

EUTHANASIA AND ASSISTED SUICIDE

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EUTHANASIA AND ASSISTED SUICIDE*

ISSUE DEFINITION

Because of advances in medical treatment, people are now able to live longer and to delay death. But the ability to live longer often entails a diminished quality of life for those who suffer from degenerative or incurable diseases. The desire to achieve greater control over decisions relating to life and death has been fuelled by a number of factors, including: the desire to be spared from prolonged suffering; the increased incidence of seriously debilitating diseases such as AIDS and Alzheimer's disease; and a better understanding of how medical technology can prolong life and affect the dying process. These factors fostered an interest in euthanasia and cessation of medical treatment. More recently, the focus seems to have moved to quality end-of-life care, but that is a health care issue beyond the scope of this paper.

BACKGROUND AND ANALYSIS

A. Historical Background

Despite the fact that euthanasia has gained considerable media attention of late, neither the practice nor the controversy it engenders are new. While we now stress the conceptual distinctions between euthanasia, suicide and cessation of treatment, in early times euthanasia was generally equated with suicide. The tolerance for suicide that developed during the ancient classical period to some extent reflected a disdain for weakness, illness and the inability to contribute to society past a certain age. At the same time, however, it also reflected a concern for a "worthy and good life," something that was elusive in the presence of extensive physical decline. In classical times, the Greeks and the Romans succeeded in moving suicide out of a dark and mysterious realm into the field of public discourse and debate.

* The original version of this Current Issue Review was published in February 1992; the paper has been regularly updated since that time.

An intolerance for suicide began to take hold in the second and third centuries and gained increasing momentum under the influence of Christianity. Whereas in the classical period suicide was criticized only if it was irrational or without cause, Christianity saw this act as a direct defiance of or interference with God's will; thus, suicide resulted in the denial of a Christian burial and tended to bring great shame upon family members. St. Augustine declared that "life and its sufferings are divinely ordained by God and must be borne accordingly." In the thirteenth century, the teachings of St. Thomas Aquinas epitomized the intolerance for suicide. According to him, suicide violated the biblical commandment against killing and was ultimately the most dangerous of sins because it precluded an opportunity for repentance.

The impact of scientific and medical discoveries in recent times has changed the nature of the debate on suicide. The increasing ability of physicians to treat bodily ailments, and to extend life, caused the state to have a more direct interest in questions of life and death in the medical context. Strict adherence to religious principles and teachings was complicated by the advances of science and medicine. Issues such as medically assisted death and cessation of treatment, which characterize much of the contemporary debate, have their roots in this period. By the beginning of the nineteenth century, the medical profession was engaging in a fair amount of discussion on euthanasia, in which philosophers and theologians joined. Much of the discourse focused on the issue of "quality of life" and on the right to determine when this quality had deteriorated to the point where it was acceptable to cease living.

In North America, the seminal case on the question of quality of life and cessation of treatment was that of Karen Ann Quinlan, a 21-year-old who had suffered permanent brain damage, and went into a coma, after an episode involving the consumption of alcohol and drugs. Ms. Quinlan's parents signed a release form to allow physicians to cease use of a respirator in the treatment of their daughter. When the hospital refused to follow the directive, her parents requested the courts to reverse the hospital's decision. In 1976, following a ruling by the New Jersey Supreme Court, the respirator was removed. Ms. Quinlan died in 1985 in a nursing home where she had remained in a coma, fed through tubes, for some ten years.

In Canada, the increase in such chronic conditions as Alzheimer's disease and incurable diseases such as AIDS and some forms of cancer meant that afflicted people could see their probable future before they became incapacitated. This prompted some to lobby for more direct input into their medical care; in some cases, they sought assistance to die.

More generally, the extent to which medical technology can prolong life, quite independent of considerations about the quality of that life, has become common knowledge for most citizens. This means that many persons give active consideration to the limits they will place on their own medical treatment and that of family members.

The increasing cost of health care is another relevant consideration. Estimates indicating that individuals incur their highest health care costs in the final days of life illustrate the delicate balance between sustaining life and containing health care expenses. This fact, some health policy analysts suggest, will become increasingly apparent as more and more of the population move into the older age groups, in which health care needs and their attendant costs increase.

B. Legal Issues

Although the definitions used in discussions of euthanasia and assisted suicide can vary, the following are based on the report of the Special Senate Committee on Euthanasia and Assisted Suicide (*Of Life and Death*, 1995). *Euthanasia* is the deliberate act undertaken by one person with the intention of ending the life of another person in order to relieve that person's suffering. *Assisted suicide* is the act of intentionally killing oneself with the assistance of another who provides the knowledge, means or both.

Voluntary euthanasia occurs when the act is done in accordance with the wishes of a competent individual or a valid advance directive. *Non-voluntary euthanasia* occurs when the act is done without knowledge of the wishes of a competent individual or with respect to an incompetent individual. *Involuntary euthanasia*, which is indistinguishable from murder or manslaughter, occurs when the act is done against the wishes of a competent individual or a valid advance directive.

A *competent* individual is capable of understanding the nature and consequences of the decision to be made and capable of communicating this decision. An *incompetent* individual is not capable of understanding the nature and consequences of the decision to be made, and/or is not capable of communicating the decision.

1. The *Criminal Code* and Euthanasia

A number of *Criminal Code* provisions impinge upon the issues of euthanasia and cessation of treatment.

Section 14 of the Code provides that:

No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.

In the medical context, a doctor who, at a patient's request, gives the patient a lethal injection would be criminally liable.

A number of other provisions of the *Criminal Code* may also come into play, depending upon the circumstances; these provisions include:

- section 45 (Surgical operations);
- section 215 (Duty of persons to provide necessities);
- section 216 (Duty of persons undertaking acts dangerous to life);
- section 217 (Duty of persons undertaking acts);
- section 219 (Criminal negligence);
- section 220 (Causing death by criminal negligence);
- section 221 (Causing bodily harm by criminal negligence);
- section 222 (Homicide);
- section 229 (Murder);
- section 231 (Classification of murder);
- section 234 (Manslaughter);
- section 245 (Administering noxious thing); and
- the various assault and bodily harm provisions.

Theoretically, one would expect euthanasia to be prosecuted as first-degree murder, because there is an intent to cause death, which is the definition of murder, and the act is most often planned and deliberate, which is the definition of first-degree murder. However, charges of euthanasia have been influenced principally by other criteria: the fact that the primary intent is to relieve suffering; the unpredictable attitude of juries; and technical difficulties in proving the exact cause of death when a person is in any case close to death and taking considerable pain medication. Charges in Canada have ranged from administering a noxious substance, to manslaughter, to murder.

The most controversial euthanasia case in Canada occurred after Robert Latimer had killed his disabled 12-year-old daughter Tracy in 1993 by placing her in the family truck and then piping exhaust fumes into it. Evidence showed that Tracy had a severe form of cerebral palsy, and could not walk, talk or feed herself. She had suffered considerable pain; Mr. Latimer told the police that “his priority was to put her out of her pain.”

Mr. Latimer was charged with first-degree murder, convicted of second-degree murder by a jury, and sentenced to life imprisonment with no possibility of parole for ten years. He subsequently lost an appeal to the Saskatchewan Court of Appeal. However, in February 1996, the Supreme Court of Canada agreed to hear a further appeal; and in June 1996, the original Crown prosecutor was charged with attempting to obstruct justice through jury tampering. In February 1997, the Supreme Court of Canada ordered a new trial for Mr. Latimer because of the allegations of jury tampering.

After a new trial, Mr. Latimer was again found guilty of second-degree murder in late 1997. At the sentencing hearing, Mr. Latimer’s lawyer argued that he should be given a “constitutional exemption,” or that the judge should find the mandatory minimum sentence of ten years to be “cruel and unusual punishment” in the circumstances, and therefore a violation of Mr. Latimer’s rights under the *Canadian Charter of Rights and Freedoms*. On 1 December 1997, in a decision that surprised most legal commentators, the sentencing judge found that a ten-year sentence would indeed be “grossly disproportionate” to the offence. He sentenced Mr. Latimer to two years less a day, half of which would be served in a provincial jail and half on his farm.

On appeal, the Saskatchewan Court of Appeal confirmed its earlier decision, and substituted the mandatory minimum sentence of ten years, noting that it is always “open to Parliament to modify the existing law by appropriate legislation that establishes sentencing criteria for ‘mercy’ killing.”

The Supreme Court of Canada granted Mr. Latimer leave to appeal on the grounds of whether the defence of necessity should have been left to the jury, whether the trial judge should have informed the jury that Mr. Latimer had the legal right to decide to commit suicide for his daughter as her surrogate decision-maker, and whether the minimum sentence for murder is cruel and unusual punishment in these circumstances contrary to the *Charter*. In January 2001, the Court upheld the conviction and the sentence. It did, however, note that section 749 of the *Criminal Code* provides for the royal prerogative of mercy, which is a matter for the executive, not the courts, to consider.

2. The *Criminal Code* and Aiding Suicide

Under section 241 of the *Criminal Code*, it is an offence to counsel or to aid suicide, although suicide itself is no longer an offence:

241. Every one who

(a) counsels a person to commit suicide, or

(b) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

The validity of section 241 under the *Canadian Charter of Rights and Freedoms* was challenged in the 1992 case of Sue Rodriguez, a woman suffering from amyotrophic lateral sclerosis or Lou Gehrig's disease. Ms. Rodriguez sought to have the section struck down on the grounds that it prohibits a terminally ill person from committing physician-assisted suicide. She argued that her right to "life, liberty and security of the person" – which, in her view, included the right to control the method, timing, and circumstances of death – were denied by section 241.

The British Columbia Supreme Court ruled that section 241 did not deprive Ms. Rodriguez of her right to life, liberty and security of the person, nor did it restrict her freedom of choice or affect her ability to make fundamental decisions about her life. In the court's view, it was the nature of her illness, not the legal system or the state, that deprived Ms. Rodriguez of the ability to carry out her wishes. The court also concluded that section 241 does not discriminate against persons on the grounds of physical disability.

This decision was appealed to the British Columbia Court of Appeal which, in March 1993, dismissed the appeal in a two-to-one decision. Both of the justices who favoured dismissal felt that the matter should be dealt with by Parliament rather than the courts. In deciding whether section 241 violated section 7 of the Charter, Mr. Justice Hollinrake held that, although section 241 of the *Criminal Code* might have deprived Ms. Rodriguez of her right of security of the person under section 7 of the Charter, the prohibition against physician-assisted suicide was not contrary to the principles of fundamental justice.

The Chief Justice, however, would have allowed the appeal. He concluded that section 241 violated Ms. Rodriguez's section 7 rights to liberty and security of the person and went on to state that "... any provision which imposes an indeterminate period of senseless physical and psychological suffering upon someone who is shortly to die anyway cannot conform with any principle of fundamental justice."

Ms. Rodriguez appealed to the Supreme Court of Canada, which, in a five-to-four decision, dismissed the appeal. Ms. Rodriguez had argued before the Court that section 241(b) of the *Criminal Code*, which makes it an offence to aid or abet suicide, violated sections 7, 12 and 15 of the Charter.

The majority of the Court held that, although section 241(b) deprived Sue Rodriguez of her security of the person under section 7 of the Charter, the deprivation was justified because it accorded with principles of fundamental justice. Writing for the majority, Mr. Justice Sopinka noted that respect for life is a fundamental principle upon which there is substantial consensus in Canadian society. The prohibition against assisted suicide reflects this consensus and is designed to protect the vulnerable who might be persuaded to commit suicide. To allow physician-assisted suicide, he observed, would erode the belief in the sanctity of human life and suggest that the state condones suicide. Furthermore, concerns about abuse and the difficulty in establishing safeguards to prevent abuse make it necessary to prohibit assisted suicide.

The majority also refused to find that section 241(b) constituted cruel and unusual treatment under section 12 of the Charter.

Mr. Justice Sopinka assumed that Ms. Rodriguez's equality rights under section 15(1) of the Charter had been infringed, but concluded that the infringement was justified under section 1 of the Charter. The purpose of s. 241(b), he noted, is to protect individuals from others who may wish to control their lives. To create an exception to the prohibition against assisted suicide for some groups or individuals would create inequality and lend support to the notion that we are starting down the "slippery slope" toward full recognition of euthanasia. He considered the creation of safeguards to prevent abuse unsatisfactory and insufficient to calm fears of the likelihood of abuse. Even if an exception could be made for the terminally ill, he felt there could be no guarantee that assisted suicide could be limited to those who genuinely wished to die.

In her dissenting opinion, Madam Justice McLachlin held that section 241(b) violates section 7 of the Charter. She concluded that it would be contrary to the principles of fundamental justice to deny Sue Rodriguez the choice available to those who are physically able, merely because of a fear that others might suffer abuse. She felt that Sue Rodriguez was being treated as a "scapegoat" for others who might be improperly persuaded to commit suicide.

Chief Justice Lamer's dissent was based on section 15(1) of the Charter. He concluded that section 241(b) creates an inequality in that physically disabled persons unable to commit suicide without assistance are prevented from choosing that option without breaking the law; those who are capable of ending their lives unassisted, however, may commit suicide with impunity. Although the Chief Justice was concerned that the decriminalization of assisted suicide might increase the risk for those vulnerable to manipulation by others, he contended that speculation to this effect and the fear of a "slippery slope" could not justify the restriction on those who are not vulnerable and who would freely consent to suicide.

In his dissent, Mr. Justice Cory agreed with the disposition of the appeal proposed by Chief Justice Lamer for the reasons put forward by the Chief Justice and Madam Justice McLachlin. He would have given the right to die with dignity protection under s. 7 of the Charter and allowed terminally ill patients to obtain assistance to terminate their lives.

3. Other Cases in Canada

In British Columbia, an inquest was held into the death of a ten-year-old girl with Rett syndrome, a rare neurological disorder that, among other symptoms, can cause severe eating disorders. At the time of her death, Katie Lynn Baker reportedly weighed only 22 pounds, was severely disabled and could not speak, being virtually non-communicative to all except her closest caregivers. According to the coroner's report, when hospitalization became the only way to save Katie, her mother had sought "the child's wishes respecting being 'hooked-up' or force fed, which [the] mother interpreted as being in the negative." To isolate Katie from the possibility of non-consensual treatment, she was moved by her mother from the family home to a new location, where she died a few days later.

The jury found that death had been caused by "severe malnutrition" as a result of "inadequate nutritional intake over a period of time caused directly or indirectly by the actions of other persons." The jury classified the death as "homicide"; however, the presiding coroner noted that "the jury's ruling of death by homicide precludes any assumption of culpability on the part of any person or agency. In the Coroner's Inquest, the term is neutral and does not imply fault or blame."

On 6 May 1997, in Halifax, Dr. Nancy Morrison was arrested on a charge of first-degree murder in the death of a terminally ill cancer patient. Mr. Mills had cancer of the esophagus, which required removing the esophagus and repairing the gap by repositioning the

stomach. All possible treatment methods were unsuccessful. By 9 November 1996, there was no hope of recovery. The patient's family was consulted and, consistent with normal and usual procedures in such circumstances, it was agreed by all those present that active life support would be discontinued.

When Mr. Mills was taken off the ventilator, pain control drugs were administered and increased several times. Mr. Mills remained in substantial distress and pain, gasping for air. One expert witness testified that the level of drugs given to Mr. Mills was in the lethal range and outside of his experience. With Mr. Mills in continuing distress, Dr. Morrison administered first nitroglycerine and then potassium chloride by syringe. Potassium chloride, administered as it was to Mr. Mills, will stop the heart.

In February 1998, Judge Hughes Randall declined to commit Dr. Morrison to stand trial. He noted that Mr. Mills had been given extraordinary amounts of Dilaudid, morphine and other painkillers prior to Dr. Morrison's involvement. Although potentially lethal, these earlier drugs had been legally administered in an unsuccessful attempt to relieve the intense suffering that Mr. Mills appeared to be experiencing after being removed from the respirator. Judge Randall found that, whatever Dr. Morrison's intentions when she allegedly administered potassium chloride, Mr. Mills could have died from either the enormous amount of painkillers received earlier or, because the intravenous line delivering the various drugs to Mr. Mills was not working, from natural causes.

Based on these conclusions, Judge Randall found that "a jury properly instructed could not convict the accused of the offence charged, any included offence, or any other offence and therefore, she is hereby discharged."

This decision was appealed to the Nova Scotia Supreme Court. In November 1998, the appeal was dismissed. Judge Hamilton personally disagreed with the preliminary inquiry decision, and felt that there was some evidence before the Preliminary Inquiry Judge on which a reasonable jury could return a verdict of guilty by manslaughter. However, this was not sufficient to quash the decision provided that Judge Randall had acted within his jurisdiction, which the Supreme Court found he had. In December 1998, the Public Prosecution announced that it would not appeal the decision.

In 1998, a case arose in Manitoba which tested the boundaries of "do not resuscitate" (DNR) orders. On 25 May 1998, Mr. Andrew Sawatzky was admitted to the Riverview Health Centre in Winnipeg, suffering from Parkinson's disease and various other

ailments. The admitting physician, Dr. Engel, was of the view that Mr. Sawatzky was not a candidate for resuscitation in the event that he went into arrest, but acquiesced to Mrs. Sawatzky's request and ordered resuscitation in spite of his own views.

During the summer, Dr. Engel decided that Mr. Sawatzky required a specific medical procedure, a cuffed tracheostomy tube. Mrs. Sawatzky refused to consent, and an order of supervision was applied for and granted under the Manitoba *Mental Health Act*. This had the effect of appointing the Public Trustee as guardian of the person of Mr. Sawatzky, with the authority to consent to medical treatment on his behalf.

Mr. Sawatzky's condition continued to deteriorate and in late October 1998, Dr. Engel initiated a DNR order. Mrs. Sawatzky retained legal counsel and applied for an interlocutory injunction suspending the DNR until her case could be tried. The defendant hospital opposed the application on the basis that: (1) this would order a doctor to provide medical treatment which he/she feels is not in the patient's best interests, putting her/him in conflict with the Code of Conduct of the College of Physicians and Surgeons; and (2) there is no authority in law to impose such an obligation on a doctor.

In November 1998, Justice Holly Beard granted the interlocutory injunction, on limited conditions. The DNR order was withdrawn, and the Public Trustee and the defendant hospital were each ordered to obtain an independent medical opinion as to Mr. Sawatzky's current condition and the advisability of the "do not resuscitate" order. The court described the issues of public concern as follows: (1) in what factual circumstances can a doctor or health facility issue a "do not resuscitate" order; (2) do those factual circumstances apply in this case; and (3) can a doctor in a health care facility legally issue a "do not resuscitate" order if the patient or the person entitled to consent to health care treatment for the patient refuses to consent to that order?

According to press reports, the two independent medical opinions were complete by January 1999. Both agreed that Mr. Sawatzky was not able to make or communicate informed decisions, and that the DNR order was appropriate. On 26 October 1999, Mr. Sawatzky, 79, died at Victoria General Hospital in Winnipeg. Mrs. Sawatzky had been due back in court two days later to continue her battle for the right to make his treatment decisions.

More recently, charges of assisted suicide were laid in British Columbia and Quebec. On 5 November 2004, a British Columbia court acquitted Evelyn Martens, 73, of aiding and abetting the suicide of two women in 2002. Martens was an active member of the Right to Die Society of Canada, had sent literature to the two women, and apparently

admitted she was with them when they died. On 28 September 2004, Marielle Houle was charged with aiding and abetting the suicide of her 36-year-old son, a well-known playwright.

4. The Right to Refuse Medical Treatment

The common law recognizes the right of an adult, competent person to refuse medical treatment or to demand that treatment, once begun, be withdrawn or discontinued.

In a 1990 decision, the Ontario Court of Appeal held that instructions on blood transfusions issued when a patient was competent had to be followed even when she was incapable of making a decision. The Court found that a physician must follow a Jehovah's Witness's written instruction refusing all blood transfusions, even in an emergency situation where the patient was unable to give consent. However, the Court emphasized that its decision applied only to the specific case before it, and not to: situations of terminal or incurable illness where a patient seeks to reject medical treatment by way of a living will or an advance medical directive; or situations where the family of a person in a persistent vegetative state wishes to withdraw medical treatment.

In the January 1992 decision in the case of Nancy B., the Quebec Superior Court ruled that a competent, adult patient suffering from an incurable disease and bedridden for life had the right to request that her doctor disconnect the respirator keeping her alive. In making his decision, Mr. Justice Dufour cited sections of the *Quebec Civil Code* which provide that the human person is inviolable and that no one can be made to undergo treatment without consent.

The case also dealt with the issue of the criminal liability of the doctor who, at Nancy B.'s request, would be required to remove her from the respirator. After referring to sections 216, 217, 45 and 219 of the *Criminal Code*, as well as the provisions dealing with homicide, the judge concluded that it was neither unreasonable nor wanton and reckless conduct for a physician, at the request of a patient, to disconnect the patient's respirator and allow the patient's disease to take its natural course. The doctor would not be aiding the patient to commit suicide or committing an act of homicide, because Nancy B.'s death would result from the underlying disease.

5. Advance Directives

A number of provinces have sought to deal with the issue of medical treatment in the event of a patient's future incompetence. Advance directives have emerged as one method of response to the problem. Commonly known as a "living will," an advance directive is a document signed by a competent individual dealing with health care decisions to be made in the event that the person becomes incapable of making those decisions. In the *Quebec Civil Code*, an advance directive is referred to as a "mandate."

Advance directives can be divided into two categories:

- an instruction directive, in which an individual sets out *what types of treatment* he or she does not want in the event that he or she becomes incompetent; and
- a proxy directive, in which an individual sets out *who* is to make such health care decisions on his or her behalf.

A "substituted judgement" directive involves a subjective test to seek to determine what decision the incapacitated person would have made had he or she been capable of doing so. In the event of a dispute, the court might look at any opinions about terminating life-sustaining treatment that the person expressed before becoming incompetent. Some courts have adopted more relaxed evidentiary requirements and relied on distant and occasional opinions expressed by the incompetent person; still others have considered the patient's prior religious beliefs, lifestyle choices, and the opinions of family and friends as to the type of treatment he or she would have chosen.

The "best interests" test involves an examination of the benefits and burdens of continued treatment. Among the factors considered are the person's present condition, degree of pain, and prognosis as well as the risks, side effects and benefits of various forms of treatment. In some situations, the quality of life and the interests of the person's family are also taken into account.

Advance directives should not be viewed as purely a legal document. Whether a person gives too little or too much detail in their advance directive, there may well be interpretation problems, with physicians and family members sometimes disagreeing on the meaning. Most people do not keep their advance directives up to date, and family members may feel that a dated advance directive does not reflect the patient's current thinking. Sometimes, medical staff may not be aware that an advance directive exists.

Many of these problems are associated with the traditional view of advance directives as based on the principle of the patient's autonomy, whereas advance directives are increasingly seen as part of a planning and communication process that helps people prepare for death in the context of their loved ones. The preparation of an advance care directive can facilitate discussions between people and their family, and provide guidance and support for substitute decision-makers who must make the difficult decisions regarding life-sustaining treatment. If loved ones and medical professionals have engaged in a process of serious communication, the problems associated with the interpretation and application of advance directives are much less likely to arise. Advance directives ease the passage to death, raise the level of comfort, and minimize any residual guilt in the substitute caregiver.

Advance directive forms, or living wills, are now widely available. They can even be found on the Internet⁽¹⁾.

6. Guidelines and Reports

In 1983, the Law Reform Commission of Canada (the "Commission") published its report on *Euthanasia, Aiding Suicide and Cessation of Treatment* following a working paper on the subject which had been published the previous year.

The Commission noted widespread consensus in Canada on three basic principles reflected in our law:

- The protection of human life is a fundamental value.
- The patient has the right to autonomy and self-determination in making decisions about his or her medical care.
- Human life needs to be considered from a quantitative and qualitative perspective.

Subsequent to the publication of its report on euthanasia, the Commission recommended that the General Part of the *Criminal Code* contain a provision that no one has a duty to continue medical treatment that is therapeutically useless or for which consent is expressly refused or withdrawn. This recommendation, however, did not define "therapeutically useless" or set out the requirements for consent.

(1) See, for instance, the University of Toronto Joint Centre for Bioethics living will form (http://www.utoronto.ca/jcb/outreach/living_wills.htm).

In November 1993, the British Columbia Ministry of the Attorney General issued guidelines for Crown Counsel with respect to charging individuals who, out of compassion for the deceased, participate in causing a death. Under the guidelines, Crown Counsel will approve a prosecution only where there is a “substantial likelihood of conviction and the public interest requires a prosecution.”

In determining whether a substantial likelihood of conviction exists, Crown Counsel will be required to classify the conduct of the person involved in the death and the resulting consequences as “active euthanasia,” “assisted suicide,” “palliative care,” or “withholding or withdrawing medical treatment.” The factors to be considered in characterizing such conduct include the provable intention of the person and, in cases involving physicians and their patients, the position of the Canadian Medical Association and expert medical opinions as to generally accepted ethical medical practices.

The public interest criterion involves a consideration of the following factors:

- society’s support of proper professional and ethical standards for health care professionals;
- society’s interest in protecting vulnerable persons; and
- society’s interest in protecting the sanctity of human life, while recognizing this does not require life to be preserved at all costs.

According to the guidelines, palliative care and withholding or withdrawing medical treatment will not be subject to criminal prosecution when provided or administered according to accepted ethical medical standards.

In February 1994, the Senate of Canada established a Special Committee to study the issues of euthanasia and assisted suicide. Issued in June 1995, the report of the Special Committee, entitled *Of Life and Death*, also canvassed a number of related issues including palliative care, pain control and sedation practices, withholding and withdrawal of life-sustaining treatment, and advance directives.

The Special Committee urged all levels of government in Canada to make palliative care programs a top priority and to develop national guidelines and standards for such care. The Special Committee felt that there was no moral difference between withholding and withdrawing life-sustaining treatment. In either case, the wishes of a competent patient should be respected. The report recognized that there was uncertainty on the part of the medical profession and the public as to what is legally permissible and recommended that practice in the area be clarified in law.

The question of assisted suicide was more contentious. Some Committee members favoured changes to the existing law, while others opposed such changes. A majority of the members recommended that the provision of the *Criminal Code* that proscribes aiding and abetting suicide remain intact.

For the purposes of the report, the Special Committee defined euthanasia as “the deliberate act undertaken by one person with the intention of ending the life of another person in order to relieve that person’s suffering where that act is the cause of death.”

The report then set out three types of euthanasia, all of which are illegal under the *Criminal Code* of Canada. The three types are:

- voluntary – when euthanasia is conducted in accordance with the wishes of a competent individual;
- non-voluntary – when euthanasia is done without the actual knowledge of the wishes of the patient; and
- involuntary – when euthanasia is performed against the wishes of an individual.

The majority of the Committee members opposed voluntary euthanasia, recommending that it continue as a criminal offence, but with a less severe penalty in cases where mercy or compassion is an element. The minority recommended that the *Criminal Code* be amended to permit voluntary euthanasia for competent individuals who are physically incapable of committing assisted suicide.

Non-voluntary euthanasia would also remain a criminal offence. However, the Committee recommended that a less severe penalty be applied where compassion or mercy is an element. The Committee was unanimous in its conclusion that involuntary euthanasia continue to be treated as murder under the *Criminal Code*.

In November 1999, a Senate Subcommittee was established to study developments with respect to the unanimous recommendations made in *Of Life and Death* in the five years after the report was published. The Subcommittee submitted its report, entitled *Quality End-of-Life Care: The Right of Every Canadian*, in June 2000, concluding that “the principles, expertise, and medical infrastructure for the care of people facing death were evolving far too slowly” (p. 3).

C. Other Countries

1. United States

In 1994, a Federal District Court in Seattle declared unconstitutional a Washington State law prohibiting doctor-assisted suicide. In March 1995, a three-member panel of the United States Court of Appeal for the Ninth Circuit overturned this decision, stating that a right to doctor-assisted suicide had no place in “the traditions of our nation” and was “antithetical to the defence of human life that has been a chief responsibility of our constitutional government.” In March 1996, however, the full Ninth Circuit reheard the case and decided, by an eight-to-three majority, that the Washington law prohibiting doctor-assisted suicide was indeed unconstitutional and violated the liberty interest under the due process clause of the 14th amendment. The decision was binding on all nine western states.

In April 1996, a three-member panel of the United States Court of Appeal for the Second Circuit unanimously struck down a similar law from New York. The court held that the New York law, which made it illegal for doctors to help terminally ill patients end their own lives, violated the equal protection clause of the 14th amendment in that it protected the rights of patients on life support to order their life support terminated, while denying comparable relief to other terminally ill, mentally competent patients not on life support.

On 1 October 1996, the Supreme Court of the United States agreed to hear an appeal of the two Court of Appeal rulings. The Court had previously refused to hear an appeal of a Michigan State Court decision upholding a Michigan law prohibiting assisted suicide, passed after Dr. Kevorkian began his campaign of assisting terminally ill people to die.

On 26 June 1997, the Supreme Court reversed both Court of Appeal decisions, and upheld the Washington and New York statutes prohibiting assisted suicide. However, the court’s finding that these two statutes are constitutional does not mean that a law permitting assisted suicide would be found unconstitutional.

In November 1994, Oregon voters passed Measure 16 which allowed a terminally ill adult resident of Oregon, diagnosed with less than six months to live, to obtain a prescription for medication to end his or her life. Before a physician could issue such a prescription, certain conditions would have to be met:

- the patient would have to make two oral and one written request for medication;
- a second medical opinion would be required; and
- at least 15 days would have to have elapsed since the initial request for a prescription.

A legal challenge to the legislation prevented its proclamation, and in August 1995 a District Court judge found it to be unconstitutional and invalid. However, in October 1997, the Ninth Court Circuit of Appeals found that the plaintiffs in the action had no legal standing to challenge Measure 16. The Court did not decide the constitutional merits of physician-assisted suicide, and the United States Supreme Court refused to hear an appeal. In June 1997, the Oregon legislature voted to send the *Death with Dignity Act* back to the electorate for a second vote in November 1997, at which time the Oregon voters reaffirmed the Act by a 60% majority.

Opponents of the *Death with Dignity Act* quickly began lobbying for federal interference with the state initiative. In June 1998, Attorney General Janet Reno announced that the U.S. *Controlled Substances Act* would not allow federal officials to prosecute physicians who assisted in suicides in Oregon. **However, under the current Bush administration, Attorney General Ashcroft announced that he would commence prosecutions of Oregon doctors who prescribed lethal doses of federally controlled drugs. Although the government lost an initial court decision, on 9 November 2004 the Attorney General asked the U.S. Supreme Court to hear an appeal.**

In February 1999, the Oregon Health Division – whose role is to act as a neutral party and collect information regarding compliance with the statute – published the first annual report on the *Death with Dignity Act*. **On 10 March 2004, the sixth annual report was published, outlining the situation in 2003:**

1998

24 patients received lethal prescriptions, and 16 of these patients died as a result of taking the prescription (including 1 who died in 1999).

Physician-assisted suicide accounted for approximately 6 of every 10,000 deaths in Oregon in 1998. Patients with cancer who chose physician-assisted suicide accounted for 19 of every 10,000 cancer deaths in Oregon.

2003

42 physicians wrote a total of 67 prescriptions for lethal doses of medication. Thirty-nine of these patients died by physician-assisted suicide; 3 other patients died using prescriptions issued in previous years; 18 died from their illnesses; and 10 were still alive at the end of 2003.

Physician-assisted suicide accounted for approximately 14 per 10,000 deaths.

1998

Fear of intractable pain and concern about the financial impact of their illnesses were not disproportionately associated with the decision to choose physician-assisted suicide. The choice of physician-assisted suicide was most strongly associated with concerns about loss of autonomy and personal control of bodily functions.

Patients who chose physician-assisted suicide in 1998 were similar to all Oregonians who died of similar underlying illnesses with respect to age, race, and sex. Patients who chose physician-assisted suicide were not disproportionately poor (as measured by Medicaid status), less educated, lacking in insurance coverage, or lacking in access to hospice care. The average age was 70 years.

Many hospitals and physicians in Oregon were unable or unwilling to participate in physician-assisted suicide. Physicians who wrote prescriptions for lethal medications for patients who chose physician-assisted suicide represented a wide range of specialties, ages, and years in practice.

2. The Netherlands

In the Netherlands, the term “euthanasia” has one clear meaning and is normally not qualified by adjectives such as voluntary or involuntary. The practice is the deliberate termination of a patient’s life by a physician acting on the patient’s request and according to strict guidelines.

Traditionally, euthanasia was prohibited under the Dutch penal code, which states that anyone who terminates the life of another person at that person’s explicit request is guilty of a criminal offence punishable by up to 12 years in prison. However, although it was a criminal offence, euthanasia was practised in the Netherlands and was not prosecuted, as long as certain guidelines were followed. These guidelines were developed through a series of court decisions where physicians who had been charged with practising euthanasia were found not to be

2003

The three most commonly mentioned end-of-life concerns during 2003 were loss of autonomy, a decreasing ability to participate in activities that made life enjoyable, and a loss of dignity.

Compared to all Oregon deaths, participants in physician-assisted suicide were more likely to have malignant neoplasms, to be younger, and to have more formal education.

Complications were reported for three patients, and all involved regurgitation.

criminally liable for their action. Under the guidelines, all the following requirements had to be met:

- the patient must repeatedly and explicitly express the desire to die;
- the patient's decision must be well informed, free and enduring;
- the patient must be suffering from severe physical or mental pain with no prospect of relief (but need not be terminally ill);
- all other options for care must have been exhausted (so that euthanasia is a last resort) or the patient must have refused other available options;
- the euthanasia must be carried out by a qualified physician;
- the physician must consult at least one other physician (and may also consult other health care professionals); and
- the physician must inform the local coroner that the euthanasia has been carried out.

Prior to 1990, reliable estimates of the extent of euthanasia in the Netherlands were unavailable. In September 1991, the Remmelink Commission (a Dutch government commission of inquiry into euthanasia and other medical decisions about the end of life) reported that its scientific studies had revealed about 2,300 cases of euthanasia in the previous year in the Netherlands, representing 1.8% of the year's deaths. Many more requests (about 9,000) were made for euthanasia in that year than were actually carried out. Furthermore, the majority of patients who requested euthanasia (i.e., about 70%) were terminally ill cancer patients.

In February 1993, the Lower House of Parliament in the Netherlands passed legislation on the reporting procedure for euthanasia. Although not legalizing euthanasia, the legislation would guarantee immunity from prosecution to physicians who follow certain guidelines for practising it.

In 1994, the Supreme Court of the Netherlands decided the controversial *Chabot* case, finding Dr. Chabot technically guilty of assisted suicide. Dr. Chabot's patient, Hilly Boscher, had been 50 years old and had simply not wished to live. She had experienced a violent marriage, the death of one son by suicide, and the death of her second son from cancer. She had a 20-year history of depression, and had attempted to commit suicide immediately after the death of her second son. She was determined to commit suicide but wished to do so in a humane way that would not be intrusive on others.

Dr. Chabot undertook to work with her in the hope of altering her viewpoint, and suggested she keep a journal. What emerged from this was Ms. Boscher's unswerving determination to die. Although there was no physical or psychiatric illness, Dr. Chabot was of the opinion that Ms. Boscher was experiencing intense, long-term psychic suffering with no prospect of improvement. He sent transcripts of the therapy sessions to seven expert colleagues, all of whom agreed with his assessment. Considering the situation hopeless, Dr. Chabot considered that the lesser evil was to provide his patient with the means to commit suicide painlessly and with as little violence as possible.

The Supreme Court accepted the principle that assisted suicide could be justifiable when no physical illness was present, but when a patient was experiencing intense emotional or mental suffering. However, the Court held that such situations required extreme caution; it found that Dr. Chabot had violated the procedural requirements in that none of the seven experts had personally examined Ms. Boscher. Nonetheless, the Court declined to impose a penalty on Dr. Chabot, which may well have indicated ambivalence towards such a difficult situation. The issue of assisting suicide as a relief from non-somatic (or non-physical) suffering remains a contentious one.

In 1995, Dutch courts dealt with two separate but similar cases in which doctors had ended the lives of severely disabled infants, both in pain and not expected to survive their first year. In both cases, the doctor had acted at the explicit request of the child's parents. These cases illustrate the troubling gap between the parents' right to refuse treatment for their child, with death as the inevitable result of such refusal, and their inability to relieve pain during the dying process.

In August 1995, the Royal Dutch Medical Association adopted new guidelines for euthanasia and assisted suicide. These stated that, where possible, the patient, rather than the doctor, should administer the drug. The new guidelines also emphasize that the required consultation with a second physician should involve an experienced doctor who has no professional or familial relationship with either the patient or the first doctor.

In August 1999, the Minister of Justice and the Minister of Health tabled a legislated proposal in the Lower House of Parliament legalizing euthanasia and assisted suicide. The bill was passed by the Lower House on 28 November 2000 by a vote of 104-50 and by the Senate on 10 April 2001 by a vote of 46-28. **The Act came into effect on 1 April 2002.**

The new statutory provisions make no substantive change to the grounds on which euthanasia (termination of life on request) and assisted suicide are permitted, but do spell out the existing due care criteria in more detail. The doctor must:

- be satisfied that the patient's request is voluntary and well considered;
- be satisfied that the patient's suffering is unbearable and that there is no prospect of improvement;
- inform the patient of his or her situation and further prognosis;
- discuss the situation with the patient and come to the joint conclusion that there is no other reasonable solution;
- consult at least one other physician with no connection to the case, who must then see the patient and state in writing that the attending physician has satisfied the due care criteria listed above; and
- exercise due medical care and attention in terminating the patient's life or assisting in his/her suicide.

The most controversial aspect of the new legislation was a proposal that children as young as 12 be permitted to request euthanasia or assisted suicide. However, the legislation as passed follows the *Medical Treatment Contracts Act*, and parental consent is required for persons under age 16. In principle, 16- and 17-year-olds can decide for themselves, but their parents must always be involved in the discussion.

In June 2004, an article in *The Lancet* suggested that the strict regulations governing euthanasia in the Netherlands might be loosened, in part because of a concern they might be causing under-reporting. The situation with respect to persons with Alzheimer's disease, or other non-terminal illnesses, remains somewhat ambiguous.

3. Australia

In February 1995, the Chief Minister of the Northern Territory of Australia introduced a Private Member's Bill, the *Rights of the Terminally Ill Bill (1195)* (NT), in the Legislative Assembly. The bill was intended to provide terminally ill persons with the right to request assistance from a medically qualified person in voluntarily terminating their lives. A Select Committee on Euthanasia was established to inquire into the bill and report back to the

Legislative Assembly. In May 1995, after more than 50 amendments had been made to the original bill, the Legislative Assembly passed the legislation by 15 votes to 10. The Northern Territory thus became the first jurisdiction in the world to legalize physician-assisted suicide and euthanasia.

Unsurprisingly, the bill created considerable controversy, both within Australia and internationally. There were calls for its repeal, and for the Governor-General of Australia to disallow it under the *Northern Territory (Self-Government) Act, 1978*; however, the Administrator of the Northern Territory assented to the Act in June 1995, and to regulations under the Act in June 1996. These came into effect, with the Act itself, on 1 July 1996. In the interim, the Northern Territory Legislative Assembly had passed further amendments to the legislation, whereby the number of doctors involved was increased from two to three, one of whom must be a qualified psychiatrist and another a specialist in the patient's illness.

The *Rights of the Terminally Ill Act 1995* (NT) included numerous administrative safeguards, as well as numerous references to treatment and levels of suffering "acceptable to the patient." Section 4 stated the essential philosophy of the Act:

A patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient, may request the patient's medical practitioner to assist the patient to terminate the patient's life.

A "terminal illness" was defined as one that will result in the death of the patient unless extraordinary measures, or treatment that is unacceptable to the patient, are used. A medical practitioner who received a request for assistance and followed all the procedures laid out in the legislation could legally assist the patient to terminate his or her life. The assistance could consist of prescribing or preparing a substance, which would be either given to the patient for self-administration or would be administered to the patient. Alternatively, the physician could, at any time and for any reason, refuse to give such assistance.

The other criteria that had to be met included the following:

- the patient had to be at least 18 years old;
- there could be no palliative care options reasonably available to the patient that would alleviate pain and suffering to a level he or she found acceptable; and
- there had to be two "cooling off" periods, totalling nine days, between the first request to the doctor and the assistance itself.

In an attempt to prevent the bill from becoming law, the President of the Northern Territory Branch of the Australian Medical Association, Dr. Wake, and an aboriginal leader, Reverend Dr. Gondarra, challenged its validity. One of the grounds was that the exercise of legislative power by the Legislative Assembly is constrained by an obligation to protect an inalienable “right to life,” deeply rooted in the democratic system of government and the common law. By a two-to-one majority, the court upheld the legislation, stating that it need not decide whether the legislation infringed any fundamental right because, in the absence of a constitutionally enshrined Bill of Rights, that issue was “ethical, moral or political” in nature rather than legal.

Although some critics had argued that the amended bill was too cumbersome to be workable, controversy again erupted in late September 1996, when a Darwin man became the first person to use the new legislation successfully. The patient had suffered from prostate cancer for five years and, according to press reports, the lethal injection was triggered by a lap-top computer through which the patient confirmed his wish to die. Three other people used the provisions of the Act before it was overruled by the national Parliament.

Under section 122 of the Australian Constitution, the Commonwealth Parliament has a plenary power to pass legislation overriding any territorial law. In September 1996, Mr. Kevin Andrews, a government backbencher, introduced a Private Member’s bill to overturn the Northern Territory’s euthanasia law. The bill passed the House of Representatives on 9 December 1996 and the Senate on 24 March 1997.

4. Others

End-of-life decisions have caused considerable controversy in the United Kingdom. In December 1999, a British MP, Mrs. Ann Winterton, who had drawn first place in the Private Members’ ballot, announced that she would be introducing a bill to prevent doctors from intentionally bringing about the death of their patients.

Euthanasia is unlawful throughout the United Kingdom. However, it is lawful, in certain cases, to withhold or withdraw life-prolonging treatment from patients, thus hastening their death. The issue came to the fore in 1993, when the parents and doctors of a young man, Tony Bland – who had been in a persistent vegetative state for several years – sought court permission to end artificial nutrition and hydration. The House of Lords decided that artificial feeding and hydration constituted medical treatment and could be lawfully withdrawn; this would constitute an omission, not an act. Subsequent cases established that there are circumstances when doctors may lawfully cease to offer life-prolonging treatment, on the basis that the quality of life made possible by the treatment is intolerable to the individual patient.

In June 1999, the British Medical Association (BMA) published guidelines on withholding and withdrawing life-prolonging treatment, including artificial hydration and nutrition. In early December 1999, a series of press reports appeared, alleging that older patients were being starved to death in public hospitals. Mrs. Winterton concluded that many people, particularly the disabled and the elderly, were increasingly fearful of entering hospital because of the BMA guidelines on the withdrawal of medical treatment, including tubal feeding, from patients who were not dying.

Mrs. Winterton's bill, the *Medical Treatment (Prevention of Euthanasia) Bill*, would have made it unlawful for any person responsible for the medical care of a patient to withdraw or withhold medical treatment or sustenance if the purpose, or one of the purposes, was to hasten or cause the death of the patient. Mrs. Winterton stated that her bill did not aim to force doctors to continue life-prolonging treatment where patients are dying or in cases where the treatment would have no effect or be burdensome to the patient. Rather, she intended it to prevent doctors or others from taking quality-of-life issues into account when deciding whether future treatment should be withheld. Debate on the bill was adjourned in April 2000 and the bill was dropped.

The issue remains contentious in Britain, and in July 2004 the House of Lords established a Select Committee to consider and report on a Private Member's bill, *Assisted Dying for the Terminally Ill*, which would enable a terminally ill competent adult to request medical assistance to die in specified circumstances. The Committee is expected to report in late 2004 or early 2005.

In 2002, Belgium legalized euthanasia, provided that strict criteria were met.

Switzerland considers assisted suicide a crime only if the motive is selfish. Otherwise it is legally condoned and does not require the participation of a physician. Euthanasia remains illegal, although it is the subject of continuing debate.

In France, the Health Minister reopened the euthanasia debate in an interview published in *Le Figaro* in August 2004. Philippe Douste-Blazy called for a law that would ensure the right to die in dignity, but ruled out the legalization of euthanasia. He suggested a draft law defining the legal options for the terminally ill would be placed before the National Assembly before the end of the year.

PARLIAMENTARY ACTION

Until 1991, when Private Members' bills on the subject were introduced in the House of Commons, euthanasia had received only fleeting references in the House and had never been debated there. Introduced in close succession were: Bill C-203, by Robert Wenman (Fraser Valley West), on 16 May 1991; and Bill C-261, by Chris Axworthy (Saskatoon-Clark's Crossing), on 19 June 1991. (Mr. Wenman had introduced Bill C-351 in March 1991, but it had died on the *Order Paper* with the ending of the parliamentary session.) Mr. Axworthy's bill incorporated most of Mr. Wenman's "passive euthanasia" bill but would have extended its scope to provide for "active euthanasia."

Mr. Wenman's bill, An Act to amend the Criminal Code (terminally ill persons), was designed to protect medical practitioners from possible criminal liability in three treatment scenarios: first, where the practitioner withholds or withdraws medical treatment at the request of a terminally ill patient; second, where the practitioner withholds or withdraws medical treatment from a terminally ill patient because the treatment is therapeutically useless and not in the best interests of the patient; and third, where the practitioner, to ease the suffering of the patient, provides palliative care, such as pain-relieving drugs, whose side effect might be to hasten the patient's death. In summary, the purpose of the bill was to protect medical practitioners who provide proper and ethical treatment to their terminal patients but who, by so doing, incur the possibility of violating certain sections of the *Criminal Code*.

Mr. Wenman's bill was not intended to provide for active euthanasia in any circumstances. It would have allowed passive euthanasia to be practised, however, in that a medical practitioner would not have been held criminally liable for withdrawing life-sustaining treatment by, for example, turning off a respirator at the request of a terminally ill patient.

Mr. Axworthy's bill, on the other hand, made no distinction between passive euthanasia, i.e., allowing individuals to die by withholding or withdrawing treatment, and active euthanasia, such as administering a lethal dose of a drug. This bill included the same exculpatory provisions as Mr. Wenman's but added provisions that would have legalized active euthanasia in certain conditions. The bill proposed that a person suffering from an irremediable condition could apply to a euthanasia referee for a "euthanasia certificate" giving permission for the process.

Both bills were debated in the House of Commons at second reading. Mr. Wenman's bill, which was less controversial, was referred to a legislative committee for review. Even those members who expressed reservations about the bill in the debate were nevertheless in favour of its referral to a committee, because they recognized a need to examine the issues it raised. Mr. Axworthy's bill, on the other hand, inspired very strong criticism during the debate at second reading and was dropped from the *Order Paper*.

Following several weeks of committee hearings, Mr. Wenman's bill also met an early demise. The legislative committee charged with reviewing the bill, after completing its hearings and without considering any amendments, decided to adjourn the proceedings *sine die*. By adjourning without assigning a further meeting date, the Committee effectively halted further parliamentary action on the bill.

In December 1992, a Private Member's bill to legalize physician-assisted suicide was introduced in the House of Commons by Svend Robinson.

Three months later, in March 1993, the House of Commons defeated a motion by Ian Waddell, MP, calling upon the government to consider the advisability of introducing legislation on euthanasia.

In February 1994, Mr. Robinson introduced another Private Member's bill to legalize physician-assisted suicide for terminally ill persons. This bill was subsequently debated and dropped from the *Order Paper*.

On 23 February 1994, the Senate passed a motion to create a special committee to examine and report on the legal, social and ethical issues relating to euthanasia and assisted suicide. The report of the Special Committee, entitled *Of Life and Death*, was issued in June 1995.

On 4 November 1997, Mr. Robinson introduced Motion M-123, calling for a special committee to be appointed to review the *Criminal Code* provisions dealing with euthanasia and physician-assisted suicide and to prepare a bill. On 25 March 1998, the motion was rejected by a considerable margin.

In November 1999, a Senate Subcommittee was established to study developments with respect to the unanimous recommendations made in *Of Life and Death* in the five years after the report was published. The Subcommittee submitted its report, entitled *Quality End-of-Life Care: The Right of Every Canadian* in June 2000, concluding that "the principles, expertise, and medical infrastructure for the care of people facing death were evolving far too slowly" (p. 3).

CHRONOLOGY

- 1983 - The Law Reform Commission of Canada recommended against legalizing or decriminalizing voluntary active euthanasia. It also recommended that aiding suicide not be decriminalized where assistance has been rendered to a terminally ill person.
- June 1987 - The Law Reform Commission of Canada released proposals for amending the *Criminal Code*. These included the recommendation that mercy killing be treated as second-degree murder (“ordinary murder”) rather than as first-degree murder (“premeditated murder”). Second-degree murder would carry no fixed or minimum jail term.
- 16 May 1991 - Private Member’s Bill C-203, An Act to amend the Criminal Code (terminally ill persons), was read for the first time in the House of Commons.
- 19 June 1991 - Private Member’s Bill C-261, An Act to legalize the administration of euthanasia under certain conditions, was read for the first time in the House of Commons.
- 10 September 1991 - In the Netherlands, the Rummelink Commission released findings from the first comprehensive study of Dutch euthanasia practices.
- 24 September 1991 - Bill C-203, An Act to amend the Criminal Code (terminally ill persons) received second reading and was referred to Legislative Committee H for consideration. The Committee began hearings on the bill on 29 October 1991.
- 24 October 1991 - Bill C-261, An Act to legalize the administration of euthanasia, was debated at second reading and dropped from the *Order Paper*.
- 6 January 1992 - The Quebec Superior Court ruled in the case of Nancy B., a woman suffering from an incurable disease, that turning off her respirator at her request and letting nature take its course would not be a criminal offence.
- 30 January 1992 - An Ontario surgeon was charged with second-degree murder in connection with the death of a seriously ill cancer patient. The patient is alleged to have died of a cardiac arrest after having been administered morphine and potassium chloride.
- 18 February 1992 - Legislative Committee H on Bill C-203 adjourned *sine die*.

- August 1992 - Scott Mataya, a Toronto nurse who had originally been charged with first-degree murder in the mercy killing of a terminally ill patient, entered a guilty plea to a lesser charge of administering a noxious substance. He received a suspended sentence and was ordered to surrender his nursing licence.
- 22 March 1993 - Members of the House of Commons defeated a motion that called upon the government to consider the advisability of introducing legislation on the subject of euthanasia and ensuring that those assisting terminally ill persons who wish to die will not be subject to criminal liability.
- April 1993 - An Ontario physician who gave a lethal injection to a seriously ill cancer patient was given a three-year suspended sentence after pleading guilty to a charge of administering a noxious substance to endanger life. The physician was originally charged with second-degree murder, but this charge was withdrawn.
- 30 September 1993 - In a five-to-four decision, the Supreme Court of Canada dismissed an appeal by Sue Rodriguez in which she challenged the validity of the *Criminal Code* prohibition on assisted suicide under the *Canadian Charter of Rights and Freedoms*.
- 3 November 1993 - The British Columbia Ministry of the Attorney General issued guidelines for Crown Counsel with respect to charging persons involved in cases of active euthanasia and assisted suicide.
- 12 February 1994 - Sue Rodriguez committed suicide with the assistance of a physician. The death was investigated by police, but no criminal charge was laid.
- 14 February 1994 - Justice Minister Allan Rock stated that the issues of cessation of treatment and assisted suicide should be considered by Parliament.
- 15 February 1994 - Prime Minister Chrétien stated that Members of Parliament would have a free vote on whether to legalize doctor-assisted suicide.
- 16 February 1994 - Private Member's Bill C-215, An Act to amend the Criminal Code (aiding suicide), was read for the first time in the House of Commons. This bill was debated and dropped from the *Order Paper* on 21 September 1994.
- 23 February 1994 - A Special Senate Committee was established to examine and report on the legal, social and ethical issues relating to euthanasia and assisted suicide.

- November 1994 - Robert Latimer was convicted of second-degree murder in the asphyxiation death of his severely disabled 12-year-old daughter Tracy and sentenced to life in prison with no eligibility for parole for ten years.
- June 1995 - The Special Senate Committee on Euthanasia and Assisted Suicide issued its report entitled *Of Life and Death*.
- February 1997 - The Supreme Court of Canada ordered a new trial for Robert Latimer.
- May 1997 - Dr. Nancy Morrison was charged with the first-degree murder of a terminally ill patient who had been removed from active life support.
- December 1997 - Robert Latimer, having again been convicted of second-degree murder, was sentenced to two years less a day, notwithstanding that the minimum sentence under the *Criminal Code* is life in prison with no possibility of parole for ten years.
- February 1998 - A Nova Scotia judge found that there was not sufficient evidence for a jury to convict Dr. Nancy Morrison, and refused to commit her to trial.
- November 1998 - The Saskatchewan Court of Appeal confirmed the conviction of Robert Latimer and imposed a sentence of life imprisonment with no eligibility for parole for ten years.
- June 2000 - The Senate Subcommittee studying developments with respect to the unanimous recommendations made in *Of Life and Death* in 1995 submitted its report, entitled *Quality End-of-Life Care: The Right of Every Canadian*, in June 2000.
- January 2001 - The Supreme Court of Canada upheld the decision of the Saskatchewan Court of Appeal with regard to Robert Latimer.

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