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## The Body and the Body Politic: Assisted Suicide under the *Canadian Charter of Rights and Freedoms*

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The author critically examines the majority judgment of the Supreme Court of Canada in *Rodriguez v. Canada (A.G.)* and concludes that the judges in the majority have adopted a legislative public policy mandate rather than carrying out a judicial function that accords with established canons of *Charter* interpretation and analysis. The author contends that the majority read section 7 of the *Charter* as enshrining the sanctity of life as an intrinsic, abstract societal value necessary to protect the ill and the vulnerable and not as an expression of the individual's entitlement to autonomy against the State. She also contends that the majority's section 1 analysis was unduly deferential not only to the Canadian Parliament but also to the legislatures of the majority of Western democracies. This came at the expense of considering the legislative pattern of abandoning laws against suicide, the common law respect for individual autonomy and quality of life regarding refusal of and withdrawal from medical treatment, and the widespread lax enforcement of laws against mercy killing. The author is particularly critical of the majority's reliance on "slippery slope" reasoning, which subordinated Ms Rodriguez's *Charter* rights to apprehended wrongdoing by the medical profession and the presumed best interests of society as a whole. The author recommends that legislators who address the question of assisted suicide look to methods of regulating access to assisted suicide that reflect respect for individual dignity under the *Charter* at the end of life, and reject any reading of the majority judgment that suggests that legislators are free to regulate or to proscribe assisted suicide according to abstract notions of the sanctity of life, pragmatic views of the public good, or the false consciousness or perceived vulnerability of the terminally ill or disabled.

L'auteure fait une analyse critique de la décision majoritaire de la Cour suprême du Canada dans l'affaire *Rodriguez c. Canada (P.G.)* et conclut que les juges qui ont signé cette décision l'ont rendu en se basant sur des considérations d'ordre public, jouant ainsi un rôle de législateur, plutôt que sur les règles établies d'interprétation et d'analyse de la *Charte*, remplissant alors leur fonction judiciaire. L'auteure soutient que les juges majoritaires ont interprété l'article 7 de la *Charte* comme un enchaînement du caractère sacré de la vie en tant que valeur sociétale intrinsèque et abstraite, nécessaire à la protection des personnes malades et vulnérables, et non comme l'expression du droit de l'individu à l'autonomie vis-à-vis l'État. Elle soutient également que l'analyse de l'article premier qu'ont faite les juges majoritaires était indûment déférentielle non seulement à l'égard du Parlement canadien, mais également à l'égard des législatures de la majorité des pays occidentaux démocratiques. En effet, cette analyse n'a pas tenu compte de la tendance législative qui prônait l'élimination des lois prohibant le suicide, du respect que voue la *common law* à l'autonomie individuelle et à l'importance de la qualité de vie lorsqu'il est question de refuser ou d'abandonner des traitements médicaux, et du laxisme de plus en plus répandu quant à l'application des lois contre les homicides effectués par pitié. L'auteure est particulièrement critique à l'endroit de la décision majoritaire lorsque celle-ci considère le problème de l'effet d'entraînement. Par ce raisonnement, les droits de Madame Rodriguez en vertu de la *Charte* furent subordonnés tant à la crainte que le corps médical ne commettent des fautes qu'aux meilleurs intérêts de la société en général. L'auteure suggère aux législateurs qui se pencheront sur le problème du suicide assisté de tenir compte des méthodes permettant de réglementer son accès tout en respectant la dignité humaine à la fin de la vie que commande la *Charte* et de rejeter toute interprétation de la décision majoritaire suggérant que les législateurs sont libres de réglementer ou d'interdire le suicide assisté selon des notions abstraites relatives au caractère sacré de la vie, des conceptions pragmatiques du bien-être public, ou une fausse conception ou perception de la vulnérabilité de l'handicapé ou du malade en phase terminale.

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"Departures from official pieties usually occur first in our practices and only later in our professions."<sup>1</sup>

"[T]he act of verbally expressing pain is a necessary prelude to the collective task of diminishing pain."<sup>2</sup>

"Whose body is this? Who owns my life?"<sup>3</sup>

#### **Introduction**

The claim of a *Charter*<sup>4</sup> right to physician-assisted suicide alerts us to a significant transition in attitudes to the body in our culture. Formerly, the law proscribed suicide and attempted suicide; it imposed capital and corporal punishment; it criminally sanctioned access to contraception and abortion and punished not only those who engaged in homosexual relations but also those who engaged in sexual acts outside of marriage. The abandonment of these laws marked a social revolution built upon respect for the dignity of the body and for equal individual autonomy. These changes did not come easily. Each produced intense political controversy and exacted high personal cost. The question of the

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<sup>1</sup>S. Kadish, "Letting Patients Die: Legal and Moral Reflections" (1992) 80 Calif. L. Rev. 857 at 859.

<sup>2</sup>E. Scarry, *The Body in Pain* (New York: Oxford University Press, 1985) at 9.

<sup>3</sup>Sue Rodriguez's words, quoted in C. Wood, "The Legacy of Sue Rodriguez" *Macleans* (28 February 1994) 22 at 23.

<sup>4</sup>*Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [hereinafter *Charter*].

role of the State in regard to the body at the end of life appears to be yet another of these issues. It pulls on us from the past with the strength of a world view that was once our own.

In *Rodriguez v. Canada (A.G.)*,<sup>5</sup> the Supreme Court of Canada produced three very different responses to a constitutional claim for medically assisted suicide for the disabled terminally ill. The majority held that the section 7 *Charter* guarantee of fundamental justice in any deprivation of the right to security of the person affords no exception to the general *Criminal Code* proscription of assisted suicide. There were two fully developed dissents: one on this question and one based on *Charter* equality guarantees.

That Ms Rodriguez's controversial claim divided members of the Court is not surprising. Only an unsophisticated understanding of our legal system requires that the *Charter* dictate single right answers. However, rights-protecting instruments such as the *Charter* prescribe certain modes of argument that share one premise: guaranteed rights restrict the policy options open to government in order to forward the equal dignity of all members of a democratic society.<sup>6</sup>

What is significant about the split in the Court in *Rodriguez* is that while the two dissents engage in this type of reasoning, the majority does not. The majority's reasons for judgment affirm what is described as a long-standing societal consensus in Canada and in other Western democracies that supports the sanctity and inviolability of life. This consensus admits certain "exceptions", such as the common law rights to refuse and to discontinue medical treatment, but it precludes a *Charter* claim to access to medically assisted suicide. The Court's emphasis on the societal consensus supposedly reflected in the *Criminal Code* undercuts consideration of the primacy of individual autonomy and human dignity.

In this article, I discuss the reasoning in the majority judgment. I argue that the reliance the majority places on social and political consensus in Canada and in other Western democracies is open to criticism. First, such reliance represents a marked departure from the role of the courts as legal guardians of the Constitution. Second, the Court may simply be wrong, having mistaken majority preferences for consensus. Third, in elevating majority preferences to constitutional stature, the Court offers no guidance to the legislators who are reviewing the policies underlying the ban on assisted suicide in Canada.

## I. Facts and Background

Ms Rodriguez's claim gripped Canadians in a collective nightmare. We watched a vibrant woman, the mother of a young child and recently estranged

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<sup>5</sup>[1993] 3 S.C.R. 519, (*sub nom. Rodriguez v. British Columbia (A.G.)*) 107 D.L.R. (4th) 342 [hereinafter *Rodriguez* cited to S.C.R.].

<sup>6</sup>Elsewhere I make the argument that this premise also binds governments when they take the position that infringements on rights constitute justified limitations under section 1 of the *Charter*. See L.E. Weinrib, "The Supreme Court of Canada and Section One of the *Charter*" (1988) 10 Supreme Court L.R. 469; L.E. Weinrib, "Limitation on Rights in a Constitutional Democracy: Models of Judicial Review under Canada's *Charter*" [forthcoming].

from her husband, cope with amyotrophic lateral sclerosis, a disease that causes the certain, inexorable deterioration of one's physical capacities.<sup>7</sup> The prognosis was that, while remaining fully aware and legally competent, she would lose, over a period of months, the ability to perform basic functions, such as swallowing or breathing, without aid. As her condition deteriorated, Ms Rodriguez made public her decision to end her life when she chose rather than to wait helplessly to die by choking or suffocation. Because she anticipated that she might want to live beyond the time when she would be able to commit suicide unaided, she wanted to secure medical assistance "to set up technological means by which she might, by her own hand, at the time of her choosing, end her suffering, rather than prolong her death."<sup>8</sup> This decision put her on a collision course with section 241 of the *Criminal Code*,<sup>9</sup> which reads:

Everyone 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.

Ms Rodriguez challenged the application of paragraph 241(b) to her or to a physician acting under her direction. She put forward a number of *Charter* arguments based on claims to security of the person and equality, as well as on the prohibition against cruel and unusual treatment or punishment.<sup>10</sup> Her purpose was to use the *Charter* to cut down the generality of the prohibition, which she believed in effect criminalizes suicide, not merely assisted suicide, for the disabled. Her claim was to a process that would bring the criminal law into conformity with the autonomy rights of extremely disabled, terminally ill individuals to seek assistance to end their lives.

Ms Rodriguez was unsuccessful only in the courts.<sup>11</sup> News reports indicate that she died on February 28th, 1994, in her home, after receiving a lethal injection from an unidentified doctor. Her death sparked a commitment by the Cana-

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<sup>7</sup>*Macleans*, *supra* note 3.

<sup>8</sup>Factum of the Appellant in *Rodriguez* at 2, para. 4 [hereinafter Factum of Rodriguez].

<sup>9</sup>R.S.C. 1985, c. C-46.

<sup>10</sup>*Charter*, *supra* note 4, ss. 7, 5, 12.

<sup>11</sup>The Supreme Court of British Columbia ruled against Ms Rodriguez on the basis that her claim would, in effect, impose a duty on physicians to assist suicide, a duty that would undermine the idea of the sanctity of life embodied in the *Charter* ((1992) 18 W.C.B. (2d) 279, [1993] B.C.W.L.D. 347). The British Columbia Court of Appeal affirmed this ruling on the basis that the general prohibition against assisted suicide reflects society's commitment to the sanctity of life, and that the issue raised was a matter of policy, better dealt with by Parliament. McEachern C.J.B.C. dissented, basing his analysis on the *Charter*'s commitment to the dignity of the human person and the rule of law rather than to an abstract idea of the sanctity of life. With the focus on Ms Rodriguez's particular claim, rather than on the general rule, he concluded that the impugned provision prolonged the physical and psychological suffering of a terminally ill person contrary to the right to security of the person, and did not conform to fundamental justice in that it undermined the human dignity and control of the individual even though no harm was visited on another person. Turning to section 1 of the *Charter*, he found that the impugned provision failed the minimal impairment standard and thus was without justification under section 1. He declared paragraph 241(b) inapplicable to her and set down conditions for her arrangement for assisted suicide ([1993] 3 W.W.R. 553, 79 C.C.C. (3d) 1).

dian Prime Minister to a review of the criminal prohibition against assisted suicide and a free vote in Parliament on any proposed legislative change to the *Criminal Code* prohibition. Both before and after Ms Rodriguez's death, Canadian public opinion polls indicated general support for her claim.<sup>12</sup>

## II. The Supreme Court's Reasons for Judgment

### A. An Overview of the Judgments

The majority judgment, written by Sopinka J. and concurred in by La Forest, Gonthier, Iacobucci and Major JJ., rejected Ms Rodriguez's arguments. The majority's primary concern was section 7 of the *Charter*, which provides:

Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

The majority determined that while section 241 of the *Criminal Code* "impinges on the security interest" of Ms Rodriguez, it did so in accordance with the principles of fundamental justice.<sup>13</sup>

McLachlin J., with L'Heureux-Dubé J. concurring, dissented from the majority's ruling on section 7. She determined that section 241 breached the right to security of the person by infringing the right to autonomy over one's body. The section failed to conform to the principles of fundamental justice, which require fair treatment of all under the law. Furthermore, McLachlin J. held that the infringement could not be justified under section 1 of the *Charter* because full autonomy could find adequate protection under the criminal justice system and added judicial safeguards to avoid abuse.<sup>14</sup>

Chief Justice Lamer based his dissent on section 15 and found an infringement on the basis that section 241 prevents the physically disabled, expressly entitled to equal benefit of the law, from ending their lives. Section 1 justification was lacking because section 241 extended beyond its legislative aim of protecting the vulnerable from coercion and pressure. By way of remedy, he provided guidelines for judges to follow on applications by disabled persons for individual exemptions from the general prohibition of assisted suicide.

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<sup>12</sup>Seventy-four per cent of those surveyed in a national poll, shortly after Ms Rodriguez's highly publicized death, indicated support for physician-assisted suicide. This figure was up four percentage points from a year-old survey (L. Priest, "Assisted Suicide Supported in Poll" *The Toronto Star* (3 March 1994) A2). The earlier survey, a 30 March 1993 Angus Reid Group Poll, was provided as Appendix II in Rodriguez's factum (*supra* note 8). The first poll surveyed 1500 Canadian adults. The results are considered 95% accurate within 2.5 percentage points. Surprisingly, given the emphasis in the reasons for judgment on public consensus, the majority did not comment on the poll.

<sup>13</sup>*Supra* note 5 at 583.

<sup>14</sup>Section 1 of the *Charter* reads:

The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

### B. *The Majority Judgment: Security of the Person*

The majority's initial discussion of life, liberty and security of the person described these three "values" as so interconnected with the "sanctity of life" that security of the person is "intrinsically concerned with the well-being of the *living* person."<sup>15</sup> The language is distinctive: "the intrinsic value of human life," "the inherent dignity of every human being," a "generally held and deeply rooted belief," "sacred or inviolable."<sup>16</sup> After noting the historical understanding that "sanctity of life" excludes "freedom of choice in the self-infliction of death," Sopinka J. observed that "no new consensus has emerged" to support assisted suicide.<sup>17</sup> He also rejected the suggestion that, for the terminally ill, the choice is merely of the time and manner of death rather than of death itself. In his view, the choice of death is always an interference with "natural forces."<sup>18</sup> The terminally ill are not in different circumstances from others, because death eventually comes to all mortals. If anything, restrictions on the terminally ill should be more stringent, because they are "particularly vulnerable as to their life and will to live."<sup>19</sup>

The underlying assumption is that section 7 enshrines the sanctity of life as a fundamental societal value. Sopinka J. treated the words "right to life" in section 7 as society's affirmation that life is inviolate and sacred, not as a reference to an individual's entitlement. On his reading of section 7, the State can affirm the principle of the sanctity of life even *against* an individual. The individual's right to life under section 7 is thereby transformed into society's right to prevent the individual from ending his or her life. Indeed, the only mention of "right" in this part of the judgment is a reference to "the right of the state" to regulate assisted suicide;<sup>20</sup> the express guarantees of section 7, in contrast, are

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<sup>15</sup>*Supra* note 5 at 584-85 [emphasis added]. The majority judgment did not deliberate at length on the question of liberty under section 7. It concluded that "any liberty interest ... involved" was, like the security of the person interest recognized, in conformity with the requirements of fundamental justice.

<sup>16</sup>Given the type of language used, it is not surprising that Sopinka J. pointed out that he did not mean to invoke religious ideas (*ibid.* at 585).

<sup>17</sup>*Ibid.* For Canadian polling information, some of which was before the Court, indicating general support for assisted suicide, see *supra* note 12.

<sup>18</sup>*Ibid.* at 586. A prohibition of attempted suicide would, based on this reasoning, pass *Charter* scrutiny. I read the majority judgment as taking the view that a prohibition of suicide would be permissible under the *Charter*. Consider the following rhetorical question, which invites a negative response:

As members of a society based upon respect for the intrinsic value of human life and on the inherent dignity of every human being, can we incorporate within the Constitution which embodies our most fundamental values a right to terminate one's own life in any circumstances (*ibid.* at 585)?

Also consider:

Sanctity of life ... has been understood historically as excluding freedom of choice in the self-infliction of death and certainly in the involvement of others in carrying out that choice. *At the very least*, no new consensus has emerged in society opposing the right of the state to regulate the involvement of others in exercising power over individuals ending their lives (*ibid.* [emphasis added]).

<sup>19</sup>*Ibid.* at 586.

<sup>20</sup>*Ibid.* at 585.

characterized as "values" and "interests". The right to life, thus refashioned into an instrumentality for the restriction of individual autonomy, becomes (along with liberty and security of the person) one of the three equipollent values entrenched in section 7.

In contrast to some of its earlier decisions, the Court here made no attempt to imagine the claim from Ms Rodriguez's point of view, as a free and equal member of a society that honours rights.<sup>21</sup> Her particular beliefs about the value of life in general or her appreciation of the value of her own life in the particular circumstances of her terminal condition were not germane. Ms Rodriguez was regarded as choosing death over life, even though life in a sense that was meaningful to her was progressively precluded by disease. Similarly, the judgment described the assisting doctor not as her agent to do what she could have done herself without criminal sanction had the inclination coincided with physical ability, but as someone who would be exercising power over her.<sup>22</sup> The Court's abstraction from the particular features of Ms Rodriguez's situation is manifest in its statements that (i) the inevitability of death for all makes questions of life and death no different for the terminally ill than for the general population, and that (ii) the terminally ill are too vulnerable to evaluate such questions properly.

While it is true that we will all die, the question is whether a law applicable to the many who are not now knowingly in the last days of life and who do not know when and how they will die, should also apply to the few who face imminent death and personally unacceptable suffering. To say that the terminally ill are too vulnerable to make the decision to seek assistance to die in their particular circumstances and must be subject to a general rule against assisted suicide leads to a number of possible inferences. In context, the reference to vulnerability suggests that the terminally ill may be too selfish (overvaluing immediate sorrow, pain and suffering), too altruistic (overvaluing the financial and emotional burdens shifted to others) or too responsive to outside influences (of friends, relatives or medical professionals who may not give priority to the best interests of the individual). Yet, if these tendencies were prevalent, one could devise a process to verify their presence in particular situations.<sup>23</sup> By denying the individual's power to decide, the judgment reveals that the focus is not on the quality of the decision-making but on the content of the decision. The terminally ill, in other words, cannot be relied upon to make decisions consistent with the general social norms that serve the community at large, in this instance, at their expense. This approach transforms the terminally ill into less

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<sup>21</sup>See *e.g.* *R. v. Big M Drug Mart*, [1985] 1 S.C.R. 295, [1985] 3 W.W.R. 481; *Singh v. Canada (Minister of Employment and Immigration)*, [1985] 1 S.C.R. 177, 17 D.L.R. (4th) 422, Wilson J.; *Reference Re Section 94(2) of the Motor Vehicle Act, R.S.B.C. 1979*, [1985] 2 S.C.R. 486, 24 D.L.R. (4th) 536, 48 C.R. (3d) 289 [hereinafter *Motor Vehicle Reference* cited to S.C.R.]; *R. v. Morgentaler*, [1988] 1 S.C.R. 30, 82 N.R. 1 [hereinafter *Morgentaler* cited to S.C.R.]; *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143, [1989] 2 W.W.R. 289; *R. v. Vaillancourt*, [1987] 2 S.C.R. 636, 81 N.R. 115. While the majority later acknowledged that its ruling will produce "suffering in certain cases", this result is apparently redeemed by the avoidance of possible future abuse in other cases (*Rodriguez, ibid.* at 605).

<sup>22</sup>*Ibid.* at 585-86.

<sup>23</sup>This is the approach of Lamer C.J.C. in his dissent.

than fully respected members of society whose decisions about health care are binding as long as they are competent. The possibility of respecting informed, rational decisions to seek a comparatively painless death, instead of the particular death that nature offers, is considered "macabre".<sup>24</sup>

Sopinka J. treated the sanctity of life as one of the values entrenched in section 7, but he did not assign it a priority over the others. The coordinate status of the three values in section 7 allowed him to conclude that the impugned legislation affects the guaranteed right to security of the person. Drawing on previous jurisprudence that held security of the person to encompass control of one's bodily integrity and freedom from state-imposed psychological stress,<sup>25</sup> Sopinka J. concluded that the prohibition of assisted suicide interfered with Ms Rodriguez's autonomy over her person by imposing physical pain and psychological stress in the period during which she would be living beyond when she would have preferred. Sopinka J. then considered whether the legislation's effect on the security of her person accorded with the principles of fundamental justice. At this point, the idea that the sanctity of life is a societal value that can override individual autonomy resurfaced to play a decisive role.

### C. *The Majority Judgment: Principles of Fundamental Justice*

#### I. The Judicial Role

To introduce his discussion of the principles of fundamental justice, Sopinka J. extensively quoted a leading American text, Tribe's *American Constitutional Law*, regarding "[t]he right of a patient to accelerate death."<sup>26</sup> In Tribe's account, courts have responded to the claim of such a right by elaborating the common law principles of consent to treatment rather than by establishing a constitutional norm of self-determination. Tribe ascribes this to a concern that a constitutionally recognized right to die "might be uncontrollable ... and susceptible to grave abuse."<sup>27</sup> He remarks that

the resulting deference to legislatures may prove wise in light of the complex character of the rights at stake and the significant potential that, without careful statutory guidelines and gradually evolved procedural controls, legalizing euthanasia, rather than respecting people, may endanger personhood.<sup>28</sup>

Sopinka J. took Professor Tribe's comments as a warning that democracy requires that the judiciary refrain from effecting "fundamental changes to long-standing policy on the basis of general constitutional principles and its own view of the wisdom of legislation."<sup>29</sup> Although he mentioned the Court's duty

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<sup>24</sup>*Supra* note 5 at 582, 604.

<sup>25</sup>*Morgentaler*, *supra* note 21; *Reference Re Sections 193 and 195.1(1)(c) of the Criminal Code (Man.)*, [1990] 1 S.C.R. 1123, 77 C.R. (3d) 1, 56 C.C.C. (3d) 1.

<sup>26</sup>*Supra* note 5 at 589. See L.H. Tribe, *American Constitutional Law*, 2d ed. (New York: Foundation Press, 1988) at 1370.

<sup>27</sup>*Ibid.* This result is not unwelcome to Tribe, who sees the need for "statutory guidelines and gradually evolved procedural controls" to ensure that the law respects rather than endangers personhood" (*ibid.* at 1370-71).

<sup>28</sup>*Ibid.* at 1370-71.

<sup>29</sup>*Supra* note 5 at 590.

to deal with *Charter* violations, Sopinka J. was apprehensive lest judges rely on personal judgment and subjective evaluation in determining the principles of fundamental justice.

Sopinka J. did not mention that Tribe indicates that the resistance to recognition of full autonomous decision-making with respect to medical treatment has not rested on principle, but rather on rhetorical convenience, as the courts have sought to establish clear, common law limits to the right to refuse treatment.<sup>30</sup> What makes the patient's right to accelerate death problematic is the difficulty of establishing clear-cut categories and avoiding possible abuses, such as uncontrolled discretion and discrimination against the disabled. Such concerns reflect the difficulty of realizing autonomy under the law in the variety of circumstances embraced by the "right to die" question. They do not compete with or diminish the individual claim to prescribe the time and manner of one's death.

Moreover, Sopinka J.'s reading of Tribe's comments does not reflect more recent developments in the United States. Since Tribe wrote in 1988, the United States Supreme Court has recognized that the right of a competent person to refuse life-sustaining treatment — including medical care, nutrition and hydration — is constitutionally protected. While it is not completely clear, it is possible to read the judgment as sustaining the view that the State must honour a sufficiently reliable advance directive to refrain from administering such treatment when the patient is incompetent to make a contemporaneous decision.<sup>31</sup> The Michigan Court of Appeals has under consideration a lower court decision that the state law against assisted suicide was unconstitutional.<sup>32</sup> Even more recently, a federal judge struck down the 140 year-old Washington State law against assisted suicide as infringing the Fourteenth Amendment's liberty guarantee. Rothstein J. made an analogy between the autonomy rights recognized in a woman's personal and intimate decision to end a pregnancy and the decision of a terminally ill person to end his or her life, which she described as "central to individual dignity and autonomy."<sup>33</sup> On May 11th, 1994, a jury acquitted Dr. Kevorkian of a charge of violating the Michigan law against assisted suicide.<sup>34</sup>

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<sup>30</sup>See Tribe, *supra* note 26 at 1364-65, n. 14.

<sup>31</sup>*Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990)[hereinafter *Cruzan*]. See *infra* note 58 and accompanying text.

<sup>32</sup>A number of prosecutions against Dr. Jack Kevorkian, who has made public his assistance of several people in their suicides, are now working their way through the Michigan court system. Several charges have been dismissed. One of the rulings invalidating the state law against assisted suicide determined that suicide in some circumstances may be protected by the United States Constitution (see "Michigan Court Invalidates Law Banning Aid for Suicide" *The New York Times* (11 May 1994) A22 [hereinafter "Michigan Court"]). For an account of the constitutional argument in this case, written by one of the litigators, see R.A. Sedler, "The Constitution and Hastening Inevitable Death: The Fourteenth Amendment and the Rights of the Terminally Ill" (1993) 23:5 *Hastings Center Rep.* 20.

<sup>33</sup>T. Egan, "Federal Judge Says Ban on Suicide Aid is Unconstitutional" *The New York Times* (5 May 1994) A1.

<sup>34</sup>"Michigan Court", *supra* note 32.

## 2. The Relationship between the Two Stages of Section 7 Inquiry

In considering whether the legislation's adverse effect on the security of the claimant's person accords with the principles of fundamental justice, the Court set up a two-stage inquiry. The first stage concerned "values at stake with respect to the individual"; the second involved consideration of "possible limitations" of the "values" recognized in the first.<sup>35</sup> Compare this formulation to the view, set out in the *Motor Vehicle Reference*, that the principles of fundamental justice are specified by the basic substantive and procedural tenets of our legal tradition.<sup>36</sup> Whereas the formulation in the *Motor Vehicle Reference* circumscribes the guaranteed rights set out in section 7 only on the basis of operative, fundamental, legal principles, the *Rodriguez* formulation, as we shall see, opens the door to a wider range of considerations.

## 3. Societal Notions of Justice

Considering the content of the notion of fundamental justice, Sopinka J. formulated the objective underlying the prohibition of assisted suicide as the preservation of life and protection of the vulnerable.<sup>37</sup> He then set out what he described as the arguments against section 241 in light of the principles of fundamental justice:

(i) The legislation is over-inclusive in precluding suicide as an option to those who are terminally ill and mentally competent but unable to take their own lives without assistance.

(ii) The legislation is arbitrary and unfair because suicide is not an offence, and because the common law permits a patient to instruct a doctor to withhold or discontinue life-saving or life-sustaining medical treatment and also to administer palliative care to provide comfort even though the result may be to shorten life.<sup>38</sup>

Sopinka J.'s presentation suggests that these propositions embody Ms Rodriguez's arguments under section 7. An examination of Ms Rodriguez's *factum* shows that these arguments, as their language and structure indicate, were adduced for the purposes of an analysis under section 1 rather than under section 7.<sup>39</sup> The Court's treatment of the claimant's arguments under section 1 as relevant to her claim under section 7 accords with its earlier statement that the latter part of section 7 imposes a limitation on the first. This reasoning thus raises the

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<sup>35</sup>*Supra* note 5 at 584. The idea that the second part of section 7 affords a limitation on the first appears inconsistent with the language of section 1 of the *Charter*, which states that the rights are subject *only* to the type of limitations expressly provided.

<sup>36</sup>*Motor Vehicle Reference*, *supra* note 21: fundamental justice "serves to establish the parameters of the interests but it cannot be interpreted so narrowly as to frustrate or stultify them" because they are fundamental rights (*ibid.* at 501); "the principles of fundamental justice are to be found in the basic tenets of our legal system. They do not lie in the realm of general public policy but in the inherent domain of the judiciary as guardian of the justice system" (*ibid.* at 503).

<sup>37</sup>*Supra* note 5 at 590.

<sup>38</sup>*Ibid.*

<sup>39</sup>*Supra* note 8 at 25, para. 47ff.

possibility that the Court will consider tests now familiar as section 1 limitation tests, *i.e.*, rational connection and minimal impairment, in the context of section 7. Such a transposition would mark a dramatic contraction of *Charter* protection because it would impose on the rights claimant the burden of disproving justification that now rests, as a positive burden, on the State under section 1.<sup>40</sup> One might ask, given this formulation, whether a section 1 justification remains available to the State after a finding of a section 7 violation.<sup>41</sup>

Further reduction of *Charter* protections follows from Sopinka J.'s reading of the *Charter* text. He interpreted the words of section 7 to "imply" that "fundamental principles" are "principles upon which there is some consensus that they are vital or fundamental to our societal notion of justice."<sup>42</sup> Sopinka J. offered no specification of the textual directive that equates fundamentality with vitality or renders both subject to consensus.<sup>43</sup> Nor did he indicate how the text's reference to multiple *principles* of justice translates into a shared, societal *notion* of justice at large. Sopinka J.'s reading privileges general social policy preferences over established and particularized legal norms.

When the judgment turns to *Charter* case law, it retreats momentarily from this weak reading of the text of section 7. Sopinka J. drew from the *Motor Vehicle Reference* the need to discern a precise, intelligible legal principle, one that reveals its underlying rationale and principles.<sup>44</sup> Nevertheless, the inclination towards social convention and consensus is merely in temporary abeyance; it will return and prevail.

The argument ascribed to Ms Rodriguez is that respect for human dignity and autonomy is a principle of fundamental justice and that, by proscribing assisted suicide, paragraph 241(b) subjected her to needless suffering and impaired her dignity.<sup>45</sup> Sopinka J. rejected this argument on the basis that human dignity informs much of the *Charter*, including the first stage guarantees set out in section 7, and thus cannot provide the benchmark against their deprivation. If this were not so, every violation of security of the person would constitute a violation of the principles of fundamental justice.

Ms Rodriguez's actual submissions were more forceful. She argued that the principles of fundamental justice are not general policy concerns, but rather the basic tenets of the legal system of which the courts stand as guardian. The relevant principle is the equal worth and autonomy of every human being. This principle requires, as in the circumstances at bar, a procedure to ensure that a

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<sup>40</sup>*R. v. Oakes*, [1986] 1 S.C.R. 103, 26 D.L.R. (4th) 200.

<sup>41</sup>See the reasons for the decision of Wilson J. in the *Motor Vehicle Reference* (*supra* note 21). See also *R. v. Swain*, [1991] 1 S.C.R. 933 at 977, 5 C.R. (4th) 253, 63 C.C.C. (3d) 481 [herein-after *Swain* cited to S.C.R.], where Lamer C.J.C. stated that "societal interests are to be dealt with under s. 1 of the *Charter*", where the Crown bears the burden of proving justification, not under section 7.

<sup>42</sup>*Supra* note 5 at 590.

<sup>43</sup>Later, Sopinka J. stated that principles are fundamental when they "would have general acceptance among reasonable people" (*ibid.* at 607).

<sup>44</sup>*Ibid.* at 591.

<sup>45</sup>*Ibid.* at 592; Factum of Rodriguez, *supra* note 8 at 26ff.

disabled, dying person can assert the control over his or her body that his or her disease denies.<sup>46</sup>

The majority gave Ms Rodriguez's argument short shrift by omitting what her *factum*, following the *Motor Vehicle Reference*, proposed, namely that fundamental justice involves reference to an underlying legal rationale or principle. To rank as a principle of fundamental justice, a value must animate the legal system in a fundamental way. Ms Rodriguez's claim was that the Court should respond to her argument as a matter of justice to her, not on the basis of a legislative mandate to forward the good of society as a whole over time.

The majority judgment reverts at this juncture to the idea that societal consensus informs the principles of fundamental justice, describing the appropriate judicial function as one of balancing.<sup>47</sup> It also endorses the often concomitant standard of reasonableness and the tendency to defer to the majoritarian instruments of policy formation. These latter approaches deny the operation of rights guarantees as protection against majoritarian malevolence, ignorance or indifference.

The call for balancing precipitated a re-formulation of the test for conformity to the principles of fundamental justice:

The issue ... can be characterized as being whether the blanket prohibition on assisted suicide is arbitrary or unfair in that it is unrelated to the state's interest in protecting the vulnerable, and that it lacks a foundation in the legal tradition and societal beliefs which are said to be represented by the prohibition.<sup>48</sup>

Where one would expect a balancing test, the majority offers what is better described as a means-end test. The "end" stated here is both similar and dissimilar to the earlier statement of objectives. It is similar in its aim to protect the vulnerable. Instead of clearly positing the preservation of life as the second substantive value, however, this formulation is more diffuse. It describes as the second objective the advancement of the legal tradition and of the popular beliefs that are said to be represented by the prohibition. This is a broader statement because it widens the focus from a substantive value, the sanctity and inviolability of life, to include societal beliefs. Absent from the discussion is one of the common features of a means-end evaluation: the critical consideration of the

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<sup>46</sup>Factum of Rodriguez, *ibid.* at 13-15.

<sup>47</sup>Sopinka J. approved the approach La Forest J. adopted in several judgments, namely that the principles of fundamental justice are the product of balancing the interest of the State and the individual (*Rodriguez, supra* note 5 at 592-93). The main reference and quotation is to *Thomson Newspapers Ltd. v. Canada (Director of Investigation and Research)*, [1990] 1 S.C.R. 425 at 539, 76 C.R. (3d) 129, which refers back to *R. v. Lyons*, [1987] 2 S.C.R. 309 at 327, 61 C.R. (3d) 1, and *R. v. Beare*, [1988] 2 S.C.R. 387 at 402-403, [1989] 1 W.W.R. 97. Sopinka J. did not refer specifically, however, to Lamer C.J.C.'s statement in *Swain (supra* note 41 at 977) that balancing individual and societal interests is a section 1 consideration, not a section 7 question. It is not clear what Sopinka J. means by balancing. He stated elsewhere that "[a]n analysis of our legislative and social policy in this area is necessary in order to determine whether fundamental principles have evolved such that they conflict with the validity of the balancing of interests undertaken by Parliament" (*Rodriguez, ibid.* at 596). This formulation suggests that the courts are to balance what the legislature has already balanced, and the question is whether fundamental values, by which he means values supported by consensus, conflict with current legislation.

<sup>48</sup>*Rodriguez, ibid.* at 595.

State's purposes or their relationships with one another. Such an inquiry serves to distinguish legally informed statements of purpose from mere assertions. One would expect questions such as the following: Who are the "vulnerable"? In what way are they vulnerable? Are they actually or only potentially vulnerable? Are there different types and levels of vulnerability, some meriting more protection than others, or meriting different kinds of protection? May the State treat vulnerability as a single category or must it respect its variations? On what basis, *e.g.* expert opinion, factual record, personal testimony, does the Court recognize and apply the category? Is vulnerability a subjective or objective state? Must the State protect all the vulnerable in order to fulfil this purpose, or only some? May the State protect some at the expense of others? The reference to "legal tradition and societal beliefs" is no less puzzling than the reference to vulnerability. How do judges reliably ascertain the content of our "legal tradition and societal beliefs"? Is there a difference between legal tradition and societal beliefs? What if they do not, or no longer, coincide? What if our legal tradition, societal beliefs and/or concern for the vulnerable are inconsistent with the values entrenched in the *Charter*?

The new formulation increases the burden on the rights-claimant because its vague terms impose no appreciable constraint on government policy formation. How does a litigant establish that the impugned provision is "unrelated" to protecting the vulnerable? How does he or she demonstrate that the blanket prohibition "lacks a foundation" in, or fails to "represent", "legal tradition and societal beliefs"? These terms weaken the language of section 7, which speaks of *conformity*, not of relationship or representation, to the *principles of fundamental justice*, not to legal tradition and societal beliefs.

The balancing metaphor that precipitated the presentation of this test does not invite an evaluation of the merits of the opposed positions. Nowhere does the majority judgment quantify or compare the State's interest in protecting the vulnerable or in upholding societal beliefs with Ms Rodriguez's claim as a disabled and terminally ill person to seek medical care to terminate her life when it becomes intolerable.<sup>49</sup> Nor does the Court explain how or why it is better situated than Ms Rodriguez to quantify the value to her of a longer, increasingly more impaired life, leading to an uncertain time and manner of death, and to compare this with the prospect of enjoying stronger physical and emotional strength at the time of a planned earlier death, so that she can choose the human contacts with whom to share her last hours, make arrangements for her final comforts, and avoid anxiety as to what lies ahead. How are we to understand the Court's view that the State's general and abstract belief in the sanctity of all life — realized here by requiring complete debilitation, suffering and the uncertain timing and circumstances of a natural death — outweighs Ms Rodriguez's own evaluation?

The Court next considered the extent to which our culture and society regard life as an unmitigated good.<sup>50</sup> It found that, while reverence for life is not

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<sup>49</sup>Sopinka J. later concluded that a law that causes "suffering in certain cases" is "*preferable* to a law that might not adequately prevent abuse" (*ibid.* at 605 [emphasis added]).

<sup>50</sup>*Ibid.* at 595-605.

an absolute, our legal system reflects great respect for life. The Court found confirmation of this in the *Criminal Code* preclusion of consent to murder or violent acts, the absence of capital punishment, and the long history of the prohibition of suicide.

These examples are unpersuasive. The incapacity to consent to murder or bodily injury is only marginally relevant to the much narrower question of whether the terminally ill and disabled may, under the *Charter*, seek medical assistance to end their lives. The example ignores the long-standing tendency of legal systems to refrain from enforcing laws against murder in the context of mercy killing.<sup>51</sup> The capital punishment example is equally inapposite. Whether the State may *take* life as an authorized punishment against the will of the right-holder has nothing to do with Ms Rodriguez's desire to assert her autonomy by seeking an easier death than nature affords her.

The example of suicide is the most relevant and interesting. The long history of the prohibition of suicide, however, should not be taken as evidence of a legitimating consensus. Rather, it should bring to mind the fact that the particular political and religious ideas that originally informed the offence are inappropriate to a society under the *Charter*.<sup>52</sup> Moreover, as is the case with mercy killing, legal history demonstrates so persistent an aversion to punishing suicide and attempted suicide as to suggest the existence of a consensus to condemn generally but to exempt on an *ex post*, case-by-case basis. Paradoxically, Sopinka J. saw consensus in the offence but not in its repeal. He ascribed no normative significance to the decriminalization of suicide and preferred to understand it as the relegation of the issue to non-legal domains.<sup>53</sup> He acknow-

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<sup>51</sup>J.A. DiCamillo, "A Comparative Analysis of the Right to Die in the Netherlands and the United States after *Cruzan*: Reassessing the Right of Self Determination" (1992) 7 Am. U.J. Int'l. L. & Pol'y 807; Note, "Physician Responsibility and the Right to 'Death Care': The Call for Physician Assisted Suicide" (1993) 42 Drake L. Rev. 225 at 246-52; L.T. Nerland, "A Cry for Help: A Comparison of Voluntary Active Euthanasia Law" (1989) 13 Hastings Int'l & Comp. L. Rev. 115 at 117, 128; L.K. Altman, "Jury Declines to Indict a Doctor Who Said He Aided in a Suicide" *The New York Times* (27 July 1991) A1; P. Berkowitz, "Euthanasia Isn't Legal in Holland — But the Dutch Have Found a Working Compromise" *The Calgary Herald* (20 February 1994) B10.

<sup>52</sup>Suicide was proscribed to deter acts against God, nature and the King. It was considered a sin to interfere with divine prerogatives over life, death and suffering. The King, as divine ruler, needed living, productive subjects. There is historical evidence that prosecution and punishment were not considered appropriate in all circumstances. Coke, for example, took the view that an individual did not have the requisite *mens rea* if, *non compos mentis*, he killed himself "by the rage of sickness or infirmity." Blackstone called for mitigation by way of the King's pardon where mercy was appropriate. Coroners in the eighteenth century deemed "every one who kills himself ... *non compos* ... ; for it is said to be impossible that a man in his senses should do a thing so contrary to nature and all sense and reason." See T.J. Marzen *et al.*, "Suicide: A Constitutional Right?" (1985) 24 Duquesne L. Rev. 1 at 60-63.

<sup>53</sup>Sopinka J. took the view that there is no legislative or public consensus in favour of autonomy over the sanctity of life reflected in the decriminalization of suicide. He distinguished this measure from the partial decriminalization of abortion, which he suggested did reflect such a consensus. The legislative history of the exemption for therapeutic abortions, however, illustrates that it had as its motivation not recognition of the autonomy rights of pregnant women to end unwanted pregnancies, but the desire of doctors to be free from criminal sanction when they performed the abortions they deemed permissible. Pregnant women enjoyed no rights under the invalidated therapeutic abortion committee procedure, not even to have their application come up before a committee.

ledged no general trend to abandon religious-based restrictions on bodily autonomy or denials of individual dignity, which led to the repeal of the suicide prohibition. However, such a change in legal policy can be regarded only as a legislative determination that the principles that apply to instances of one person taking another's life do not apply to the taking of one's own life. To say that deterrence and/or punishment do not operate in the same way here is to say that the underlying moral understanding of the act of suicide is not the underlying moral understanding of a crime.

Even more relevant than the question of the law's past treatment of suicide is the current understanding that the offence of assisting suicide is inappropriate as applied to the circumstances that Ms Rodriguez brings forward. The Law Reform Commission of Canada, the American Law Institute and the Attorney General of Canada are unanimous on this point.<sup>54</sup>

#### 4. Common Law Rules as Exceptions to the Societal Consensus on the Sanctity of Life

In the context of its assessment of societal consensus, the majority next examined the common law cases relating to medical treatment in Canada, England and the United States.<sup>55</sup> These cases establish the right of a competent,

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See L.E. Weinrib, "The *Morgentaler* Judgment: Constitutional Rights, Legislative Intention, and Institutional Design" (1992) 42 U.T.L.J. 22. The autonomy rights of women were vindicated in the total invalidation, under the *Charter*, of the criminal abortion law by the Supreme Court of Canada in *Morgentaler* (*supra* note 21) — not by public opinion or by legislators. The public outcry after that decision was rendered would appear to demonstrate that there was no broad public consensus in favour of women's rights to abortion. The failure of a subsequent proposal to re-criminalize abortion due to a tie vote in the Senate suggests that legislators were not substantially committed to any such autonomy right either.

<sup>54</sup>In its 1982 Working Paper No. 28, entitled *Euthanasia, Aiding Suicide and Cessation of Treatment* ((Hull, Que.: Supply & Services Canada, 1982) at 53-54), the Law Reform Commission of Canada stated:

[T]he prohibition ... is not restricted solely to the case of the terminally ill patient, for whom we can only have sympathy, or solely to his physician or a member of his family who helps him to put an end to his suffering. The question is more general and applies to a variety of situations for which it is much more difficult to feel sympathy.

Examples might include duress exerted for self-interest, inducement to mass suicide, and undue influence on a suicidal adolescent.

The American Law Institute rejected a proposed defence of unselfish motive to a charge of assisted suicide but stated:

[I]n principle it would seem that the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request, of the suicide victim. On the other hand, [cases such as the one in which] a husband yielded to the urging of his incurably sick wife to provide her with the means of self-destruction, sorely test the resiliency of a principle that completely fails to take account of the claim for mitigation that such a circumstance presents (*Model Penal Code* § 210.5 (Official Draft and Revised Comments 1980)).

That the Attorney General of Canada subscribes to this understanding is evident from three statements in his *factum* indicating that section 241 is not directed at Ms Rodriguez's claim, but affects her "incidentally" or "indirectly" (*Factum of the Respondent, the Attorney General of Canada, in Rodriguez* at 11, paras. 22, 16, 32, 24, 47).

<sup>55</sup>*Supra* note 5 at 598-602.

otherwise healthy person to refuse treatment, even if death will ensue,<sup>56</sup> as well as the right of competent persons to require that doctors withdraw or discontinue treatment, not only in the context of terminal illness, but also where medical care or life support systems are necessary to sustain life but death is not imminent.<sup>57</sup> For patients who are not competent to exercise such rights, doctors turn to family members, to reliable evidence of the patient's likely preferences or to consideration of the patient's best interests. Courts have ordered termination of life support — including feeding and hydration, as well as medical treatment and life support systems — for patients in incurable, irreversible vegetative states, upon application by family members.<sup>58</sup> In addition, it is now acceptable palliative practice for doctors to administer drugs to the dying to reduce pain and suffering, even though the treatment may shorten life.<sup>59</sup>

The majority read the common law as honouring the sanctity of life “as a general principle” but for “limited and narrow *exceptions*” where “notions of personal autonomy and dignity must prevail.”<sup>60</sup> This arrangement of the general rule and its exceptions is startling. In *Morgentaler*, in contrast, the common law respect for personal autonomy and individual dignity in matters both physical and psychological informed both stages of the section 7 analysis, not as exceptions, but as paramount *Charter* values understood to be rooted in the common law.<sup>61</sup> Here we see the reverse, the common law providing counter-examples to what is described as the foundational value of our society. This finding of exceptionality seems inconsistent with the cases cited. For example, in the United States Supreme Court's decision in *Cruzan*, both the majority and the dissent recognized the *constitutional right* of the competent patient to refuse treatment and may have gone so far as to establish the incompetent patient's right to establish advance directives as to treatment.<sup>62</sup> The House of Lords decision in *Bland* determined that the prolongation of life through artificial nutrition and hydration was not beneficial to someone in a persistent vegetative, but not terminal, condition.<sup>63</sup> The reasoning in the decision makes clear that terminating

<sup>56</sup>*Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119, 100 D.L.R. (4th) 609; *Malette v. Shulman* (1990), 72 O.R. (2d) 417, 67 D.L.R. (4th) 321 (C.A.).

<sup>57</sup>*Nancy B. v. Hôtel-Dieu de Québec*, [1992] R.J.Q. 361, 86 D.L.R. (4th) 385 (Sup. Ct.).

<sup>58</sup>*Cruzan*, *supra* note 31; *Airedale N.H.S. Trust v. Bland*, [1993] 1 All E.R. 821, [1993] 2 W.L.R. 316 [hereinafter *Bland* cited to W.L.R.]. For the view that substituted consent and advance directives do not fulfil ideas of autonomy, see Kadish, *supra* note 1; N. Rhoden, “Litigating Life and Death” (1988) 102 Harv. L. Rev. 375 at 377:

[C]ourts, in their eagerness to couch nontreatment choices for incompetents within the familiar framework of patients' rights to refuse treatment, have stretched the concept of an incompetent's right to choose past its breaking point ... [In some cases,] although proxy decisions may humanely look to such concerns as the patient's interests or probable preferences, they do not, properly speaking, implement the patient's right to choose, because the patient has made no actual choice.

<sup>59</sup>Law Reform Commission of Canada, *Euthanasia, Aiding Suicide and Cessation of Treatment* (Report No. 20) (Hull, Que.: Supply & Services Canada, 1983) at 35.

<sup>60</sup>*Supra* note 5 at 605 [emphasis added].

<sup>61</sup>*Supra* note 21. See also Weinrib, *supra* note 53.

<sup>62</sup>*Supra* note 31.

<sup>63</sup>*Supra* note 58 at 367, Lord Goff:

[T]he fundamental principle is the principle of the sanctity of life ... [which] is not absolute ... We are concerned with circumstances in which it may be lawful to withhold

such life support, which meant certain death for Bland, was consistent with respect for the sanctity of life.<sup>64</sup>

A survey of world jurisprudence turns up only one judicial deliberation of assisted suicide under a rights-protecting instrument: a 1983 European Commission of Human Rights decision under the *European Convention for the Protection of Human Rights and Fundamental Freedoms*.<sup>65</sup> This was a case in which an individual who aided in a suicide claimed the protection of the right to privacy. The passage Sopinka J. quoted from the Commission decision makes clear that the State enjoys a "right" to "guard against the inevitable criminal abuses that would occur, in the absence of legislation, against the aiding and abetting of suicide," particularly with respect to those who are vulnerable due to age and infirmity.<sup>66</sup> He did not quote the following passage:

The Commission does not consider that the activity for which the applicant was convicted, namely aiding and abetting suicide, can be described as falling into the sphere of his private life ... While it might be thought to touch directly on the private lives of those who sought to commit suicide, it does not follow that the applicant's rights to privacy are involved.<sup>67</sup>

This qualification does not necessarily intimate a different result, but it does acknowledge the need for a different analysis when actual autonomy rights are in issue.

It is not difficult to understand why one cannot find more adjudication of claims for physician-assisted suicide. The cost of litigation, the limited time frame available, and the desire to shun publicity at the end of life militate against litigation. The European Court of Human Rights may, nevertheless, hear such a case in the future, on appeal from Spain.<sup>68</sup> The claim of a fifty-one year-old paraplegic to assisted suicide is currently before the Spanish Superior Court of Justice. The applicant is not terminally ill. He seeks assistance to die after twenty-six years of deliberation ever since the diving injury that broke his spine. His public statements echo those of Ms Rodriguez: "I feel like a slave to other people's consciences and ethics. My life is, after all, my own. ... [L]iberty is one

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from a patient medical treatment or care by means of which his life may be prolonged. But here too there is no absolute rule that the patient's life must be prolonged by such treatment or care, if available, regardless of the circumstances.

<sup>64</sup>Sopinka J.'s comments on *Bland* indicate that he read the case as one in which the "principle of the sanctity of life ... was ... not ... violated" (*supra* note 5 at 598).

<sup>65</sup>4 November 1950, Eur. T.S. 5, 213 U.N.T.S. 221; *X. v. United Kingdom* (No. 10083/82) (1983), 33 Eur. Comm. H.R. D.R. 270 at 272 [hereinafter *U.K.*], referred to in *Rodriguez, ibid.* at 602.

<sup>66</sup>*U.K., ibid.* at 272.

<sup>67</sup>*Ibid.* at 271 [emphasis added]. At issue was the protection of one's own private life under the *Convention, i.e.* to be secure in developing and fulfilling one's own personality, subject to the concerns of public life or other protected interests. The claimant was an accused who, as a member of a voluntary euthanasia association, introduced people who desired to kill themselves to his co-accused, who helped them to do so.

<sup>68</sup>The lower court ruled that courts have no duty to supplement or alter the Spanish legal system on the basis of constitutional claims to liberty, dignity and the development of the personality under the Spanish Constitution (R. Anguita, "No End in Court" *The [Manchester] Guardian* (8 March 1994) 16).

of the few things that gives life meaning."<sup>69</sup> Spanish polls, like Canadian polls reacting to Ms Rodriguez's situation, register that sixty-six per cent of the population supports the applicant's position.<sup>70</sup>

This case, combined with *Cruzan*, *Bland* and the Kevorkian prosecutions in the United States, suggests that modern medicine has thrust the issue of the right to die upon us in a host of varying contexts. The majority took comfort in the fact that no law against assisted suicide has been invalidated for infringing fundamental human rights.<sup>71</sup> Nonetheless, the legal issue still remains to be resolved on its merits.

##### 5. The General Prohibition or the Slippery Slope

After quoting the Law Reform Commission's observation that fear of excesses and abuses is the probable reason that assisted suicide for the terminally ill has not been decriminalized, Sopinka J. drew this conclusion about the significance of the potential for abuse:

[T]here is no certainty that abuses can be prevented by anything less than a complete prohibition. Creating an exception for the terminally ill might therefore frustrate the purpose of the legislation of protecting the vulnerable because adequate guidelines to control abuse are difficult or impossible to develop.<sup>72</sup>

According to Sopinka J., the inevitability of abuse precludes narrowing the offence to exclude assistance to the terminally ill. A narrower prohibition, intended and designed to apply only to a subset of cases meriting condemnation, would spill over to situations beyond the subset.

To support this view, Sopinka J. reviewed the legal arrangements in various Western democracies. He found no express legislative permission for assisted suicide; on the contrary, most countries have legislative restrictions at least as stringent as section 241.<sup>73</sup> This reference to other legal systems evinces more interest in examples of general condemnation than in more recent efforts to guard against abuse.

The majority thus mentioned, but had minimal regard for, efforts in other jurisdictions to avoid abuse through guidelines or through a more specific articulation of the criminal offence. The specific content of various sets of guidelines drew no analysis. (Unfortunately, there was no mention of the conditions set down by the Japanese High Court in 1963 for cases of mercy killing, which may have produced results different from those attributed to the Dutch guidelines.<sup>74</sup>) Similarly, no detailed attention was paid to efforts by Switzerland, Denmark and some American jurisdictions to provide more severe punishment in cases where there is evidence of coercion, force, duress, deception or self-interest.<sup>75</sup> In the

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<sup>69</sup>*Ibid.* See also text accompanying note 3.

<sup>70</sup>*Supra* note 12.

<sup>71</sup>*Supra* note 5 at 605.

<sup>72</sup>*Ibid.* at 601.

<sup>73</sup>*Ibid.* at 601-605. The countries canvassed: Austria, Spain, Italy, the United Kingdom, Australia, the Netherlands, Switzerland, Denmark and the United States.

<sup>74</sup>Nerland, *supra* note 51 at 131-32.

<sup>75</sup>Sopinka J. accepted the palliative care "exception" to the sanctity of life principle on the basis that intention provides a sound basis of distinction, even though there are difficulties of proof

majority's view, what is decisive is the fact that most Western democratic countries have not legalized assisted suicide. Consensus, this time of Western democracies, is the touchstone of a rights claim.<sup>76</sup>

Sopinka J. accepted as authoritative, literature tendered by the Attorney General of Canada that ascribes an increase in prohibited involuntary active euthanasia in the Netherlands to guidelines that set out the circumstances in which prosecution is inappropriate. Instead of considering the general features of Dutch culture, possible inadequacies in the guidelines or lax enforcement practices, Sopinka J. drew the conclusion that a narrower prohibition would take Canada down the same "slippery slope".<sup>77</sup>

It is surprising, given the emphasis in *R. v. Keegstra*<sup>78</sup> on the *Charter* as a post-war rights-protecting instrument, that the Court did not mention the slippery slope example most frequently cited in the literature — the Nazi "euthanasia" policy. This policy had nothing to do with euthanasia as the provision of a merciful death to the suffering terminally ill. From 1939 to 1945, the Nazis killed, on the authority of official rulings, approximately 100,000 mentally and physically disabled persons without the latter's consent or that of their next of kin. The killing did not promote the welfare of the individual but rather realized the destruction of life that was considered worthless to the State.<sup>79</sup>

The structure of slippery slope arguments renders them particularly inappropriate in *Charter* cases, especially in difficult cases lacking guidance from precedent. As *Rodriguez* shows, the slippery slope argument is characterized by the refusal to provide a more precise specification of what is unacceptable behaviour on the ground that the specification would lead to a wider incidence of the behaviour. This counter-intuitive conclusion results from substituting an oversimplified set of considerations for the full complexity of the specific problem.<sup>80</sup> Slippery slope arguments involve an "instant case", which is up for deci-

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(*supra* note 5 at 607). He also seems to have approved of the view that an exception to the assisted suicide prohibition for the terminally ill might lead to abuse because it would be difficult to determine the "true" motivation underlying the act (*ibid.* at 601).

<sup>76</sup>There are important methodological implications of this approach. There was no discussion of the existence of rights-protecting instruments, their specific terms or the institutional roles they dictate. Canada's *Charter* cannot provide rights protection that goes beyond the pattern of legislated policy in Western democracies.

<sup>77</sup>*Supra* note 5 at 603. No supporting material is cited. The Factum of the Attorney General of Canada sets out this argument with supporting material (*supra* note 54, para. 31). The Dutch compromise, worked out over 20 years — legal prohibition with judicial guidelines against prosecution — was to become part of parliamentary law in May 1994 (Berkowitz, *supra* note 51). Nerland (*supra* note 51 at 136-37) suggests that the distinctiveness of the Dutch situation has been attributed to the lack of religious opposition and "a Dutch dislike of wasteful spending." She also posits that the real difference may not be in policy or in behaviour, but in openness. This is an interesting point. It may well be that the criminal prohibition in Canada hides the incidence of assisted suicide, particularly in respect to the terminally ill. Without any data for Canada, it is not possible to pinpoint our place on the slippery slope, *i.e.* whether there is a problem to avoid or a problem to regulate.

<sup>78</sup>[1990] 3 S.C.R. 691, 1 C.R. (4th) 129.

<sup>79</sup>J. Noakes & G. Pridham, *Documents on Nazism, 1919-1945* (New York: Viking Press, 1975) at 613-15.

<sup>80</sup>See F. Schauer, "Slippery Slopes" (1985) 99 Harv. L. Rev. 360; J. Downie, "Voluntary Eutha-

sion, as well as a projected "danger case". Implicit in the argument is the non-problematic quality of the "instant case" if considered on its own merits.<sup>81</sup> The slippery slope designation means that the safe "instant case" is held hostage to the "danger case" that must be rejected.

In *Rodriguez*, the slippery slope thinking takes the following form. The current, stable position is a ban on all assisted suicide. The "instant case" is doctor-assisted suicide for competent, terminally ill, disabled persons who request it and undergo a rigorous pre-determination process. The "danger case" is involuntary active euthanasia.<sup>82</sup> The Court's desire to avoid the "danger case" led it to reject Ms Rodriguez's otherwise safe and justified claim.

The connection between the "instant case" at the top of the slope and the "danger case" at the bottom takes one of two forms, conceptual or pragmatic.<sup>83</sup> In the conceptual version, a particular resolution of the "instant case" compels an unacceptable result in the "danger case" because the two cases are deemed to be conceptually indistinguishable. In the pragmatic version, the "danger case" consists of a projected change in the way the world works.

Conceptual slippery slope arguments are often wrong because of this tendency to overestimate the strength of the conceptual connection between the two "cases". In trying to decide both "cases" at once, judges may give short shrift to the "instant case" and decide the "danger case" before it is ripe for decision. Because in advance it may seem a simplified monolith rather than the multifaceted set of nuances that it would present in the future, the "danger case" may give rise to exaggerated apprehensions. Moreover, because the "danger case" is not actually in issue, the factual, professional or theoretical resources necessary for its full comprehension may be unavailable. Finally, evaluation of the social, cultural and constitutional implications of the "danger case" may be inappropriate before the "instant case", decided on its own merits, has the opportunity to generate its own network of informed experiences and familiar understandings.

Examples from the past are illustrative. Many believed that permitting abortion in early pregnancy would *logically* necessitate the legalization of late abortions — even on the delivery table at the end of pregnancy — and infan-

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nasia in Canada" (1993) 14 Health L. in Can. 13 at 23ff; J. Rachels, "Medical Ethics and the Rule against Killing: Comments on Professor Hare's Paper" in S.F. Spicker & H.T. Engelhardt, Jr., eds., *Philosophical Medical Ethics: Its Nature and Significance* (Dordrecht, Neth.: D. Reidel, 1977) 63. The slippery slope characterization is such a frequent device in legal thinking that it manifests itself through a number of metaphors: the foot in the door, the thin edge of the wedge, the camel's nose in the tent (Schauer, *ibid.* at 361). The "instant case" and "danger case" nomenclature is well presented by Schauer (*ibid.* at 364ff).

<sup>81</sup>Schauer (*ibid.* at 368-69) says:

[A] slippery slope argument necessarily contains the *implicit concession* that the proposed resolution of the instant case is not itself troublesome. By focusing on the consequences for future cases, we implicitly concede that this instance is itself innocuous, or perhaps even desirable. If we felt otherwise, then we would not employ the slippery slope argument, but would rather claim much more simply that this case, in itself, is impermissible.

<sup>82</sup>*Supra* note 5 at 603.

<sup>83</sup>Downie, *supra* note 80 at 23ff; Rachels, *supra* note 80 at 65ff.

ticide.<sup>84</sup> The liberalization of abortion laws has not, however, had this effect. Similarly, some argued that *voluntary* passive euthanasia, *i.e.* permitting individuals to refuse or discontinue life-saving or life-sustaining treatment, would legitimate, first, *involuntary* passive euthanasia and, ultimately, *active* euthanasia — voluntary, non-voluntary (euthanasia without consent, *e.g.* of an unconscious person) and involuntary (euthanasia against the person's expressed will). Despite the earlier slippery slope claims, no one now takes the position that the common law acceptance of passive voluntary, and narrowly defined passive non-voluntary euthanasia, dictates, as a matter of logical consistency, acceptance of involuntary active euthanasia.<sup>85</sup> The fact that slippery slope arguments loom so much larger prospectively than retrospectively reveals their *in terrorem* quality.

As these examples illustrate, it is important to evaluate the strength of the conceptual tie between the two "cases" or, to continue the metaphor, the slipperiness of the slope. When the context is judicial and legislative law-making, the rules and distinctions available to break the connection — and thus impede the tendency to slide — are manifold and, if necessary, open to improvement on a step-by-step basis.<sup>86</sup> Accordingly, an additional "exception" — to use the Court's terminology — to the rule of the inviolability of life in the context of physician-assisted suicide, on the basis of autonomy and individual dignity, would invoke legal distinctions such as intent and informed consent, which safeguard the refusal of treatment and the provision of palliative care, and are now both firmly positioned on the slope.

The Court's slippery slope argument also includes pragmatic correlations of the "instant case" to future consequences. The reasons for judgment referred to the Dutch experience as illustrative of the undesired progression to uncontrolled involuntary euthanasia and the difficulty of discerning which acts are culpable on the basis of intent.<sup>87</sup> Also of concern is the possibility that guidelines might send a message that the State does not value life, a message that may encourage people to opt for suicide in borderline cases or for selfless reasons.<sup>88</sup>

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<sup>84</sup>Weinrib, *supra* note 53, n. 13.

<sup>85</sup>Permitting active voluntary euthanasia is not necessitated conceptually by the permissibility of voluntary passive euthanasia. Experience with passive euthanasia has, however, brought awareness of the terrible, painful deaths that people experience when they refuse or direct discontinuation of treatment or artificial feeding and hydration — deaths that impose great suffering on the dying as well as on their loved ones.

<sup>86</sup>"One major purpose of doctrine is to provide those very toeholds that keep us from sliding to the bottom of the slippery slope" (Schauer, *supra* note 80 at 362). For example, the rules might be very stringent and detailed until acceptable patterns of operation emerge.

<sup>87</sup>*Supra* note 5 at 603, 607.

<sup>88</sup>*Ibid.* at 608. There are other possibilities. There may be apprehension that one cannot establish or express sufficiently reliable distinctions between the two cases to ensure different results in future decision-making. Or one may hold the view, based on predictions about human behaviour, that giving the power to decision-makers to act in the non-problematic "instant case" will inexorably lead to decisions to act in the "danger case" as well, despite the formulation of adequate directives to the contrary. Projections of future action may involve human frailties — such as malevolence, ineptitude, inappropriate self-interest, duress — or what one would usually consider strengths, such as considerations of the public interest, large scale economies and allocation of limited resources to those who stand to benefit most.

The Court appears particularly apprehensive that, under assisted suicide guidelines, doctors will move from aiding the (voluntary) suicide of competent, terminally ill patients — as would be permissible — to performing (involuntary or nonvoluntary) homicide of, for example, the aged or mentally ill.<sup>89</sup> Such results might follow from deliberate flouting of the narrow prohibition, or they might reflect unwillingness or inability to deliberate reliably on questions of competence and consent or situations of undue influence or misplaced altruism. If the problem is activity in deliberate breach of the criminal law, then the solution is enforcement, not reluctance to change the law while maintaining the prohibition of the unwanted activity. If the other concerns have merit, then it would seem appropriate to set up a procedure to oversee decisions that relate to all medical treatment, not just to those that relate to ending life.<sup>90</sup>

The Court expressed concern that the State not send a message that it approves of suicide in certain circumstances, lest it encourage suicidal tendencies in individuals for whom “life is unbearable at a particular moment” or who feel that their continued existence imposes a burden on others.<sup>91</sup> Ms Rodriguez’s desired remedy would not necessarily have this effect. A demanding process would, when established, attract only serious applications, and the imposition of appropriate standards would soon send the message that the State honours autonomy in medical decision-making, most of all when the stakes are highest. It is possible that the availability of a formal process would precipitate conversations about death that would signal the need for assessment and care for reversible depressive illness and additional attention to comfort and pain-killing, not assisted suicide. The majority acknowledged that its rejection of Ms Rodriguez’s claim will produce “suffering in certain cases” but preferred to protect the vulnerable through the blanket prohibition.<sup>92</sup> Thus, Ms Rodriguez’s certain end-of-life suffering underwrites a possible future benefit which will accrue to others who will escape acts that would be breaches of professional responsibility and/or criminal law, regardless of whether she died a natural death or not. This preference highlights the significance of the designation of the terminally ill as “vulnerable”.<sup>93</sup> The *Charter* as a rights-protecting instrument has concern for the vulnerable members of society because their political voice is unlikely to be asserted or valued in the rush and tumble of political life. The legally competent and disabled terminally ill are unlikely — historically or currently — to have had input into the policy underlying the *Criminal Code* provisions in issue.

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<sup>89</sup>See Downie (*supra* note 80) for refutation of a fuller range of possible arguments under the “abuse” rubric: competence, voluntary request, abuses, risk of error, possibility of cure, delay, value of suffering, loss of hope, proper pain control, research for cures, palliative care, research, doctor as healer, trust in doctors and the Hippocratic oath.

<sup>90</sup>The majority’s views on future professional behaviour seem inconsistent with its earlier discussion of respect for life as the basic underpinning of Western society. If the judges are correct in their reading of the value structure of Canadian society and Western democracies at large, then the principle of the sanctity of life should dominate the thinking of medical professionals who shape our decision-making, purportedly in our best interests, in routine, as well as end-of-life, contexts.

<sup>91</sup>*Supra* note 5 at 608.

<sup>92</sup>*Ibid.* at 605.

<sup>93</sup>See text accompanying notes 22-24.

The majority was content to leave their marginalization and political powerlessness aside, and to treat its "vulnerable" classification as the occasion to privilege abstract values, at the cost of individual suffering.

The *Charter* text and case law suggest that Ms Rodriguez was entitled to justice in her own case, to criminal law prohibitions the formation and application of which express society's highest disapprobation, to medical care of the highest professional standards, and to evaluations of the costs and benefits of public policy that would not burden her in order to remedy lax enforcement of professional standards or criminal law. Instead, the Court offered her general and abstract social preferences, purportedly supported by wide-spread and long-standing consensus, in the name of avoiding abuse and preserving a public regard for the sanctity of life, both of which can be served in ways that do not impose particular suffering. To support this approach, the majority read the principles of fundamental justice as consensus-based social norms, regarded the common law as creating exceptions to the principle of the sanctity of life — not as honouring that value in the case-by-case elucidation of the autonomy rights of living people — and invoked slippery slope arguments to broaden its concerns beyond Ms Rodriguez's claim. In effect, the Court has substituted an open-ended legislative policy-making function for its mandate as legal guardian of the Constitution.

### III. *Rodriguez*, the Body and the Body Politic

The majority judgment in *Rodriguez* endorsed what it read as the social consensus represented in the impugned legislation and found no new consensus in Canada in support of assisted suicide in Ms Rodriguez's circumstances. It did not rely on current polls, which suggest otherwise, perhaps because such polls may not translate into votes in an election or in Parliament.<sup>94</sup> Its reading of the cultural mores embedded in the social and legal history of suicide law in Western democracies produces an abstract general respect for the sanctity of life, embodied in general laws against suicide and assisted suicide, and common law exceptions that respect individual autonomy in narrow circumstances, such as passive euthanasia and palliative care. It rejected the example of jurisdictions that have narrowed the criminal prohibition in prescribed circumstances to respond to the general sympathy evoked by the terrible circumstances at issue.

This understanding may be wrong. History and comparative study offer a different possibility, that the criminal law has long been regarded as inappropriate to such circumstances. While the majority correctly cited the predominance of general prohibitions of suicide in our legal tradition that apply in situations of grave illness and suffering at the end of life, it did not mention the equally long-standing tendency to relax the rigours of the general prohibition of suicide and its harsh penalties in individual cases involving grave illness, a tendency that culminated in the repeal of the offences of suicide and attempted suicide in

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<sup>94</sup>Recent voter initiatives to legalize physician-assisted suicide in Washington State and California won in the polls but lost at the ballot box (*supra* note 5 at 604-605).

most jurisdictions.<sup>95</sup> While the law books have provided a general prohibition, the legal system in operation has offered *ex post* relief in individual cases of "mercy killing" by doctors and family members, *e.g.* no charges are laid or prosecution is for lesser offences, acquittal or temporary insanity verdicts, token or suspended sentences.<sup>96</sup> This pattern, reproduced in many countries over significant periods of time, suggests that general moral condemnation against taking life tends to dissolve when prosecutors, judges and jurors deliberate upon actual cases of mercy killing by doctors and by family members.

The common law builds case by case upon the same understanding. In 1976, the United States Supreme Court's decision in *Quinlan* precipitated a legal and social revolution by establishing that family members could apply to have extraordinary life support systems withdrawn from a comatose but not terminally ill individual.<sup>97</sup> Since then, common law courts have elaborated the core value of individual dignity and autonomy in a host of cases, which are not usually understood, as the majority presents them, as departures from the commitment to the sanctity of life. On the contrary, these thoughtful judgments distil and apply this value in the real world of people's lives, including their deaths. Where the withdrawal of medical care and life support marked an earlier line, withdrawal now extends to nutrition and hydration, as well. Consultation with family members has now developed, often with legislative support, into reliance upon advance directives, living wills and designated substitute decision-makers. The reality of modern medicine is that most people die after some degree of negotiation as to the health care to be provided.

These legal arrangements are new because they reflect the extraordinary advances of modern medicine, which have transformed our experience of both life and death. In recent decades, modern medicine has demonstrated unprecedented capacity to intervene at moments of severe illness and injury — to cure, to repair and to maintain life long beyond nature's grant. We are just beginning to fully appreciate that extending life in this way exacts unexpected emotional, spiritual and physical costs, as well as great expense. The courts have responded by establishing that there is no requirement to prolong life in all circumstances, either by ordinary or extraordinary means, and have set out on a case-by-case basis the rules that match medical treatment to respect for human dignity and autonomy. There is no indication that this approach undercuts a prevailing consensus or expectation as to the sanctity of life. Many churches have contributed to and supported these developments.<sup>98</sup> While the question of medically assisted suicide divides many moral theorists, medical ethicists, and medical and legal experts, most people appear to fear a lack of control in end of life situations, which can lead to the provision of non-beneficial treatment and care and the undesired prolongation not of living but of dying.

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<sup>95</sup>See Marzen *et al.*, *supra* note 52.

<sup>96</sup>See *supra* note 51.

<sup>97</sup>*Matter of Quinlan*, 355 A.2d 647 (1976).

<sup>98</sup>See Y. Kamisar, "When Is There a Constitutional 'Right to Die'? When Is There *No* Constitutional 'Right to Live'?" (1991) 25 Georgia L. Rev. 1203 at 1214, recounting the success of G. Williams's suggestion, before the *Quinlan* decision, that proponents of euthanasia rely upon the Catholic distinctions between acts and omissions and ordinary and extraordinary treatment.

The public opinion polls in support of medically assisted suicide in Canada reflect a deepening awareness of the issue and increasing acceptance of active participation in advancing death in some circumstances.<sup>99</sup> Many people have personally experienced the deaths of relatives and friends in circumstances that they would not want to live through themselves. AIDS has riveted public attention on the politics of dying. There are indications that, as was the case with abortion in decades past, there is an underground network of information, access to experienced experts, and lists of co-operative doctors for those who seek aid to die. There are also indications that many family members and friends of the terminally ill are supporting and assisting those who want to die, in their homes, at the time of their choosing. Despite strong professional taboos and medical association disagreement, many doctors are beginning to speak out in favour of re-thinking their role at the end of life, and to recount instances in which it might have been appropriate to assist in ending a suffering patient's life. Polls, professional meetings and medical journals demonstrate an increasing willingness to debate the merits of assisted suicide as an acceptable alternative. In rare cases, doctors have publicly stated that they have assisted someone to die.

If the test for the constitutionality of public policy changes is public support — agreement among reasonable people — then legislative changes may well be in the offing in the foreseeable future. When the substantive issues are debated, there will be little guidance afforded by the Supreme Court of Canada's majority opinion in *Rodriguez*. In reading the *Charter* as sustaining broad public policy mandates based on consensus, the majority gave Parliament *carte blanche* in the eventuality of a revised consensus, and missed the opportunity to elaborate the substantive value that it described as inherent and intrinsic in our culture. The judges in the majority would likely have preferred that any legislative changes reflect the dignity and autonomy of every member of society, but in reading the *Charter* language as value-based rather than rights-based, and in exercising a legislative public policy mandate rather than building on the common law approaches, they have left the law-makers free to move forward on any basis upon which they can find public approval.

One hopes that Canadian parliamentarians will move forward on this issue with a richer view of their political role than the judges in the majority hold of their judicial role. There is ample indication in our legal system that the general prohibitions of suicide and assisted suicide have been relaxed in circumstances where the criminal process and sanction have been understood to lack respect for individual dignity and autonomy. In accepting Ms Rodriguez's claim, one is not necessarily approving suicide or diminishing our society's commitment to the sanctity of life. The social meaning of such a step depends on the process devised and the normative values it establishes and maintains. The transition to

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<sup>99</sup>*Toronto Star* columnist Tom Harpur, who writes on religious matters, advocates changes to the *Criminal Code* to permit the terminally ill and those with irreversible debilitating disease to obtain assisted suicide. He also states that Reform Party Leader Preston Manning and four other Calgary MPs have indicated that they will vote in favour of physician-assisted suicide, not as a reflection of their own views, but because of clear public support demonstrated during and after a town hall meeting (T. Harpur, "Ensuring We Each Have the 'Perfect End' We Want" *The Toronto Star* (8 May 1994) F9).

an *ex ante* deliberative process provides the opportunity to re-establish the idea that the dying are full members of the community, and that their lives, as diminished in enjoyment as they might be, are of the utmost value to the State.<sup>100</sup>

The legislators who deliberate on the question of permitting assisted suicide must resist the idea that consensus is the touchstone of their role. Questions of life and death are too important to leave to popular opinion, which may not be completely informed, especially when the medical system's potential demands on public resources are limitless. The path that makes the most sense of the legislative role under the *Charter* is to devise a process that carries forward the common law respect for individual physical autonomy for those who wish to meet a natural death, as well as for those who seek an individualized process to seek active control over the end of life.

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<sup>100</sup>Any process that authorizes suicide assistance must operate at the highest moral level of the medical profession, with fully articulated, documented expert opinion and under professional, administrative review. In addition, the deliberative process, unlike that of the abortion committees invalidated in *Morgentaler* (*supra* note 21), must allow applicant participation to the greatest extent possible, must be based on duly established and clear standards, and provide an accessible, expeditious and accountable process. The process must engage legal expertise but without precluding the poor and poorly educated.