

**EUTHANASIA AND ASSISTED SUICIDE IN CANADA**

**Marlisa Tiedemann  
Dominique Valiquet  
Law and Government Division**

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N.B. Any substantive changes in this publication which have been made since the preceding issue are indicated in **bold print**.

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EUTHANASIA AND ASSISTED SUICIDE IN CANADA \*

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.

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\* **Current Issue Review 91-9E, originally entitled *Euthanasia and Assisted Suicide*, was written by Mollie Dunsmuir, formerly of the Library of Parliament. It was first published in February 1992 and has been regularly updated since that time. This latest version focuses on the issue as it exists in Canada. A companion publication, *Euthanasia and Assisted Suicide: International Experiences (PRB 07-03E)*, is also available.**

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.

**In February 2008, the Appeal Division of the National Parole Board granted Mr. Latimer day parole. The Board initially denied his bid for parole in December 2007. Convinced he was sentenced unjustly, Mr. Latimer now wants a new trial.**

## 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, Andrew Sawatzky was admitted to the Riverview Health Centre in Winnipeg, suffering from Parkinson’s disease and 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. On 23 January 2006, she pled guilty to this offence and was sentenced four days later to three years' probation with conditions. Ms. Houle's counsel had submitted that a one-year conditional sentence would be appropriate; Crown counsel had emphasized the seriousness of the offence, but did not make a submission with respect to the appropriate sentence.

From the outset, the Superior Court Judge emphasized that Ms. Houle's sentence took into account the particular circumstances involved in the case, and was not to be seen as a model sentence for other cases. He also stressed that it was not the Court's role either to legislate with respect to assisted suicide or to articulate an opinion on the law; rather, it is up to legislators to determine the law, and it is up to citizens to elect their legislators. With respect to the crime committed by Ms. Houle, he noted that the particular circumstances of the case meant that her risks of recidivism were non-existent, and that since she was not a threat to society, there was no reason to incarcerate her. The judge also concluded that her incarceration would not necessarily deter others, as it was well known that incarceration was not an effective means of deterrence.

In July 2005, André Bergeron was charged with the attempted murder of his spouse, Marielle Gagnon, who had been diagnosed with Friedreich's ataxia (a progressive disorder that mainly affects the nervous system) 25 years earlier. Mr. Bergeron contacted authorities after attempting to asphyxiate Ms. Gagnon with a plastic bag. She was unconscious when she was taken to the hospital where she died three days later. Neighbours told media that Ms. Gagnon had asked Mr. Bergeron that she not be resuscitated in the event of a heart attack.

In February 2006, Mr. Bergeron's lawyer stated that his client should instead be charged with assisted suicide. **On 19 October 2006, Mr. Bergeron was sentenced to three years' probation for aggravated assault.**

**In September 2006, 62-year-old Raymond Kirk pled guilty to aiding the suicide of his wife. Because of a back spasm, Patricia Kirk was in tremendous pain, and various specialists were unable to diagnose the problem or provide comfort. The Ontario Court of Justice suspended Mr. Kirk's sentence and imposed a sentence of three years' probation.**

**In May 2007, a young man from Alma, Quebec, Stéphan Dufour, was accused of helping his uncle, Chantal Maltais, hang himself. Mr. Maltais, who was 49 years old, had muscular dystrophy and was in a wheelchair. The Crown laid charges against Mr. Dufour under section 241 of the *Criminal Code* (Counselling or aiding suicide). On 21 April 2008, Mr. Dufour's lawyer asked for a trial by jury.**

**In June 2007, a BC court sentenced Ramesh Kumar Sharma, a general practitioner, for aiding the suicide of Ruth Wolfe, a 93-year-old woman suffering from heart problems, by prescribing her a deadly dose of drugs. The court imposed a conditional sentence of two years less a day to be served in the community. His licence was also revoked by the province's college of physicians.**

**In July 2007, the Royal Canadian Mounted Police (RCMP) decided not to lay charges in the assisted suicide case of Elizabeth MacDonald, a Canadian with multiple sclerosis who died in Switzerland with the assistance of the organization Dignitas. Her husband, Eric MacDonald, was with her when she died. The RCMP stated that no infraction of the *Criminal Code* was committed in Canada.**

#### 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.

## 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.

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).

**In November 2007, the Canadian Medical Association (CMA) made minor changes to its Policy on Euthanasia and Assisted Suicide, as the association’s Committee on Ethics found it unnecessary to radically alter the organization’s position. The CMA’s policy therefore still prohibits physician participation in either of these acts. The changes to the policy relate primarily to the definition of terms and the updating of physician concerns about the legalization of euthanasia and assisted suicide in light of recent international events.**

#### 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 (Burnaby–Kingsway).

Three months later, in March 1993, the House of Commons defeated a motion by Ian Waddell (Port Moody–Coquitlam), 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).

On 15 June 2005, Bill C-407, An Act to Amend the Criminal Code (Right to Die with Dignity) was introduced by Francine Lalonde (La Pointe-de-l'Île, Quebec). It was placed on the *Order of Precedence* on 17 June 2005, and was given one hour of debate on 31 October 2005. It was anticipated that the bill would have been voted on in December 2005, but due to the dissolution of Parliament and the call of the federal election, that vote did not take place.

Bill C-407 would have amended sections 14 (Consent to Death), 222 (Homicide), and 241 (Counselling or aiding suicide) of the *Criminal Code* so that, provided that certain criteria are met, a person who assists another person to die would be neither committing a homicide nor counselling or aiding suicide. The bill would have required that the individual whose death is assisted:

- be at least 18 years old;
- be either experiencing “severe physical or mental pain without any prospect of relief” or terminally ill;
- have, while appearing to be lucid, made two requests more than 10 days apart stating his or her free and informed wish to die;
- have designated in writing someone to act for him or her “with respect to the person who aids him or her to die ... and with respect to any medical practitioner” in the event that the individual appears not be lucid.

The bill would also have required that the person who is assisting the death:

- be a medical practitioner or be assisted by a medical practitioner;
- have received confirmation of the diagnosis from one or two medical practitioners (depending on whether the person assisting the death is a medical practitioner);
- be entitled by law to provide health services or be assisted by a team of people so entitled;
- act as directed by the individual whose death is assisted; and
- provide the coroner with a copy of the diagnosis from one or two medical practitioners (depending on whether the person assisting the death is a medical practitioner).

**On 12 June 2008, Ms. Lalonde introduced in the House of Commons Bill C-562, An Act to amend the Criminal Code (right to die with dignity). The bill is more or less identical to former Bill C-407, apart from providing that only a medical practitioner may legally aid a person to die with dignity. The medical practitioner must always comply with the conditions set out in the bill.**

## 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.
- September 2004 - Marielle Houle was charged with aiding and abetting the suicide of her 36-year-old son, Charles Fariala.
- November 2004 - Evelyn Martens was acquitted of aiding and abetting the suicides of two women that took place in 2002.
- June 2005 - Bill C-407, An Act to Amend the Criminal Code (Right to Die with Dignity) was introduced by Francine Lalonde, MP.
- July 2005 - André Bergeron was charged with the attempted murder of his spouse, Marielle Gagnon, who had Friedreich's ataxia.

- October 2005 - Bill C-407 was given one hour of debate in the House of Commons. It died on the *Order Paper* in November 2005 with the dissolution of Parliament.
- January 2006 - Marielle Houle pled guilty to aiding and abetting the suicide of her son, and was sentenced to three years' probation.
- September 2006 - Raymond Kirk pled guilty to aiding the suicide of his ailing wife. The Ontario Court of Justice sentenced him to three years' probation.**
- October 2006 - André Bergeron was sentenced to three years' probation for aggravated assault.**
- May 2007 - Stéphan Dufour was accused of helping his uncle, Chantal Maltais, hang himself. Mr. Maltais, who was 49 years old, had muscular dystrophy and was in a wheelchair.**
- May 2007 - A *Health Psychology* study found that 6% of patients in palliative care surveyed (22 out of a total of 379) said that they would request physician-assisted suicide if such a procedure were legally available.**
- June 2007 - Dr. Ramesh Kumar Sharma was sentenced for aiding the suicide of Ruth Wolfe, a 93-year-old woman who suffered from heart problems. The court imposed a sentence of two years less a day to be served in the community.**
- June 2007 - An Ipsos Reid survey of 1,005 Canadians found that 76% of respondents supported the right to die for patients with an incurable disease (this figure has remained unchanged for 14 years). The strongest support was in Quebec with 87%, while Alberta had the lowest, with 66%.**
- July 2007 - The Royal Canadian Mounted Police (RCMP) decided not to lay charges in the assisted suicide case of Elizabeth MacDonald, a Canadian with multiple sclerosis who died in Switzerland with the assistance of the organization Dignitas.**
- November 2007 - The Canadian Medical Association's Committee on Ethics found it unnecessary to radically alter the association's position on euthanasia and assisted suicide. The CMA's policy therefore still prohibits physician participation in either of these acts.**
- February 2008 - The Appeal Division of the National Parole Board granted Robert Latimer day parole.**

**June 2008 - MP Francine Lalonde introduces Bill C-562, An Act to amend the Criminal Code (right to die with dignity).**

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