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## The Private and Public Deaths of Sue Rodriguez

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Sue Rodriguez died on Saturday, February 12th, 1994. It was a private death. She spent her final moments surrounded by her friend, Svend Robinson,<sup>1</sup> and a physician. Her death was investigated by the RCMP as a physician-assisted suicide. Several months earlier, the Supreme Court of Canada had ruled, in a five to four decision, that the statutory provision criminalizing such an act was not in violation of the *Charter*.<sup>2</sup> When Sue Rodriguez died, her story appeared in almost every newspaper, as well as on every radio and television news broadcast in the country. The Minister of Justice commented that the time may finally have come for Parliament to consider the issues of physician-assisted suicide and euthanasia. It had become, indeed, a very public death.

Sue Rodriguez tried to accomplish two seemingly irreconcilable goals. She tried to live her personal life to the fullest while searching for meaning in the tragic context of her imminent and untimely death. She jealously guarded her family's privacy. There was no media circus surrounding her husband, child and friends. At the same time, she had decided to devote the last months of her life to a very public crusade. When Sue Rodriguez took her case to court, she changed the very nature of the decision-making process that might affect how she would live out her final days and how she would die. She tried to change the law of the land.

Critics and supporters alike wondered why Sue Rodriguez tried to turn a very private act into a very public one. After all, she could have accomplished much of what any dying person might wish for — the kind of "good death" optimally achieved through excellent palliative care — under existing laws. If she was so determined to go one step further and determine the exact moment and means of her death, she could have, in all likelihood, succeeded without exposing anyone to legal sanction. She could have simply kept the plan secret. According to Marilyn Seguin of the Toronto-based Death with Dignity Society, hundreds of Canadians do just that every year.<sup>3</sup>

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<sup>2</sup>*Rodriguez v. Canada (A.G.)*, [1993] 3 S.C.R. 519, (*sub nom. Rodriguez v. British Columbia (A.G.)*) 107 D.L.R. (4th) 342 [hereinafter *Rodriguez*].

<sup>3</sup>J. Kapica, "Jurists Asked to Overrule Disease" *The [Toronto] Globe and Mail* (4 December 1992) A1.

Few decisions about death are easy. Most of us will die in hospitals or other health care institutions. Relatively few will die quietly, gently, our physical symptoms palliated, our psyches and souls at peace, at home, surrounded by our friends and loved ones. Many of us will want to have some control, some say in the decisions regarding the circumstances surrounding our deaths. Every day, the families, friends, doctors and nurses of terminally ill, incompetent patients struggle with the decision of when and how to forego life-sustaining medical interventions. Should the patient be transferred to a palliative care ward, or should she receive yet another course of chemotherapy? Should a gastrostomy feeding tube be surgically inserted to maintain adequate nutrition, or should she gradually waste away as she eats less and less? Should the same feeding tube be removed when she becomes unresponsive? Will an intravenous solution prevent thirst and prolong life, or will it be a meaningless intervention that prolongs suffering? Will a higher dose of morphine be more effective in controlling pain, or will it contribute to shortening her life? Will resuscitation restore her to meaningful life in the event of cardiopulmonary arrest, will it condemn her to a more burdensome condition, or will it merely serve to inflict a final indignity?

For many of us who contemplate our own inevitable death or that of a loved one, the process of arriving at any of these decisions is often an agonizing one, fraught with doubts, uncertainty and second-guessing. Conflicting emotions of guilt, sadness and relief are played out against the competing perspectives of the patient, her family, friends and care-givers. The angst is as ubiquitous as the motive to do the best thing.

The nine Supreme Court justices also had a difficult time in their deliberations in the *Rodriguez* case. That very difficulty may be reflected in the closeness of the final five to four decision. Doubtless, the opinions of legal scholars, philosophers, theologians, journalists and other commentators on the case were also the result of serious contemplation. Yet, for all the obvious similarities involved in the process of making these decisions, the differences between the private decision of a dying patient surrounded by her family, friends and care-givers may be fundamentally, profoundly and irreconcilably different from that of social commentators, judges and legislators.

In the case of a dying patient, the intimate nature of the relationship with her family, friends and care-givers is reflected in the immediacy and degree of impact of any decision. The impact of Sue Rodriguez's death on her husband, her son, Svend Robinson and the physician who may have assisted her in her alleged suicide might be qualitatively different from the impact it had on the Minister of Justice, other lawmakers and the public at large.

Even the settings where private and public decisions about death are made are significantly different in tangible ways that are nevertheless difficult to articulate. Any parent who has accompanied a sick child to hospital to undergo unpleasant medical tests, procedures and therapies; any adult child who has stood uneasy vigil, day and night, by the bedside of a dying parent; anyone who has accompanied a best friend in an ambulance after a near-fatal accident, can attest to the immediate psychological, emotional and spiritual reality which cannot be recaptured or appreciated by even the most sensationalized media

accounts. Courtrooms, public auditoriums, the chambers of Parliament and the air waves may be remote and poor substitutes for the bedside of a dying patient as the appropriate place for making a decision on how that individual will die. Another basic difference between private and public decisions about death is the primary motive of the parties involved. The dying patient is usually concerned about her suffering, her dignity, respect for her autonomy, and the burden she might impose on her loved ones. The family, friends and care-givers are usually involved in a loving, caring, compassionate relationship. Their struggle is often between their instinct to protect the patient's life and the desire to respect her wishes to preserve at least a minimal standard of quality of life. Ultimately, their common goal is to promote her best interests. The lawmakers, in contrast, are entrusted with the mandate to protect the public, especially the interests of the most vulnerable members of society, and to uphold the principle of justice. Given the choice of serving the immediate interests of one individual or protecting the long-term interests of the collective, the latter goal would likely predominate.

The motives of politicians, special interest groups, self-appointed moral authorities and the media may be more suspect. Individuals or groups who are confident in their knowledge of the truth concerning the morality of assisted death are often eager to share, and occasionally impose their views on others. In the end, Sue Rodriguez had to battle not only the government, the Council of Catholic Bishops, the Pacific Physicians for Life, professional "ethicists" and the media, but she also felt compelled to distance herself from John Hofsess and the Right to Die Society. When Mr. Hofsess allegedly forged Ms Rodriguez's signature on a press release statement, she seemed as unwilling to become a pawn in his personal agenda for change as she was to accept the status quo. The media have occasionally appeared to work from a more shifting moral stance, manipulating particular aspects of such cases to fuel public interest and controversy in a deliberately selective fashion. Their primary motive to present current news in a prioritized fashion supersedes any interest to pursue the best interests of an individual or the collective.

When a terminally ill patient faces the range of difficult decisions that have to be made, she considers her own thoughts and feelings and often seeks the support of her family and friends — those directly and intimately involved in such decisions. As a group, they rarely have much experience, let alone any formal expertise in making such decisions. In the absence of formal techniques of mediation, conflict resolution and consensus building, the long-standing dynamics of the group will likely dictate how such decisions will be reached. There are significant drawbacks to this process. Even in the most loving, caring families, long-standing inter-personal dynamics may make consensus building a difficult process. Health care professionals often struggle to help previously dysfunctional families whose ability to cope with these responsibilities is further compromised by the existing crisis. Sometimes, the patient is no longer competent to make a decision. Occasionally, there are no family or friends involved. Faced with imminent death, patients and their families find it difficult to understand the facts and balance their emotional reactions with their intellectual reasoning. Nevertheless, everyone has an intimate knowledge of the situa-

tion, everyone tries to do what is best for the patient, and the degree of sensitivity to the specific dimensions of the individual case is as high as it can be.

The nurses and physicians caring for dying patients are involved in some aspects of this process. They are intimately involved, the facts of the case are directly accessible, and they are sensitive to the specific needs of the individual. Their primary obligation is to work in the patient's best interests. While they may not have had any specific training, they will, no doubt, have had considerable experience in contributing to such "clinical" judgments. Presumably, such experience enables them to balance the emotional and rational components of such decisions more effectively.

Most lawmakers have relatively little experience with decisions about death and dying. The nine justices of the Supreme Court most likely approached the issue from a rational, legalistic perspective. Any emotional or psychological biases they had might have stemmed from their own personal experience with the death of a loved one, as well as their religious beliefs or moral stances. Interestingly, while judges are professionals who "judge" for a living, there seems to be little, if any, formal training in this process. Are lawyers and judges specifically trained in logic and reasoning? Do they have special skills in how to balance the relevant emotional, psychological and rational components of a decision? Do they have a special talent for resolving moral dilemmas? Like the "clinical judgment" of experienced physicians, the "legal judgments" of judges are based on their experience in the area.

Nevertheless, their involvement in the case is more remote, indirect and impartial than that of the patient, her family, friends or physician. The complexity of such decisions in any given case might require a knowledge and appreciation which is inherently beyond the scope of "strangers". One of the most profound differences in the decision-making process in this particular case was that the judges had to balance the best interests of Sue Rodriguez against those of society and the State. Unlike the family and friends at Ms Rodriguez's bedside, the judges could not focus exclusively on her needs. The arguments presented in court were not exclusively specific and sensitive to Sue Rodriguez. The decision, in reality, was more categorical in nature and involved all citizens.

With her private death, Sue Rodriguez moved the issue of assisted death into the very political public domain. With Parliament considering the issue, there is a real possibility that the people most intimately involved — dying patients, their families, friends and care-givers — will be the least influential constituency in determining the outcome. Once the political process has been initiated, the rules of politics, not the ethics of patient-centred medicine, come into play. The most vocal, the most organized, the best financed and the most manipulative interest groups may be most likely to succeed. In the ensuing debate, the dynamics will not be that of open-minded consideration of the legitimate arguments on all sides of the issues. They will not be oriented to consensus building. More likely, they will facilitate the expression of polar extremes, much as has occurred in the abortion debate. Individuals and special interest groups on either side of the issue will proclaim, with absolute conviction, that their position is the only morally and legally acceptable one.

In a process more akin to a battle than reasoned ethical discourse, the egos and self-righteousness of the main proponents may be the primary source of the motives in attaining "victory". In such political debates, little effort is made to acknowledge the weak points in one's position and the legitimate strengths of the opposition. On the contrary, every effort is made to ignore or deflect legitimate questions and criticisms and focus exclusively on the Achilles heel of one's opponents. Arguments such as sanctity of life, quality of life, patient autonomy, and protection of the most vulnerable may be used selectively in a hypocritical fashion to further a cause. In the end, this process may transgress into the proceedings of the courtroom. Chief Justice McEachern of the British Columbia Court of Appeal, frustrated by such a dynamic, admonished the two lawyers in the *Rodriguez* case as resembling "two deaf people at a debate, not hearing what the other is saying."<sup>4</sup>

There is a real danger in leaving decisions about assisted death to the secret deliberations of a circumscribed group of individuals. Dysfunctional families with ulterior motives, morally corrupt physicians and nurses, and hospital administrators intent on cutting budget deficits could all contribute to the abuse of the vulnerable — the incompetent, overwhelmed or socially isolated dying patient. However, these dangers should be considered in light of the political agendas of individuals and groups most removed from the bedside of the dying patient.

The *private* death of Sue Rodriguez might have involved a compassionate, autonomy-respecting physician who would, with a deep sense of sadness and regret, assist her in her suicide. Such a physician might have acknowledged that while her physical pain was adequately palliated, her "suffering" could not be dealt with by any psychiatric or spiritual intervention, as it was premised on her strong conviction of what constituted personal dignity. Such a physician might even have found it impossible to participate in an assisted suicide, but would have found it difficult to judge another physician who could bring himself to help Ms Rodriguez.

The *public* death of Sue Rodriguez might have involved the same physician who would resist changing the current law under which no physician has yet been prosecuted. Significant changes to the law could potentially lead to significant abuses of vulnerable individuals and depreciate our fundamental respect for life.

Perhaps the private and public deaths of Sue Rodriguez are irreconcilable. The potential for abuse in her private death would normally have been vigilantly monitored by a caring family, friends, care-givers and community. In a society where such safeguards appear to be deteriorating, the law of strangers has replaced the love of friends. Perhaps judges and politicians in Ottawa do need to stand vigil over the bedsides of unseen and unknown citizens throughout the country. On the other hand, as former Canadian Prime Minister Pierre E. Trudeau once declared, the government has no business in the bedrooms of its cit-

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<sup>4</sup>D. Wilson, "Suicide a Social Problem, Not a Right, Court Told" *The [Toronto] Globe and Mail* (17 February 1993) A5.

izens. Perhaps the government has no business at the bedside of dying patients, unless there is no one else there to watch over them.

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