

Euthanasia: the debate continues

Euthanasia

by Bob Lane

Part One: Introduction

I started to write "the Sue Rodriguez case has reminded us all...." and then I realized how wrong that is. It is not the Sue Rodriguez "case"- it is Sue Rodriguez who has reminded us all of our own mortality and our need to think carefully about the kind of society we want to live and to die in. I knew Sue Rodriguez only through the media, heard her speak so eloquently and painfully in support of what she believed in, watched as her strength was sapped by the devastating disease (amyotrophic lateral sclerosis), and was moved by her clear thought and her bravery as a person facing death. Here was a woman who acted on her beliefs with courage and tenacity and whose grace has enriched us all.

She challenged us to think about the difference between what our law of the land says and what our people say. Her death, and her life, say to us "think carefully about these matters of life and death for they are not academic and distant but are a necessary part of everyone's existence."

In this paper I want to focus on the controversial and difficult issue of assisted suicide or euthanasia. First some ground clearing and preparation: "euthanasia" means "a gentle and easy death" and has come to mean "the good death of another" or "mercy killing." It is controversial because it brings into focus and conflict some very powerful and competing values. Certainly one of society's traditional attitudes, expressed morally, legally, philosophically, and religiously is that human life merits special protection. In fact, some claim that human life is an absolute value. For them the taking of human life then becomes a wrong even in the case of voluntary euthanasia. And for some this perceived moral wrong should be prohibited by the full force of the law. The clash here is between protection of human life and the right to decisional autonomy, and as well raises the question of the extent to which the criminal law should be used to enforce particular moral positions. And the conflict is one of absolutism versus consequentialism. Are some acts absolutely morally prohibited, or do we assess the goodness or badness of acts based upon their consequences?

More ground clearing: one of the bad arguments sometimes used against euthanasia comes from an oft-cited article written in 1949 by Leo Alexander. Alexander was a judge at the Nuremberg trials after World War II who employed a classic slippery slope argument (a fallacy that occurs when the conclusion of an argument rests upon the claim that a certain event will set off a chain reaction leading in the end to some undesirable consequence, and there is not sufficient reason to think that the chain reaction will actually take place) to suggest that any act of mercy killing inevitably will lead to the mass killings of unwanted persons. He wrote: "The beginnings at first were a subtle

shifting in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually, the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans." Critics of this position point to the fact that there is no relation at all between the Nazi "euthanasia" program and modern debates about euthanasia. The Nazis, after all, used the word "euthanasia" to camouflage mass murder. All victims died involuntarily, and no documented case exists where a terminal patient was voluntarily killed. The program was carried out in the closest of secrecy and under a dictatorship. One of the lessons that we should learn from this experience is that secrecy is not in the public interest.

Advances in medical science have also had a stunning effect on social policy. Medical advances and technology have made it possible, for example, for us to cure pneumonia in a person suffering from terminal cancer by administering antibiotics; before this discovery that patient would have died of pneumonia. Cardiac arrest and kidney failure are no longer fatal with the appropriate technological intervention. AIDS has intensified the debate over assisted suicide. Palliative care has improved, and it is rare now to find a physician who is worried about giving too much of a painkilling narcotic to a suffering patient on the grounds that it may be habit forming. In the midst of all these changes in the art of medicine and care-giving there remains the moral question of, not what can be done, but what should be done?

Euthanasia is discussed in churches, philosophy classes, pubs, street corners, homes, medical societies, nursing classes, hospices, journals, and in legislative assemblies across the land. There is no shortage of information and opinion. Anyone interested in obtaining more information will find an abundance of books and articles in the Malaspina University-College library. I suggest that you start with the Law Reform Commission of Canada's Working Paper 28 (euthanasia, aiding suicide and cessation of treatment) from 1982. This paper reviews the relevant issues of law, medicine, religion, and societal attitudes in a readable format, and after reviewing the situation makes several recommendations. Though a dozen years old now, it still provides an excellent overview of the arguments.

Here is the question: is it possible for us as a society to recognize and assert the fundamental importance of life while at the same time recognizing and asserting the right of a terminally ill patient to die with dignity?

Part Two: The Law

"There is no record in Canadian case-law of a single conviction of a doctor for having shortened the life of one of his or her terminal patients by administering massive doses of pain-killing drugs." (Law Reform Commission, 1982) [A news report on June 22, 1996 reads "Toronto Dr. Maurice Genereux ... became the first doctor in Canada to be charged with assisting a suicide" *The Weekend Sun, Vancouver*] [also consult the [Dr. Nancy](#)

[Morrison](#) case.] [On November 19, 1998 that case was stopped by the courts; see also [crown.htm](#).]

Given that there have been few problems in case law, why should we consider changing the law?

One reason for considering change is that prosecution is possible for anyone assisting another in committing suicide, and the **Criminal Code of Canada** has a penalty of up to fourteen years for the act. (see sections 205-223) There is, as it stands, no degree of predictability for patients or physicians in how the courts will rule on the general rules established in the Criminal Code. Yet another concern is that according to recent polls (1989) some 77% of Canadians disagree with the law against assisted suicide. And yet another reason for considering legal changes to the Code is that many people believe that assisted suicides are being carried out now on humanitarian grounds even though the law forbids such action. It is often the case that laws lag behind society's attitudes, beliefs, and moral arguments.

The Criminal Code of Canada reads: (Martin's Annual Criminal Code, 1994)

222. (1) A person commits homicide when, directly or indirectly by any means, he causes the death of a human being.

(2) Homicide is culpable or not culpable.

(3) Culpable homicide is murder or manslaughter or infanticide.

224. Where a person, by an act or omission, does anything that results in the death of a human being, he causes the death of that human being notwithstanding the death of that human being might have been prevented by resorting to proper means.

In addition it is no defense to point to the fact that a person has requested to be killed: "No person is entitled to consent to have death inflicted upon him, and such consent does not affect the criminal responsibilities of any person by whom death may be inflicted upon the person by whom consent is given," which seems to mean that no one has a right to consent to have death inflicted on him or her. In addition, if a person causes the death of another, the consent of the deceased does not provide the person who caused the death a defense to criminal responsibility.

Section 217 says, "Every one who undertakes to do an act is under a legal duty to do it if an omission to do the act is or may be dangerous to life." But if one contrasts that with Section 45 which allows for protection to surgeons, one finds that the interpretation in case-law (Nancy B. V. Hotel-Dieu de Quebec, 1992) of that section reads, "The conduct of a physician in stopping the respiratory support treatment of his patient, is not unreasonable within the meaning of this section and would not attract criminal liability."

It seems then that the law is less than clear and consistent and that some changes to the Criminal Code would be useful.

A more basic problem however has to do with the use of criminal law to enforce moral positions held by some members of society. The challenge for us in Canada today is to allow for sometimes competing and strongly held moral principles in the euthanasia debate. On the one hand we should value autonomy and on the other we should value life. The Law Reform Commission Working paper of 1982 puts it this way: (p.37): "Law must also recognize, as it now does implicitly, the principle of personal autonomy and self-determination, the right of every human being to have his [her] wishes respected in decisions involving his [her] own body. It is essential to recognize that every human being is, in principle, master of his [her] own destiny. He [She] may, of course, for moral or religious reasons, impose restrictions or limits on his [her] own right of self-determination. However, these limits must not be imposed on him [her] by the law except in cases where the exercise of this right is likely to affect public order or the rights of others."

In 1972, for example, the criminal offense of attempted suicide was repealed. Laws should, in general, allow for the maximum expression of individual moral and religious beliefs, and should not be used to restrict or limit individual autonomy as long as that expression of autonomy is not harmful to others. Thus, even if one is religiously opposed to euthanasia, it does not follow that one has a right to insist, through the criminal law, that others follow one's religious beliefs. Dr. Gifford-Jones, writing in *The Ottawa Citizen*, October 6, 1989, puts this point strongly: "I'm sure Canadian physicians will find a host of moral, ethical and religious reasons to damn... active euthanasia. Some would agree with it in the privacy of the doctors' lounge. But publicly they will not have the courage to say so. Current attitudes on ethical issues in this country worry me and they should concern others who believe in personal privacy and freedom of choice. I'm tired of listening to moralists who believe they have a profound understanding that the rest of us don't.. And that their moral code, having the stamp of the Almighty, is beyond reproach."

James Rachels, an American philosopher, in an influential paper titled "Active and Passive Euthanasia" writes: "Fixing the cause of death may be very important from a legal point of view, for it may determine whether criminal charges are brought against the doctor. But I do not think that this notion can be used to show a moral difference between active and passive euthanasia. The reason why it is considered bad to be the cause of someone's death is that death is regarded as an evil - and so it is. However, if it has been decided that euthanasia - even passive euthanasia - is desirable in a given case, it has also been decided that in this instance death is no greater an evil than the patient's continued existence. And if this is true, the usual reasons for not wanting to be the cause of someone's death simply do not apply."

Is there a difference, do you think, between a person who, at a dying person's request, prepares a poison and leaves it on the bedside for her to take, and a person who helps the patient to drink it or who administers it directly at the request of a dying person who is

unable to take it herself? Is there, in short, a real distinction between killing and letting die?

Part Three: Killing and Letting Die

Sue Rodriguez and Karen Ann Quinlan have done more than ethicists, doctors, and moralists to rivet public attention on the legal and moral aspects of euthanasia. In 1994 Sue Rodriguez chose to die. In 1975 Karen Ann Quinlan, for reasons still unknown, ceased breathing for several minutes. Failing to respond to mouth-to-mouth resuscitation by friends she was taken by ambulance to a hospital in New Jersey. Physicians who examined her described her as being in "a chronic, persistent, vegetative state," and later it was judged that no form of treatment could restore her to cognitive life. Her father asked to be appointed her legal guardian with the expressed purpose of discontinuing the respirator which kept Karen alive. After some delay the Supreme Court of New Jersey granted the request. The respirator was turned off. Karen Ann Quinlan remained alive but comatose until June 11, 1985, when she died at the age of 31.

These cases and others like them demand that we think carefully through a number of conceptual issues. *What is a person?* What is death? How does the difference between active and passive function in arguments for and against euthanasia? Is there any difference between killing and letting die?

The question of personhood bears on euthanasia as on abortion debates. What criteria should be used to determine personhood? Is it just a matter of species? That is, are all and only biological humans persons? That does not seem right because for the theist, it must be the case that God or gods, angels and so forth are also persons in the moral sense. Further, if we do discover some alien race on a distant planet would their lack of a certain DNA string be sufficient to say that they were not persons, capable of making decisions and acting on them? And in fact, here on our own planet is there not a strong argument for treating the Great Apes as persons, as a recent book advocates? The importance of this conceptual issue is just that if we could establish the criteria for personhood then those qualifying enjoy the same rights as any other patient. It seems right to say, for example, that the person Karen Ann Quinlan died sometime in 1975 though her body survived until 1985.

It used to be that death meant the termination of breathing. Later physicians defined death as a total stoppage of the circulation of blood. This definition served well until recent technology made it possible to sustain respiration and heartbeat indefinitely, even when there is no brain activity. The need for still viable organs for transplantation has resulted in a refined definition based on brain wave activity.

It has long been held that the distinction between active and passive euthanasia is crucial for medical ethics. The idea is that although it may be permissible in some cases to withhold treatment and allow a patient to die, it is never permissible to take any direct action to bring about that death. North American Medical Associations base their ethical conduct on this distinction, as in this statement by the American Medical Association:

"The intentional termination of the life of one human being by another ... is contrary to that for which the medical profession stands...The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family."

This so-called distinction between active and passive was challenged by the philosopher James Rachels in a paper first published in 1975 in the *New England Journal of Medicine*. In that paper Rachels challenges both the use and moral significance of that distinction for several reasons. First, he argues, active euthanasia is in many cases more humane than passive; second, the doctrine leads to decisions concerning life and death being made on irrelevant grounds; and third, the doctrine rests on a distinction between killing and letting die that itself has no moral significance. Rachels urges doctors to reconsider their views. He writes: "To begin with a familiar type of situation, a patient who is dying of incurable cancer of the throat is in terrible pain, which can no longer be satisfactorily alleviated. He is certain to die within a few days, even if present treatment is continued, but he does not want to go on living for those days since the pain is unbearable. So he asks the doctor for an end to it, and his family joins in this request."

"Suppose the doctor agrees to withhold treatment...The justification for his doing so is that the patient is in terrible agony, and since he is going to die anyway, it would be wrong to prolong his suffering needlessly. But now notice this. If one simply withholds treatment, it may take the patient longer to die, and so he may suffer more than he would if more direct action were taken and a lethal injection given. This fact provides strong reason for thinking that, once the initial decision not to prolong his agony has been made, active euthanasia is actually preferable to passive euthanasia, rather than the reverse."

Is killing someone worse than letting them die? Rachels asks us to consider these two cases: In the first Smith will gain a large inheritance if anything should happen to his young cousin. One evening while the youngster is taking a bath, Smith sneaks into the bathroom and drowns the child, and then arranges things so it will look like an accident. In the second parallel case, Jones will gain a large inheritance and plans to drown his cousin, but as he enters the bathroom Jones sees the child slip and hit his head and fall face down in the water. Jones watches and does nothing. Now, Smith killed the child while Jones "merely" let the child die.

Rachels' question: did either man behave better, from a moral point of view? "If the difference between killing and letting die were in itself a morally important matter, one should say that Jones's behavior was less reprehensible than Smith's. But does one really want to say that?"

If the crucial issue in the euthanasia debate is the intentional termination of the life of one human being by another, then how can it be consistent to forbid mercy killing and yet deny that the cessation of treatment is the intentional termination of a life? What is the cessation of treatment if it is not the "intentional termination of the life of one human

being by another"? The so-called distinction between active and passive does not provide a useful moral distinction.

Part Four: Deliberations

Courts in the United States and Canada have upheld the right of competent adult patients to refuse life-preserving medical treatment. The famous *Cruzan v. Missouri Health Services* case went to the United States Supreme Court in 1990, and the court ruled that even if the patient is not competent to make the decision to stop treatment it may be made by a surrogate acting according to the patient's wishes. One consequence of such rulings is the increased interest in so-called Living Wills.

Living Wills as yet have no legal status in Canada, but efforts are being made to allow for people to express their wishes in the form of advance directives to physician, next of kin, and lawyer as to the treatment desired when the situation arises.

In the meantime, we need to consider carefully the arguments for and against Voluntary active euthanasia. And after that deliberation is complete, the second part of the debate will centre on what we want the law to allow or prohibit. Euthanasia raises two basic moral issues that should be distinguished: the morality of euthanasia, and following that, the morality of euthanasia legislation.

Arguments for Voluntary Active Euthanasia

- Individuals have the right to decide about their own lives and deaths.
- Denying terminally ill patients the right to die with dignity is unfair and cruel.
- The golden rule requires that we allow active euthanasia for terminally ill patients who request it in certain situations.
- People have the right to die with dignity and lucidity.

The words of two recent letter writers (*Vancouver Sun*, Feb. 23) add another dimension to the discussion, reminding us again of the human dimension, the personal, lived, existential component of the decision. Gayle Stelter writes, "For almost seven years I have been living with cancer, mostly joyously and gratefully, but gradually seeing the disease encroaching relentlessly on my once healthy body. Throughout these years, I have thought long and hard about death and I've discovered that it's not the prospect of death itself that is so frightening, but the process of dying. So to give myself courage, I have held an option in reserve. When I can see no quality ahead, when I am capable of bidding my loved ones a coherent farewell, when I am still in control of my resources, I will enlist someone's help to speed me on my journey. ... For those of us who may choose to leave while there is still an element of control, of coherence, may we be fortunate to have a friend, a loved one, a health professional who will use their gifts in order that we may be excused. To deny such expert guidance in this last rite would be both heartless and inhuman."

Or, listen to Susan Hess from Vancouver, "I have multiple myeloma...a rare bone marrow cancer...[that] destroys the blood, bones, immune system, kidneys and sometimes liver and spleen. The worst of it is the disintegration of the skeleton...Unless one is lucky enough to die of sepsis first, the death is long and agonizing. The act of sitting up can fracture the vertebrae and lifting the dinner tray can fracture both forearms. Who deserves that? For what principle?"

Arguments against Voluntary Active Euthanasia

- Active euthanasia is the deliberate taking of a human life.
- We cannot be sure that consent is voluntary.
- Allowing active euthanasia will lead to abuses.
- There is always the possibility of mistaken diagnosis, a new cure, or spontaneous remission.

The philosopher J. Gay-Williams has argued against euthanasia in this way: "I hope that I have succeeded in showing why the benevolence that inclines us to give approval of euthanasia is misplaced. Euthanasia is inherently wrong because it violates the nature and dignity of human beings. But even those who are not convinced by this must be persuaded that the potential personal and social dangers inherent in euthanasia are sufficient to forbid our approving it either as a personal proactive or as a public policy." ("The Wrongfulness of Euthanasia," 1979)

Everyone has heard of the Netherlands experiment with legalized euthanasia, and I recommend Barney Sneiderman's paper "Euthanasia in the Netherlands: A Model for Canada?" published in *Humane Medicine*, April, 1992, for a sensitive and intelligent review of the Dutch approach. Sneiderman argues that we must provide the best care, the best pain control, but when the patient is still plagued by unbearable and unrelievable suffering and asks for release then "we will abide by your request because there is no other way that we can show you our compassion."

Recommendations for now

I believe that there are some circumstances when euthanasia is the morally correct action. I also understand that there are real concerns about legalizing euthanasia because of fear of misuse and/or overuse and the fear of the slippery slope leading to a loss of respect for the value of life. We do need to proceed with caution. We need full and open discussion, improvements in research, the best palliative care available, and above all we need to think about the topic together. Our best approach at this time may be to modify homicide laws to include motivational factors as a legitimate defense. Just as homicide is acceptable in cases of self-defense, it could be considered acceptable if the motive is mercy. Obviously, strict parameters would have to be established that would include patients' request and approval, or, in the case of incompetent patients, advance directives in the form of a living will or family and court approval.

Euthanasia is homicide. Some homicides are justified.

Euthanasia

by Richard Dunstan

"The Latimer case raises questions about Canada's rigid murder laws," read the headline in Canada's Weekly Magazine (**Maclean's**, Nov. 28, 1994).

Say what?

Robert Latimer, nearly everyone remembers, is the Saskatchewan farmer who in 1993 killed his profoundly and painfully handicapped 12-year-old daughter with carbon monoxide. He was found guilty of second degree murder, which carries a minimum prison term of life with no parole for 10 years. Support and sympathy for Latimer has poured in from all parts of Canada. And **Maclean's'** idea of how to mend matters is to give Canada more flexible murder laws.

On one level, it is entirely unfair to begin a paper on euthanasia by citing the Latimer tragedy. So let me be clear: I am *not* suggesting that Tracy Latimer's death is what the mainstream euthanasia debate is all about. Responsible advocates of "death with dignity" do *not* support actions like those of Bob Latimer, who killed without consultation or safeguards a person who did not and could not consent. Instead, they are looking for legal relief for people like Sue Rodriguez, whose lucid adult decision was to ask for help in committing suicide when her battle with amyotrophic lateral sclerosis became too much to endure - help she in fact received, though illegally, at her death in 1994.

I am suggesting, however, that euthanasia supporters are stuck with the Latimer case whether they support it or not. For follow what route you will, the logical or the merely sociological, the high road approach to euthanasia leads right down to Tracy Latimer, and in a hell of a hurry.

Logically, if death is good for Sue Rodriguez, why not for Tracy Latimer? She seems to have been suffering just as much. Why should she be denied escape just because she couldn't understand what ailed her, let alone consent to euthanasia? And as for consultation and safeguards, with whom could Bob Latimer have consulted? He could no more have gotten legal permission for euthanasia than Rodriguez did. Why should Tracy be held hostage to that?

Sociologically, if media coverage is any indication, there has been just as much of an outpouring of public support for Latimer as for Rodriguez (though, to be fair, he has also gotten some criticism from the public that she did not get).

This is no "slippery slope" argument - it is more of a precipice. Start killing people (or helping to kill them) for "good reasons," and over you drop. That is why they make murder laws "rigid."

Enough of the soapbox for now. I have made the euthanasia debate sound very simple, because in some crucial respects I think it is. But of course, in many ways it is not simple at all. And it is time now to look at some of those ways.

Some of the complexities in the euthanasia debate stem from new factors - developments in medical technology, in ethical reasoning, in legal hazards - and we will get into those in a minute. But two of the most serious complicating factors are as old as can be, and as relevant as ever.

First, the factor of pain and suffering. I have been speaking as if life, in the sense of survival, were always and completely a blessing, but of course that is not always the case. Life can become so unpleasant and so hopeless that virtually no one would wish to continue it, and the opponent of euthanasia must face up to this fact honestly. Suffering can take many forms, physical, mental and emotional. Not all of these are relevant to euthanasia - I have not heard anyone suggest, for example, mercy killing for the clinically depressed - but many are, in particular physical agony and the emotional despair of extreme disability.

Second is the factor of suicide. People have always killed themselves, for reasons that seemed good to them, and it has long been recognized that laws against suicide serve little or no purpose. The debate on that point effectively ended in Canada in 1972, with the decriminalization of suicide, but the issue remains a live one with respect to euthanasia because it is plausibly pointed out that, if I have a legal right to commit suicide, and I am physically unable to do so unaided, it seems unfair to prosecute someone who helps me.

Suffering and suicide are perennial factors, but today's conditions have added a host of other complications. In particular, we have medical techniques that can preserve life far beyond what would have been possible in the past. All this is cause for gratitude; I myself have three bright, healthy granddaughters who would not be alive today apart from lifesaving technology and procedures developed well within my lifetime. In other cases, the value is less obvious: "life" of a sort can be preserved by artificial means when everything that makes life worth living is gone.

One consequence of this sort of medical development is that it is now possible, indeed almost common, to die in pieces. Where once brain function, heartbeat and breathing would have failed at almost the same time, the latter two can now be maintained when the brain is finished. So the question arises, what counts as death? And *who* counts as alive? If the euthanasia debate is about mercy killing, how long can we continue to insist that there is somebody there to be killed?

That last question, too, can be expanded well beyond the issue of timing of death, to other issues often referred to collectively as "quality of life." Is a life of unrelieved suffering worth living? Is a terminally ill person really "alive" in the fullest sense? What about someone who is not merely terminal but actively engaged in dying? What about someone whose cognitive life is over while their bodily processes continue?

Personhood

One way that is sometimes used to deal with the question of the end of cognitive life is a redefinition of personhood. My friend Bob Lane, in his adjoining paper, suggests that being a "person" is not merely a matter of one's status as a human being, since (to the extent that one believes in them) it seems reasonable to consider God, angels, extra-terrestrials and perhaps even Great Apes as persons. Thus, he suggests, we need to look for appropriate criteria for determining personhood and ask ourselves whether someone in, for example, a persistent vegetative state meets those criteria.

Euthanasia itself is also far more than a simple moral "yes" or "no." Some distinguish between "active" and "passive" euthanasia, between mercy killing and deliberately letting someone die. Others, ranging from Lane in the adjoining paper to Pope John Paul II in 1995 encyclical *The Gospel of Life* (section 65), reject the idea that there is any moral difference between the two, since in either case a decision is being made to bring about someone's death. There is also what might be called "secondary euthanasia:" sometimes a patient dies the sooner because of the use of painkilling drugs or because doctors discontinue or do not begin a life-prolonging treatment which seems useless or cruel. In these cases a speedy death is not (in theory) the purpose of the decision, but it happens anyway.

Finally, all these complexities have produced a difficult legal situation for medical personnel. Doctors could theoretically face prosecution under the Criminal Code of Canada for doing, ceasing to do, or not beginning to do some of things discussed above. This seldom if ever happens (*Euthanasia, Aiding Suicide and Cessation of Treatment*, Law Reform Commission of Canada Working Paper 28, 1982, p. 8). But the theoretical possibility is an added burden on doctors in an already difficult situation, and it is a principle of natural justice that the person should be able to know in advance whether what he or she is doing will be subject to legal penalties.

One of the best-known attempts to deal with all these factors is the system now in place in the Netherlands. There, court decisions (not legislation, which still outlaws even voluntary euthanasia) have supported Royal Dutch Medical Association policy which permits euthanasia for competent patients who persistently request it, and who are experiencing unbearable suffering that cannot otherwise be relieved. Euthanasia is normally administered, via a lethal drug, by family doctors, who are required to consult with another physician beforehand and to report the case to the coroner afterward.

A 1990 study found that 2,700 of the 129,000 deaths in the Netherlands that year were by euthanasia (including assisted suicide) that met the RDMA and court criteria. Another 1,000 cases of lethal injection - .8% of the deaths in the Netherlands that year - did not meet the criteria. Of these, about 600 were cases where patients had made their wishes known, but not in the manner required by RDMA policy; in the other 400 - all incompetent patients - no wish to die had been expressed.

The same study found that only 28% of the cases which did meet euthanasia criteria had been reported as required, though the percentage reported has been growing as policies are clarified. (All information on the Dutch situation is from Barney Sneiderman and Joseph M. Kaufert, eds. , *Euthanasia in the Netherlands: A Model for Canada?*, Legal Research Institute of the University of Manitoba, 1994, chapters 1 - 3.)

Though I do not in the least support the Dutch approach, and though I will be arguing for an entirely different and much more conservative policy, I mention it here only for its obvious interest to the euthanasia debate, and not to hang it (so to speak) for its obvious shortcomings in living up to its objectives. For any approach to the horrendous problems of human suffering involved in the euthanasia discussion, including my approach, will have similar shortcomings. Tracy Latimer dead by her father's hand is to me an altogether unacceptable outcome of the Bob Latimer approach; but Tracy Latimer alive in the condition she was in (let alone what she would have faced as her condition deteriorated in the future) is hardly cause for celebration either. Neither supporters nor opponents of euthanasia have any panaceas to offer, and neither side has the right to demand a panacea from the opposite side. All we can do is our best in an imperfect world, and in my view our best is to maintain the scarceness of life, even in horrendous circumstances, as the essential bulwark to all other rights, privileges and benefits human beings (or most of them) can enjoy on earth.

Does this mean, then, that life is an absolute value? In a word, no; there is precious little support for that concept from either religious or secular sources - if there were, religions would not honor their martyrs, not nations their war dead. But we are talking about law here, and at law, *other people's* lives are generally treated as having absolute value. Oh, there are exceptions: the lawlessness (Geneva Conference notwithstanding) of war; the war-in-miniature of self-defense against street crime; capital punishment; abortion. But even these exceptions are shrinking in our society nowadays (except for abortion, which tends to be regarded as a "life" issue mainly by its opponents). Canada has abolished capital punishment. War is less condoned and more avoided than formerly; Canadian public opinion tends to oppose any involvement by our armed forces in actual fighting. Even self-defense is harder to use as a legal plea than it once was. And all with good reason: enforcing and following the rigid rule "keep your hands off other people's lives: is the primary task of a civilized government; back away from that, and no other government service - health care, highways, pensions or passports - will be of much value for long.

So. How does the "other people's lives" principle apply to the euthanasia debate? It applies by specifying that anything resembling euthanasia can be justified only on the basis that the subject is not *other* than oneself, or that the subject is not a *person*, or that his or her *life* is not truly at stake.

The second of these alternatives, however, that the subject is not a person, seems extremely dangerous, not to say catastrophic. References to God or Great Apes may show us that personhood is not such a simple matter as we may once have supposed. But while this argument may give us reason to expand the definition of personhood beyond human

beings, it is not at all clear that it gives us even a theoretical basis to shrink the definition so as to exclude some human beings. And as a practical matter, says the Law Reform Commission (pp. 33-34), "History reveals too clearly the dangers of such a categorization ... history is filled with cases in which witches, the mentally ill, various ethnic groups and entire races have been eliminated after having first been characterized as non-persons... [we] must firmly disagree that any such distinction between person and non-person should be applied to living humans."

That the subject is not alive, however, or that life is not truly at stake, is in many cases a valid approach. There seems to be no reason not to accept the advances of medical science with respect to the determination of death. Death is now often measured by the absence of brain waves.. If someone wants to argue against that policy on the basis that brain waves might unexpectedly (or even miraculously) resume, I can only point out that the same argument can be made about breathing or heartbeat. That would mean we could never bury anybody. And, of course, if we accept that someone is dead, the moral issue of killing him or her cannot arise.

Life is also not truly at stake when a patient's death is inevitable and so imminent that a course of treatment can make no significant difference. In such a case, other considerations may properly determine, for example, the dosage of painkiller; killing the pain becomes the crucial issue, and if that hastens an already imminent death somewhat, so be it. But this criterion must be used with caution: regardless of the imminence of death, if you *set out* hasten death, you are making a "significant difference."

Finally, the question of whether the proposed subject is somebody else, or oneself. Tracy Latimer was clearly "somebody else" to her father (as well as being clearly a person and clearly alive, however far she might have fallen short of the ideal in both respects). Even most euthanasia supporters would agree that Bob Latimer's action was inappropriate, for no one could wish to universalize the principle he acted on: that some person may decide unilaterally to end another's life. It might be argued, of course, that a responsible review process should be in place to make it possible for someone like Tracy, who could not give consent, to be put out of her misery. But with no chance to check out Tracy's wishes, what could such a "death committee" do except weigh the value of Tracy's painful life against yours or mine? Nothing could give them the right to do that. For a committee, as surely as for her father, Tracy Latimer was "somebody else" whose life no one might rightfully take.

We come now to the best case for euthanasia: the case in which the patient is not "somebody else" - where, as with Sue Rodriguez, a lucid, competent adult patient chooses to die. We have already agreed there is no point in a law which would forbid her to commit suicide if physically able to do so. Beyond that, I would also agree that as a competent adult she would have a right to refuse any medical treatment she might choose, for any reason at all, including the desire to die. So why, one might ask, should she be refused help - legally permissible help - in killing herself if she wants?

The answer, in part, is that even the right to unassisted suicide is not so simple as it has been made to sound. True, you cannot be prosecuted under the Criminal Code of Canada for attempting suicide. But suicide is still regarded at law as a great evil, and the police, if they hear of a proposed suicide will intervene as forcefully as necessary to prevent it. This is partly because the police, like the rest of us, assume that those who attempt suicide aren't in fact following their own true and considered wishes, and partly because the police consider failure to intervene in a known suicide attempt as "aiding, abetting or counseling" suicide, which is still prohibited by the Criminal Code of Canada even though suicide itself is not. (Nanaimo RCMP spokesman, 1995, telephone interview.)

Now none of this may appear to apply to Rodriguez, who obviously knew her own mind and had an impressive reason for wishing to end her life. Yet we are making rules here to cover all cases, and consent can be a slippery concept. Do we have competent consent? Uninfluenced consent? Present consent? Last year's consent (preserved in writing)? Presumed consent? Consent that could not change tomorrow - if there is a tomorrow? Consent will be suspect in a significant number of cases, and while it would be easy to design a process to separate the Sue Rodriguezes from people getting ready to jump off the Lions Gate Bridge, it would be impossible to design a process that would separate the Sue Rodriguezes from the not-quite-Sue Rodriguezes. Any defect in consent will turn even this, the very best case for euthanasia, into a matter of "other people's lives." A rigid, absolutist "hands off" is the only appropriate rule.

Must everyone, then, just continue to suffer until death comes at last, after every delay medical technology can devise? I cannot promise that that will never happen, any more than a supporter of euthanasia can promise that no one will ever be euthanized who would have had a change of heart the following day. But for the most part, the answer is no. Palliative care, and especially adequate painkillers, must be available to all, and doctors must be free to omit or discontinue medically useless treatment. But the law must never permit any act or omission which has as its chief purpose the hastening of death. "It's criminal to leave people in pain," Margaret Somerville, director of McGill University Centre for Medicine, "Ethics, and Law, said in commenting on the Latimer case (*Maclean's*, November 28, 1994).

"But the answer is to kill the pain, not the person."

Euthanasia is known as many different things like mercy killing, physician assisted suicide, and the right to die, but they all mean the same thing. Euthanasia is administering a lethal dosage of a certain medication, or ending all life support means, and letting a person who is terminally ill pass away at their own will. Many different things charge the debate surrounding this hot button issue. Terminal diseases and illnesses are painful, especially when the person inflicted is nearing the end of their battle. Unimaginable pain, uncertainty, and a loss of control are things that no one should Disparity on legalising euthanasia persists in European countries. Three have legalised euthanasia: the Netherlands, Belgium and Luxembourg. (Photo: AFP). Berlin: Can the state help an incurable patient to die without pain? Germany, where the Church retains significant influence, reopens this debate today before its highest court.Â The question is sensitive in a country where the elderly are more numerous, but also where the spectre of Nazism continues to float, the 3rd Reich having largely resorted to euthanasia especially to kill the disabled. In 2015, the Bundestag, after passionate exchanges, had banned the "organised" assistance to suicide, punishable by three years in prison. euthanasia continued to be practised. In 1678, the publication of Caspar Questel's *De pulvinari morientibus non-subtrahend*, ("On the pillow of which the dying should not be deprived"), initiated debate on the topic. Questel described various customs which were employed at the time to hasten the death of the dying, (including the sudden removal of a pillow, which was believed to accelerate death), and argued against their use, as doing so was "against the laws of God and Nature".[29]:209â€"211 This view was shared by others who followed, including Philipp.