

Jocelyn Downie, *Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada*. Toronto: University of Toronto Press, 2004. Pp. x, 201.

Pressure to permit voluntary euthanasia and/or physician-assisted suicide is mounting in several jurisdictions around the world, not least ours. Much of that pressure takes the form of academic opinion, both legal and philosophical. Professor Jocelyn Downie's *Dying Justice* reflects this trend. Professor Downie, Director of the Health Law Institute at Dalhousie University, shines a Canadian perspective on the subject, though her book will be of interest beyond Canada as the arguments she advances reflect the arguments deployed elsewhere. Her volume could, however, benefit from a more informed understanding of principle and practice.

In Part I, Downie paints an accessible picture of the current legal status of euthanasia and assisted suicide in Canada. This picture provides a backdrop to the author's argument (in Parts II and III) in favour of relaxation of the law. The essence of Downie's position is that voluntary euthanasia and physician-assisted suicide should be treated, in law, in the same fashion as the withholding and withdrawing of life-sustaining treatment (47). For Downie, the promotion of autonomy is itself sufficient to justify legalization (9-10). Abandoning restrictions commonly found in contemporary proposals for reform (76-84)—including “terminal illness” and “unbearable suffering”—Downie argues that *any* voluntary request for assisted death made by a competent individual should be honoured (12).

Downie argues that the principle of autonomy that justifies withholding or withdrawing treatment also justifies voluntary euthanasia or physician-assisted suicide. She rejects the argument that the intention behind the former and the latter may be different (93-94) and asserts that “the motive or goal of all forms of assisted death is to alleviate suffering” (93), whether the health care provider withdraws treatment or “injects a lethal dose of potassium chloride” (93-94). Furthermore, she reasons, in all of these practices the patient's death is a foreseeable outcome (*ibid.*).

With respect, Downie's argument betrays an elementary confusion. Even leaving aside issues of causation, the crucial question is not whether death in both cases is foreseen; it may well be. The question is whether death in both cases is intended, and it may well not be. It is not sufficient to argue that the motive in both cases is to relieve suffering. Dr. A and Dr. B may well share the same motive of putting an end to the suffering of patient C, but if Dr. A intends to do so by administering morphine, which merely foreseeably hastens death, and Dr. B does so by administering potassium chloride, the cases are not morally (or, indeed, legally) equivalent. Indeed, if there were no morally significant distinction between the actions of Dr. A and Dr. B, there would hardly be a debate about legalizing voluntary euthanasia; there would hardly be a distinction between Dame Cicely Saunders and Dr. Jack Kevorkian.

The distinction between, on the one hand, administering morphine to ease pain, merely foreseeing that death will be hastened and, on the other, injecting potassium

chloride with the purpose of ending the patient's life, has long been accepted in Western medical law and ethics. In recent years, the distinction has been reaffirmed by the U.S. Supreme Court,¹ the World Medical Association,² and the House of Lords Select Committee on Medical Ethics.³ It is accepted by the Dutch, whose definition of euthanasia includes intended, but not foreseen, life shortening. Nor is it a philosophically or legally abstruse distinction. Which patient would register with a doctor who intended, rather than merely foresaw, the bad side effects of the drugs he or she prescribed?

It is not until chapter 10 (entitled "Invalid Arguments") that Downie considers principled objections to euthanasia and assisted suicide, including the principle of the "sanctity of life" (100-101). She confines herself to a consideration of the "secular" version of the argument, which, by her account, holds that "killing is wrong" (101). Downie claims that this principle is "not absolute" (*ibid.*) and cites a number of examples, such as self-defence (*ibid.*). She goes on to suggest that "the principle that 'killing is wrong' does not effectively distinguish between the withdrawal of potentially life-sustaining treatment, on the one hand, and euthanasia and assisted suicide, on the other" (*ibid.*) and concludes that much more is needed than "a simple recitation of the principle" (*ibid.*) to ground a prohibition of assisted suicide and voluntary euthanasia.

Downie's argument is undermined by her misinterpretation of the principle of the sanctity of life. The principle (whether secular or religious) does not simply hold, as Downie asserts, that "killing is wrong". Rather, the core of the principle is its prohibition against the intentional killing of the innocent (that is, those not engaged in unjust aggression). In the medical context, the principle rules out any conduct that is intended to hasten the death of a patient. The principle accepts as legitimate the withholding or withdrawal of futile or excessively burdensome treatment (even though death will foreseeably be hastened as a result) but prohibits the withholding or withdrawal of medical treatment with the intention of shortening life. Although it may be accurate to say, as Downie does, that self-defence is, indeed, a defence to murder (101), she is wrong in thinking that this represents an exception to the principle of the sanctity of life. She makes the basic mistake that the sanctity of life principle prohibits all killing.

In chapter 11 (106-32), Downie gives the "slippery slope" argument against legalization "separate and extended" (88) consideration, not only because so many people find it "compelling" (*ibid.*) but also because of the "serious concerns" (*ibid.*) it raises that must be taken into account by any regulatory regime. Her approach reflects

¹ *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997).

² John R. Williams, *Medical Ethics Manual* (Ferney-Voltaire Cedex, France: World Medical Association, 2005) at 57-60, online: World Medical Association <http://www.wma.net/e/ethicsunit/pdf/manual/ethics_manual.pdf>.

³ U.K., H.L., "Report of the Select Committee on Medical Ethics" (London: Her Majesty's Stationery Office, 1994).

the trend towards eschewing issues of principle in favour of the practical considerations surrounding the regulation of assisted death. Downie correctly recognizes the two forms of “slippery slope” argument: the “logical” and the “empirical” (106-107). Her response to the “logical” argument’s contention—that permitting voluntary euthanasia logically entails permitting at least non-voluntary euthanasia—is unconvincing. Her riposte is simply to assert, as a “barrier” (*ibid.*), the need for a “free and informed consent” (*ibid.*). Plainly, this will not do. If death can be a benefit for patients in condition X who can request it, why can it not equally benefit patients in condition X who cannot request it? Surely, the professional duty of the doctor is to act in the best interests of the patient. If this precept is accepted (however wrongly) as justification for allowing them to dispatch patients who ask for death to avoid unbearable suffering, why does it not allow them to put an end to the suffering of their patients who cannot make a request? Why should a doctor deny a patient a benefit because the patient is incompetent? Why does this denial not discriminate against the incompetent? As Dutch court decisions justifying the administration of lethal injections to disabled newborns have confirmed,⁴ the Dutch are now realizing the logical implication of permitting voluntary euthanasia.

Downie gives greater weight to what she thinks is the “more difficult” (107) empirical argument, drawing largely on the Dutch experience. Downie considers some of the data from the Netherlands (109-31) and concludes that the evidence “does not provide a basis on which to conclude that assisted suicide and voluntary euthanasia should not be decriminalized in Canada” (110). Downie’s evaluation of the Dutch evidence, however, lacks critical rigour. Her conclusion that there is no evidence of extensive abuse is unsupported by her data. It now seems widely acknowledged (by, for example, the UN Human Rights Committee)⁵ that there are serious deficiencies in the Dutch system. For example, the fact that the vast majority of cases have been suppressed by Dutch doctors, and the fact that thousands of patients (mainly, but not always, incompetent) have been terminated without request, refutes Dutch claims of effective control. That Downie does not evince more concern about the persistent incidence of non-voluntary euthanasia is surprising, given her argument that euthanasia is justified only by the patient’s request.

Downie rightly recognizes the inherent difficulties surrounding all decision making at the end of life, and accepts that there are valid concerns about “freedom, competence, and equality” (11) in the context of a patient’s right to refuse medical treatment (96-99). Given her acknowledgement of concerns about pressure and abuse in cases of treatment refusal (*ibid.*), her willingness nonetheless to call for the

⁴ Prins; Gerechtshof [Hof], Court of Appeal, Amsterdam, 7 November 1995, NJ 113 (Neth.); Kadijk, Gerechtshof [Hof], Court of Appeal, Leeuwarden, 4 April 1996, Tijdschrift voor Gezondheidsrecht 20 (Neth.).

⁵ *Consideration of Reports Submitted by State Parties Under Article 40 of the Covenant: Concluding Observations of the Human Rights Committee; Netherlands*, UN, Human Rights Committee, 72d Sess., Doc. CCPR/CO/72/NET (2001) at paras. 5-6, online: <[http://www.unhchr.ch/tbs/doc.nsf/\(Symbol\)/CCPR.CO.72.NET.En?Opendocument](http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/CCPR.CO.72.NET.En?Opendocument)>.

extension of patients' rights to include voluntary euthanasia and assisted suicide seems injudicious.

In sum, Downie's book reflects the continuing importance of the debate about the legalization of voluntary euthanasia. Whether it adds significantly to that debate is another matter.

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