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"Solutions in Sciences Outside of the Law!?" Rodriguez v. British Columbia (A.G.)

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Introduction

While we are forced, somewhat begrudgingly, to face the fact that there are limitations to what medicine can achieve, we still seem to have an undisturbed faith in what law can achieve. The limitations to what litigation under the *Canadian Charter of Rights and Freedoms*[1] can achieve was highlighted most recently in the case of *Rodriguez* v. *British Columbia (A.G.)*[2] where the Supreme Court of Canada, by a five to four margin, upheld the constitutionality of the assisted suicide provisions of the *Criminal Code*.[3] The Court recognized that Ms. Rodriguez's rights were violated but concluded that the infringement did not contravene the principles of fundamental justice. Sue Rodriguez's right to autonomy and bodily control was, in essence, pitted against a vague notion of the state's interest in the "sanctity of life" and in the protection of the vulnerable. Although it may be persuasively argued that the principles enshrined in the *Charter* could conceivably lead to progressive social change,[4] individual rights litigation will rarely succeed if the Court, when performing this balancing act, continually conceptualizes the state's interests as superior to those of the individual. This case illustrates this recurring dilemma within the *Charter* framework.

As Ms. Rodriguez and her supporters discovered, an individual's right to die is subordinate to the state's right to protect life. As this case recently demonstrated, the solution to the dilemma is one which continues to lie "outside the law."[5]

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1. Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [hereinafter *Charter*].
2. [1993] 3 S.C.R. 519 [hereinafter *Rodriguez*, S.C.C.].
3. R.S.C. 1985, c. C-46 [hereinafter *Code*].
4. It has been argued, for example, that the *Charter* could be interpreted to require that social programmes be applied equitably; see Parkdale Community Legal Services, "Homelessness and the Right to Shelter" (1988) 4 J.L. & Social Pol'y 33.
5. On February 12, 1994, Sue Rodriguez died, apparently with the assistance of a physician; M. Cernetig, "Police Suspect Rodriguez Suicide" *The [Toronto] Globe and Mail* (14 February 1994) A1.

Historical Background

At common law, suicide was considered an offence against both God and the King. Until 1823, English law provided for the forfeiture of property of a person who committed suicide and also that the body be placed at the crossroads of two highways with a stake driven through it.[6] In Canada, as in Britain, the common law recognized that aiding suicide was also criminal and this was enshrined in Canada's first *Code*[7] in 1892. The policy rationale behind these prohibitions appears to be that since one's life was owned by God, one had no licence to take away that life or to assist in the taking of the life of another.

Although suicide is no longer a criminal offence in Canada, assisted suicide and aiding and abetting (counselling) a suicide remain offences under the *Code*. The offence of attempted suicide was repealed in 1972[8] when Parliament acknowledged that suicide "has its roots and its solutions in sciences outside of the law."[9] The policy rationale here would appear to be that it is impossible to prosecute a person for successful suicide and inhumane to prosecute an unsuccessful attempt. Assisting suicide, on the other hand, is still considered opprobrious in many situations because suicide, though decriminalized, is still apparently not acceptable to many people. Despite these *Code* prohibitions, cases of assisted suicide are rarely prosecuted.[10] Sue Rodriguez pinned her hopes on the *Charter* and sought to ensure that no criminal prosecution would ensue following her assisted death.

Facts of the Case

Susan Rodriguez was a 42 year old woman from Victoria, British Columbia who had amyotrophic lateral sclerosis (ALS), commonly known as Lou Gehrig's disease. Ms. Rodriguez was terminally ill and, at

6. B.T. Gates, *Victorian Suicide: Mad Crimes and Sad Histories* (Princeton, N.J.: Princeton University Press, 1988) at 3.
7. *The Criminal Code, 1892*, S.C. 1892, c. 29, s. 237.
8. By the *Criminal Law Amendment Act, 1972*, S.C. 1972, c. 13, s. 16.
9. *House of Commons Debates* (27 April 1972) at 1699.
10. See, *e.g.*, Law Reform Commission of Canada, Working Paper 28, *Euthanasia, Aiding Suicide and Cessation of Treatment* (Ottawa: Law Reform Commission of Canada, 1982) at 54.

the time of argument in this case, had a life expectancy of between 2 and 14 months. Ms. Rodriguez wanted the opportunity to choose physician-assisted suicide in the event that she was no longer able, in her view, to enjoy life. She believed that by the time she reached that stage she would be unable to terminate her life without the assistance of another person. She sought a Court order which would allow a medical practitioner to set up the "technological means by which she might, by her own hand, at the time of her choosing, end her life."[11] More specifically, Ms. Rodriguez applied to the British Columbia Supreme Court for an order pursuant to section 24(1) of the *Charter* that the provisions of the *Code* prohibiting assisted suicide[12] be declared void.

She argued that section 241 of the *Code* violated her *Charter* right to life, liberty and security of the person (s. 7); her right not to be subject to cruel and unusual punishment (s. 12); and her right not to be discriminated against on the basis of physical disability (s. 15).[13]

Lower Court Decisions

Melvin J. of the Supreme Court of British Columbia[14] dismissed Ms. Rodriguez's application. The Court concluded that s. 7 of the *Charter* was not applicable since it only comes into play when a person is placed in the justice system and, more specifically, is placed under the threat of penal sanction or detention. According to this reasoning, Ms. Rodriguez would never come in contact with the justice system regardless of her

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11. *Rodriguez*, S.C.C., *supra* note 2 at 531.
12. Section 241 of the *Code* states:

> Every one who
> (a) counsels or procures 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.

13. The relevant sections of the *Charter* read:

> 7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.
>
> 12. Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.
>
> 15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

14. *Rodriguez* v. *British Columbia (A.G.)* (1992), 18 W.C.B. (2d) 279, [1993] B.C.W.L.D. 347 (B.C.S.C.).

actions and it would be the physician who assisted her who would be subject to criminal sanctions. Using the same reasoning, the Court dismissed s. 12 as inapplicable. Moreover, Melvin J. found that s. 15 did not single out the physically disabled but, on the contrary, was designed to protect rather than discriminate against them.

The British Columbia Court of Appeal upheld the lower Court decision[15] with a dissenting opinion written by MacEachern C.J. The majority of the Court had two separate reasons for its conclusion. Hollinrake J.A. found that, in light of the Supreme Court of Canada's decision in *R.* v. *Morgentaler*,[16] Ms. Rodriguez was deprived of her s. 7 right to security but that the deprivation did not contravene the principles of fundamental justice. Hollinrake J.A. concluded that while there was a fine line between physician-assisted suicide and palliative care, nonetheless the difference was a "marked and significant one."[17] He did not view the facts as engaging either ss. 12 or 15 of the *Charter*. Proudfoot J.A. restricted her judgment to the appellant's section 7 rights and concluded that the decision in *Morgentaler* was inapplicable to Ms. Rodriguez for two reasons. First, *Morgentaler* dealt with the right to security of the person only with respect to the preservation of health which is not what this appellant was seeking. Second, she found that *Morgentaler* was a criminal case and Ms. Rodriguez could never be charged criminally under s. 241(b). Proudfoot J.A. did not address any infringement under ss. 12 or 15. She concluded that the matter would be best left to Parliament since the Court was "in no position to assess the consensus in Canada with respect to assisted suicide."[18] Neither majority decision necessitated a progression to a section 1 analysis.

MacEachern C.J., dissenting, found a *prima facie* violation of the appellant's s. 7 liberty and security interests in light of *Morgentaler* and he determined that the infringements were contrary to the principles of fundamental justice. He did not consider it necessary to consider ss. 12 and 15. He concluded that the section 7 violations were not saved by section 1 of the *Charter*. Applying the second test of "proportionality"

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15. *Rodriguez* v. *British Columbia (A.G.)* (1993), 76 B.C.L.R. (2d) 145, 79 C.C.C. (3d) 1, [1993] 3 W.W.R. 553 [hereinafter *Rodriguez*, C.A. cited to B.C.L.R.].
16. [1988] 1 S.C.R. 30 [hereinafter *Morgentaler*].
17. *Supra* note 15 at 171.
18. *Supra* note 15 at 186.

from *R.* v. *Oakes*,[19] he concluded that the legislative means did not impair, as little as possible, the right or freedom under consideration. He found s. 241 to be unconstitutional with respect to its effect on Ms. Rodriguez. He fashioned a remedy specifically tailored to her which guaranteed that the physician assisting her to commit suicide would not be violating the law of Canada if the following conditions were met:

> (1) the Appellant must be deemed competent by her treating physician and an independent psychiatrist not more than 24 hours before arrangements for the assisted suicide and one of the physicians must be present with the Appellant;
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> (2) the physicians must certify that: (i) the Appellant is terminally ill and near death and that there is no hope of recovery; (ii) that she is, or but for medication would be, suffering unbearable physical pain or severe psychological stress; (iii) that they have informed her, and that she understands, that she has a continuing right to change her mind; and (iv) when, in their opinion, the Appellant would likely die (a) if palliative care is being or would be administered to her, and (b) if palliative care should not be administered to her;
>
> (3) notice may be given to the Regional Coroner not less than three clear days before any psychiatrist examines her and the Coroner must be present for the examination;
>
> (4) one of the physicians giving the certificate must re-examine her each day to ensure she does not change her mind;
>
> (5) no one may assist her after expiration of thirty-one days to ensure that she has not changed her mind since she was examined by a psychiatrist; and
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> (6) the act causing the death must be the unassisted act of the Appellant herself, and not of anyone else.[20]

Ms. Rodriguez appealed the decision of the majority of the Court of Appeal to the Supreme Court of Canada.

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19. [1986] 1 S.C.R. 103, 65 N.R. 87, 50 C.R. (3d) 1. These tests were reviewed in *Morgentaler* by Dickson C.J.C. at 73–74:

> In *Oakes*, at p.139, the Court referred to three considerations which are typically useful in assessing the proportionality of means to ends. First, the means chosen to achieve an important objective should be rational, fair and not arbitrary. Second, the legislative means should impair as little as possible the right or freedom under consideration. Third, the effects of the limitation upon the relevant right or freedom should not be out of proportion to the objective sought to be achieved.

20. *Supra* note 15 at 168–69.

Supreme Court of Canada Judgments

The following constitutional questions were stated by order of the Supreme Court of Canada on March 25, 1993:

1. Does s. 241(b) of the *Criminal Code* of Canada infringe or deny, in whole or in part, the rights and freedoms guaranteed by ss. 7, 12 and 15(1) of the *Canadian Charter of Rights and Freedoms*?
2. If so, is it justified by s. 1 of the *Canadian Charter of Rights and Freedoms* and therefore not inconsistent with the *Constitution Act, 1982*?[21]

The Supreme Court of Canada upheld the British Columbia Court of Appeal decision by a five to four margin. The majority judgment was written by Sopinka J. and concurred in by Justices La Forest, Gonthier, Iacobucci and Major. The majority found that, in light of the *Morgentaler* decision, section 7 "encompass[ed] a notion of personal autonomy involving, at the very least, control over one's bodily integrity free from state interference and freedom from state-imposed psychological and emotional stress."[22] As a result, the majority concluded that s. 241(b) deprived the appellant of autonomy over her person and caused her psychological and emotional stress which impinged upon her security of the person.

In considering whether the infringements were in accordance with principles of fundamental justice, the Court reviewed the common law and legislative history of s. 241(b). The long-standing prohibition in s. 241(b) was deemed to be for the protection of the vulnerable and grounded in the state interest in protecting life. The Court considered the state's interest in protecting life to be part of the fundamental concept of the sanctity of life. The Court also recognized a valid distinction between passive and active intervention in the dying process and stated that Canadian law accepts passive intervention, such as the withdrawal of life support, but does not accept active intervention, such as the injection of a lethal drug. Sopinka J. was of the view that the active/passive distinction was one which could be "persuasively defended."[23] The Court concluded that, in light of concerns about abuse and the difficulty in creating adequate safeguards, s. 241(b) was not arbitrary or unfair and therefore that it did not infringe s. 7 of the *Charter*.

21. *Supra* note 2 at 543.
22. *Supra* note 2 at 587–88.
23. *Supra* note 2 at 608.

In analyzing the alleged violation of section 12 of the *Charter*, the Court considered whether or not Ms. Rodriguez was subject to "treatment" and concluded that a mere prohibition by the state of certain actions did not constitute "treatment." Since the appellant could not in any way be subject to the justice system, s. 12 was deemed inapplicable.

With respect to the alleged violation of section 15, the Court summarily dismissed this portion of the argument in one page of its thirty-five page decision. Rather than addressing whether or not there had been a breach of s. 15, as alleged by Ms. Rodriguez and many of the intervenors,[24] Sopinka J. stated: "Since I am of the opinion that **any infringement** is clearly saved under s. 1 of the *Charter*, I prefer not to decide these issues in this case."[25]

The Court accepted that there was "probably" a violation of Ms. Rodriguez's s. 15 right not to be discriminated against on the basis of physical disability, but that in any event it was justifiable under section 1 of the *Charter*. In assessing section 1, the Court reviewed the three considerations in assessing proportionality of means to ends as specified in *Oakes* and concluded that: (1) s. 241(b) has a pressing and substantial legislative objective and the means chosen to achieve it were rational and fair; (2) in light of support for this type of legislation the government had a reasonable basis for concluding that it had complied with the requisite minimum impairment test; and (3) the balance between the restriction and the government objective was also met since there were no procedural safeguards which could have been relied upon to achieve the legislation's purpose. As a result, the s. 15 infringement was justified under s. 1 and the appeal was dismissed.

There were three minority decisions delivered by Lamer C.J.C., McLachlin J. and Cory J. McLachlin J.[26] addressed both the s. 15 and s. 7 arguments. In relation to s. 15 she stated that the case was not a section 15 case about discrimination and that treating it so may deflect equality jurisprudence from the true focus of s. 15, "to remedy or prevent discrimination against groups subject to stereotyping, historical disadvantage and political and social prejudice in Canadian society."[27] However, in relation to s. 7 she argued that, in light of *Morgentaler,* Ms. Rodriguez's right to

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24. See, *e.g.*, factum of the British Columbia Coalition of People with Disabilities at 4–12 and factum of the Right to Die Society of Canada at 3.
25. *Supra* note 2 at 613 [emphasis added].
26. L'Heureux-Dubé J. concurring.
27. *Supra* note 2 at 616 [citing *R.* v. *Swain*, [1991] 1 S.C.R. 933 at 992, *per* Lamer C.J.C.].

security of the person had been arbitrarily violated. She proposed that the effect of the distinction which makes suicide lawful and assisted suicide unlawful is to deny to some people the choice of ending their lives solely because they are physically unable to do so and that this prevents them from exercising autonomy over their bodies. McLachlin J. drew an analogy to the *Morgentaler* decision and concluded that since Parliament cannot justify the arbitrary legislative scheme found in s. 241(b), the law is not saved under s. 1 of the *Charter*. The solution proposed by McLachlin J. was that the *Code* be supplemented to require a Court order permitting assistance of suicide only where a judge is satisfied that the consent is freely given.

Lamer C.J.C. based his dissenting judgment solely on the infringement under s. 15 and did not address either ss. 7 or 12. He concluded that s. 241(b) treats physically disabled people differently from able-bodied people. The treatment is also unequal because it prevents people who are physically unable to end their lives unassisted from choosing assisted suicide when suicide is an option available to others. Lamer C.J.C. found that while the legislative objective of s. 241(b) was defensible, it was over-inclusive because those who are not vulnerable or who do not want the state's protection are affected. This over-inclusiveness was deemed to be unjustifiable under s. 1 of the *Charter*.

Lamer C.J.C. also suggested a cure for the situation by declaring the section of no force or effect but he suspended the declaration for one year to allow Parliament to amend the legislation, during which time a superior Court would have power to grant a personal remedy. The remedy, according to Lamer C.J.C., would have to be considered in light of the individual's context, and the guidelines as outlined by McEachern C.J. in the court below were approved.

Although Cory J. gave a separate set of reasons, he was essentially in agreement with the other two dissenting judgments except he found that both sections 7 and 15 were infringed. Cory J. also agreed with the conditions as outlined by the McEachern C.J.

Comment on Majority Judgment

There are a number of aspects of this case which are particularly troubling,[28] not the least of which is the personal tragedy of Sue Rodriguez and the choices she was forced to make in light of the decision. It is also a difficult decision because of the manner in which the whole issue was framed and the terminology which was used to describe what Ms. Rodriguez was seeking. The labels used to describe the phenomenon inevitably shape the form of the debate itself. Whether we refer to an act as "suicide," "euthanasia" or "mercy killing," each term carries the weight of values and assumptions which are inherent in the use of the label itself. The word "suicide" is not one which is generally thought of in a particularly positive light and our laws and legal decisions go to great lengths to distinguish suicide from other "acceptable activities." For example, the decision to refuse a blood transfusion is conceptualized as the exercise of an individual's right to autonomy and self-determination.[29] Why is the refusal of antibiotics by a terminally ill person suffering

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28. One of the issues which I find perplexing is the question: Why have most of the publicized Court cases involving "right to die" issues involved women? In Canada we have seen in recent years the cases of Nancy B., Mrs. Malette, Mary Astaforoff and, most recently, Sue Rodriguez. In the United States, the cases which come to mind include Nancy Cruzan, Karen Ann Quinlan, Janet Adkins, Patricia Diane Trumbell and the many women assisted by Dr. Kervorkian. One author attempts to explain the phenomenon as follows:

> As the sex that traditionally has been considered less authoritative and less capable of achieving autonomy, and has had greater difficulty in asserting itself, women symbolize the extent to which the movement towards letting people die on their own terms rather than be compelled to live on others' terms is a movement of the disadvantaged against the powerful. (B.M. Dickens, "From Letting Die to Inducing Death—The Legal Transition" (1991) 8 *Transplantation/Implantation Today* 13 at 20)

This, I believe, is too simplistic and it presumes that seeking Court approval is a challenge to authority, when it could more reasonably be considered as an acceptance of an authoritarian, hierarchical and male-dominated Court system. Perhaps women have been socialized to seek approval or assistance through legal channels rather than by taking the law into their own hands.

It may be that women are more conscious of the issues surrounding control of their bodies since there is so much legal regulation of a woman's reproductive capacity. When Sue Rodriguez asked: "Who owns my body?" she may have been expressing this desire for control.

Possibly, as well, women are accustomed to caregiving and are less comfortable with accepting the care of others when ill. Or perhaps women do not want the memories of family and friends to be those from the final stages of a debilitating disease? I do not know the answer to this question but I believe it is more than a mere coincidence that the majority of cases appear to involve women.

29. In *Malette* v. *Shulman* (1990), 72 O.R. (2d) 417 (C.A.), the court decided, based upon Mrs. Malette's right to bodily integrity and self-determination, that the blood transfusion given to her against her previously expressed wishes (via a "no blood products" card) amounted to a battery. Damages of $20,000 were upheld.

from pneumonia not considered suicide? The right to refuse treatment is one of the most fundamental rights in our society[30] even though it may inevitably result in death, but it is not considered "suicide."

The fundamental imperative, then, in examining any debate is to question the language and framing of the problem. Some of the alternatives to the legalization of assisted suicide which have evolved in the post-*Rodriguez* debate go to great lengths to avoid using the word "suicide." One such suggestion is that "simply ceasing to eat is a dignified way to die."[31] This solution is never described as "suicide," but surely this is what is contemplated since the person is taking her or his life voluntarily. Arguably, then, the administration of analgesics to alleviate pain and discomfort to people who are "simply ceasing to eat" should also be considered "assisting suicide."

The use of the word "euthanasia" also carries certain negative connotations. Without this pejorative label, the acts and decisions described would likely be viewed by most people as ones of benevolence and compassion. In Mi'kmaq communities in Nova Scotia, for example, when a person lay dying it was common practice to prepare for death with dignity and if death did not occur after a period of time cold water was poured on the person to hasten death as an act of kindness.[32] In the eyes of the Roman Catholic Church, however, such practices were seen as "euthanasia" or even "murder."[33]

Even more unfortunate is the fact that language choices create dichotomies which inevitably lead to dualistic thinking, such the distinction between "active" and "passive" euthanasia. The Supreme Court of Canada's reliance upon the distinction between active/passive euthanasia as one which is justifiable under law describes "passive" euthanasia as the withdrawal or withholding of treatment that allows a person to die, while "active" euthanasia requires a positive act, such as providing a lethal dosage of narcotics or a lethal injection, to hasten death. This either/or dichotomy, however, ignores the relationships and situations where the distinction does not appear to fit. "Passive" euthanasia, for example, may include turning off a respirator, withdrawing treatment, but it is, at the

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30. Perhaps with the exception of forced obstetrical intervention for pregnant women; see, *e.g.*, I. Grant, "Forced Obstetrical Intervention: A *Charter* Analysis" (1989) 39 U.T.L.J. 217 who argues that forced intervention amounts to a violation of a woman's right to bodily integrity and constitutes discrimination on the basis of sex.

31. G.L. Frederick, "An Easy Alternative to Assisted Suicide" *The [Toronto] Globe and Mail* (23 September 1993) A29.

32. "Mi'kmaq Spirituality" in *Mi'kmaq Past and Present: A Resource Guide* (Halifax: Nova Scotia Department of Education, 1993) at 10.

33. *Ibid.* at 10.

same time, an "act." Similarly, providing pain-killing medication which may hasten death has not been considered active euthanasia.[34]

The distinction has caused a great deal of confusion, especially among religiously affiliated hospitals across Canada. After the *Rodriguez*, C.A. decision, for example, the Archbishop of Vancouver sought to clarify the matter and condemned both "active and passive" euthanasia. The Archbishop's directive on health care stated that withdrawal of intravenous food and water is acceptable "if it causes physical risks and hardships, psychological burdens or economic and other burdens to caregivers."[35] This is confusing since the withdrawal of artificial nutrition and hydration has always been considered to fall in the category of "passive" euthanasia.

The distinction between active and passive euthanasia appears frequently throughout the medical and legal literature on the subject, but it has recently been subject to serious criticism due to its creation of false categories which are not clearly delineated.[36] As a result, the term "euthanasia" is now applied generically, and "most experts now reject the use of the term 'passive euthanasia'."[37] Similarly, others argue that since the underlying motive (*i.e.*, compassion) and the end sought (*i.e.*, the termination of suffering) are the same in both cases, there is also no moral distinction to be made between the two.[38]

One of the most persuasive criticisms of the active/passive distinction has been made by Professor Leslie Bender:

> The law seems to use similar justifications for its active/passive or killing/letting die distinctions. These rationales are legitimate only if we agree with three underlying assumptions: 1) laws and ethical principles must be

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34. It is widely accepted that if there is no other way to assuage pain, a doctor would be morally justified in administering a pain-killing drug to a patient whose death was imminent, even if she or he believed that the drug might have the incidental effect of hastening death. See P.G.D. Skegg, *Law, Ethics and Medicine: Studies in Medical Law* (Oxford: Clarendon Press, 1988) at 131 [citing Pope Pius XII, Allocution to the Italian Society for the Science of Anaesthetics, 24 February 1957, (1957) 49 Acta Apostolicae Sedis 129–47 and Archbishop D. Coggan, "On Dying and Dying Well: Moral and Spiritual Aspects" (1977) 70 Proc. Roy. Soc'y Med. 75 at 130].

35. S. Mertl, "Vancouver Archbishop Clarifies Stand on Euthanasia" *The [Halifax] Chronicle-Herald, The Mail-Star* (12 May 1993) A14.

36. See, *e.g.*, J. Rachels, "Active and Passive Euthanasia" in R.M. Baird & S.E. Rosenbaum, eds. *Euthanasia: The Moral Issues* (Buffalo, N.Y.: Prometheus Books, 1989) 45.

37. Council on Ethical and Judicial Affairs, *Decisions Near the End of Life* (American Medical Ass'n, Report: D (A-91), 1991) at 3.

38. J. Rachels, "Active and Passive Euthanasia" in J.E. Thomas, ed., *Medical Ethics and Human Life: Doctor, Patient and Family in the New Technology* (Toronto: Samuel Stevens, 1983) 291 at 295.

> designed for the "bad actors"; 2) each line must be firmly set to prevent a precipitous decline down the proverbial slippery slope; and 3) truly bad actors are in fact deterred by laws. I am unpersuaded by each. Although there are, and always will be, a number of bad actors, most of us do not fall in that category. If we write our laws or set our standards to curtail the actions and improper motivations of a small contingent of people on the margin, we may disempower the majority of us in the center from acting on noble and virtuous impulses. Physician aid-in-dying exemplifies this critique.[39]

Sopinka J. seems particularly concerned about bad actors and refers to the "macabre" trend seen in the United States with Dr. Kervorkian's suicide machine.[40] Most people, including proponents of assisted suicide, however, are also disturbed by this trend and many argue that allowing assisted suicide with strict procedural safeguards will prevent Kervorkian-type initiatives. Additionally, Sopinka J. refers to the French suicide guide *Suicide, mode d'emploi: histoire, technique, actualité*[41] which is similar to the best-seller *Final Exit* by Derek Humphreys of the Hemlock Society. While these types of suicide manuals were disturbing to the majority, a recent study in New York suggests that the number of suicides in the city did not increase after publication of the book. There was merely an increase in the method of suicide outlined in the manual.[42]

What, then, is the majority's rationale for maintaining this distinction between active and passive euthanasia? It appears to be a familiar one: the "slippery slope" argument. The typical "slippery slope" argument is that the long term consequences of social policy X will lead to the socially undesirable result Y. In this case, the decriminalization of assisted suicide (a so-called form of voluntary "active" euthanasia) will lead to involuntary active euthanasia of people who are disabled, vulnerable or those which society considers not worth keeping alive.[43] As has been articu-

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39. L. Bender, "A Feminist Analysis of Physician-Assisted Dying and Voluntary Active Euthanasia" (1992) 59 Tenn. L. Rev. 519 at 532.

40. Dr. Jack Kervorkian, a retired Michigan pathologist, developed a crude but effective suicide machine which enabled people to take their own lives. Kervorkian has assisted in twenty deaths since 1990, some of which involved individuals who were not terminally ill; see J. Persels, "Forcing the Issue of Physician-Assisted Suicide: Impact of the Kervorkian Case on the Euthanasia Debate" (1993) 14 J. Legal Med. 93.

41. C. Guillon & Y. Le Bonniec (Paris, France: A. Moreau, 1982).

42. P.M. Marzuk *et al.*, "Increase in Suicide by Asphyxiation in New York City after the Publication of *Final Exit*" (1993) 329:20 New Eng. J. Med. 1508 analyzed 1335 suicides one year before and one year after the release of *Final Exit*. The number of people using the plastic bag method jumped from 8 to 33 but there was no overall increase in the city's suicide rate.

43. Y. Kamisar, "Some Non-Religious Views Against Proposed 'Mercy Killing' Legislation" (1958) 42 Minn. L. Rev. 969 at 976 puts it this way: "[T]he danger [is] that legal machinery initially designed to kill those who are a nuisance to themselves may someday engulf those who are a nuisance to others."

lated elsewhere, however, the "slippery slope" is often invoked in order to express objection to the original social policy itself.[44] This is sometimes the case with objections to abortion which are based on a slippery slope that ends in infanticide. This may simply be another way of expressing the objection that abortion is an instance of killing an innocent human being. To put it more critically, slippery slope arguments are often used as scare tactics to prevent the implementation of a particular policy in the first place.

The decision of the majority also appears to be premised upon a "lack of consensus" on the issue of assisted suicide:

> . . . I am unable to discern anything approaching unanimity with respect to the issue before us. Regardless of one's personal views as to whether the distinctions drawn between withdrawal of treatment and palliative care, on the one hand, and assisted suicide on the other are practically compelling, the fact remains that these distinctions are maintained and can be persuasively defended. To the extent that there is a consensus, it is that human life must be respected and we must be careful not to undermine the institutions that protect it.[45]

Sopinka J. does not use Canadian statistics but he places reliance on the recent state referenda in Washington and New York[46] where the voters in both states rejected "aid-in-dying" legislation by votes of 54 percent to 46 percent.[47] What is not referred to in the Court's decision, other than through reference to the lack of procedural safeguards, is the concern of the citizens surveyed during exit polls that the initiatives could lead to abuse by physicians motivated by profit alone. Under a Canadian medical system this should be less of a concern and it is not likely that a "specialty" field would develop for doctors interested only in profiting from assisted suicide or "active" euthanasia. While voters narrowly rejected these initiatives, in the three months following the Washington vote, four states—Michigan,[48] New Hampshire,[49] Maine,[50] and Iowa[51]—introduced

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44. B. Williams, "Which Slopes are Slippery?" in M. Lockwood, ed., *Moral Dilemmas in Modern Medicine* (New York: Oxford University Press, 1985) 126 at 127.
45. *Rodriguez*, S.C.C., *supra* note 2 at 607–08; Sopinka J.'s comments about "a lack of consensus" from society opposing the state's right to regulate assisted suicide have been severely criticized in the popular media, see S. Fine, "Rodriguez Lost to Public Opinion" *The [Toronto] Globe and Mail* (2 October, 1993) A5.
46. Washington Initiative 119 (I-119) and New York Proposition 161 (P-161).
47. See J. Gross, "Voters Turn Down Mercy Killing Idea" *The New York Times* (7 November 1991) B16 and "Assisted Suicide Stays in the News" *Choice in Dying News* (New York, N.Y.: The National Council for the Right to Die, 1992) at 2.
48. H.B. 5415, Mich. 86th Legis., 2d Sess. (1992).
49. H.B. 1275, N.H. Legis., 1992 Sess. (1992).
50. Legis. Doc. 2257, Me. 115th Legis., 2d Sess. (1992).
51. S. File 2066, Iowa 74th Legis., 2d Sess. (1992).

legislation to legalize either assisted suicide or physician aid-in-dying for the terminally ill.[52] The Court also does not discuss the results of a 1991 U.S. nationwide opinion poll by *The Boston Globe* and the Harvard School of Public Health which revealed that almost two-thirds of Americans favoured both physician assisted suicide and active euthanasia for terminally ill patients requesting either.[53]

It is questionable, in fact, whether the Court is correct in concluding that most Canadians do not agree with the use of assisted suicide. According to the Canadian Medical Association, 60 percent of Canadian physicians who responded to a survey favoured some form of euthanasia.[54] Similarly, a survey of Alberta physicians showed that 51 percent favoured decriminalization of voluntary euthanasia which is requested by the patient. Ironically, however, the same survey showed that 55 percent rejected "physician assisted-suicide" which was seen as a "moral copout" because the doctor leaves while active euthanasia is more a medical act which a physician is better capable of controlling.[55] A national Angus Reid poll commissioned by the Right to Die Society of Canada showed that 34 percent of voters would react favourably to a candidate who expressed support for doctor-assisted suicide for terminally ill persons, 17 percent would react negatively and 47 percent said it would make no difference to them.[56]

The fact that euthanasia appears to be happening "in one form or another on a daily basis"[57] in Canada is not as reassuring to proponents of euthanasia as one might expect. Why should the law turn a blind eye to the activities of the medical profession? If it is occurring daily and Crown Attorneys are either unaware of it or are using prosecutorial discretion in not laying charges, this approach should be reflected in the current law so that medical professionals do not risk criminal prosecution and/or professional sanctions. By the same token, there should also be procedural safeguards in place to attempt to control potential abuses by physicians.[58]

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52. C.K. Smith, "What about Legalized Assisted Suicide?" (1993) 8 Issues L. & Med. 503 at 503.
53. R.A. Knox, "Poll: Americans Favour Mercy Killing" *The Boston Globe* (3 November 1991) 1.
54. "Euthanasia 'Daily' Event in Canada, Doctor Says" *The [Halifax] Daily News* (25 August 1993) 10; see also "Sue Rodriguez's Last Request" *The [Toronto] Globe and Mail* (2 October 1993) D6.
55. See J. Morris, "Most Alberta Doctors Oppose Legalizing Assisted Suicides" *The [Halifax] Chronicle-Herald* (30 September 1993) A18.
56. M. Smyth, "Poll Shows Leadership Sought on Euthanasia" *The [Halifax] Chronicle-Herald, The Mail-Star* (19 October 1993) A7.
57. "Euthanasia Daily Event in Canada," *supra* note 54.
58. The safeguards outlined by McEachern C.J. *supra* note 20 provide a good example.

Even if it could be definitively established that there is a lack of consensus, is this sufficient to justify the violation of Sue Rodriguez's rights under the *Charter*? McLachlin J. said "no" to this question:

> Nor do I agree with the fact that medically assisted suicide has not been widely accepted elsewhere bars Sue Rodriguez's claim. Since the advent of the *Charter*, this Court has been called upon to decide many issues which formerly lay fallow. If a law offends the *Charter*, this Court has no choice but to so declare.[59]

Sopinka J., however, seems to support the principle that judges must not readily impose or amend laws which the legislators have seen fit to ignore or delay. This notion[60] belies the fact that the Courts have pushed government into arenas which it avoids because of a perceived lack of consensus or, more significantly, because of the potentially divisive nature of the subject within the political parties themselves.[61] In addition to remedying legislative omissions, Courts have also removed legislative obstacles to, for example, equality rights under the *Charter*. This approach was displayed in *Morgentaler* where the Supreme Court of Canada struck down the abortion provisions contained in the *Code* because the effect of the provisions was to deny or delay therapeutic abortions and thereby endanger the security interests of some women. This violated a woman's section 7 security of the person rights and did not comport with the principles of fundamental justice. In the view of McLachlin J. the decision in *Morgentaler* was dispositive of the issues on appeal in this case as well.

Conclusion

The Supreme Court of Canada concluded that the assisted suicide provisions of the *Code* deprived Sue Rodriguez of autonomy over her person and caused her psychological and emotional stress. This infringed

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59. *Rodriguez*, S.C.C., *supra* note 2 at 617.

60. "[N]ot to yield to spasmodic sentiment, to vague and unregulated benevolence" as articulated by B.N. Cardozo, *The Nature of the Judicial Process* (New Haven: Yale University Press, 1949), quoted in *Re President & Directors of Georgetown College, Inc.*, 331 F.2d 1010 at 1017 (D.C. Cir. 1964) (Burger J., concurring in dissent), *cert. denied* 377 U.S. 978 (1964).

61. The new federal Justice Minister's original response to the call for a Parliamentary re-examination of assisted suicide is not particularly reassuring in suggesting that the Senate study the issue; see B. Cox, "Senate Should Re-Examine Euthanasia—Rock," *The [Halifax] Chronicle-Herald* (24 December 1993) A14. Since the death of Sue Rodriguez, however, the Minister has agreed that the issue should be "reconsidered by Parliament and that a potential change to the law should be put to a free vote of MPs"; see H. Winsor & M. Cernetig, "Rodriguez Death Puts Focus on Ottawa" *The [Toronto] Globe and Mail* (15 February 1994) A1.

upon her s. 7 interests but was found to be in accordance with fundamental justice as reflected in the fundamental concept of "sanctity of life." The s. 15 violation, which "probably" occurred, was deemed justifiable in light of the state's s. 1 interests. The case demonstrates that the hurdle for individuals who are litigating rights violations under the *Charter* is not the proof of the violation itself but the difficult proportionality test under s. 1.

In spite of its balancing of interests and discussion about consensus, the majority appears to simply have disagreed, fundamentally, with what Ms. Rodriguez was requesting. The following comment of Sopinka J. seems particularly revealing:

> The appellant suggests that for the terminally ill, the choice is one of time and manner of death rather than death itself since the latter is inevitable. I disagree. Rather it is one of choosing death instead of allowing natural forces to run their course. . . . Even when death appears imminent, seeking to control the manner and timing of one's death constitutes a conscious choice of death over life.[62]

In the final analysis, though, in choosing to end her life with assistance Sue Rodriguez did take control over her right to autonomy and bodily integrity. In so doing, she may have helped move the government towards what she spent the last years of her life fighting for: changes in the law to allow assisted suicide for the terminally ill. For this she will long be remembered.

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62. *Supra* note 2 at 585–86.