" in relation to euthanasia and regarded "the withholding and withdrawal of treatment as a separate issue."¹⁶

The rhetoric of metaphysics was even more pronounced among hospice/palliative care workers testifying before the *Special Senate Committee on Euthanasia and Assisted Suicide*. In fact, "traces" of the Christian tradition included a belief in the "intrinsic value" of human life, the "transcendent meaning" found in prolonged suffering, and the impending nature of the "slippery slope." Dr. Balfour Mount, chair of palliative care medicine at McGill University, agreed that "religious beliefs and values influence the views of many" when addressing euthanasia and assisted suicide. He insisted that solutions for the dying should include "something more," specifically the spiritual dimensions of "meaning, values, and purpose." Dr. Louise Dionne, a palliative care specialist at Quebec City's Hôtel-Dieu hospital, rejected euthanasia because, in the

¹⁶ To understand more on the rhetoric surrounding absolute moral distinctions, particularly between positive and negative acts, see Chapter IV: Medicine's Rejection of Euthanasia and Assisted Suicide, 1970s-1990s under "The Omission/Commission Moral Distinction."

terminal phase of death, “the final days have to be lived out.” Dr. James McGregor, board member of the Ontario Palliative Care Association, claimed that if he could not relieve suffering, he would “suffer along with the patient and family.” According to Dr. Elizabeth Latimer, a Hamilton-area palliative care expert, maintaining the sanctity of human life as first principle would aid in “the continued safety and protection of large numbers of frail people in Canada.”¹⁷ A possible reason why this profession objected strenuously to decriminalization may be due to its religious origins. Since hospice care was founded by Cicely Saunders, a devout Christian, her influence on the ethics of the movement should not be understated. Since she first founded hospice care, Saunders lobbied aggressively against euthanasia and assisted suicide.¹⁸

Furthermore, representatives from health care institutions that gravitated toward the sanctity of life ethos—whether religious or secular in affiliation—relied on the same normative assumptions as other metaphysicians. Randy Bottle, Chairman of the Alberta Indian Health Care Commission, rejected euthanasia and assisted suicide because not only do such acts “alter nature,” but dying should be left “in the hands of the Creator.” Ms. Eleanor Ross, president of the Canadian Nurses Association, believed that there was value in “living life to its natural end.” As well, Dr. John S. Senn of the Sunnybrook Health Science Centre in north-central Toronto felt that it was important to “support them

¹⁷ The views of all hospice/palliative care workers in support of the sanctity of life ethos can be found in Chapter IV: Medicine’s Rejection of Euthanasia and Assisted Suicide, 1970s-1990s under “Metaphysicians in Hospice/Palliative Care.”

¹⁸ The opening of St. Christopher’s hospice in South London, England, in 1967 started from Christian motivations, and those who work in hospice/palliative care have followed in Cicely Saunders’ footsteps, the result being a worldwide movement in end-of-life care and compassion for the dying. However, Saunders also brought her own religious biases into the hospice movement’s philosophy, remaining steadfast in her rejection of an intentionally hastened death. She not only condemned euthanasia as wrong, but viewed the “slippery slope” as inevitable. Writing to Jack Kevorkian in 1985, she stated that “any law that gave the possibility of a hastened death . . . would detract immeasurably from our commitment to care for the weaker members of our society. . . .” She felt strongly that there would be “major social dangers in any law allowing an active ending of life.” See Cicely Saunders, in David Clark, *Cicely Saunders: Founder of the Hospice Movement, Selected Letters 1959-1999* (Oxford: Oxford University Press, 2005), 257, 361.

[the terminally ill] through suffering, but not support them by causing their death so that they do not suffer.” Likewise, Dr. Paul V. Adams from the Manitoba Physicians for Life opposed euthanasia because when “life is no longer considered to have intrinsic value, and becomes subject to interventions causing death, we all suffer.” Dr. André Lafrance of the Ottawa and District Physicians Who Respect Life also warned of the “slippery slope.” He reminded the *Special Senate Committee* that social acceptance of euthanasia and assisted suicide threatened the weaker members of society, such as “the elderly, the uneducated, the poor, the retarded.”¹⁹

For those doctors, hospice/palliative care workers, and health care professionals who embraced postmodern pluralism, quality of life could “only be defined by patients themselves,” prolonged suffering was viewed as “pointless,” and the “slippery slope” was depicted as arbitrary since safeguards had been feasible and/or flexible for acts of omission. Those favouring decriminalization argued how important it was that doctors “be prepared to live with diversity” and “be tolerant of other positions.” Some physicians agreed with the Dutch medical approach to intractable suffering, hoping that “the terminally ill [would] be given alternatives, as they were in Holland.” Still, others believed that physician-assisted suicide was a “moral right” and, with proper safeguards, should also be viewed as a “legal right.”²⁰

However, of all witnesses who appeared before the *Special Senate Committee on Euthanasia and Assisted Suicide*, only two doctors within hospice/palliative care were

¹⁹ For the discourse of all health care representatives, both religious and secular advocates of the sanctity of life ethos, see Chapter IV: Medicine’s Rejection of Euthanasia and Assisted Suicide, 1970s-1990s under “Health Care Representatives as Metaphysicians.”

²⁰ For the views of Canadian doctors in support of the quality of life ethos, see Chapter IV: Medicine’s Rejection of Euthanasia and Assisted Suicide, 1970s-1990s under “Holland’s ‘Slippery Slope’ and Nazi Analogue.”

representative of Vattimian postmodernism. Dr. Marcel Boisvert told the Committee that growing acceptance of an intentionally hastened death was due to a decline in a belief in stewardship. In other words, life no longer possessed “transcendent value” or “belonged to God.” Dr. Robert Buckman agreed, stating that the greatest motive behind requests for euthanasia was existential. Patients were more concerned about assessing “their own quality of life” and their desire to end a life they regarded as “not worth living.” Moreover, the comments of a small minority of health care representatives were indicative of Vattimian postmodernism. Dr. Michael Wyman, President of the Ontario Medical Association, submitted that, for the terminally ill, quality of life may be so poor that “extension of life even for a short time is more painful than death.” Other health care representatives added that specific “events of being,” namely Nancy B. and Sue Rodriguez, had called into question the prohibition against euthanasia and assisted suicide.²¹

Legal discourse revealed several key observations. The rhetoric of the Law Reform Commission of Canada from 1976-1986 demonstrated how secular legal opinion harboured “traces” of religious beliefs in the form of “objectivistic metaphysics.” The Commission confirmed that the criminal law was “fundamentally a moral system,” one in which society should “speak out and reaffirm” essential values, such as the “sanctity of life.” Such a doctrine implied a belief in the “objective, absolute value of human life and worth.” In one of the Commission’s background papers, author Edward W. Keyserlingk admitted he would not support decriminalization even for cases of “excruciating and

²¹ For more in-depth views of hospice/palliative care workers embracing the quality of life ethos, see Chapter IV: Medicine’s Rejection of Euthanasia and Assisted Suicide, 1970s-1990s under “Vattimian Postmodernists in Hospice/Palliative Care” and “Health Care Representatives as Vattimian Postmodernists.”

intractable pain and suffering.” The Commission’s conclusions helped maintain the reigning absolute—the *qualified* sanctity of life ethos—along with its inherent omission/commission distinction.²²

Moreover, Christian normative assumptions were influential in shaping future legal matters dealing with euthanasia and assisted suicide, particularly the cases of Sue Rodriguez and Robert Latimer. Rodriguez’s trial was illuminating because as an “event of being,” she threatened to expose the *qualified* sanctity of life ethos as one competing principle among others. Her request for physician-assisted suicide was turned down by split decisions in the British Columbia Supreme Court, the British Columbia Court of Appeal, and the Supreme Court of Canada even though she was a consenting, terminally ill adult. Those justices siding with prohibition noted how the “sanctity of life” was foundational to their belief system, how the prohibition against physician-assisted suicide was historically “absolute,” and how “absolute moral distinctions” between acts of omission and commission were legally valid. Although Rodriguez would experience prolonged suffering and paralysis—a condition that would inevitably lead to death by suffocation—limitations on her section 7 and 15 constitutional rights were *not* considered contrary to “the principles of fundamental justice.” The five justices opposed to an intentionally hastened death felt that ceding to her request would result in “mass suicides,” “erroneous diagnoses,” and “targeting of the vulnerable.”²³

²² For a summary of the findings of the Law Reform Commission of Canada from 1976-1986, see Chapter V: The “Weakening” of the Sanctity of Life Ethos in Law under “Metaphysics and the Law Reform Commission of Canada.”

²³ A complete discourse analysis of the Rodriguez trial can be found in Chapter V: The “Weakening” of the Sanctity of Life Ethos in Law under “Sue Rodriguez and the Weakening of Metaphysics.”

The minority shared a different interpretation of the Rodriguez case. As Vattimian postmodernists, they focused on self-determination, the relative value of human life (Rodriguez's lived reality), and the workability/flexibility of safeguards. Since Rodriguez was going to experience an "indeterminate period of senseless physical and psychological suffering," Justice McEachern concluded in the British Columbia Court of Appeal that any limit on her section 7 Charter rights should be characterized as "the opposite of fundamental justice." In the Supreme Court of Canada, Justice Peter Cory called the state prohibition "an affront to human dignity." As well, Justices Claire L'Heureux-Dubé and Beverly McLachlin did not view the case from a utilitarian or communal perspective. They pointed out how the principles of fundamental justice required that each person, "considered individually," be treated fairly under the law. Lastly, Chief Justice Antonio Lamer noted how "self-determination" was not only a central value in the decriminalization of attempted suicide in 1972, but it was also key to the state regulation of suicide in the present context. Lamer did not recognize concerns over the "slippery slope" as valid reasoning since there was "no evidence of vulnerability" in Rodriguez's situation. Lamer even noted how safeguards were both feasible and flexible, the tenets of which could be "tailored to the particular circumstances of Ms. Rodriguez."²⁴

Interveners in the Rodriguez Supreme Court case were also polarized between metaphysicians and Vattimian postmodernists. Two religious organizations, the Canadian Conference of Catholic Bishops and the Evangelical Fellowship of Canada, felt that society should "speak out and affirm" the sanctity of life whenever it was seriously

²⁴ The minority view of the Supreme Court can be found in Chapter V: The "Weakening" of the Sanctity of Life Ethos in Law under "The Metaphysical-Postmodern Divide in the Courts."

transgressed. The Court was informed that stewardship was foundational to their belief in a “natural death,” the “intrinsic worth” of human life, and the omission/commission moral distinction. As the interveners noted, human beings are “stewards of what God has entrusted to us.” Therefore, any weakening of the *qualified* sanctity of life ethos would, in their opinion, lead to a “slippery slope” in the form of increased suicide rates.²⁵

Even secular opposition to Rodriguez’s request was based on a “civil rights” discourse or “equality metaphysic.” People in Equal Participation Incorporated (PEP) and the Right to Die Society (the “Society”) both lobbied against Rodriguez’s request for assistance in suicide. PEP argued that, if Rodriguez won her Supreme Court challenge, the severely disabled would be denied equal treatment in the form of “adequate resources to live independently,” contributing to their status as “vulnerable persons in need of protection.” Although the Society promoted a quality of life ethic, they lobbied against a constitutional exemption for Rodriguez, claiming that “any drafting considerations would fail to take into account other individual situations as compelling as Rodriguez’s.”²⁶

Those interveners adopting a Vattimian postmodernist position based their arguments on a quality of life ethic. Inverting PEP’s “equality metaphysic,” the British Columbia Coalition of People with Disabilities (the “Coalition”) felt that opposition to Rodriguez’s demands created a “harmful stereotype.” The disabled were being labeled as “inherently less capable than others of being entrusted with fundamental decisions about their lives.” Similarly, the Coalition of Provincial Organizations of the Handicapped (COPHO) defined equality in individualistic, rather than communal, terms. Self-

²⁵ See Chapter V: The “Weakening” of the Sanctity of Life Ethos in Law under “Facta of the Intervenors: Religious Opposition.”

²⁶ See Chapter V: The “Weakening” of the Sanctity of Life Ethos in Law under “Secular Opposition and ‘Civil Rights’ Discourse.”

determination and autonomy were seen as “essential components of true equality.”

Finally, Dying with Dignity promoted a different interpretation of the “life” ethic.

According to its mandate, individual free choice and self-determination were considered “fundamental constituents of life.” Therefore, the value of life “may be lessened rather than increased by the failure to allow a competent human being the right to choice.”²⁷

In similar fashion, the Robert Latimer affair pitted metaphysicians against Vattimian postmodernists. During Latimer’s first trial, the lower court described the law as “unremitting when it comes to the taking of human life.” Despite Tracy Latimer’s intractable pain, her situation was described as “a life that was hers to make of it what she could.” Robert Latimer was informed that he also possessed a viable alternative to his daughter’s mercy killing: He could have made Tracy as comfortable as possible “however disagreeable and heartwrenching those attempts might be.” In the Saskatchewan Court of Appeal, Justice Tallis indicated that the Court’s opinion was guided by an “unqualified interest in the preservation of human life.” Consequently, a judgement of “diminished value” was no defence for a mercy killing. However, the dissenting opinion of Chief Justice Bayda was sympathetic to Latimer’s request for a constitutional exemption. Since Tracy suffered from severe seizures, bed sores, muscle atrophy, and an abnormal curvature of the spine, Bayda concluded that Robert Latimer possessed “a severe preoccupation or an obsession with that pain.” At the retrial, Justice Noble indicated that all the evidence pointed to Latimer’s concern for “the pain he saw

²⁷ See Chapter V: The “Weakening” of the Sanctity of Life Ethos in Law under “Intervenors as Vattimian Postmodernists.”

flowing from her illness” and that he was “compelled to do what he did out of concern for her present and future pain.”²⁸

An appeal before the Supreme Court revealed further polarization between metaphysicians and Vattimian postmodernists. Arguing for the Appellant, Edward L. Greenspan viewed the prolongation of extreme suffering as pointless. He explained how Tracy could only use Tylenol since strong painkillers “put her at risk of aspirating and developing pneumonia.” Due to bed sores, a bath was described as “torture,” and her dislocated hip was so badly degenerated that her only medical option was “to remove the top quarter of her thigh.” Greenspan noted how Laura Latimer, Tracy’s mother, referred to the operation as “inhumane” and “something you wouldn’t do to your pet.” In contrast, arguments of the respondent resembled the discourses of other metaphysicians. Tracy’s life possessed “value and meaning,” and her humanity was not diminished “because she suffered pain.” It was feared that state-sanctioning of mercy killing would lead to an intentionally hastened death “regardless of the child’s wishes.”²⁹

As with the Rodriguez trial, interveners in Latimer’s Supreme Court case were divided between sanctity of life advocates (metaphysicians), quality of life advocates (Vattimian postmodernists), and those promoting a “civil rights” discourse. Religious interveners advocated for the “protection of human life from its beginning to its natural end” and sought to “uphold a universal respect for the value of all human life.” Irrespective of her condition, Tracy possessed “the same qualities and dignity as any other human being because she was made in the image of God.” Although the case had

²⁸ An analysis of discourse of the lower court as well as the comments of Justice Tallis and Bayda in the Saskatchewan Court of Appeal can be located in Chapter V: The “Weakening” of the Sanctity of Life Ethos in Law under “Tracy Latimer, Suffering and the Sanctity of Life Ethos.”

²⁹ Arguments of the appellant and the respondent can be found in Chapter V: The “Weakening” of the Sanctity of Life Ethos in Law under “Tracy Latimer, Suffering and the Sanctity of Life Ethos.”

“irrevocable consequences for Tracy” and caused “enormous suffering for her family,” religious interveners were clear that no circumstances existed in which a parent could “decide on death rather than life for a child.” It was generally feared that if the “inherent dignity of all persons” became relativized, it would lead to “the abuse and killing of the most vulnerable in society.”³⁰

Secular interveners who supported the sanctity of life ethos used normative assumptions similar to those of their religious counterparts. The Attorney General of Canada felt that the “slippery slope” was inescapable if an exception were granted to Robert Latimer. Vulnerable populations would become fearful of “people with non-compassionate motives.” The Attorney General of Ontario also reminded the Court that it was imperative to “avoid any slide down the slippery slope of relative worth.” In addition, disabled groups feared that an acquittal for Latimer would “open the door to very real risks” and would be “a threat to the lives and security of disabled people generally.”³¹

“Civil rights” discourse and postmodernist rhetoric were also present in the normative assumptions of interveners. Although AIDS organizations had previously supported Sue Rodriguez, their rhetoric was more absolutist in the case of Robert Latimer. Since autonomy was foundational to the values of the Canadian AIDS Society (CAS), Robert Latimer’s actions were condemned. Tracy was never mentally competent, so it was “impossible to determine her wishes.” Ironically, this same logic never applied to acts of omission for incompetent minors. Hence, the CAS not only relied on the same

³⁰ See Chapter V: The “Weakening” of the Sanctity of Life Ethos in Law under “The Intervenors: Religious Organizations.”

³¹ See Chapter V: The “Weakening” of the Sanctity of Life Ethos in Law under “The Intervenors: Secular Organizations.”

absolute moral distinctions embraced by sanctity of life advocates, but “autonomy” as absolute justified the prolongation of Tracy Latimer’s suffering. Only one intervener was representative of Vattimian postmodernism. The Canadian Civil Liberties Association (CCLA) rejected the “slippery slope” analogy, arguing that there was no credible evidence that any leniency shown to Latimer would “open the floodgates.”³²

In 2001, the Supreme Court of Canada sided with the arguments of metaphysicians. Although it agreed that Tracy “experienced a great deal of pain” and that Robert Latimer “faced challenges the sort most Canadians can only imagine,” Latimer’s decision to end her life was “an error in judgment.” Latimer was expected “to suffer the harm rather than break the law.” Although Latimer believed that further surgeries amounted to “imminent peril” for his daughter, the Court rejected this premise, stating that it was “not reasonable” for him to form this belief. According to the Court, Latimer’s defence of necessity was rejected because it would eventually become “a mask for anarchy.” The Court declared that Latimer’s mandatory ten-year prison sentence was a “symbolic, collective statement,” a punishment fitting for someone who encroached upon “society’s basic code of values.”³³

Political discourse was also divided between metaphysicians (sanctity of life advocates) and Vattimian postmodernists (quality of life supporters). While the political left (Block Québécois and New Democratic Party) approved of euthanasia and assisted suicide, the centre-right (Liberals, Progressive Conservatives/Conservative Party of

³² See Chapter V: The “Weakening” of the Sanctity of Life Ethos in Law under “‘Civil Rights’ Discourse” and “Vattimian Postmodernists.”

³³ See Chapter V: The “Weakening” of the Sanctity of Life Ethos in Law under “Metaphysics Maintained in the Latimer Affair.”

Canada, and Reform Party) opposed decriminalization of either. The latter would only sanction acts of omission, claiming that death was not intended. Progressive Conservative Robert Wenman represented this “middle path” with Bill C-203. Although his discourse resembled the normative assumptions of quality of life advocates (i.e., individual rights, dying with dignity, and avoiding unnecessary suffering), Wenman was seeking “passive” euthanasia only in the form of withholding/withdrawal of treatment. He felt that by “allowing natural death to occur,” an appropriate compromise could be reached.³⁴

Others adopted a more postmodern approach to death and dying. New Democrat Chris Axworthy took Wenman’s idea one step further by introducing Bill C-261 in an attempt to legalize euthanasia. He felt that the terminally ill deserved a “better quality of life” rather than “lingering, painful deaths.” Axworthy told the House that legislation that was “carefully developed and crafted” would safeguard against “slope” concerns.³⁵ Motions to decriminalize euthanasia and assisted suicide were introduced by two more New Democrats, Ian Waddell and Raymond Skelly. Waddell argued degenerative diseases “caused extensive physical and emotional suffering.” He even questioned whether, just prior to death, the “quality of life in these last days is worth the effort to keep the patient alive.” However, Waddell still insisted on safeguards to make sure that individual choice was “not taken advantage of.” Raymond Skelly further advocated for the decriminalization of physician-assisted suicide. Influenced by Sue Rodriguez’s Supreme Court challenge, Skelly did not believe ALS sufferers should have to endure a

³⁴ Robert Wenman’s defence of Bill C-203 can be found in Chapter VI: Political Discourse under “Robert Wenman and the Qualified Sanctity of Life Ethos.”

³⁵ Chris Axworthy’s defence of Bill C-261 can be found in Chapter VI: Political Discourse under “Chris Axworthy and the Quality of Life Ethos.”

“gruesome death.” Instead of leaving death in the hands of God, Skelly felt that society had “an opportunity to control it.” He dismissed accusations of a “slippery slope” as “false and misleading,” claiming instead that stringent controls could be set.³⁶

Two other New Democrats were strong supporters of an intentionally hastened death. Influenced by the plight of Sue Rodriguez, Svend Robinson introduced Bill C-215 in 1994. As an advocate of physician-assisted suicide, Robinson claimed decriminalization would lead to “a more decent and civilized society for all Canadians.” Although he acknowledged the religious conviction that suffering had a “special place in God’s saving plan,” he believed that imposing such a viewpoint was both “cruel and inhuman.” For pain that was untreatable, Robinson told the House that it was up to “an individual to put an end to that suffering.” By 1997 Robinson introduced Motion-123, calling for a special committee to review the *Criminal Code* provisions dealing with both euthanasia and assisted suicide. Describing the current law as “profoundly cruel and unjust,” Robinson lobbied for “the right of competent adults to decide for themselves how their lives will end.”³⁷ This postmodern trend continued into the 21st century. Francine Lalonde of the Bloc Québécois introduced Bill C-407 in 2005, an act that would decriminalize assistance in suicide. The bill was tabled to help those “facing a very difficult and painful end of life.” She told her fellow Members of Parliament that it would be insensitive to ignore “the cries of pain and desire for dignity of so many people who are facing death.”³⁸

³⁶ Comments regarding Ian Waddell’s and Raymond Skelly’s motions can be found in Chapter VI: Political Discourse under “Ian Waddell, Raymond Skelly, and the Continuing Postmodern Trend.”

³⁷ Robinson’s comments on Bill C-215 and Motion-123 can be found in Chapter VI: Political Discourse under “Svend Robinson and the Aftermath of the Rodriguez Case.”

³⁸ Francine Lalonde’s comments on Bill C-407 can be found in Chapter VI: Political Discourse under “The Metaphysical/Postmodern Divide of the 21st Century.”

However, the centre-right adopted normative assumptions indicative of metaphysicians. Liberal Don Boudria's belief in the sanctity doctrine prevented him from supporting euthanasia, an act he claimed "cheapens human life." A vocal opponent of both Wenman's and Axworthy's bills, Boudria insisted that matters over life and death were not an individual decision since "no one on earth had the right to decide whether someone may live or die." Life, for Boudria, was "even more precious when there is little left to live." In terms of the "slippery slope," Boudria insisted that there were "10,000 cases of active euthanasia per year" in Holland and that people entering a hospital in the Netherlands were unsure of their chances of "escaping euthanasia."³⁹ Liberal Roseanne Skoke was of a similar mindset. For her, life began at "the moment of conception" and continued until "natural death." Since an intentionally hastening death would "diminish respect for human life," she noted that "the laws of nature must be upheld." Liberal Dan McTeague subscribed to the same foundational beliefs. What made euthanasia categorically wrong was the intention to hasten death. Instead of "allowing people to die naturally," it "makes them die."⁴⁰

Most Progressive Conservative party members also supported the prohibitionist position, based largely on "slope" fears." Ross Belsher thought that sanctioning euthanasia would be dangerous for "the weak, the infirm, the elderly and the dependent." Doug Fee was concerned that euthanasia would become "a cheap substitute for palliative care." Fernand Jourdenais indicated that, if euthanasia were decriminalized, the terminally and chronically ill may "feel pressure from society and family not to remain a

³⁹ Don Boudria's views can be found in Chapter VI: Political Discourse under "Robert Wenman and the Qualified Sanctity of Life Ethos," "Chris Axworthy and the Quality of Life Ethos," and "Ian Waddell, Raymond Skelly, and the Continuing Postmodern Trend."

⁴⁰ Rosanne Skoke's and Dan McTeague's views can be found in Chapter VI: Political Discourse under "Svend Robinson and the Aftermath of the Rodriguez Case."

burden on scarce resources.” Barbara Sparrow added that decriminalization would negatively affect those who were “incapable of requesting assisted suicide or euthanasia.”⁴¹

Of all political discourse, the normative assumptions from those of the Reform Party / Conservative Party of Canada (CPC) were the most overtly religious. Myron Thompson admitted that “the giver of life is the only one who should have the authority to take it.” Gary Brietkreuz believed in “the inherent value of life” and “a need to protect the most vulnerable individuals in our society.” Jason Kenney rejected any notion that individuals had a right to destroy “the inviolable dignity stamped on them by the Creator.” Kenney feared that changing our understanding of the “infinite and inherent value” of the human person would turn the individual into “a disposable object which can be eliminated at will.” Kenney’s normative assumptions were grounded in the fact that “the human person is created in the image and likeness of God.”⁴²

An interrogation of the discourse was based on the Vattimian concept of passive-reactive nihilism. The intent was to discover how “masks” and “disguises” were used “to cover up the absence of objective, given structures.” Two claims made by metaphysicians—the inevitability of a “slippery slope” and the existence of absolute moral distinctions—were examined to demonstrate how the sanctity of life ethos was maintained as first principle. The primary “slope” concerns involved Canada’s adoption of Dutch medical policy and a possible return to Nazi eugenics. However, the evidence

⁴¹ Progressive Conservative opinion can be found in Chapter VI: Political Discourse under “Robert Wenman and the Qualified Sanctity of Life Ethos,” “Chris Axworthy and the Quality of Life Ethos,” and “Ian Waddell, Raymond Skelly, and the Continuing Postmodern Trend.”

⁴² The views of Reformers and Conservative Party of Canada members can be found in Chapter VI: Political Discourse under “Svend Robinson and the Aftermath of the Rodriguez Case” and “The Metaphysical/Postmodern Divide of the 21st Century.”

of a “slippery slope” was not convincing. Although active euthanasia in Holland increased from 1990-1995, in the same time frame, physician-assisted suicide remained static, and active nonvoluntary euthanasia (explicit consent unknown) actually decreased. It was admitted that *nonvoluntary* euthanasia was being performed under mitigating circumstances (i.e., the patient experienced extreme suffering or slipped into a coma before the explicit stage of consent had been reached). Moreover, *involuntary* euthanasia (hastening death against consent), a method of death-hastening that defined Hitler’s eugenics program, had not occurred in Holland in the above time period. The Rummelink Report itself concluded no concrete evidence of a “slippery slope” existed.⁴³

To further “unmask” perceptions of a Dutch “slide,” several physicians from the Netherlands testified before the *Special Senate Committee on Euthanasia and Assisted Suicide*. Dutch medical practitioners debunked several myths held by Canadian ethicists, doctors, justices, and politicians. First, hospice medicine was not in decline in Holland. It was admitted that a “high standard of palliative care” existed in both the hospital and home situation. Moreover, Dutch citizens did not have to worry about being a financial burden on their families since “100 percent of the people in the Netherlands are insured for their medicare and all other kinds of care.” In fact, the *Special Senate Committee* was told that “refusing or discharging a patient for economic reasons is a criminal offence” in Holland. There was also misinformation on how quickly terminally ill patients’ deaths were hastened. Those dying were not given euthanasia within hours of their initial request; their deaths were, in fact, hastened shortly after “their last request.” In terms of doctors feeling reluctant to report cases, the *Special Senate Committee* was informed that

⁴³ To examine findings in the Rummelink Report and competing claims of a “slippery slope,” see Chapter VII: Interrogating the Discourse: The “Slippery Slope” as a Form of Negative Nihilism under “The Dutch ‘Slippery Slope’ Unmasked” and “The ‘Slippery Slope’ from the Dutch Viewpoint.”

many physicians avoided protocol since euthanasia was still technically a criminal offence in the 1990s. Of import was also how Dutch physicians viewed “intent.” If they knew the consequences of their actions would shorten a patient’s life, which included *both* negative *and* positive acts, then doctors felt obliged to admit, even partially, their intent to hasten death.⁴⁴

Despite these clarifications by Dutch physicians, the *Special Senate Committee* remained divided between metaphysicians and Vattimian postmodernists. The beliefs of the former were founded in a “respect for life.” They feared legalization would result in abuses against “the most vulnerable members of society.” Although prohibition may be “unfair and harsh in an individual circumstance,” decriminalization would threaten the “fundamental value of life in society.” In contrast, quality of life advocates on the Committee were more concerned about “the loss of autonomy experienced by individuals.” They were equally worried over the “pain and suffering of persons with debilitating and irreversible illnesses.” As with other Vattimian postmodernists, they sided with the feasibility of safeguards, citing a “greater risk to the vulnerable from unregulated medical assistance at the end of life.”⁴⁵

A second “mask” entailed the claim by sanctity of life advocates that absolute moral distinctions exist between acts of omission and commission, particularly in the case of Nancy B. Since she was completely paralyzed, the removal of her ventilator meant death “within minutes.” When the ventilator was removed and Nancy B. died “seven minutes” later, the cause of death was attributed to her “underlying illness rather

⁴⁴ For a more detailed explanation by Dutch Physicians, see Chapter VII: Interrogating the Discourse: The “Slippery Slope” as a Form of Negative Nihilism under “The ‘Slippery Slope’ from the Dutch Viewpoint.”

⁴⁵ For a comparison of the attitudes of Senate Committee members, see Chapter VII: Interrogating the Discourse: The “Slippery Slope” as a Form of Negative Nihilism under “The ‘Slippery Slope’ from the Dutch Viewpoint.”

than the disconnection of the respirator.” In Quebec Superior Court, Justice Dufour stated that the physician that removes Nancy B.’s life support is letting “nature take its course.” In other words, although Nancy B.’s death did “result from the patient’s inability to breathe spontaneously,” the doctor who disconnected the ventilator did not legally “cause the death” that followed. For sanctity of life advocates, mechanical and scientific causation differ between acts of omission and commission. As Raphael Cohen-Almagor theorizes, “The end of life is something granted only to *nature*, and is not a decision that is incumbent upon human beings [emphasis mine].” Without the omission/commission distinction as absolute, ethicist Daniel Callahan acknowledges that not only would “biology” be displaced by “human agency” as the cause of death, but “a quick and direct killing of the patient or assisting the patient to commit suicide would be seen as the next most reasonable step on grounds of both humaneness and economics.”⁴⁶ In other words, an admission of the situated and contested nature of the omission/commission distinction would permanently weaken the *qualified* sanctity of life ethos. Its status would become one competing principle among others, thus allowing a shift toward the *quality of life ethos*.

The logic behind absolute moral distinctions has been called “patently artificial.” The same killing/letting die distinction was accepted by the *Special Senate Committee* when discussing the difference between euthanasia and terminal sedation; however, this distinction was seen as dubious by Helga Kuhse, who referred to terminal sedation as “slow euthanasia.” Similarly, Dr. Timothy Quill argued that when terminal sedation was used, it seemed implausible to make the claim that “death is unintended when a patient

⁴⁶ For more detailed arguments discussing the case of Nancy B. and the belief in absolute moral distinctions, see Chapter VII: Interrogating the Discourse: The “Slippery Slope” as a Form of Negative Nihilism under “‘Masking’ Causation: Nancy B. and Absolute Moral Distinctions.”

who wants to die is sedated to the point of coma, and intravenous fluids and artificial nutrition are withheld, making death certain.” From a consequentialist viewpoint, doctors do assume a role responsibility for what they know will happen as a result of their choices and actions. As R. G. Frey previously noted, physicians cannot divorce themselves from the chain of causation. Even for acts of omission, the doctor “retains causal responsibility.”⁴⁷

Limitations, Challenges, and the Promise of the Vattimian Perspective

There are some limitations of the Vattimian perspective that should be noted. For instance, one should not automatically conclude that support for the reigning paradigm—the *qualified* sanctity of life ethos—implies either absolutist or Christian-based motives. In fact, the status quo may be embraced for pragmatic reasons. Evidence of this occurred within chapter VI (Political Discourse in Canada) in which one Liberal party member (Eleni Bakopanos) supported prohibition because the socio-legal culture required to implement new policies for euthanasia and assisted suicide was not in place (e.g., legislation on advanced directives). Her discourses did not exhibit the rhetoric of objectivistic metaphysics (absolutes), nor was any “mask” or “disguise” used to maintain the *qualified* sanctity of life ethos. Even though the terminally ill may suffer longer, this was not due to any dependency on immutable principles. In other words, political

⁴⁷ For more details on the case of Nancy B. as well as arguments outlining absolute moral distinctions, see Chapter VII: Interrogating the Discourse: The “Slippery Slope” as a Form of Negative Nihilism under “‘Masking’ Causation: Nancy B. and Absolute Moral Distinctions.”

pragmatism is not necessarily synonymous with a Vattimian understanding of metaphysics nor does it entail the same normative assumptions.⁴⁸

Critics of postmodernism may also challenge the Vattimian perspective, claiming a dilemma arises between unity and fragmentation of knowledge.⁴⁹ Theoretically speaking, a “crisis of legitimacy” and the problem of adjudication between competing claims may arise from an emerging pluralism. A “rogue” agent, at any level from the individual to the state, may demand conduct that is “at least coercive and at worst explicitly violent” and, in the process, may “roll back changes that have occurred as a consequence of [positive] nihilism, reasserting authoritarian structures akin to those that characterized metaphysics.”⁵⁰ However, examining specific cases of death and dying on their own merits does not lead to an “anything goes” mentality. Vattimo explains in *Nihilism and Emancipation* that hermeneutics, in order to prevent the violence of metaphysical thinking, should be reduced neither to “the letting loose of the conflict of interpretations” nor to “antifoundationalism.” Like all interpretations, even these options “must strive to articulate, develop, and advance arguments for [themselves].”⁵¹ This implies that any interpretation offered must be based on merit; it cannot hide behind strong relativism. Vattimo simply makes two claims in the spirit of postmodernism: (1) one’s position becomes less dogmatic if the basis of philosophy remains positively nihilistic (non-absolute); and (2) post-metaphysical thinking speaks to the history of eventuation, not the peremptoriness of first principles. As Vattimo notes, “The world

⁴⁸ For a summary of Eleni Bakopanos’ views on decriminalization, see Chapter VI: Political Discourse under “Svend Robinson and the Aftermath of the Rodriguez Case.”

⁴⁹ Anselm Min, *The Solidarity of Others in a Divided World: A Postmodern Theology after Postmodernism* (Continuum International Publishing Group: London, 2004); also see Zygmunt Bauman, *Alone Again: Ethics after Certainty* (London: Demos, 1994).

⁵⁰ Robert T. Valgenti in Silvia Benso and Brian Schroeder, eds., *Between Nihilism and Politics: The Hermeneutics of Gianni Vattimo*, 59-60.

⁵¹ Vattimo, *Nihilism and Emancipation: Ethics, Politics, & Law*, 94.

with which Dasein [human existence] is always already familiar is neither a transcendental screen nor a categorical schema. . . . the foundation of Dasein coincides with its groundlessness.”⁵²

Yet Vattimo’s affinity for positive nihilism is still contingent upon the community of actors who use it as a hermeneutic device. Who defines “positive”? Who defines “nihilism”? Who dictates when values are “no longer working”? Will various interpretations be examined in an open, adversarial review, or will claims of “objectivity,” immutable values, and first principles limit the dialectic? Even if values shift and a different ethos is established, there is no guarantee that “sanctity of life” will not be replaced by another form of objectivistic metaphysics. It is important to reiterate a surprising finding within this research: Secular organizations supported autonomy and equality in an absolutist sense (“civil rights” discourse), even when it was recognized that such a position would prolong the suffering experienced by Sue Rodriguez and Tracy Latimer.

Moreover, Ian Dowbiggin points out that quality of life advocates and situation ethicists acted dogmatically before and after World War II. According to Dowbiggin, early twentieth-century euthanasia pioneers sought legislation to terminate “defectives,” such as the mentally and physically handicapped, without their consent. Quality of life enthusiasts, therefore, have to reconcile their support of the autonomy principle with frequent appeals to negating the liberty of those depicted as non-normal individuals. This is something Dowbiggin claims is an outright contradiction.⁵³ As well, Sally Kerry

⁵² Vattimo, *The End of Modernity*, 116.

⁵³ Ian Dowbiggin. *A Merciful End: The Euthanasia Movement in Modern America*, 32-62, 151; also see Ian Dowbiggin. *A Concise History of Euthanasia*, 54-55, 91-96, 127, 152-153. A specific example of this contradiction was most apparent in the situation ethics promoted by Joseph Fletcher. In 1962, while

Hayward notes how quality of life rhetoric, if absolutized, can embrace a violent ethos. She asserts that the Rodriguez and Latimer cases inform and problematize Canada's concept of itself as a liberal, tolerant, and progressive nation. In the author's view, emancipatory, multicultural pluralism that attempts to support *all* differences actually creates legal/political discourses that are both antagonistic and imminently violent. For Hayward, this has potentially dire consequences for those who exist outside of the legally-defined norm. For example, people with disabilities may face increasing marginalization once abstract notions of "normal" become reified in practice.⁵⁴

These concerns by sanctity of life advocates are certainly legitimate ones. However, as the research has pointed out, supporters of the sanctity doctrine are no less prone to absolutes, contradictions, or violent impositions than their counterparts. One way to avoid the metaphysical trap to which both paradigms are susceptible is by adopting Vattimo's affinity for postmodern pluralism. This transforms absolute value into situated *values* through the contestation of competing normative assumptions and the "events" that shape and reshape these beliefs. Vattimo not only provides the means for overcoming the heritage of exclusivist metaphysics—a method potentially applicable to even non-Christian cultures—but he also recognizes that truth and knowledge must remain contested within an endless, open conversation. In opposition to metaphysics, a

president of the Human Betterment Association of America (HBAA), he recommended *involuntary* sterilization as a means of curbing the fertility of the mentally handicapped. In other words, he not only described cases situationally, but also prescribed ethical virtues under the guise of collective beneficence, a form of utilitarianism often espoused by sanctity of life advocates. As Fletcher himself admitted: "The interest of the public welfare and the very 'spiritual nature' of the individual permitted it [compulsory sterilization]. Even sterilization of criminals was 'ethically sound' [without consent]." See Joseph Fletcher, *Morals and Medicine: The Moral Problems of the Patient's Right to Know the Truth, Contraception, Artificial Insemination, Sterilization, Euthanasia* (Princeton, NJ: Princeton University Press, 1954), 170, 205, 209.

⁵⁴ Sally Kerry Hayward, *Managing Death: Diagnosing the 'New' Eugenics in Canadian Legal Discourses and Narratives of Disability*, Diss. University of Alberta, 2006. Edmonton: UMI, 2007.

postmodern pluralistic approach imparts something meaningful to others because the dialectic is never closed; it simply awaits the arrival of a new interpretation or “event” that will reorganize Being.

Overall, Vattimo’s nihilistic perspective facilitates a legitimate critique of the sanctity of life ethos in Canada because it illuminates the presence, weakening, and resilience of metaphysics within debates surrounding euthanasia and assisted suicide. Supporting the concept of history as “eventuation,” Vattimo claims that the arrival of alternative realities, or new “events,” weakens our dependency on objectivistic metaphysics. Although a possible shift toward the quality of life ethos nearly occurred in Canada in the 1990s, due in large part to Nancy B., Sue Rodriguez, and Robert Latimer, the result was a reinforcement of the *qualified* sanctity of life ethos. A discourse analysis was instrumental in showing how far specific Canadian elites (i.e., ethicists/bioethicists, medical practitioners, judges, and politicians) have travelled on the issue of an intentionally hastened death, particularly the controversy surrounding euthanasia and assisted suicide. The evidence demonstrates that even in a so-called secular society, Christian normative assumptions still hold sway, determining which paradigm in Canada has *absolute* importance over all others.

The Vattimian perspective is also useful in a post-Christian era because one of its purposes lay in revealing “masks” and “illusions” that maintain immutable principles, such as the sanctity of life ethos. Moreover, the Vattimian perspective is instructive in demonstrating an important function of metaphysics, that being the use of disguises to prevent further weakening of absolutes. Heidegger notes that disclosing this property of the metaphysical tradition is one of the key imperatives of philosophy: “If the question of

Being is to have its own history made transparent, then this hardened tradition must be loosened up, and the concealments which it has brought about must be dissolved.”⁵⁵ If Vattimo is right in that “one gets back to truth as opening by taking the unfoundation as destiny,”⁵⁶ then an acceptance of the weakening of Being (along with the history of eventuation) leaves open the possibility of further respect for alterity and ontological difference in other fields of inquiry.

⁵⁵ Martin Heidegger, *Being and Time* (San Francisco: Harper and Row, 1962), 44.

⁵⁶ Vattimo, *Beyond Interpretation: The Meaning of Hermeneutics for Philosophy*, 93-94.

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	1,000 (0.8%)	900 (0.7%)
without explicit request		
Intensification of pain	22,500 (17.5%)	20,000 (14.8%)
and symptom treatment		
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.

Works Cited

Books

- Appiah, Kwame Anthony. *The Honor Code: How Moral Revolutions Happen*. New York: W.W. Norton & Company, 2010.
- Badham, Paul. *Is There a Christian Case for Assisted Dying?* London: SPCK, 2009.
- Battin, Margaret P. et al., eds. *Physician-Assisted Suicide: Expanding the Debate*. New York: Routledge, 1998.
- Battin, Margaret P. *Ethical Issues in Suicide*. Englewood Cliffs, NJ: Prentice Hall, 1995.
- . *The Least Worst Death: Essays in Bioethics on the End of Life*. New York: Oxford University Press, 1995.
- Bauman, Zygmunt. *Alone Again: Ethics after Certainty*. London: Demos, 1994.
- Beaman, Lori G. *Defining Harm: Religious Freedom and the Limits of the Law*. Toronto: UBC Press, 2008.
- Beauchamp, Tom L. and James F. Childress. *The Principles of Biomedical Ethics*. Oxford: Oxford University Press, 2001.
- Beauchamp, Tom L., ed. *Intending Death: The Ethics of Assisted Suicide and Euthanasia*. New Jersey: Prentice Hall, 1996.
- Bennett, John Sutton. *History of the Canadian Medical Association, 1954–1994*. Ottawa: Canadian Medical Association, 1996.
- Benso, Silvia and Brian Schroeder, eds. *Between Nihilism and Politics: The Hermeneutics of Gianni Vattimo*. Albany, New York: SUNY Press, 2010.
- Bentham, Jeremy. *Utilitarianism*. Charleston, SC: Bibliolife, 2010.
- Berger, Peter L. *The Sacred Canopy: Elements of a Sociological Theory of Religion*. New York: Anchor Books, 1990.
- Bergmann, Frithjof. *On Being Free*. Notre Dame, Indiana: University of Notre Dame Press, 1977.
- Bhargava, Rajeev et al., eds. *Multiculturalism, Liberalism, and Democracy*. New Delhi: Oxford University Press, 2008.
- Bhaskar, Roy. *The Possibility of Naturalism: A Philosophical Critique of the Contemporary Human Sciences*. Brighton: The Harvester Press, 1979.

- Biggs, Hazel. *Euthanasia: Death with Dignity and the Law*. Portland, Oregon: Hart Publishing, 2001.
- Birnie, Lisa Hobbes and Sue Rodriguez. *Uncommon Will: The Death and Life of Sue Rodriguez*. Toronto: Macmillan Canada, 1994.
- Bouma III, H. et al., eds. *Christian Faith, Health, and Medical Practice*. Grand Rapids, Michigan: Eerdmans, 1989.
- Burleigh, Michael. *Ethics and Extermination: Reflections on Nazi Genocide*. Cambridge: Cambridge University Press, 1997.
- Burns, Chester R., ed. *Legacies in Ethics and Medicine*. New York: Science History Publications, 1977.
- Callahan, Daniel. *The Troubled Dream of Life: In Search of a Peaceful Death*. New York: Simon & Schuster, 1993.
- Caplin, Arthur L., James J. McCartney, and Dominic A. Sisti, eds. *The Case of Terri Schiavo: Ethics at the End of Life*. New York: Prometheus Books, 2006.
- Caputo, John D. and Gianni Vattimo. *After the Death of God*. Edited by Jeffrey W. Robbins. New York: Columbia University Press, 2007.
- Carrick, Paul. *Medical Ethics in Antiquity: Philosophical Perspectives on Abortion and Euthanasia*. Washington: Georgetown University Press, 2001.
- Cassell, Eric J. *The Nature of Suffering and the Goals of Medicine*. New York: Oxford University Press, 1991.
- Clark, David. *Cicely Saunders: Founder of the Hospice Movement, Selected Letters 1959–1999*. Oxford: Oxford University Press, 2005.
- Colby, William H. *Long Goodbye: The Deaths of Nancy Cruzan*. Carlsbad, California: Hay House, Inc., 2002.
- Connolly, William. *Pluralism*. Durham and London: Duke University Press, 2007.
- Crawford, S. Cromwell. *Dilemmas of Life and Death: Hindu Ethics in a North American Context*. Albany: State University of New York Press, 1995.
- D’Emilio, John and Estelle B. Freedman. *Intimate Matters*. New York: Harper & Row, 1988.
- Douglas, Mary. *Purity and Danger: An Analysis of the Concepts of Pollution and Taboo*. New York: Routledge, 1966.

- Dowbiggin, Ian. *A Merciful End: The Euthanasia Movement in Modern America*. Oxford: Oxford University Press, 2003.
- _____. *A Concise History of Euthanasia: Life, Death, God, and Medicine*. Maryland: Rowman & Littlefield Publishers, Inc., 2005.
- Downie, Jocelyn. *A Case for Decriminalizing Euthanasia & Assisted Suicide in Canada*. Toronto: University of Toronto Press Incorporated, 2004.
- Durkheim, Émile. *The Elementary Forms of Religious Life*. Translated by Carol Cosman. New York: Oxford University Press, 2001.
- Dworkin, Gerald, ed. *Morality, Harm, and the Law*. Oxford: Westview Press, Inc., 1994.
- Dworkin, Gerald et al., eds. *Euthanasia and Physician-Assisted Suicide: For and Against*. New York: Cambridge University Press, 1998.
- Dworkin, Ronald. *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom*. New York: Vintage Books, 1993.
- Dyck, Arthur J. *Life's Worth: The Case against Assisted Suicide*. Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 2002.
- Emanuel, Ezekiel J. *The Ends of Human Life: Medical Ethics in a Liberal Polity*. Cambridge, Massachusetts: Harvard University Press, 1994.
- Emanuel, Linda L, ed. *Regulating How We Die: The Ethical, Medical, and Legal Issues Surrounding Physician-Assisted Suicide*. Cambridge, Massachusetts: Harvard University Press, 1998.
- Filene, Peter G. *In the Arms of Others: A Cultural History of the Right-to-Die in America*. Chicago: Ivan R. Dee, 1998.
- Fletcher, Joseph. *Morals and Medicine: The Moral Problems of the Patient's Right to Know the Truth, Contraception, Artificial Insemination, Sterilization, Euthanasia*. Princeton, New Jersey: Princeton University Press, 1954.
- _____. *Situation Ethics: The New Morality*. London: Westminster John Knox Press, 1966.
- Foucault, Michel. *The Foucault Reader*. Edited by Paul Rabinow. New York: Pantheon Books, 1984.
- Frascati-Lochhead, Marta. *Kenosis and Feminist Theology: The Challenge of Gianni Vattimo*. Albany: State University of New York Press, 1998.

- Girard, René. *The Scapegoat*. Translated by Yvonne Freccero. Baltimore: The John Hopkins University Press, 1986.
- _____. *Violence and the Sacred*. Translated by Patrick Gregory. New York: Continuum, 2005.
- Goeschel, Christian. *Suicide in Nazi Germany*. Oxford: Oxford University Press, 2009.
- Gorsuch, Neil M. *The Future of Assisted Suicide and Euthanasia*. Princeton: Princeton University Press, 2006.
- Grayling, A.C. *What is Good?: The Search for the Best Way to Live*. London: The Orion Publishing Group Ltd., 2003.
- Great Britain. *Committee on Homosexual Offences and Prostitution: The Wolfenden Report*. New York: Stein and Day, 1963.
- Grisez, Germain and Joseph M. Boyle, Jr. *Life and Death with Liberty and Justice: A Contribution to the Euthanasia Debate*. Notre Dame, Indiana: University of Notre Dame Press, 1979.
- Hayward, Sally Kerry. *Managing Death: Diagnosing the 'New' Eugenics in Canadian Legal Discourses and Narratives of Disability*. Dissertation, University of Alberta, 2006. Edmonton: UMI, 2007.
- Heath, Joseph. *The Efficient Society: Why Canada Is as Close to Utopia as It Gets*. Toronto: Viking Press, 2001.
- Heidegger, Martin. *Being and Time*. San Francisco: Harper and Row, 1962.
- Hillyard, Daniel and John Dombrink. *Dying Right: The Death with Dignity Movement*. New York: Routledge, 2001.
- Humphry, Derek and Ann Wickett. *The Right to Die: An Historical and Legal Perspective of Euthanasia*. Eugene, Oregon: The Hemlock Society, 1990.
- Humphry, Derek. *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*. New York: Random House, 1991.
- Hyde, Michael J. *The Call of Conscience: Heidegger and Levinas, Rhetoric and the Euthanasia Debate*. Columbia, South Carolina: University of South Carolina, 2001.
- _____. *The Life-Giving Gift of Acknowledgement*. West Lafayette, Indiana: Purdue University Press, 2006.

- . *Perfection: Coming to Terms with Being Human*. Waco, Texas: Baylor University Press, 2010.
- Jecker, Nancy S. et al., eds. *Bioethics: An Introduction to the History, Methods, and Practice*, 2nd ed. Toronto: Jones and Bartlett Publishers, 2007.
- Jensen, Jeppe Sinding. *The Study of Religion in a New Key: Theoretical and Philosophical Soundings in the Comparative and General Study of Religion*. Denmark: Aarhus University Press, 2003.
- Jones, Robert P. *Liberalism's Troubled Search for Equality: Religion and Cultural Bias in the Oregon Physician-Assisted Suicide Debates*. Notre Dame, Indiana: University of Notre Dame Press, 2007.
- Kazantzakis, Nikos. *Friedrich Nietzsche on the Philosophy of the Right and State*. Albany: State University of New York Press, 2006.
- Keown, John. *Euthanasia Examined: Ethical, Clinical, and Legal Perspectives*. New York: Cambridge University Press, 1995.
- . *Euthanasia, Ethics, and Public Policy: An Argument against Legalization*. New York: Cambridge University Press, 2002.
- Kevorkian, Dr. Jack. *Prescription: Medicide: The Goodness of Planned Death*. New York: Prometheus Books, 1991.
- Kluge, Eike-Henner W. *The Ethics of Deliberate Death*. New York: Kennikat Press, 1981.
- Kuczewski, Mark G. and Ronald Polansky. *Bioethics: Ancient Themes in Contemporary Issues*. Cambridge, Massachusetts: The MIT Press, 2002.
- Kuhse, Helga. *The Sanctity of Life Doctrine in Medicine: A Critique*. Oxford: Oxford University Press, 1987.
- Larson, Edward J. and Darrel W. Amundsen. *A Different Death: Euthanasia and the Christian Tradition*. Downers Grove, Illinois: InterVarsity Press, 1998.
- Lavi, Shai J. *The Modern Art of Dying: A History of Euthanasia in the United States*. Princeton, New Jersey: Princeton University Press, 2005.
- Leary, Timothy. *Design for Dying*. New York: HarperCollins Publishers, 1997.
- Macmillan, R.C., H.T. Englehardt, and S.F. Spicker, eds. *Euthanasia and the Newborn: Conflicts about Saving Lives*. Dordrecht, Netherlands: Reidel, 1987.

- Manning, Michael. *Euthanasia and Physician-Assisted Suicide: Killing or Caring?* New York: Paulist Press, 1998.
- Marker, Rita. *Deadly Compassion: The Death of Ann Humphry and the Case against Euthanasia*. London: HarperCollins Publishers, 1993.
- McKenzie, Nancy F., ed. *The AIDS Reader: Social Political Ethical Issues*. New York: Meridian, 1991.
- Mill, J.S. *A System of Logic*. London: Longman's, 1959.
- . *The Basic Writings of John Stuart Mill: On Liberty, the Subjection of Women, and Utilitarianism*. Notes and Introduction by J.B. Schneewind. New York: Random House, 2002.
- Min, Anselm. *The Solidarity of Others in a Divided World: A Postmodern Theology after Postmodernism*. New York: T & T Clark International, 2004.
- Modood, Tariq. *Multiculturalism*. Cambridge, UK: Polity Press, 2007.
- Moreno, Jonathan D., ed. *Arguing Euthanasia: The Controversy over Mercy Killing, Assisted Suicide, and the "Right to Die."* New York: Touchstone, 1995.
- Mullens, Anne. *Timely Death: Considering Our Last Rights*. Toronto: Alfred A. Knopf, 1996.
- Nicol, Neal and Harry Wylie. *Between the Dying and the Dead: Dr. Jack Kevorkian's Life and the Battle to Legalize Euthanasia*. Madison, Wisconsin: The University of Wisconsin Press, 2006.
- Nietzsche, Friedrich. *The Anti-Christ*. Translated by R.J. Hollingdale. Harmondsworth, England: Penguin Books, 1968.
- . *The Will to Power*. Translated by W. Kaufmann and R.J. Hollingdale. New York: Random House, 1968.
- Otlowski, Margaret. *Voluntary Euthanasia and the Common Law*. New York: Oxford University Press, 1997.
- Quill, Timothy E. and Margaret P. Battin, eds. *Physician-Assisted Dying: The Case for Palliative Care & Patient Choice*. Baltimore: The John Hopkins University Press, 2004.
- Quill, Timothy E. *Death and Dignity: Making Choices and Taking Charge*. New York: W.W. Norton & Company, 1993.

- Rachels, J. *The End of Life: Euthanasia and Morality*. New York: Oxford University Press, 1986.
- Ramsey, Paul. *Ethics at the Edges of Life: Medical and Legal Implications*. New Haven: Yale University Press, 1978.
- Reginster, Bernard. *The Affirmation of Life: Nietzsche on Overcoming Nihilism*. Cambridge, Massachusetts: Harvard University Press, 2006.
- Rorty, Richard and Gianni Vattimo. *The Future of Religion*. Edited by Santiago Zabala. New York: Columbia University Press, 2005.
- Rothman, David. *Strangers at the Bedside*. New York: Basic Books, 1991.
- Schiavo, Michael and Michael Hirsch. *Terri: The Truth*. New York: Penguin Books Ltd., 2006.
- Schneewind, J.B. *The Invention of Autonomy: A History of Modern Moral Philosophy*. New York: Cambridge University Press, 1998.
- Sen, Amartya. *Identity & Violence: The Illusion of Destiny*. Toronto: Penguin Group, 2006.
- Singer, Peter. *Rethinking Life and Death: The Collapse of our Traditional Ethics*. New York: St. Martin's Press, 1994.
- Smith, Wesley J. *Forced Exit: The Slippery Slope from Assisted Suicide to Legalized Murder*. New York: Random House, 1997.
- Sneiderman, B., J. Irvine, and P. Osborne, eds. *Canadian Medical Law: An Introduction for Physicians and Other Health Professionals*. Toronto: Carswell, 1989.
- Somerville, Margaret. *The Ethical Canary: Science, Society and the Human Spirit*. Toronto: Penguin Books, 2000.
- _____. *Death Talk: The Case against Euthanasia and Physician-Assisted Suicide*. Montreal and Kingston: McGill–Queen's University Press, 2001.
- Stingl, Michael, ed. *The Price of Compassion: Assisted Suicide and Euthanasia*. Peterborough, Ontario: Broadview Press, 2010.
- Sullivan, Joseph F. *Catholic Teaching on the Morality of Euthanasia*. Washington, D.C.: Catholic University of America Press, 1949.
- Tännsjö, Torbjörn. *Terminal Sedation: Euthanasia in Disguise?* Dordrecht: Kluwer Academic Publishers, 2004.

- Taylor, Charles. *Multiculturalism*. Edited by Amy Gutmann. Princeton, New Jersey: Princeton University Press, 1994.
- Tempkin, O. and C. Tempkin, eds. *Ancient Medicine: Selected Papers of Ludwig Edelstein*. Baltimore: Johns Hopkins University Press, 1967.
- Thomasma, David C. et al., eds. *Asking to Die: Inside the Dutch Debate about Euthanasia*. Dordrecht, The Netherlands: Kluwer Academic Publishers, 1998.
- Valverde, Mariana. *Law's Dream of Common Knowledge*. Princeton: Princeton University Press, 1999.
- Vattimo, Gianni. *The End of Modernity*. Baltimore: Johns Hopkins University Press, 1988.
- _____. *The Transparent Society*. Malden, Massachusetts: Polity Press, 1992.
- _____. *The Adventure of Difference: Philosophy after Nietzsche and Heidegger*. Translated by Cyprian Blamires with the assistance of Thomas Harrison. Cambridge, U.K.: Polity Press, 1993.
- _____. *Beyond Interpretation: The Meaning of Hermeneutics for Philosophy*. Translated by David Webb. Cambridge: Polity Press, 1997.
- _____. *Belief*. Translated by Luca D'Isanto and David Webb. Stanford, California: Stanford University Press, 1999.
- _____. *After Christianity*. Translated by Luca D'Isanto. New York: Columbia University Press, 2002.
- _____. *Nihilism and Emancipation: Ethics, Politics, and Law*. New York: Columbia University Press, 2003.
- _____. *Dialogue with Nietzsche*. Translated by William McCuaig. New York: Columbia University Press, 2006.
- _____. *The Responsibility of the Philosopher*. Edited by Franca D'Agostini. New York: Columbia University Press, 2010.
- _____. *A Farewell to Truth*. Translated by William McCuaig. New York: Columbia University Press, 2011.
- Vattimo, Gianni and Piergiorgio Paterlini. *Not Being God: A Collaborative Autobiography*. Translated by William McCuaig. New York: Columbia University Press, 2009.

- Vattimo, Gianni and René Girard. *Christianity, Truth, and Weakening Faith: A Dialogue*. Translated by William McCuaig. New York: Columbia University Press, 2010.
- Walton, D. *On Defining Death: An Analytic Study of the Concept of Death in Philosophy and Medical Ethics*. Montreal: McGill-Queen's University Press, 1979.
- Washington Report, The. *Assisted Suicide and Euthanasia: Christian Moral Perspectives*. Harrisburg, Pennsylvania: Morehouse Publishing, 1997.
- Weiner, Bernard. *Judgements of Responsibility: A Foundation for a Theory of Social Conduct*. New York: The Guilford Press, 1995.
- Weir, Robert F. *Abating Treatment with Critically Ill Patients: Ethical and Legal Limits to the Medical Prolongation of Life*. New York: Oxford University Press, 1989.
- _____. *Physician-Assisted Suicide*. Bloomington: Indiana University Press, 1997.
- Williams, Glanville. *The Sanctity of Life and the Criminal Law*. New York: Alfred A. Knopf, Inc., 1957.
- Williams, John R. *Christian Perspectives on Bioethics: Religious Values and Public Policy in a Pluralistic Society*. Ottawa: Novalis, 1997.
- Woodman, Sue. *Last Rights: The Struggle over the Right to Die*. New York: Plenum, 1998.
- Zabala, Santiago, ed. *Weakening Philosophy: Essays in Honour of Gianni Vattimo*. Montreal & Kingston: McGill-Queen's University Press, 2007.
- Zaner, R.M., ed. *Death: Beyond the Whole-Brain Criterion*. Dordrecht: Kluwer Academic Publishers, 1988.
- Zohar, Noam J. *Alternatives in Jewish Bioethics*. Albany, New York: SUNY Press, 1997.

Bills

- Axworthy, Chris. "Bill C-261: Euthanasia and Cessation of Treatment Act." *The House of Commons Canada* (3rd Session, 34th Parliament). First Reading, June 18, 1991.
- Lalonde, Francine. "Bill C-407: An Act to Amend the Criminal Code (Right to Die with Dignity)." *The House of Commons Canada* (1st Session, 38th Parliament). First Reading, June 15, 2005.
- Robinson, Svend. "Bill C-215: An Act to Amend the Criminal Code (Aiding Suicide)." *The House of Commons Canada* (1st Session, 35th Parliament). First Reading, February 16, 1994.

Wenman, Robert. "Bill C-203: An Act to Amend the Criminal Code (Terminally-ill Persons)." *The House of Commons Canada* (3rd Session, 34th Parliament). First Reading, May 16, 1991.

Commons Debates

"Amendment Respecting Attempted Suicide by Mentally Ill." *Commons Debates* (1st Session, 27th Parliament) Vol. II (February 14th–March 4th, 1966), 1299–1300.

"Criminal Code: Amendment Respecting Attempted Suicide." *Commons Debates* (2nd Session, 28th Parliament) Vol. II (November 24th–December 19th, 1969), 1946.

"Criminal Code: Amendment to Remove Attempted Suicide as an Offence." *Commons Debates* (3rd Session, 28th Parliament) Vol. III (January 11th–February 12th, 1971), 2929.

"Criminal Code." *Commons Debates* (2nd Session, 27th Parliament) Vol. VII (February 26th–April 23rd, 1967–68), 7405.

"Criminal Code." *Commons Debates* (1st Session, 28th Parliament) Vol. VII (March 20th–April 25th, 1969), 7612.

"Criminal Code." *Commons Debates* (1st Session, 35th Parliament) Vol. 133, no. 023 (February 9th–March 16th, 1994), 1434.

"Criminal Code: Measure to Amend." *Commons Debates* (2nd Session, 34th Parliament) Vol. IV (March 12th–May 8th, 1991), 19083.

"Criminal Law Amendment Act, 1972: Amendment to Criminal Code, Criminal Records Act, National Defence Act and Visiting Forces Act." *Commons Debates* (4th Session, 28th Parliament) Vol. II (March 20th–May 5th, 1972), 1699.

"Deaths from Alcoholism, Drugs and Suicide." *Commons Debates* (1st Session, 28th Parliament) Vol. VI (February 19th–March 19th, 1969), 5699–5700.

"Euthanasia and Cessation of Treatment Act." *Commons Debates* (3rd Session, 34th Parliament) Vol. III (September 25th–October 25th, 1991), 3992–4000.

"Private Members' Business: Criminal Code." *Commons Debates* (1st Session, 35th Parliament) Vol. 133, no. 094 (June 8th–September 27th, 1994), 5968–76.

"Private Members' Business: Criminal Code." *Commons Debates* (1st Session, 38th Parliament) Vol. 140, no. 144 (Monday, October 31st, 2005), 9219–26.

“Private Members’ Business: Criminal Code, Measure to Amend.” *Commons Debates* (3rd Session, 34th Parliament) Vol. II (June 10th–September 24th, 1991), 2663–73.

“Private Members’ Business: Criminal Code, Physician-Assisted Suicide.” *Commons Debates* (3rd Session, 34th Parliament) Vol. XVI (June 2nd–June 23rd, 1993), 20419–27.

“Private Members’ Business: Euthanasia.” *Commons Debates* (3rd Session, 34th Parliament) Vol. XII (December 8th–February 17th, 1992–1993), 16093–102.

“Private Members’ Business: Euthanasia.” *Commons Debates* (3rd Session, 34th Parliament) Vol. XIII (February 18th–March 23rd, 1993), 16565–76.

“Private Members’ Business: Euthanasia.” *Commons Debates* (3rd Session, 34th Parliament) Vol. XIII (February 18th–March 23rd, 1993), 17321–28.

“Private Members’ Business: Euthanasia.” *Commons Debates* (1st Session, 36th Parliament) Vol. 135, no. 127 (October 27th–November 7th, 1997), 1557–65.

“Private Members’ Business: Euthanasia and Assisted Suicide.” *Commons Debates* (1st Session, 36th Parliament) Vol. 135, no. 080 (March 12th–March 25th, 1998), 5352–62.

“Public Bills.” *Commons Debates* (3rd Session, 28th Parliament) Vol. I (October 8th–November 12th, 1970), 389.

Court Cases

Airedale Hospital Trustees v. Bland [1992] UKHL 5 (4 February 1993).
<www.bailii.org/uk/cases/UKHL/1992/5.html>

Court of Appeal for British Columbia. No. V01800, Victoria Registry, McEachern CJ, Proudfoot J, and Hollinrake J. (1993).

Cruzan v. Harmon, 760 S.W.2d 408, 57 USLW 2324 (Mo. Nov 16, 1988) (NO. 70813).

In re Quinlan, Supreme Court of New Jersey 70 N.J. 10; 355 A.2d 647; 1976 N.J. LEXIS 181; 79 A.L.R.3d 205.

Latimer v. Her Majesty the Queen. The Court of Appeal for Saskatchewan. C.A. 6515, Justices Bayda, Tallis, and Sherstobitoff (18 July 1995).

_____. The Court of Appeal for Saskatchewan, No. C.A. 7413, 7416, Cameron, Vancise and Wakeling, JJ. A. (23 November 1998).

_____. Transcription of Cassettes. No. 26980, Wednesday, June 14th, 2000, 09:47 hours, (2000).

Nancy B. v. Hôtel-Dieu de Québec (Q.C.A.), [1992], 86 D.L.R. (4th) 385, 69 C.C.C. (3d) 450, 1992 CarswellQue 387, J.E. 92-132, EYB 1992-84012 (C.S. Que., Jan 06, 1992) LexisNexis Quicklaw.

Re Conroy, 486 A. 2d 1209 (N.J. 1985).

Rodriguez v. British Columbia (Attorney General). British Columbia Supreme Court (SCBC) No. 4040/92, Victoria Registry, Melvin J. (1992).

Rodriguez v. British Columbia (Attorney General), 3 S.C.R. 519
Docket: 23476 (1993).
<<http://scc.lexum.umontreal.ca/en/1993/1993rcs3-519/1993rcs3-519.html>>

R. v. Kitching and Adams (1976) 6 W.W.R. 697 (Manitoba Court of Appeal).

R. v. Latimer, [1997] 1 S.C.R. 217, File No. 24818.

R. v. Latimer, [2001] 1 S.C..R. 3, 2001 SCC 1, File No. 26980.

R. v. Morgentaler, 1 S.C.R. 30 (1988).

R. v. Oakes. S.C.R. 103. 1985: March 12; 1986: February 28, Docket: 17550.

Vacco, Attorney General of New York, et al, No. 95-1858 v. *Quill et al.*, 117 S.Ct.2293 (1997).

Washington et al., Petitioners No. 96-100 v. *Harold Glucksberg et al.*, 117 S.Ct. 2258 (1997).

Editorials

Burns, John. "Suicide Attempt Won't Be Crime Under New Law, Turner Says." *The Globe and Mail*, 3 March 1971, A1-2.

Homola, Victor and Nicholas Kolish. "German Court Liberalizes Rules for Right to Die Cases." *The New York Times*,
<www.nytimes.com/2010/06/26/world/europe/26berlin.html>

Hunter, Justine. "Discussing My Life: Sue Rodriguez Watches Court Debate Her Right to Die." *Ottawa Citizen*, 21 May 1993, A1.

Johnson, Kirk. "Montana Court to Rule on Assisted-Suicide Case." *The New York Times*, 31 August 2009; accessed 19 October 2010. <www.newyorktimes.com>

Johnson, William. "Rodriguez Shouldn't Be Condemned to Slow Death." *Ottawa Citizen*, 22 May 1993, A8.

O'Neill, Juliet. "Majority of Canadians Want to Legalize Doctor-assisted Suicide, Poll Shows." *Ottawa Citizen*, 10 June 2007, A5.

"Police Investigate Sue Rodriguez's Death. *Ottawa Citizen*, 13 February 1994, A1.

Rodriguez, Sue. "Death with Dignity: Reflections by Sue Rodriguez." *Ottawa Citizen*, 20 February 1993, B3.

Rodriguez, Sue. "Please Answer the Question." *Ottawa Citizen*, 18 January 1993, A7.

———. "The Rodriguez Decision: Majority Says Ban on Assisted Suicide Doesn't Violate Charter." *Ottawa Citizen*, 1 October 1993, A11.

Schafer, Arthur. "The Great Canadian Euthanasia Debate." *The Globe and Mail*, 5 November 2009; accessed 11 November 2009. <theglobeandmail.com.>

"Two Sides Demonstrate at Suicide-MD's Home." *Ottawa Citizen*, 28 February 1993, B7

Usborne, David. "Kevorkian Patient Tried to Halt Euthanasia, Report Suggests." *Ottawa Citizen*, 27 February 1993, A12.

"Woman Sues for Right to Die." *The Winnipeg Free Press*, 28 November 1991, A15.

Yardley, William. "Report Finds 36 Died under Assisted Suicide Law." *The New York Times*, 4 March 2010; accessed 19 October 2010. <www.newyorktimes.com>

Electronic Mail

Communication with Dr. Timothy E. Quill by e-mail. Topic: Terminal Sedation. Sent Wed 04/03/2009 4:22 PM.

Communication with Torbjörn Tännsjö by e-mail. Topic: Terminal Sedation. Sent Wed 16/01/2008 3:20 PM.

Encyclopedias

Edwards, Paul, ed. "Nihilism." In *The Encyclopedia of Philosophy*, vol. 5–6 (1967), 514–16.

Fitzgerald, A.D., ed. *Augustine through the Ages: An Encyclopedia*. Grand Rapids: Eerdmans, 1999.

Facta of the Interveners (Latimer)

- Factum of the Interveners*. Canadian Civil Liberties Association. No. 26980. In the Supreme Court of Canada (On Appeal from the Court for the Province of Saskatchewan) (26 April 2000).
- _____. The Catholic Group for Health, Justice and Life. No. 26980. In the Supreme Court of Canada (On Appeal from the Court of Appeal for the Province of Saskatchewan) (28 April 2000).
- _____. *Council of Canadians with Disabilities et al.* No. 26980. In the Supreme Court of Canada (On Appeal from the Court for Appeal for the Province of Saskatchewan) (1 May 2000).
- _____. The Attorney General of Canada. No. 26980. In the Supreme Court of Canada (On Appeal from the Court of Appeal for the Province of Saskatchewan) (1 May 2000).
- _____. The Attorney General for Ontario. No. 26980. In the Supreme Court of Canada (On Appeal from the Court of Appeal for the Province of Saskatchewan) (1 May 2000).
- _____. *The Evangelical Fellowship of Canada. Christian Medical and Dental Association, and Physicians for Life.* No. 26980. In the Supreme Court of Canada (On Appeal from the Court of Appeal for the Province of Saskatchewan) (2 May 2000).
- _____. The Canadian AIDS Society. No. 26980. In the Supreme Court of Canada (On Appeal from the Court for the Province of Saskatchewan) (1 June 2000).

Facta of the Interveners (Rodriguez)

- Factum of the Interveners. Rodriguez v. British Columbia.* No. 23476. British Columbia Coalition of People with Disabilities (7 May 1993).
- _____. *Rodriguez v. British Columbia.* No. 23476. Canadian Conference of Catholic Bishops and the Evangelical Fellowship of Canada (10 May, 1993).
- _____. *Rodriguez v. British Columbia.* No. 23476. People in Equal Participation Incorporated (10 May 1993).
- _____. *Rodriguez v. British Columbia.* No. 23476. Dying with Dignity (11 May 1993).
- _____. *Rodriguez v. British Columbia.* No. 23476. Pro Life Society of British Columbia and the Pacific Physicians for Life Society (14 May 1993).

_____. *Rodriguez v. British Columbia*. No. 23476. Coalition of Provincial Organizations of the Handicapped (17 May 1993).

_____. *Rodriguez v. British Columbia*. No. 23476. The Right to Die Society of Canada. (18 May 1993).

Government Reports

BC Royal Commission on Health Care and Costs. *Closer to Home: The Report of the BC Royal Commission on Health Care and Costs*. Victoria: Crown Publ., 1991.

British Medical Association. Council. *Homosexuality and Prostitution: A Memorandum of Evidence/Prepared by a Special Committee of the Council of the British Medical Association for Submission to the Departmental Committee on Homosexuality and Prostitution*. London: British Medical Association, 1955.

Dunsmuir, Mollie. *Euthanasia and Assisted Suicide*. Library of Parliament: Law and Government Division (24 November 2004).

Law Reform Commission of Canada. *Our Criminal Law*. Ottawa: Crown Copyrights, 1976.

_____. *Sanctity of Life or Quality of Life in the Context of Ethics, Medicine and Law*. Protection of Life Series by Edward W. Keyserlingk. Ottawa: Minister of Supply and Services Canada, 1979.

_____. (Working Paper 28). *Euthanasia, Aiding Suicide and Cessation of Treatment*. Ottawa: Minister of Supply and Services Canada, 1982.

_____. *Report on Euthanasia, Aiding Suicide and Cessation of Treatment*. Ottawa: Ministry of Supply and Services, 1983.

_____. *Some Aspects of Medical Treatment and Criminal Law*, Report 28. Ottawa: Ministry of Supply and Services, 1986.

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

President's Commission for the Study of Ethical Problems in Medicine. *Defining Death: A Report on the Medical, Legal and Ethical Issues in the Determination of Death*. Washington, D.C.: U. S. Government Printing Office, 1981.

Schwarzenegger, Christian and Sarah J. Summers. *Hearing with the Select Committee on the Assisted Dying for the Terminally Ill Bill, House of Lords*. University of Zurich: Faculty of Law (3 February 2005).

- Smith, Margaret. *The Rodriguez Case: A Review of the Supreme Court of Canada Decision on Assisted Suicide*. Ottawa: Law and Government Division, Research Branch, 1993.
- Tiedemann, Marlisa and Dominique Valiquet. *Euthanasia and Assisted Suicide in Canada*. Parliamentary Information and Research Service: Library of Parliament (17 July 17 2008).
- Turner, John. "Respecting Bill C-218, An Act to Amend the Provisions of the Criminal Code Relating to the Release from Custody of Accused Persons before Trial or Pending Appeal." *Minutes of Proceedings and Evidence of the Standing Committee on Justice and Legal Affairs*. Issue 10 (2 March 1971).
- van der Maas, P.J., J.J.M. van Delden, and L. Pijnenborg. *Euthanasia and Other Medical Decisions Concerning the End of Life: An Investigation Performed upon Request of the Commission of Inquiry into the Medical Practice Concerning Euthanasia*. Amsterdam: Elsevier, 1992.

Journal Articles

- Akabayashi, Akira. "Euthanasia, Assisted Suicide, and Cessation of Life Support: Japan's Policy, Law, and an Analysis of Whistle Blowing in Two Recent Mercy Killing Cases." *Social Science & Medicine* 55 (2002): 517-27.
- Altizer, Thomas J.J. "The Challenge of Nihilism." *Journal of the American Academy of Religion* 62, no. 4 (1994): 1013-22.
- Amundsen, Darrel W. "Suffering and the Sovereignty of God: One Evangelical's Perspective on Doctor-Assisted Suicide." *Christian Bioethics* 1, no 3 (1995): 285-313.
- Appel, Jacob M. "A Suicide Right for the Mentally Ill?: A Swiss Case Opens a New Debate." *Hastings Center Report* 37, no. 3 (May-June 2007): 21-23.
- Asai, Atsushi, et al. "Doctors' and Nurses' Attitudes towards Experiences of Voluntary Euthanasia: Survey of Members of the Japanese Association of Palliative Medicine." *Journal of Medical Ethics* 27, no. 5 (Oct. 2001): 324-30.
- Askin, W. Joseph, et al. "Nazi Medicine." *Can Med Assoc J* 148, no. 11 (1 June 1993): 1865-66.
- Battagin, Mina Gasser. "Giving Death a Helping Hand." *Can Med Assoc J* 144, no. 3 (1 February 1991): 358-59.
- Battin, Margaret P. "Assisted Suicide: Can We Learn from Germany?" *Hastings Center Report* 22, no. 2 (1992): 44-51.

- Baume, Peter and Emma O'Malley. "Euthanasia: Attitudes and Practices of Medical Practitioners." *MJA* 161 (1994): 137–40.
- Baume, Peter, Emma O'Malley, and Adrian Bauman. "Professed Religious Affiliation and the Practice of Euthanasia." *Journal of Medical Ethics* 21 (1995): 49–54.
- Beecher, Henry. "The New Definition of Death: Some Opposing Viewpoints." *International Journal of Clinical Pharmacology* 5 (1971): 120–21.
- Billings, J. Andrew and Susan D. Block. "Slow Euthanasia." *Journal of Palliative Care* 12, no. 4 (1996): 21–30.
- Boorman, J. Arthur. "To Live or Not to Live: The Moral and Practical Case against Active Euthanasia." *Can Med Assoc J* 121 (18 August 1979): 483–85.
- Bright, Howard. "Dutch Health Care." *Can Med Assoc J* 151, no. 3 (1 August 1994): 273.
- _____. "Euthanasia in the Netherlands." *Can Med Assoc J* 151, no. 10 (15 November 1994): 1393, 1396.
- Broeckaert, B. et al. "Palliative Care Physicians' Religious/World View and Attitude towards Euthanasia: A Quantitative Study among Flemish Palliative Care Physicians." *Indian J Palliat Care* 15, no. 1 (2009): 41–50.
- Burgess, J.A. "The Great Slippery-Slope Argument." *Journal of Medical Ethics* 19 (1993): 169–74.
- Burkholder, Leslie. "Discussion Article: Nancy B and Nancy F." *Journal of Applied Philosophy* 18, no. 2 (2001): 193–96.
- Cantor, Norman L. "On Kamisar, Killing, and the Future of Physician-Assisted Death." *Michigan Law Review* 102 (2004): 1793–1842.
- Chambers, Stuart. "Pierre Elliott Trudeau and Bill C–150: A Rational Approach to Homosexual Acts, 1967–69." *Journal of Homosexuality* 57, no. 2 (February 2010): 249–66.
- Clouser, K.D. and B. Gert. "A Critique of Principlism." *J Med Philos* 15 (1990): 219–36.
- Cohen–Almagor, Raphael. "The Right to Die with Dignity: An Argument in Ethics and Law." *Health, Law & Policy* 2, no. 1 (30 October 2008): 2–8. Available at SSRN: <<http://ssrn.com/abstract=1292302>>
- Dartana, Francis S.H. "Ethics of Euthanasia." *Can Med Assoc J* 146, no. 4 (15 February 1992): 445.

- de Wachter, Maurice A.M. "Euthanasia in the Netherlands." *Hastings Center Report* 22, no. 2 (March–April 1992): 23–30.
- Dickens, Bernard M. "Medically Assisted Death: Nancy B. v. Hotel-Dieu De Quebec." *McGill Law Journal* 38 (1993): 1053–1070. Available at SSRN: <http://ssrn.com/abstract=1226060>.
- _____. "The Continuing Conflict between Sanctity of Life and Quality of Life: From Abortion to Medically Assisted Death." *Annals of the New York Academy of Sciences* 913 (September 2000): 88–104.
- Doerflinger, Richard. "Assisted-Suicide: Pro-Choice or Anti-Life?" *Hastings Center Report* 19, no 1 (Jan./Feb. 1989): 16–19.
- Downie, Jocelyn and Simone Bern. "Rodriguez Redux." *Health Law Journal* 16 (2009): 27–54.
- Eastwell, H.D. "The Forefather Needs No Fluids: Voodoo Death and Its Simulacra." *American Anthropologist* 86, no. 1 (1984): 133–36.
- Emanuel, E.J. "Euthanasia and Physician-assisted Suicide: A Review of the Empirical Data from the United States." *Arch Inter Med* 162 (2002): 142–152.
- Emson, Harry E. "Euthanasia and Physician-Assisted Suicide." *Can Med Assoc J* 151, no. 12 (15 December 1994): 1691.
- _____. "Defining Physician-Assisted Suicide and Euthanasia." *Can Med Assoc J* 152 no. 2 (15 June 1995): 1961.
- "Euthanasia around the World." *BMJ* 304, no 6818 (Jan. 4, 1992), 7–10.
- Fish, Arthur and Peter A. Singer. "Nancy B.: The Criminal Code and Decisions to Forgo Life-Sustaining Treatment." *Can Med Assoc J* 147, no. 5 (1 September 1992): 637–42.
- Fleming, Daniel M. "Euthanasia, Physician-Assisted Suicide." *Can Med Assoc J* 149, no. 12 (15 December 1993): 1771–72.
- Forrest, David M. "Euthanasia and the American Medical Association." *Can Med Assoc J* 131 (15 September 1984): 629–32.
- Gevers, J. "Legal Developments Concerning Active Euthanasia on Request in the Netherlands." *Bioethics* 1 (1987): 156–62.
- Goddard, Hans. "'Voluntary Euthanasia Declaration' Goes Step beyond Living Will." *Can Med Assoc J* 139 (1 August 1988): 246.

- Godfrey, Elizabeth. "Patients' Right to Die Becoming Major Issue for MDs and MPs." *Can Med Assoc J* 146, no. 4 (15 February 1992): 608–10.
- Goodman, William E. "Nazi Medicine." *Can Med Assoc J* 148, no. 11 (1 June 1993): 1866.
- Gray, Charlotte. "Is the Pendulum of Public Opinion Swinging in Favour of Euthanasia?" *Can Med Assoc J* 152, no. 6 (12 March 1995): 956–58.
- Griffiths, J. "Assisted Suicide in the Netherlands: The Chabot Case." *Mod. L. Rev.* 58 (1995): 232–48.
- Gutowski, Willi D. "Nazi Medicine." *Can Med Assoc J* 148, no. 11 (1 June 1993): 1866.
- Harrison, Colin P. "Euthanasia, Medicine, and the Law." *Can Med Assoc J* 113 (8 November 1975): 833–34.
- Hurst, Samia A. and Alex Mauro. "Assisted Suicide and Euthanasia in Switzerland: Allowing a Role for Non-Physicians." *BMJ* 326, no. 7383 (Feb. 1, 2003): 271–73.
- Hyde-Williams, Wena V.P. "Nazi Medicine." *Can Med Assoc J* 148, no. 11 (1 June 1993): 1866.
- Jansen, Donald G. "Questioning the Taboo." *Can Med Assoc J* 144, no. 11 (1 June 1991): 1382–84.
- Kai, Katsunori. "Euthanasia and Death with Dignity in Japanese Law." *Waseda Bulletin of Comparative Law* 27 (2009): 1–13.
- Kamisar, Yale. "The Reasons So Many People Support Physician-Assisted Suicide – and Why These Reasons Are Not Convincing." *Issues in Law & Medicine* 12, no. 2 (1996): 113–31.
- _____. "Physician-Assisted Suicide: The Problems Presented by the Compelling, Heartwrenching Case." *Journal of Criminal Law and Criminology* 88, no. 3 (1998): 1121–46.
- Kenny, Nuala P. "The CMA Code of Ethics: More Room for Reflection." *Can Med Assoc J* 155, no. 8 (15 October 1996): 1063–65.
- Keown, J. "Physician-Assisted Suicide and the Dutch Supreme Court." *Law Q Rev.* 111 (1995): 394.

- Kinsella, T.D. and M.J. Verhoef. "Determinants of Canadian Physicians' Opinions about Legalized Physician-Assisted Suicide: A National Survey." *The Annals of the Royal College of Physicians and Surgeons* 32, no. 4 (Jun., 1999): 211–15.
- Kirshen, Albert J. "Should Doctors Kill Patients?" *Can Med Assoc J* 139 (1 December 1988): 1041.
- _____. "Euthanasia in the Netherlands." *Can Med Assoc J* 140 (1 June 1989): 1258.
- Kluge, Eike–Henner. "Euthanasia and Related Taboos." *Can Med Assoc J* 144, no. 3 (1 February 1991): 359–60.
- _____. "Dr. Kluge Responds." *Can Med Assoc J* 144, no. 11 (1 June 1991): 1383–84.
- Kuhse, H. and P. Singer. "Doctors' Practices and Attitudes Regarding Voluntary Euthanasia." *MJA* 148 (1988): 623–27.
- Lafollette, Hugh. "Living on a Slippery Slope." *The Journal of Ethics* 9, no. 3/4 (2005): 475–99.
- Langlois, Stéphanie and Peter Morrison. "Suicide Deaths and Attempts." *Canadian Social Trends* (Autumn, 2002): 20–25.
- Le Baron de Veber, L. "Physicians and Euthanasia." *Can Med Assoc J* 150, no. 2 (15 January 1994): 124–25.
- Leduc, Eugene. "Euthanasia and Physician-Assisted Suicide." *Can Med Assoc J* 151, no. 12 (15 December 1994): 1691.
- Leenen, H.J.J. and C. Ciesielski–Carlucci. "Force Majeure (Legal Necessity): Justification for Active Termination of Life in the Case of Severely Handicapped Newborns after Forgoing Treatment." *Cambridge QHealthcare Ethics* 2 (1993): 271–74.
- Legemaate, J. "Legal Aspects of Euthanasia and Assisted Suicide in the Netherlands 1973–1994." *Cambridge QHealthcare Ethics* 4 (1995): 112–21.
- Lemmens, Trudo. "Towards the Right to be Killed?: Treatment Refusal, Assisted Suicide and Euthanasia in the United States and Canada." *British Medical Bulletin* 52, no. 2 (1996): 341–53.
- Lisker, R. et al. "Physician-Assisted Death. Opinions of a Sample of Mexican Physicians." *Archives of Medical Research* 39 (2008): 452–458.

- Long, Susan Orpett. "Becoming a Cucumber: Culture, Nature, and the Good Death in Japan and the United States." *Journal of Japanese Studies* 29, no. 1 (Winter, 2003): 33–68.
- . "Negotiating the 'Good Death': Japanese Ambivalence about New Ways to Die." *Ethnology* 40, no. 4 (Autumn 2004): 271–89.
- Lowy, Frederick, Douglas M. Sawyer, and John R. Williams. "Canadian Physicians and Euthanasia: 4. Lessons from Experience." *Can Med Assoc J* 148, no. 11 (1993): 1895–99.
- Martel, Joane. "Examining the Foreseeable: Assisted Suicide as a Herald of Changing Moralities." *Social and Legal Studies* 10, no. 2 (2001): 147–70.
- Mullens, Anne. "Society Must Lead in Determining Canadian Position on Euthanasia, Doctors Say." *Can Med Assoc J* 148 (15 April 1993): 1367.
- . "The Dutch Experience with Euthanasia: Lessons for Canada?" *Can Med Assoc J* 152, no. 11 (1 June 1995): 1845–52.
- "Newsbriefs." *Can Med Assoc J* 129 (1 December 1983): 1213–15.
- Ney, Philip G. "Ethics of Euthanasia." *Can Med Assoc J* 144, no. 8 (15 April 1991): 956–57.
- O'Reilly, Michael. "Nazi Medicine: 'The Perversion of the Noblest Profession.'" *Can Med Assoc J* 148, no. 5 (1 March 1993): 819–21.
- Orentlicher, David. "The Legalization of Physician-Assisted Suicide: A Very Modest Revolution." *Boston College Law Review* 38 (1997): 443–75.
- "Outrage in Japan over Euthanasia without Consent." *British Medical Journal* 312, no. 7047 (Jun. 29, 1996): 1627.
- Parker, M. "Moral Intuition, Good Deaths and Ordinary Medical Practitioners." *J Med Ethics* (1990): 28–34.
- Perrett, Roy W. "Buddhism, Euthanasia and the Sanctity of Life." *Journal of Medical Ethics* 22, no. 5 (1996): 309–13.
- "Physician-Assisted Death." *Can Med Assoc J* 152, no. 2 (15 January 1995): 248A–248B.
- Rafuse, J. "CMA Continues Development of Euthanasia Policy after Supreme Court's Rodriguez Ruling." *Can Med Assoc J* 149, no. 9 (1993): 1305.

- _____. "CMA Rejects Neutral Stand, Comes Out Firmly against MD Participation in Euthanasia." *Can Med Assoc J* 151, no. 6 (1994): 853–54.
- Ritger, H., E. Borst–Eilers, and H.J.J. Leenen. "Euthanasia in the Netherlands." *Can Med Assoc J* 140 (1 April 1989): 788.
- Sawyer, Douglas M., John R. Williams, and Frederick Lowy. "Canadian Physicians and Euthanasia: 2. Definitions and Distinctions." *Can Med Assoc J* 148, no. 9 (1 May 1993): 1463–66.
- Sawyer, Douglas M. "What Do Canadian MPs Think about Euthanasia? An Update Following the CMA Annual Meeting." *Can Med Assoc J* 150, no. 3 (1 February 1994): 395–97.
- Schöne–Seifert, Bettina and Klaus–Peter Rippe. "Silencing the Singer: Antibioethics in Germany." *Hastings Centre Report* 21, no. 6 (1991): 20–27.
- Scoccia, Danny. "Slippery Slope Objections to Legalizing Physician-Assisted Suicide and Voluntary Euthanasia." *Public Affairs Quarterly* 19, no. 2 (2005): 143–61.
- Silversides, Ann. "Passive Euthanasia Simply Means Cruel Death, Dutch MD Maintains." *Can Med Assoc J* 140 (15 June 1989): 1482, 1484.
- Singer, Peter A. "Should Doctors Kill Patients?" *Can Med Assoc J* 139 (1 June 1988): 1000–01.
- Singer, Peter. "On Being Silenced in Germany." *The New York Review of Books* (15 August 1991): 36–42.
- Sneiderman, Barney. "The Case of Nancy B.: A Criminal Law and Social Policy Perspective." *Health Law Journal* 1 (1993): 25–38.
- Spanjer, M. "Dutch Psychiatrist Reprimanded for Assisting Suicide." *Lancet* 345 (1995): 914.
- Sullivan, A., K. Hedberg, and D. Hopkins. "Legalized Physician-assisted Suicide in Oregon, 1998–2000." *New England Journal of Medicine* 342 (2000): 598–604.
- Sullivan, Patrick. "Take Stand on Euthanasia, Assisted Suicide, MDs Tell CMA in Survey Released during Annual Meeting." *Can Med Assoc J* 149, no. 6 (15 September 1993): 858–59.
- _____. "Ethics Committee Inundated by Mail during Development of Policy on Euthanasia." *Can Med Assoc J* 150, no. 6 (15 March 1994): 950.

- Tanida, Noritoshi. "'Bioethics' is Subordinate to Morality in Japan." *Bioethics* 10, no. 3 (1996): 201–11.
- . "The View of Religions toward Euthanasia and Extraordinary Treatments in Japan." *Journal of Religion and Health* 39, no. 4 (Winter 2000): 339–54.
- ter Borg, Meerten B. "The Problem of Nihilism: A Sociological Approach." *Sociological Analysis* 49, no. 1 (1988): 1–16.
- Tuttle, Morley J. "Ethics of Euthanasia." *Can Med Assoc J* 144, no. 8 (15 April 1991): 956.
- van Delden, J.J.M., Loes Pijnenborg, and Paul J. van der Maas. "The Rummelink Study: Two Years Later." *Hastings Center Report* 23, no. 6 (Nov.–Dec. 1993): 24–27.
- van der Maas, P.J., J.J.M. van Delden, and L. Pijnenborg. "Euthanasia and Other Decisions Concerning the End of Life." *Lancet* 338 (1991): 669–74.
- Van Der Weyden, Martin. "Medicine and the Community—the Euthanasia Debate." *MJA* 162 (1995): 566.
- Vattimo, Gianni. "The End of (Hi)story." *Chicago Review* 35, no. 4 (1987): 20–30.
- Verhoef, Marja J. and T. Douglas Kinsella. "Alberta Euthanasia Survey: 3-Year Follow-up." *Can Med Assoc J* 155, no. 7 (1 October 1996): 885–90.
- Verster, Arnoldus J. "The Death of Bill C–203." *Can Med Assoc J* 147, no. 12 (15 December 1992): 1748.
- . "Euthanasia in the Netherlands." *Can Med Assoc J* 151, no. 10 (15 November 1994): 1393–96.
- Voth, Arnold. "Euthanasia and Physician-Assisted Suicide." *Can Med Assoc J* 151, no. 12 (15 December 1994): 1691–92.
- Weitzer, Ronald. "The Social Construction of Sex Trafficking: Ideology and Institutionalization of a Moral Crusade." *Politics & Society* 35 (2007): 447–75.
- . "The Mythology of Prostitution: Advocacy Research and Public Policy." *Sex Res Soc Policy* 7 (2010): 15–29.
- Williams, John R. et al. "Canadian Physicians and Euthanasia: 1. An Approach to the Issues." *Can Med Assoc J* 148, no. 8 (15 April 1993): 1293–97.

Williams, John R., Frederick Lowy, and Douglas Sawyer. "Canadian Physicians and Euthanasia: 3. Arguments and Beliefs." *Can Med Assoc J* 148, no. 10 (15 May 1993): 1699–1702.

Legal Documents

Criminal Code, R.S.C., c. C-46, s. 241 [*Criminal Code*].

Criminal Code. 1892, S.C. 1892, c. 29, s. 237.

Criminal Code Law Amendment Act, 1972, S.C. 1972, C.13, s.16.

Magazines

Driedger, Sharon Doyle. "Should Latimer Go Free?" *Maclean's*, 17 November 1997, 12–21.

Petrou, Michael. "A Time to Die: Is the Dutch Model of Euthanasia—Even for Infants—the Solution When Suffering Can't Be Relieved?" *Maclean's*, 5 September 2005, 22–26.

"The Law: Between Life and Death." *Time*, 29 September 1975, 75.

"The Law: Implications of Mercy." *Time*, 5 March 1973, 70.

Wood, Chris. "The Legacy of Sue Rodriguez." *Maclean's*, 28 February 1994, 22–28.

Senate Committee Reports

Proceedings of the Senate Special Committee on Euthanasia and Assisted Suicide (First Session, Thirty-fifth Parliament), Chairperson: Joan Neiman, Issues No. 1–32 (February 24th, 1994–January 13th, 1995).

Senate of Canada. *Of Life and Death: Report of the Special Senate Committee on Euthanasia and Assisted Suicide*. Ministry of Supply and Services Canada, (May 1995).

Videotape

CBC News in Review. VHS. "Nancy B.: The Right to Decide" (Ottawa: Canadian Broadcasting Corporation, February 1992).

Web Sites

CBC Archives. "Nancy B Dies after Winning the Right to Refuse Treatment." Broadcast Date: Feb. 13, 1992; accessed September 22, 2010.

<archives.cbc.ca/politics/rights_freedoms/clips/6406/>

CBC Digital Archives. "'Sue Rodriguez and the Right-to-Die Debate: Suicide.'" Broadcast Date: February 21, 1994; accessed September 22, 2010.

<archives.cbc.ca/politics/rights_freedoms/topics/1135>

CBC News Online. "Compassionate Homicide: The Law and Robert Latimer." Last Updated: March 17, 2008; accessed September 22, 2010.

<www.cbc.ca/news/background/latimer>

CMAJ archives

<<http://www.pubmedcentral.nih.gov/tocrender.fcgi?journal=77&action=archive>>

Frontline. "The Death of Nancy Cruzan." Air Date: March 24, 1992.

<www.pbs.org/wgbh/pages/frontline/programs/transcripts/1014.html>

"Judge Noble's Ruling," Q.B.J. A.D. 1994 No. 37 J.C.B., In the Queen's Bench Judicial Centre of Battleford between: Her Majesty The Queen-and-Robert W. Latimer Eric J. Neufeld, Q.C. and Graeme G. Mitchell for the Crown Mark Brayford, Q.C. for Robert W. Latimer Ruling on Defence Motion, Noble J. (December 1, 1997), 5: <www.robertlatimer.net>

Netherlands. *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*. Dutch Ministry of Foreign Affairs—Netherlands Ministry of Foreign Affairs. <www.minbuza.nl/binaries/en-pdf/pdf/euth-amendedbill'en.pdf>

Oregon Department of Human Services. *Summary of Oregon's Death with Dignity Act—2007 and Tables 1 and 2*. <www.Oregon.gov/DHS/ph/pas/ar-index.shtml>

Somerville, Margaret. "Law and Ethics: Who's the Boss?" *McGill Faculty of Law* (15 November 2005): <www.law.mcgill.ca/minilaw/somervilleqanda.htm>

Statistics Canada. "Suicides, and suicide rate, by sex and by age group, 1981–1997." <[www.40statscan.ca/01/cst01/health01/htm](http://www40statscan.ca/01/cst01/health01/htm)>

Statistics Canada. "Suicide Death Rates (x 100,000): Canada and the Provinces: Both Sexes." Vital Statistics Mortality Database from 1950 to 1999. Historical Death Shelf Tables for Summary List of Causes. Ottawa: Health Statistics Division. <www.statscan.gc.ca>

Switzerland. *Criminal Code of the Swiss Confederation*, art. 115. Legislationonline. <www.legislationline.org/legislations.php?jid=49&Itid=15>

The World Federation of Right to Die Societies. "The Zurich Declaration on Assisted Dying." 12th International Conference of the World Federation of Right to Die Societies. Zurich, Switzerland (October 12–15, 1998).
<www.worldrtd.net/node/155>